

---

Theses, Dissertations, and Projects

---

2010

**Winnicottian object relations and behavioral theory  
conceptualizations of difficult-to-treat binge-type eating disorders  
: proposal for a synthesized treatment approach through  
dialectical behavior therapy**

Christy Erin O'Brien  
*Smith College*

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

---

**Recommended Citation**

O'Brien, Christy Erin, "Winnicottian object relations and behavioral theory conceptualizations of difficult-to-treat binge-type eating disorders : proposal for a synthesized treatment approach through dialectical behavior therapy" (2010). Masters Thesis, Smith College, Northampton, MA.  
<https://scholarworks.smith.edu/theses/494>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact [scholarworks@smith.edu](mailto:scholarworks@smith.edu).

Christy O'Brien  
Winnicottian object relations  
and behavioral theoretical  
conceptualizations of  
difficult-to-treat binge-type  
eating disorders: Proposal for  
a synthesized treatment  
approach through dialectical  
behavior therapy

#### ABSTRACT

This theoretical investigation creates a unique conceptualization of difficult-to-treat binge-type eating disorders (DTTBTEs) based upon the synthesis of psychodynamic and behavioral theoretical perspectives of the disorder. More specifically, a Winnicottian object relations perspective is utilized to provide a framework identifying the manner in which early relational impingements that individuals with DTTBTEs often experienced in their earliest care-giving relationships and holding environments impacted their ability to internalize affect-regulating abilities and learn adaptive object relational practices to utilize throughout their lifetime. Such a conceptualization will articulate the early reliance on food as a maladaptive transitional object in its trajectory towards the eventual development of a binge-eating disorder. The second theoretical perspective, a behavior theory lens, is applied to better conceptualize how biological vulnerabilities, conditioning processes, and behavioral reinforcement over time all interact to participate in the development, addictive maintenance, and resistance to treatment in the disorder's lifespan. Together, these perspectives will be synthesized to

create an unique comprehensive evaluation of the phenomenon of DTTBTEDs, as well as to propose the utility that dialectical behavior therapy (DBT), a multi-modal treatment approach that amends affect dysregulation through a collaboration of skills-based behavioral treatments, relationally-based acceptance strategies, closely-allied psychotherapy, and interpersonal and behavioral coaching to target life- and therapy-interfering behaviors, can have in treating both the object relational deficits and the behavioral maladaptivities inherent in DTTBTEDs in an integrated way.

WINNICOTTIAN OBJECT RELATIONS AND BEHAVIORAL THEORETICAL  
CONCEPTUALIZATIONS OF DIFFICULT-TO-TREAT BINGE-TYPE EATING  
DISORDERS: PROPOSAL FOR A SYNTHESIZED TREATMENT APPROACH  
THROUGH DIALECTICAL BEHAVIOR THERAPY

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

Christy O'Brien

Smith College School for Social Work  
Northampton, Massachusetts 01063

2010

## ACKNOWLEDGMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to extend my gratitude to my research advisor, Edmund DeLaCour, Ph.D., for his attention to and supervision of the construction of a thesis topic that satisfied my deepest psychological curiosities, his deeply-rooted psychodynamic theoretical wisdoms, his patient review of each and every chapter, and for the numerous hours he likely spent reviewing my research.

I wish to extend my gratitude to my son, Matthew, for his patient witness to the process of this thesis's construction. I similarly wish to thank my family, friends, and closest loved ones for their support during the research and writing.

Finally, I wish to acknowledge the pain and suffering of those whose struggles have inspired this research. To those that have battled or are currently suffering with difficult-to-treat binge-type eating disorders, publicly or silently in our society, I dedicate this research.

## TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	ii
TABLE OF CONTENTS .....	iii
CHAPTERS	
I. INTRODUCTION .....	1
II. THE PHENOMENON .....	6
III. THEORY ONE .....	38
IV. THEORY TWO .....	88
V. DISCUSSION .....	142
REFERENCES .....	204

## CHAPTER ONE

### INTRODUCTION

As eating disorders began to reach epidemic proportions in certain populations in recent years [e.g., it is widely reported that between 1% and 3% of young women in the United States are reported to suffer from bulimia nervosa while another 3% to 5% evidence significantly disordered eating and weight concerns (e.g., Safer, Lock, & Courier, 2007; Safer, Telch, & Agras, 2001)], research has expanded in a variety of ways, as well. Eating disorders with similar presentations are being categorized together, differentiations between types of disorders are being expanded, and new sub-groups of disorders are emerging in the treatment and research communities. For instance, restricting-type eating disorders of the anorexia variety present in significantly different ways than most other forms of eating disordered behaviors, causing them to often be evaluated in the therapeutic communities and investigated in the research communities in categorically different ways. Correspondingly, individuals with bulimia and binge-eating disorder have become increasingly linked as a sub-group of eating disorders based on their similarities in presentation. Both diagnoses are linked by shared symptomatology, such as affect-regulating binge eating behavior, heightened impulsivity, lack of control, pronounced negative mood, persistent affective dysregulation, and often have co-occurring disorders, as well (e.g., Chen, et al., 2008; Telch, Agras, & Linehan, 2001; Wisniewski, Safer, & Chen, 2007). Moreover, individuals that present with bulimia and binge-eating disorder often evidence binge eating as a maladaptive emotion regulation technique, the absence of other adaptive affect regulation skills, and the perpetuation of additional binge behaviors in an attempt to cope with the shame and guilt that is

experienced as a result of their eating behaviors (Chen & Linehan, in press, Sanftner & Crowther, 1998 as cited in Wisniewski, Safer, & Chen, 2008). Importantly, it is the more recent conceptualization of the characteristics and behaviors commonly evidenced in some individuals with bulimia or binge-eating disorder as addictive that have brought new attention to this sub-group of individuals as significantly disordered and symptomatic (von Ranson & Cassin, 2007).

Eating disorder research and treatment communities are also rapidly identifying the commonly exhibited resistance to traditionally utilized forms of treatment as characteristic of a sub-group of some individuals within the bulimic and binge-eating disorder populations (Chen, et al., 2008; Telch, Agras, & Linehan, 2001). Where such methods as cognitive behavioral therapy (CBT) and interpersonal therapy (IPT), aimed at behavior change through thought change-driven work and talk therapy, have been found to be successful in treating individuals with AN (Bowers & Ansher, 2008), the treatments have been found to be ineffective for about 50% of individuals with bulimia and binge-eating disorder (Chen, et al., 2008; Fairburn, Marcus, & Wilson, 1993). As a result, the sub-grouping of bulimia and binge-eating disorder in the literature not only helps differentiate the disorders from the symptomology of other forms of disordered eating behavior, it also helps to identify a secondary sub-group based upon their differing treatment needs and calls attention to the need for the development of new treatment approaches. For the purposes of the present research, the sub-group of individuals with treatment resistant bulimia and binge-eating disorder will be identified as difficult-to-treat binge-type eating disorders (DTTBTEs). The next chapter will provide a more detailed definition of DTTBTEDs as a phenomenon.



Treating eating disorders, in general, has been widely identified as challenging, complex, and risky due to the potentially self-harming nature of the control strategies its victims tend to employ as a form of self-regulation and control (Levitt, 2005). However, finding new and more effective treatments for nearly half of the individuals with BN or BED that have been found to be unresponsive to individual implementations of either psychotherapy or CBT has become a challenge for researchers according to recent literature (Telch, Agras, & Linehan, 2001; Wisniewski, Safer, & Chen, 2007). As a result, the current study intends to present an expanded and more comprehensive understanding of the developmental and etiological components of DTTBTEDs that afflicted individuals commonly exhibit and that ultimately contribute to the disorder's difficult-to-treat nature. This will help identify the specificities of treatment needs and further propose correspondingly appropriate advanced treatment approaches.

The present research uses two theoretical applications with the phenomenon of DTTBTEDs in order to develop a new and more informed conceptualization of the specific disorder. A psychodynamic lens will be applied to a study of the disorder in order to gain an increased understanding of the developmental and early relational contributions that impact the development of DTTBTEDs. More specifically, Winnicottian object relational theory will provide a framework illuminating the manner in which early relational impingements that individuals with DTTBTEDs often suffer in their care-giving relationships and early holding environments impacts their ability to internalize affect-regulating abilities and learn adaptive object relational practices from their maternal objects to utilize throughout their lifetime. Such a conceptualization will articulate the early reliance on food as a maladaptive transitional object in its trajectory

towards the eventual development of a binge-eating disorder. The second theoretical perspective, a behavior theory lens, is applied to better conceptualize how biological vulnerabilities, conditioning, and behavioral reinforcement over time all interact to participate in the development, addictive maintenance, and resistance to treatment in the disorders' lifespan. Together, these perspectives will be synthesized to create a more comprehensive evaluation of the phenomenon of DTTBTEDs, as well as to highlight the proposed utility that a multi-modal treatment approach that can treat both the object relational deficits and the behavioral maladaptivities in an integrated way to more effectively treat these more severe and resistant disorders.

Dialectical behavior therapy (DBT), currently the most effective treatment modality for borderline personality disorder (BPD) – another complex and difficult-to-treat psychologically- and behaviorally-reinforced disorder, is a multi-modal treatment approach aimed at amending affect dysregulation through a collaboration of skills-based behavioral treatments, relationally-based acceptance strategies, closely-allied psychotherapy, and interpersonal and behavioral coaching in order to target life-threatening, therapy-interfering, and quality-of-life-interfering behaviors. Because of the similarities in development, etiology, and presentation of individuals with DTTBTEDs and individuals with BPD, as well as the empirically evidenced efficacy in treating the affective and behavioral dysregulation inherent in BPD, the present study aims to propose DBT's utility with DTTBTEDs based upon a newly synthesized conceptualization of the disorder. Moreover, the conceptualization will also function to highlight effective elements of DBT's object relational treatment abilities, in addition to the already

established efficacy of its behavioral treatment components, in ways that have not been evaluated or proposed in recent literature.

Valued tenets of good social work practice urge clinicians to “critically examine and keep current with emerging knowledge” in order to acquire an expertise in development of knowledge as a means of upholding the integrity of the profession and assuring that each client is treated with the most advanced and empirically effective treatments available (NASW, 1996, p. 22; SCSSW Mission Statement, 2003). Given these professional values coupled with the increasing amount of information available on the similarities of DTTBTEDs and their addictive qualities, further investigating their development, etiology, and presentation in order to devise the most comprehensive and most effective treatments to be made available in everyday clinical social work practice is a vital way to ensure that best practices are being implemented in order to effectively meet clients’ needs.

## CHAPTER TWO

### THE PHENOMENON: DIFFICULT-TO-TREAT BINGE-TYPE EATING DISORDERS

#### *Introduction*

Within the overall identified eating disordered population, there exist a variety of presentations of eating disordered cognitions and behavior patterns. The following chapter will not only introduce each of the different types and provide the necessary definitions to be utilized throughout the remainder of the study, but it will also differentiate the various disorders from one another and identify important distinctions between different groupings of behaviors. More specifically restrictive-type eating behaviors, like those characteristically seen in anorexia nervosa, often stand in sharp contrast to the presentation of a binge-type eating disorder, a set of behaviors characterized by a chronic over-consumption of and lack of control around food. Within the binge-type eating disorder group, including individuals that present with binge eating disorders and bulimia, a sub-group will be identified, one that is characteristically resistant to traditionally utilized forms of treatment, has a longer natural course of active behaviors, and typically presents with more addictive-type behaviors. This group, termed *difficult to treat binge-type eating disorders* (DTTBTEs) for the purposes of this study, will be the focus of theoretical investigations throughout the paper.

#### *Eating Disorders Defined*

An eating disorder (ED) has been defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) as severe disturbances in eating behavior, usually involving “extreme forms of eating

behavior accompanied by an excessive dependence upon weight and shape as a means of self evaluation” (Wisniewski, Safer, & Chen, 2007, p.174). Individuals with EDs typically suffer difficulties in both physical and mental health in ways that generally become life inhibiting (Wisniewski, Safer, & Chen). Disturbances in the perception of body shape and weight and obsessive thoughts about food, exercise, and body image are some characteristic cognitive distortions suffered by individuals within the range of eating disorders (DSM-IV). Dramatic weight loss or emaciation, amenorrhea for postmenarcheal females, weakened bones, anemia, dehydration, cardiac arrhythmias, dental problems, electrolyte abnormalities, and dramatic weight gain or obesity are some of the common physical effects suffered depending on the type of behaviors one engages in (DSM-IV). The DSM-IV diversifies all EDs into several separate categories: *Anorexia Nervosa* (AN), *Bulimia Nervosa* (BN), and *Eating Disorder Not Otherwise Specified* (EDNOS).

#### *Anorexia Nervosa (AN)*

According to the DSM-IV, an individual with AN meet four specific criteria for the disorder: a refusal to maintain their body weight above a minimally normal weight for age and height, fear of gaining weight, a disturbance in the way their body is experienced, and amenorrhea. When the eating disordered individual intentionally reduces and maintains a weight below 85% of that considered normal for their age and height according the Metropolitan Life Insurance tables or pediatric growth charts or have a calculated body mass index equal or below 17.5 kg/m<sup>2</sup>, an individual is clinically considered to be participating in weight reducing behaviors that are defined as anorexic (DSM-IV). Despite often being underweight, individuals with AN also display “an

intense fear of gaining weight or becoming fat” (DSM-IV, p. 598). Cognitive distortions around their body image, a heightened influence of body weight on their self-evaluation, and a denial of the seriousness of their low weight and physical health are all also important diagnostic criteria of AN (DSM-IV). Finally, for females, and specifically females that are postmenarcheal, the absence of their menstrual cycle for three consecutive months is the final criteria that, when combined with the three previous, equate a diagnosis of AN. In order to achieve such criteria, individuals with AN typically present in one of two different types of the disorder: “*restricting type*,” or restrictive behaviors that do not include any binge-eating or purging behaviors, or “*binge-eating/purging type*,” or where the individual has engaged in binge-eating and purging behaviors during the course of an AN diagnosis (DSM-IV, p. 589).

AN is characteristically more prevalent in industrialized societies, such as the United States, Canada, Europe, Australia, Japan, New Zealand, and South Africa, where there are ample quantities of food and where being considered attractive has been linked to being thin (DSM-IV, p. 587). AN’s presentation is largely associated with women, and “the prevalence of AN among males is approximately one-tenth that among females” (DSM-IV, p. 587). The diagnostic features and behaviors typically present in mid- to late adolescence, although the course and outcome are highly variable. “Some individuals with AN recover fully after a single episode, some exhibit a fluctuating pattern of weight gain followed by relapse, and others experience a chronically deteriorating course of the illness over many years” (DSM-IV, p.587). Hospitalization or intensive outpatient treatment programs are often required for individuals that need to restore weight or

participate in a re-feeding process, to “address fluid and electrolyte imbalances,” or to teach nutrition or improved eating behaviors (DSM-IV, p. 588).

Recent etiological definitions of eating disorders like AN describe disturbances in beliefs, cognitions, and behaviors around food and bodies to stem from an intersection of biological, psychological, and social factors. Biological evidence for anorexia stems largely from research on familial patterns of the disorder. The DSM-IV indicates that researchers have found significantly higher rates of AN among first-degree biological relatives of individuals with the disorder and an increased rate of AN between monozygotic twins than between dizygotic twins.

Psychological factors that contribute to the development of AN have been found in deficits in early object relations of individuals, usually within the family of origin, ego functioning, body image, and personality development (Lane, 2007). For many, the development is best understood as relating to the process of separation and differentiation from early objects and the struggle to achieve separateness and individuality (Lane). “Such problems may involve the enmeshment of mother and daughter, so that boundaries are blurred and self-other differentiation is often confused. The child views herself as an extension of the mother, revealing both severe dependency on her, while desperately attempting to separate from her, wanting no similarities to her, particularly her narcissism” (Lane, pp. 135-136). The child’s experience of the relationship with a maternal figure that is “smothering, overwhelming, and annihilating” is argued to cause the experience of maternal care as “punitive and prohibitive” during separation. As a result, the individual ultimately develops an intolerance of one’s own affects during the process in an attempt to stabilize the maternal-child relationship. They exhibit self-

punishing and self-controlling attitudes towards the expression of their affect and tend to only allow their emotional expression to funnel more discretely through inner conflicts through the body (Lane). As a result, anorexic efforts can range from vengeful efforts to punish the mother in hopes of separation to frantic attempts to prevent individuation by creating a continued reliance on the mother. As the identified food provider, the mother is thought to be appeased to maintain connection through their child's self-starvation, one that requires dramatic and unremitting attention through a focus on feeding (Lane).

AN behaviors also provide other features that are often used in service of the self. For instance, AN "gives [the individual] control over bodily functions and turns the passive into the active," such as mastery over anal functions and control through oppositional behavior (Cross, 1993 in Lane, 2007, p. 136). Friedman and Tolman (2007) assert that it is important to evaluate AN within the frame of self-mutilative disorders. Friedman and Tolman highlight Suyemoto's (1998) definition of self-mutilation, described as a "direct, socially unacceptable behavior directed toward a malevolent internalized object," as fitting to AN's series of self-damaging behaviors often etiologically designed to aggressively control the self's relationship with the maternal object (p.152).

Others see AN as a refusal or inability to meet the demands of puberty and sexuality with a resulting defensive strategy of reverting back to reliance on the maternal object. Individuals with restrictive eating patterns, thinned-out bodies, and amenorrhea may be enacting an impasse during the puberty phase of development in order to prevent separation and create continued reliance on the maternal object by attempting to maintain a more child-like body (Chasseguet-Smirgel, 1995 in Lane, 2007). Many then understand



the formation of AN as a result of fear of loss of control over sexual and aggressive conflicts as expressions of the difficulty in separation/individuation that ultimately lead to defensive regression of the individual to behaviors characteristic of the oral and anal phases of development.

Finally, social factors that contribute to the occurrence of AN have been found to relate largely to the co-occurrence in industrialized nations of an abundance of food with a simultaneous social pressure to maintain a thin body (DSM-IV). “Immigrants from cultures in which the disorder is rare who emigrate to cultures in which the disorder is more prevalent may develop Anorexia Nervosa as thin-body ideals are assimilated” (p. 587). As popular mass media has continued to promote the association of thinness with beauty and success, so too have the increased rates of AN incidence in recent decades (DSM-IV).

#### *Bulimia Nervosa (BN)*

*Bulimia nervosa* (BN) is characterized by the coupling of recurrent episodes of *binge eating* and inappropriate *compensatory behaviors* to prevent weight gain. *Binge eating* is characterized by consuming larger than average amounts of food in a discrete period of time coupled with a sense of lack of control over eating. It is thought to begin “when a person turns toward food for comfort, relaxation, and escape” and provides temporary relief to problems such as “fear, frustration, rage and emotional pain” (Chassler, 1998, p. 398). It often also includes eating rapidly, until uncomfortably full, when not hungry, and in secrecy due to embarrassment. “An episode may or may not be planned in advance and is usually (but not always) characterized by rapid consumption” (DSM-IV, p.590). Additionally, binge eating is often characterized by a lack of control, a

“frenzied” eating state, and dissociative features during the episode (DSM-IV, p. 590). Like AN, individuals with BN place intense emphasis on body image in self-evaluation processes. Marked distress, including depression, and feelings of guilt and disgust, typically follow binge behavior (Fairburn & Wilson, 1993). As a result, *inappropriate compensatory behaviors* are implemented to prevent weight gain and alleviate guilt. They often include “self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise” (DSM-IV, p. 594). The binge eating and inappropriate compensatory behaviors need only occur together at least twice a week for a period of three months before official clinical diagnosis can be made. However, studies indicate that the frequency of binge eating can vary from two or three times to upwards of 14 times a day with a consumption of up to twenty thousand or more calories (Chassler, 1998).

BN can occur in two different sub-types: *purging type*, where compensatory behaviors is in the form of self-induced vomiting or the misuse of laxatives, diuretics, or enemas; or, *non-purging type*, defined by the implementation of fasting or excessive exercise as inappropriate compensatory behaviors (DSM-IV). Characteristically, individuals with BN experience shame around their disordered eating patterns, causing bingeing and inappropriate compensatory behaviors to generally occur as secretly as possible. Eight to ninety percent of individuals with BN who present for treatment at eating disorder clinics reportedly utilize self-induced vomiting as their inappropriate compensatory behavior, and the one most often utilized in order to prevent weight gain (DSM-IV).

Also like AN, BN also occurs in most of the previously mentioned industrialized nations. Individuals with BN in the United States have been largely found to be Caucasian, and 90% of those in clinic settings are female. Some research indicates that the prevalence of BN is between five and ten times that of AN (Chassler, 1998), and is currently evidenced to be around 1%-3% of community samples (Hoek & van Hoeken, 2003 as cited in Wilson, Grilo, & Vitousek, 2007). It usually begins in late adolescence or in early adult life, some suggesting that the disorder is often enacted when individuals are leaving the childhood home (Brush & Lane, 2007). Purging behavior may occur anywhere from one to three years after bingeing behavior begins (Brush & Lane). One study of 499 of women found that binge eating occurred for 5.2 years, and vomiting for 4.5 years (Schlesier-Stropp, 1984). “The course may be chronic or intermittent, with periods of remission alternating with recurrences of binge eating” (DSM-IV, p. 593). The mean duration of the illness, however, has been found to be as much as six or seven years (Brush & Lane). The quantity of binge/purge episodes can also range widely, reportedly from once or twice a week to upwards of twenty times a day (Brush & Lane). Finally, remission is commonly fleeting and relapse is common (Wilson, Grilo, & Vitousek).

Many individuals with BN are within a normal weight range, some slightly underweight and some slightly overweight. Those individuals that are actively bingeing and purging often restrict their caloric consumption in their between-binge meals, likely to manage weight and prevent triggering a binge. Many individuals also comorbidly express depressive symptoms, mood disorders, and an increased frequency of anxiety symptoms, many of which all reduce when the disordered behavior is reduced. Many individuals with BN also meet the criteria for personality disorders, most frequently

borderline personality disorder. And, notably, the prevalence of substance abuse or dependence among individuals with BN is at least 30% (DSM-IV).

Because binge/purge behaviors have the ability to serve a variety of biological, interpersonal, and intrapsychic functions the episodes can often take on cyclical and addictive qualities. Research has shown over the years that those with BN assert that binge eating satisfies a psychological craving in order to regulate moods, reduce depression, reduce anxiety, or cope with stress (Wilson, 1993). Although binge eating may temporarily alter psychological states in ways that are experienced as effective, the aftermath typically also causes intense guilt, fear of gaining weight, and shame surrounding loss of control of their behavior. These feelings often trigger a purge event, further guilt and affective dysregulation, and eventually another binge event. Some argue that binges are triggered for some individuals by a physical sensitivity or a biological vulnerability to certain foods, such as sugar and flour. Consumption of these foods has arguably caused chemical craving, loss of control, and dependence (Wilson). Strict dieting between binge/purge episodes, for instance, is often used for psychological reasons, such as elevating low mood or self-esteem following a binge. The biological factors, however, that result from reduced nutrition cause a feeling of deprivation and often trigger another binge episode. Thus, the cycle is one that becomes difficult to break (Wardle and Beinart, 1981 as cited in Brush & Lane, 2007). Vigorous exercise following a binge, intended to prevent weight gain, defend against depression, serve as a masochistic self-punishment, or to expel anxiety, can also create similar cycles of behavior based on similar biological triggers (Brush & Lane).

“Proponents of an addiction model of eating disorders believe bulimia nervosa may be functionally interchangeable with other forms of addiction (von Ramson & Cassin, 2007). Research has focused on similarities of drug and alcohol addiction with binge-type eating disordered behavior to far more than with restrictive-type disorders. This, arguably, reflects “an emphasis on the symptom of loss of control of eating rather than on the compulsive dieting that occurs in restricting” (Von Ramson & Cassin, p. 16). Similarities between binge-type eating disorders and substance abuse have been identified as

“preoccupation with thoughts about the substance, craving for the substance, a repeated urge to use the substance, impairment of social and physical functioning, continued use of the substance despite adverse consequences, loss of control, repeated attempts to stop using the substance, mounting tension until the substance is used, guilt following use of the substance, gradual return of the urge and tension, and use of the substance to temporarily regulate emotions and relieve negative affect (Gold, Frost-Pineda, and Jacobs, 2003; Marks, 1990a; Walters, 1999; Wilson, 1991; Wilson 2000 as cited in von Ramson & Cassin, p. 16).

Binge eaters often report eating in response to emotional stress, then experiencing guilt, which could lead to compensatory behaviors and/or negative affect and further binge eating. The same cyclical pattern of psychologically- and biologically-driven addictive behavior espoused by those with substance addiction is also highly evident in the behaviors of binge-type eating disorders, as well (von Ramson & Cassin).

Active BN behaviors can have a severe impact on overall mental health and debilitating effect on daily functioning. After a binge/purge episode, feelings of “disparaging self-criticism and depressed mood” generally follow (DSM-IV, p. 590). In an effort to elevate lowered self-esteem, many will again engage in uncontrollable eating and engage in the binge/purge episode again, creating a vicious and repetitive cycle

(Brush & Lane, 2007). Physical ailments are inevitable with frequent binge/vomiting behavior. Laboratory findings have identified serious fluid and electrolyte abnormalities which can create life-threatening conditions, such as cardiac arrhythmias and kidney failure. Other dangerous medical complications include urinary infections, epileptic seizures, swollen salivary glands, and gastrointestinal problems, such as a ruptured stomach or esophagus (Chassler, 1998; DSM-IV). Dental problems include the permanent loss of enamel, tooth softness and chipping, and increases in cavities. Salivary glands become enlarged, calluses form on the tops of hands, cardiac and skeletal myopathies are also common. Menstrual irregularity or amenorrhea occurs occasionally with females with BN, caused in response to either “weight fluctuations, nutritional deficiencies, or to emotional distress” (DSM-IV, p. 592). Overuse of laxatives could cause bowel dependence.

Etiologically, it is believed that BN emerges out of a variety of biopsychosocial contributors, including “biological predisposition, intrapsychic conflict, family, social factors, disturbed interpersonal relationships, interpersonal sensitivity, and social isolation” (Chassler, p. 399). Research on biological components of the development of BN has indicated there to be a likely genetic predisposition through research of first-degree family members (DSM-IV). Biological relatives of individuals with BN have been found to have significantly higher rates of BN, mood disorders, and substance abuse and dependence disorders than those not biologically related (DSM-IV).

Significant research has been evaluated on the impact of the family environment of individuals that develop BN. Many of their family systems have been repeatedly described as “disengaged, chaotic, and neglectful [where] conflict and hostility are

apparent, but open expression of this conflict is not encouraged” (Chassler, p. 399).

Transgenerational studies of families with a member who is actively bulimic indicate that there are also typically developmental deficits and difficulties with interpersonal interactions that are intergenerationally transmitted (Chassler). As a result, families and family members are disengaged and isolated. Often, the bulimic uses food “to compensate for the lack of early nurturance provided to her by her parents during childhood . . . the bulimic repetitively turns to food in a futile effort to meet the need for nurturance, never having had a nurturing mother with whom to internalize and identify” (Sands, 1991 in Brush & Lane, 2007, p.58). Additionally, individuation problems also result from an inability to effectively separate from the mother, and likely one that does not provide her child with a sense of individuality. In general, “bulimic families tend to be characterized by conflict, poor boundaries, ineffective expression of emotion, and poor communication” often preventing the ability to internalize intrapersonal and interpersonal coping skills in their children (Brush & Lane, p. 59). Additionally, there is an often identified lack of sufficient mirroring on the part of mothers to their daughters needs. Eating, then often takes on a form of affect regulation and punishment. Brenner (1983) identifies the bulimic’s struggle between needing and the anger which stems from her dependency is re-enacted with food. Bodily manifestations can express the feelings the bulimic individual likely needs to process around their maternal object and impasse at separation and individuation. “The cycle of bingeing and purging is an attempt to fill up underlying feelings of emptiness and an attempt to restore autonomy and separateness by expelling, rejecting, and undoing what was perceived as ‘needy’ and gratifying behavior” (Brush & Lane, 2007). However, because food cannot be psychologically internalized for

its nurturing qualities, the ability to nurture oneself never is learned or achieved through bingeing.

Eating disorder research has also identified various social factors that have a significant impact on the development of BN. Striegel-Moore (1993) asserts that contemporary western cultures' female sex-role stereotypes call on women to espouse beauty and thinness as a central part of being "more feminine," "more socially skilled," and more attractive and desirable in heterosexual relationships than those that are heavier (pp. 147-148). When amplified through the mass media, "highly attractive women" have definitively become only the young and thin, with very few exceptions (p. 148). As a result, strong relationships between women's eating behavior and perceived femininity have been identified (Rolls, Gedoroff, & Guthrie, 1991 as cited in Striegel-Moore). For example, one study found that women who ate smaller-sized meals were viewed significantly more feminine than women who reportedly had eaten larger-sized meals (Chaiken & Pilner, 1987 as cited in Striegel-Moore). Another study by the same authors found that women indicated that they would eat less in a social setting to project a more desirable image than they would under other circumstances where social expectations were not as important (Pliner & Chaiken, 1990 as cited in Striegel-Moore). Thus, not only has the relationship between thinness, food, and social expectations been found to exist, but it has become so ingrained as to affect women's social strategizing.

Evidently, the pressures to meet societal expectations of femininity have the ability to have a considerable impact on women's eating behaviors. Moreover, those with "identity deficits" are argued to be more susceptible to social influences (Striegel-Moore, p. 151). Because of early invalidating environments, the impaired psychological



development of an individual en route to developing a binge-type eating disorder is arguably more conscious about how they are perceived by others, how they want to be perceived, and ultimately desire to be validated by larger society for being thin, if not by their early caretakers. However, “for most girls, the contemporary beauty ideal is biologically unattainable. Efforts to create an adequate self by pursuing an adequate physical self are doomed to failure and are likely to result in a vicious cycle” (p. 151). Alternating between restrictive behaviors to meet societal feminine ideals and biologically-driven need to eat seems to contribute to the binge-style eating behaviors characteristic in BN.

*Eating Disorders Not Otherwise Specified (EDNOS) and Binge Eating Disorder (BED)*

*Eating disorders not otherwise specified (ENDOS)* includes individuals with extreme eating behaviors that may fail to meet the diagnostic criteria for AN or BN. Some individuals may display severely restrictive disordered eating patterns but continue to experience regular menses. Others may meet criteria for BN, but engage in binge/purge behaviors less than twice a week for less than three months (Fairburn & Wilson, 1993; DSM-IV). Some chew and spit out food, some engage in inappropriate compensatory behaviors after eating small amounts of food (DSM-IV).

Most individuals in the EDNOS category meet the requirements of Binge Eating Disorder (BED), or binge eating in the absence of compensatory behaviors seen in BN (DSM-IV, 1994). BED “involves persistent and frequent episodes of uncontrollable binge eating in the absence of regular compensatory behaviors” (Telch, Agras, & Linehan, 2001, p. 1061). Binge eating, or consuming in a short period of time “an amount of food that is definitely larger than most people would eat during a similar period of time and

under similar circumstances,” is the characteristic feature of the disorder (DSM-IV, p. 595). The assumption that is important in both BED’s diagnosis and treatment is that there is a loss of control over eating patterns that results in behaviors that become psychologically pleasing but also physically destructive. The proposed criteria for diagnosis also prescribes that the behavior needs to occur approximately two days a week for a minimum of six consecutive months (Safer, Telch, & Chen, 2009).

It is reported that about 2-5% of the general population suffers from BED (Safer, Telch, & Chen, 2009). It is statistically more prevalent in women and typically onsets during late adolescence, and often around 18 years-old (Striegel-Moore, 1993). Many individuals that develop BED have been found to develop the binge-type eating disorder after prolonged dieting due to weight and body image dissatisfaction (Striegel-Moore). “Although some people with BED have normal weight, people meeting criteria for BED are more likely to be overweight or obese” (Safer, Telch, & Chen, p. 6). In fact, those often diagnosed with the disorder are discovered when they present for treatment for weight control, undergoing bariatric surgery, and among members of Overeaters Anonymous, a twelve-step addiction social support group (Safer, Telch, & Chen).

Most of the biological, psychological, and social factors that intersect to contribute to the development of BN are the same or similar for individuals with BED. For instance, many assert that one of the main factors in the etiology of binge-type eating behaviors is the occurrence of a family history of a similar eating disorder (Fairburn, Hay & Welch, 1993). Other biological factors that contribute to BED include biological defenses against weight loss beyond a body’s desired weight set point, caloric

deprivation, and, genetic risk for developing affective disorders (Polivy & Herman, 1993).

Binge eating behaviors are also said to emerge out of the desire to escape awareness of negative emotional states or stress (Striegel-Moore, 1993). Stress and negative mood were found to be the most frequently identified precipitants to binge eating (Polivy & Herman, 1993). In fact, although biological/nutritional deprivation has been positively correlated to the onset of binge eating behaviors, researchers in an experimental study found that binges of individuals with BED were more significantly associated with negative mood rather than caloric deprivation (Agras & Telch, 1998 as cited in Safer, Telch, & Agras, 2001). Clearly, the ability to tolerate negative mood states is more difficult for the binge eater to bear than the consequences associated with binge behaviors.

Binge eating in response to negative mood states indicates that individuals with BED likely suffer from the same deficits in affect regulation as individuals with BN. Whiteside and colleagues (2007) found the disordered eating behaviors of individuals with BED more significantly associated with difficulties in identifying and tolerating emotional states over the effects of gender, food restriction, and overevaluation of body image (as cited in Safer, Telch, & Chen, 2009).

Polivy and Herman (1993) evaluated binge eating behaviors and its psychological etiology in five phases. The “prebinge phase,” is said to be where “sociocultural influences (such as the diet culture), personality variables (such as low self-esteem), and chronic behavioral patterns (such as dieting and excessive exercising, that have developed in response to cultural and individual predispositions” have an effect on the

individual (in Fairburn & Wilson, 1993, p. 174). The second phase is where various subjective variables that produce biological stress or negative emotions that acutely trigger binge behavior. The third phase, factors, such as the reduction of negative emotional states, privacy, and the feeling that the binge has not reached its conclusion, serve to maintain the binge behavior. The fourth stage marks the termination of the binge behavior, and is often found to be associated with absence of food, broken privacy, fullness or physical pain and discomfort, and fear of gaining weight. Finally the fifth and final phase is “the postbinge phase” where consequences of the binge, often based in biological discomfort, psychological distress, and shame associated with not meeting societal pressures are felt. Additionally, many of the factors serve to function as stressors in ‘the prebinge phase,’ as well, perpetuating the cyclical nature of binge eating behaviors (Polivy and Herman, 1993).

Finally, many of the same societal pressures that affect individuals with AN and BN are also said to contribute to the development of BED. For instance, the same powerful social associations established between femininity and thinness that apply to BN are also at play in BED. In addition to being thin, “the pursuit of the superwoman ideal,” or the exaggerated sense that women fulfill a multitude of roles in western society and to soothe themselves without making demands of others, is also said to increase binge eating behaviors, as well (Striegel-Moore, 1993, p. 157). Establishing unachievable tasks and goals for woman, that are often highly dependent on body image, also creates an all-or-none eating behaviors. Individuals that feel that they cannot achieve the social ideal or only maintain the necessary restrictive eating behaviors for a shortened period of time often give in periodically, creating binge-type episodes.

### *Distinguishing the AN Group from the BN and BED Sub-Group*

The field of eating disorder research has qualified a number of categorical differences between restrictive-type eating disorders and binge-type eating disorders. Although both types of behaviors can appear across the array of disorders on the eating disorder spectrum, individuals afflicted tend to present with generally restrictive or generally binge-type disordered eating behaviors. Although there are a number of similarities between elements of the disorders, such as age of onset, gender afflicted, biological predisposition, cognitive preoccupation with food and body, and developmental etiology, there are a number of important characteristic differences that seem to cause the presentation of one type of behavior over another. In this differentiation, individuals with eating disorders tend to fall into one of two categories: the anorexic sub-group or the binge-type sub-group.

The eating disordered individual's central conflict appears to be an important differentiating feature between the two types of disorders. For instance, individuals with AN have historically exhibited a core concern of restricting food intake in order to serve a function of feeling a sense of control over one's body (Tolman & Lane, 2007). "A sense of pleasure along with inflated self-esteem is often derived from the patient's sense of control and pursuit of thinness . . . due to distorted images of their own bodies, anorexics continually strive for a state of 'perfect thinness' that is unattainable" (Tolman & Lane, p. 178). The need for a sense of control has been repeatedly argued to stem from a need to separate from a mother that categorically prevented individuation of the child to occur. "From [anorexic] case histories, Sours (1974) observed that anorexic patients are traditionally attached to domineering and controlling mothers who are only satisfied by

complete submission on the part of their daughters . . . to fulfill their own needs rather than allow them to pursue and establish their own identities” (Tolman & Lane, p. 178). Lane’s (2002) work utilizes Freud’s symbol of the spider mother, or one that is angry and fearful to her children, to describe most mothers of anorexic children: the spider mother “overwhelms, smothers, crushes, encircles, engulfs, squeezes to death, annihilates, and devours their victims” (Lane, 2002 as cited in Friedman & Tolman, 2007). Withholding food, a theoretically internalized symbol of the mother as the nurturer and feeder, from the body may likely be an attempt to free oneself from a stifling and controlling parental relationship through restriction and emptiness.

Individuals afflicted with BN or BED, on the other hand, tend to exhibit a consistent and considerable battle negotiating a sense of perpetual and intolerable emptiness. “It is believed that the bulimic, whose main symptom is not controlling food restriction, uses food to compensate for the lack of early nurturance provided to her by her parents during childhood . . . the bulimic repetitively turns to food in a futile effort to meet the need for nurturance, never having had a nurturing mother (Brush & Lane, 1996, p. 58). Many individuals with BN and BED, after years of attempting to meet their emotional needs with binge-type episodes, develop significant weight and physical problems, as a result. Alternatively, those identified as bulimic attempt to meet their emotional needs with binge-episodes while also espousing an intense desire to maintain a certain weight tend to develop the pairing of binge/purge behaviors, where the conflict wavers between wanting to maintain a certain body image while also satisfying seemingly primitive urges to feed oneself is a preoccupying struggle. “The desire to fulfill intense infantile needs to be fed and loved becomes overwhelming and is followed

by the terrorizing thought that this transgression will be the cause of immediate weight increase” (Foehrenback & Lane, 1987). As a result, punitive undoing behaviors, such as vomiting, fasting, or over-exercising, defend against such fears. Until the individual is emotionally ‘fed and loved,’ the cycle of filling and emptying repeats.

Degrees of affective expression and impulsivity also vary greatly between restrictive-type and binge-type disorders. Tolman and Lane’s (2007) work describes individuals with AN to have been found to characteristically withhold or repress their emotions in order to remain compliant with their mother’s wishes and needs. The authors employ Selvini’s (1963) work on ego helplessness of the anorexic to describe the process of negotiating affective expression through their bodies. He argued that, because the ego is so grossly inhibited by the maternal relationship, the body becomes incorporated as an object that is impenetrably fused to the ‘spider mother’ and as the vessel for acceptable affective expression. In this manner, anorexic behavior can be seen as both a stifling of affective expression and an eventual act of individuating from the mother by depriving the body, the symbol of the relationship.

Individuals with binge-type eating disorders, conversely, “have difficulty modulating and expressing affect appropriately, becoming easily overwhelmed by activities or situations which trigger negative emotional states such as anxiety or anger” (Brush & Lane, 1996, p. 59). Additionally, they have been found to be statistically more impulsive and compulsive than restrictors in their behaviors (von Ramson & Cassin, 2007). Because the individual’s needs during early development were often not adequately attended to and the process of separation/individuation from the mother resulted in an inability to incorporate adaptive self-soothing and coping skills, the

individual tends to experience a plethora of affective needs, yet persistently deny them, lack the ability to identify them, and present an ambivalence about communicating them to others (Brush & Lane). The bulimic or binge eater “utilizes food instead of emotional support in an attempt to utilize the only perceived soothing mechanism available . . . for individuals who cannot trust that an intimate relationship with significant others can meet these same needs” (Brush & Lane, p. 60).

Case examples of the two main types of eating disorder presentations exhibit many of the characteristic differences between restricting-type and binge-type eating disorders. For instance, “the case of Nicole” in Corn and Lane’s (1997) work describes the experience of a 16 year-old Hispanic female who developed anorexia at the time of puberty. She is described to have had an enmeshed relationship with her mother, “a domineering, unhappy mother” that was “subservient, emotionally starved, jealous of any attention given to Nicole, and sexually unsatisfied” in her marriage, and only a weak attachment to her “absent or inattentive father” (Tolman & Lane, 2007, pp. 186-187). Nicole was the eldest child, and consequently the target of her mother’s projected “negative feelings, self-doubts, and insecurities” (p. 187). Nicole was described to be dependent on her mother, fearful of growing up, and further emotionally affected by her parents divorce when she was 13 years-old. Nicole soon became her mother’s confidante during her mother’s new dating life, her reliable partner during an unhappy new marriage, and the target of projected “sodomasochistic rage” (p. 187). “To maintain this dysfunctional closeness to her mother, Nicole rejected her own mature sexual strivings and . . . made herself in to an undesirable unattractive, ascetic female” in order to remain compliant and cooperative to her mother (p. 187). Nicole employed a rigid daily schedule



of regimented caloric intake and vigorous exercise, until she presented for treatment, likely in an effort to gain a sense of separation from her mother and mastery over her own life via her body (Tolman & Lane).

Hull and Lane (1990) describe the case of an 18 year-old bulimic client, “Jeanne” (p. 109). Jeanne presented in an inpatient setting after a surge in her binge/purge episodes caused her a 30-pound weight loss and a debilitated psychological state. Her history is largely qualified by a difficult and disrupted relationship with her mother, a woman described as “strong but distant, preoccupied, and ready to react in a stern and reprimanding manner whenever needs were expressed” (p. 109). Jeanne recalled, for example, a difficult time convincing her mother that she was ill when she was young. Her mother would instruct her, rather, to “bear up and contain herself at all costs” (p. 109). Jeanne describes a weak relationship with a father that was career-oriented and traveled frequently. She actively recalls his over-concern with appearances and his demand that she live up to his ideals and the impact that had on her self-worth and her life. During middle childhood, Jeanne also describes being sexually molested for a period of time by an extended family member. While the abuse was traumatizing, she also reported finding the sexual attention flattering. As she grew and developed, she became preoccupied with food to fill “a great hole which could never be filled up” and a simultaneous need to maintain a certain body image and a means to expel unwanted feelings and impulses from her body through purging (Hull & Lane).

It is evident that the etiological differences between individuals that present with restrictive-type eating disorders and binge-type eating disorders are significant. Not only do these differing groups of individuals present with vastly differing organizations of

behaviors, they also characteristically emerge from maternal relationships that demanded strikingly different needs. Moreover, the manner in which the individuals affectively respond to their lives also creates a significant impact on their ability to modulate their emotions and behaviors around food. As a result, AN has become increasingly differentiated from BN and BED in research and literature.

The sub-grouping of eating disorders has not only allowed researchers the ability to conceptualize the etiology and behavior patterns of the disorders, it has also allowed them the opportunity to investigate treatment models appropriate for the disorders. For instance, empirically successful treatment models utilized with BN, such as cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), and pharmacotherapy, have also been applied and tested in the treatment of BED because of the identified similarities in the two disorders' presentation (Telch, Agras, & Linehan, 2001, p. 1061). Researchers have also confirmed the association between the sub-groups through research of treatment effectiveness. Where (CBT) and interpersonal therapy (IPT), two treatment styles that aim to alter behavior through thought change-driven work and talk therapy, have been found to be successful in treating individuals with AN (Bowers & Ansher, 2008), the treatments have been found to be ineffective for about 50% of individuals with BN and BED (Fairburn, Marchus, & Wilson, 1993). As a result, the sub-grouping of BN and BED in the literature has not only helped differentiate the disorders from the symptomology of AN, but also helps to identify their differing treatment needs for future research.

BN and BED's similarities in etiology, symptomology, presentation, and treatment responsiveness make the disorders an undeniably different variant of the eating

disordered population. For the purposes of the present research, BN and BED will be characterized as binge-type eating disorders.

#### *Difficult-to-Treat Binge-Type Eating Disorders (DTBTEDs)*

Within the binge-type eating disorder category exists an additional sub-group that appears to be significantly unresponsive to typical treatment modalities. These individuals and the presentation of their disorders can be characterized as more impulsive, report more negative moods, and, perhaps most significantly, are more resistant to typical forms of treatment (Chen, et al., 2008). Even the most empirically effective treatment methods fail to help these types of binge-type eating disordered individuals (Wilson Grilo, & Vitousek, 2007). Because of the evidenced difficulty in effectively treating these types of individuals and the danger it presents to their physical and emotional health having chronic and prolonged active eating disordered symptoms, the present study intends to define and further evaluate this sub-group of *difficult to treat binge-type eating disorders (DTBTEDs)*.

#### *Traditional Treatment Models for Binge-Type Eating Disorders*

The research community has made it empirically clear that Fairburn's (1981) CBT model is the most commonly utilized treatment for individuals with binge-type eating disorders. For individuals with BN, it has been called "the first line treatment of choice" (Fairburn, Marcus, & Wilson, 1993, p. 362). It has also been found to be a statistically significant treatment highly utilized with binge eating disorder, as well (Marcus, 1997). When compared to other forms of treatment, including supportive psychotherapy, focal psychotherapy, behavior therapy, and psychopharmacological

medications, CBT was “shown to be at least as effective, if not more effective, as all the treatments with which it has been compared” (p.362).

CBT treatment is theory-driven, manual-based, and designed to be “semistructured, problem-oriented, and mainly concerned with the patient’s present and future rather than their past” (Fairburn, Marcus, & Wilson, 1993, p. 365). It is intended to focus on behaviors that are maintaining the problem, or “proximal influences,” as opposed to those that may have originally contributed to its development, or “distal influences” (Tobin, 1993, pp. 288-289). The proximal influences that have been found to affect the onset and maintenance of binge-type eating disorders include an over-concern of body image difficulties, hunger, sociocultural pressures, dieting behavior that predisposes binge eating, and affective symptoms (Tobin). As a result, CBT is argued to be designed to “consist of cognitive and behavioral procedures designed to enhance motivation for change, replace dysfunctional dieting with a regular and flexible pattern of eating, decrease undue concern with body shape and weight and prevent relapse” (Wilson, Grilo, & Vitousek, 2007, p. 204). The treatment is designed to last for about 20 weeks, and is broken into three phases. The first focuses on presenting the client with the cognitive view of BN, as well as, to begin implementing behavioral alterations to the maladaptive eating behaviors. The second phase continues to focus on improving healthier eating habits, and where the focus on further evaluating and changing the thoughts, beliefs, and values that are maintaining the disordered eating behaviors. The final phase is focused on maintaining changes achieved in previous stages (Fairburn, Marcus, & Wilson). CBT has been identified as the treatment approach most clinicians utilize first with their binge-type eating disordered clients (e.g., Mitchell, et al, 2002).

Historically, various forms of psychotherapy have also been routinely implemented with binge-type eating disorders. Perhaps the most widely utilized form with the binge-eating disordered population has been interpersonal psychotherapy (IPT). Klerman, Weissman, Rounsaville, & Chevron (1984) originally developed the “nonintrospective, short-term psychological treatment” for depression, and it was later reformulated treatment with binge-type eating disorders by Fairburn (Agras, 1993, p. 272; Fairburn, Jones, Peveler, Hope, & O’Conner, 1993 as cited in Wilson, Grilo, & Vitousek, 2007). The treatment evaluates and emphasizes the current interpersonal difficulties involved in the maintenance of the eating disordered behaviors in the absence of treating the disordered eating behaviors (Agras, 1993). “The thesis behind the use of IPT . . . is that eating disorders appear during late adolescence, when interpersonal issues loom large. It is hypothesized that binge eating is triggered by, and becomes a means of coping with, the negative affect associated with faulty interpersonal responding. IPT is directed toward ameliorating faulty interpersonal responding and the associated negative affect (Klerman et al., 1984)” (Agras, p. 279). Statistically, no significant differences are seen between the effectiveness of IPT in reducing binge behaviors when compared to CBT both immediately following the implementation and at a one-year follow-up (Fairburn, et al., 1991 as cited in Agras). Research has indicated that IPT is often utilized second to CBT (e.g., Mitchel, et al, 2002).

Psychopharmacological treatment methods are also a popularized method of treating binge-type eating disorders. Namely, a variety of antidepressants, appetite suppressants, and anticonvulsants have been found to significantly affect binge-eating disorders for some individuals. Antidepressants have been found to contribute to the

reduction of the frequency of binge episodes and some preoccupation with food and depressive symptoms associated with BN and BED (e.g., Telch, Agras, & Linehan, 2001; Mitchell, Agras, Wilson, Halmi, Kraemer, & Crow, 2002; & Mitchell & Zwaan, 1993). Because of abnormalities discovered in electroencephalographs (EEGs) of individuals with binge-type eating disorders, anticonvulsants have also been utilized. Some controlled studies comparing placebo drugs and appetite suppressants have identified significantly fewer binge-eating episodes in the appetite suppressant group than the placebo group (Mitchell & Zwaan, 1993).

#### *DTBTEDs and Resistance to Traditional Treatments*

There is convincing evidence that some individuals with binge-type eating disorders can be alleviated by traditional treatment models currently utilized. However, there is also ample evidence of a significant number of individuals for whom treatment resistance is also displayed (Wilson, Grilo, & Vitousek, 2007). As previously indicated, CBT, typically the most effective treatment for binge-type eating disorders, has been found in one review of the empirical literature to be ineffective for nearly 50% of individuals with BN and BED (Chen, et al, 2008; Mitchell, et al, 2004; Fairburn, Marcus, & Wilson, 1993). Those unhelped fail to respond to treatments and often drop out prior to its conclusion (Wilson, Grilo, & Vitousek, 2007). Another review of the empirical literature discovered that “a number of clients with BED and BN continue to suffer from their eating-disorder symptoms either at the end of treatment or in posttreatment with CBT (Wilson, et al., 2007)” (Safer, Telch, & Chen, 2009, p. 13). Another study presented abstinence rates ranging between 30-50% in post-treatment of CBT (Mitchell, et al, 2002), and another set of researchers remarked that about their similar findings that “a

40% abstinence rate suggests that we are far from having found the ideal treatment for binge eating” (Agras, p. 273).

Predictors of poor outcomes with CBT have been identified as attributed to severity of symptoms, comorbid personality disorder traits, or to the complication of other Axis I disorders (Wisniewski, Safer, & Chen, 2007). Fairburn, Marcus, and Wilson (1993) also found individuals with BN that exhibit low self-esteem and disordered personality features have been found to fair statistically less well than others in CBT treatment. Finally, Agras (1993) also identified disordered personality characteristics and interpersonal difficulties in individuals with binge-type eating disorders to be a root difficulty in treating eating disorders from only a cognitive and behavioral perspective.

Because the difficult-to-treat binge-type eating disorder group exhibits a variety of interpersonal difficulties and affect regulation deficits, it is likely that they often fail to respond to CBT in the way that others that are not within the difficult-to-treat sub-group might. Only treating the acute behavioral symptomatology presented by individuals with binge-type eating disorders without evaluating and healing the factors involved in the “dynamic processes that form the patient’s psychostructural organization and the corresponding historical context of the patient’s personality organization” may leave the individual with an incomplete treatment experience (Tobin, 1993, p. 289). “From a traditional psychodynamic perspective, it is of limited use to try to directly modify the proximal triggers of binge-eating symptoms without trying to provide patients with an understanding of the more distal influences, the historical and unconscious influences on their behavior” (Tobin, p. 289).

IPT and similar structured therapies have been empirically investigated in ways similar to CBT and binge-type eating disorders and have indicated a strikingly similar ineffectiveness for some binge-type eating disordered individuals. Abstinence rates exhibited in empirical literature tend to range from 12%-44% with a median of 17% (Mitchell et al., 1990; Wolf & Crowther, 1992; Agras et al., 1989; Fairburn et al., 1991, Garner et al., 1993; Kirkley et al., 1985, and, Laessle et al., 1991 as cited in Agras, 1993). Another study indicated that IPT was found to be less effective for binge-type eating disordered participants than CBT at posttreatment, and both treatments indicated significantly similar rates of ineffectiveness at one- and six-year follow-up evaluations (Fairburn, Jones, et al., 1993 as cited in Wilson, Grilo, & Vitousek). Because IPT and structured therapies are designed to treat only the 'faulty interpersonal responding and the associated negative affect' while neglecting the behavioral and psychotherapeutic components, it is likely that the group of individuals with difficult to treat binge-type eating disorders that experience both relational difficulties and behavioral maladaptivities find the treatment incomplete.

Evidence also exists for resistance to psychopharmacological treatments within the same population. In several studies, antidepressants were found to be ineffective for individuals with bingeing and vomiting behaviors (e.g., Sabine et al., 1983, Alger, Schwalberg, Bigaoutte, Michalek, & Howard, 1991; Mitchell & Groat, 1984). Research on anticonvulsants have yielded little convincing evidence indicating that the medication is effective with binge-type eating disorders, despite the abnormalities evidenced in EEG tests (Agras, 1993). Additionally, even when psychopharmacological treatments do exhibit effectiveness in treating the symptomatology of individuals with binge-type



eating disorders, there still exists a group of individuals that do not maintain lasting remission rates. “The mean percentage reduction in binge eating [from psychopharmacological methods] across active treatment cells is approximately 70%, but only 22 % of patients are in complete remission at the end of treatment (Mitchell, et al., 1989)” (Agras, p, 263). Again, although the treatment may meet some of the binge-type eating disordered individual’s complicated array of treatment needs, it is likely that it is not enough in its sole application to create effective change.

Not only is there evidence that traditional treatments for BN and BED fail for individuals in this difficult to treat sub-group, there is also research that indicates that multi-level treatments are ineffective, as well. A set of researchers that tried to improve CBT effectiveness ratings by adding a second-level treatment, such as psychopharmacology or IPT, not only found CBT to be ineffective with their BN clients, but also found the sequential treatments to fail, as well (Mitchell, Halmi, Wilson, Agras, Kraemer, & Crow, 2002). They authors assert that, since common primary and secondary treatments statistically failed to treat the disorders effectively, “alternative models for therapy need to be tested” (p. 271). However, some research indicates that, in the field of clinical practice, those treating such eating disorders may already be experimenting with alternative forms of treatment. Mussell, et al. (2000) found in their survey of psychologists in an upper Midwest state that most responders identified a treatment style other than CBT or IPT as their primary treatment modality. Moreover, responders indicated that the treatment styles they were primarily utilizing were not from empirically-tested, manual-based styles, and that they were rarely adhering to one single orientation in their practices, indicating that their styles may be more eclectic or

integrative. It is likely that those in the field may already be identifying the complicated needs of the difficult to treat binge-type eating disorder sub-group and experiencing the failures of commonly used manualized treatment modalities, and as a result, may be branching out beyond their currently available resources in response in search of something more eclectic and effective.

In sum, it appears that none of the currently utilized eating disorder treatments for binge-type eating disorders effectively address all the symptoms in the array of behaviors exhibited by individuals with the disorder nor do they seem to treat all individuals on the binge-type eating disorder spectrum. The problem seems to lie in the severity of the symptomatology and the limitations of the existing treatments. “There is some suggestion that individuals with BN and BED for whom existing treatments are less helpful are those who are not early rapid responders to treatment, have more severe eating disorder symptoms and are more impulsive, report greater negative mood or have co-occurring disorders” (Chen, et al., p. 505). Such individuals also “often have difficulty regulating emotions, and eating pathology (i.e., binge eating, vomiting, restricting) may be viewed as a way to cope with that emotional vulnerability (Wisniewski, 2003, p. 132). In fact, the individuals for whom the various treatments seem most ineffective seem to be those with the most difficulty tolerating negative affective states adaptively and who tend to respond to them with addictive behavior patterns. Wisniewski (2003) writes, “a focus on emotion regulation [in treatment] may be particularly helpful to eating disorder patients” (p. 132). Individuals that appear to be difficult-to-treat with traditional models are likely to fail because of such affective deficits, as “neither CBT or IPT is grounded in the affect regulation model” (Safer, Telch, & Chen, 2009, p. 13). Because the currently utilized

therapies do not meet the often more complex needs of certain eating disordered individuals they will be identified as the difficult to treat binge-type eating disorder subgroup for the purposes of further evaluation and research.

### *Chapter Summary*

Through a thorough analysis of the various types of eating disorders and the important ways they are differentiated from each other, it is apparent that DTTBTEDs carry with them their own unique set of identifiers and needs. The difference in presentation of symptomology between restrictive-type and binge-type eating disorders seems to be determined by their characteristically distinct etiologies. Moreover, analysis of traditionally and frequently utilized treatment methods for binge-type eating disorders has elucidated a specific population of eating disordered individuals whose more complicated, intensified, and difficult to treat needs are not being adequately met by the offerings of currently utilized treatment models.

In order to better determine the best ways to better meet their needs, a more thorough evaluation of DTTBTEDs will be explored. More specifically, the following chapters will utilize a Winnicottian object relations perspective to better elucidate the impact early developmental relationships can have on the development of eating disordered behavior systems, and a behavioral lens will be utilized to evaluate the impact addictivity plays on the maintenance of eating disordered behaviors.

## CHAPTER THREE

### DIFFICULT-TO-TREAT BINGE-TYPE EATING DISORDERS AS VIEWED FROM A WINNICOTTIAN OBJECT RELATIONS PERSPECTIVE

#### *Introduction*

As established in the previous chapter, individuals with DTTBTEDs suffer a number of more intensified, prolonged, and treatment resistant symptoms than others with eating disorders that fit into differing sub-groups typically do. Traditionally and popularly utilized treatments, such as CBT and IPT, have been shown to inadequately meet the array of often more intense needs associated DTTBTEDs. Researchers have found that affect dysregulation is a component of the disorders' presentation that is most routinely and significantly ignored, perpetuating the utilization of disordered eating behaviors to attempt to alter negative affective or emotional states (Safer, Telch, & Chen, 2009). As a result, individuals with more maladaptive affect regulation skills statistically continue to suffer from their disordered symptoms for prolonged periods of time and even after differing combinations of CBT, IPT, and behavioral weight loss treatment methods have been implemented (Wilson, et al., 2007).

In order to better understand the etiology that is powering these persistent and sustaining symptoms, better evaluating developmental histories of individuals affected is an important way to gain increased perspective on the function of the eating disorder. In particular, an object relations lens enables researchers to better evaluate the pattern of interaction individuals with DTTBTEDs have had with other individuals in their

environment from infancy forward, the style of interaction that they have adopted as a result and continue to utilize with current relationships, and the impact that the formation of maladaptive interpersonal object relations has had on their emotional development and affect regulation skills. A plethora of advanced binge-type eating disorder literature has recognized the correlation between negative emotional states and disordered eating behaviors (e.g., Safer, Telch, & Chen, 2009; Chen, Matthews, Allen, Kuo, & Linehan, 2008; Wilson, Grilo, & Vitousek, 2007). It is likely that the early developmental and object relations context significantly contributes to these related interpersonal emotion-management difficulties and the development of disordered eating patterns as a result.

### *Object Relations Theory*

Object relations theory has been categorized as a collection of conceptualizations of an individual's inner world and their building of a pattern of relating to others that they encounter in their relational world by a variety of theorists. Terming the collection of theories under the heading of one object relations theory has historically helped to differentiate them from those of drive, ego, and self psychologies (Flanagan, 2008). The major theorists that arguably most significantly contributed to the early study of object relations work include D.W. Winnicott (1896-1971), Melanie Klein (1882-1960), Ronald Fairbairn (1899-1964), and Harry Guntrip (1901-1974), from the British school of psychoanalytic thought, and Margaret Mahler (1897-1985) from the American School of Object Relations (Flanagan). It is Winnicott's theories, however, that will be primarily utilized to best demonstrate the early object developmental environment and the role it plays in the development of difficult to treat binge-type eating disorders in this paper.

Today, object relations theory centers on the notion that all individuals have unique mental representations of themselves and their external world based upon their early interactions with individuals in their lives. The process by which internalizations occur and the impact they have on individual functioning and psychological life remain highly investigated. The theory not only highlights the notion that individuals experience life through more than just drives and impulses, they also assert that individuals have needs that require participation in relationships with others and that elements of the self evolve out of those connections (Flanagan).

The evolution of the development of object relational thinking can be viewed as beginning as early as Freud's work on the processes of mourning and melancholia. It is argued that this work first illuminated in a profound way the impact that external *objects*, or individuals that present in one's relational space in a prominent way and for a significant period of time, have on an individual's internal view of themselves and working models of their world. By differentiating "mourning," or the process of being sorrowful regarding a loss, from "melancholia," or a mourning process that does not seem to end and where the experience of a loss of an individual is surmised to negatively affect the individual in a way that alters them, Freud first shifted psychoanalytic thought away from solely drive-based explanations for behavior to highlight the impact objects can have on one's internal experience (Flanagan, pp. 125-126). Freud postulated that melancholia becomes more significant than mourning when the individual attempts to internalize the image of the lost object in order to preserve it in their life, ambivalence is associated with the object followed by anger and resentment, and because the individual is no longer available the anger eventually becomes directed to the self (Flanagan).

“Rather than letting the loved one go and creating inner space for new objects and experiences, the melancholic turns her energies away from the world and toward the self” (Flanagan, p. 126). In this manner, Freud theorized that “the shadow of the object fell upon the ego” (Freud, 1917, as cited in Flanagan, p, 126). Other theorists later explained his statement as the process of an individual’s inner self being shaped and determined in part by the mental representations of other significant objects around them (Flanagan).

From Freud’s influence forward, theorists from the American and British schools of object relational thought began implanting a series of their interpretations of the relationship between an individual and objects in their environment to build the field of object relational theory. For instance, Bowlby’s work evaluated the quality of the mother-infant relationship and established categories of subsequent relational stylings that the infant might employ as a result (Shilkret & Shilkret, 2008). Klein’s understandings of “drives as ‘inherently and inseparably directed toward objects’” (Greenberg & Mitchell, 1983 as cited in Flanagan, p. 134) served to bridge the theoretical gap between internally-based theory and relational psychology. Fairbairn’s contributions came from his suspicions that unconscious internalizations could be altered by conscious parts of the ego structure (Flanagan, 2008). Guntrip’s views about individual’s deep need and simultaneous fear of love helped to broaden notions about the qualities of object relations. And, Mahler’s delineation of the infant’s separation-individuation process helped to conceptualize the importance of having an early secure home-base relationship while also developing healthy and independent identity (Flanagan). However, many have found Winnicott’s theories about the impact of the early maternal holding environment on mental health outcomes some of the most applicable, relatable, and integratable

theories about object relations that can be applied across a variety of empirical and clinical domains.

### *Winnicott*

While the work of the theorists from the British and American schools of object relational thought were influential in the process of better understanding how one's internal world is influenced by relationships in their external environment, arguably no other theorist's works capture this process and its power better than that of D.W. Winnicott's.

### *Winnicott's Theories*

Donald Woods Winnicott was born on April 7, 1896 in Plymouth, England. He was born the youngest of three children, his two older sisters were five and six years his senior. Winnicott once wrote that he felt in his childhood "in a sense . . . an only child with multiple mothers [including sisters, a governess, and a nanny] and with father extremely preoccupied in my younger years with town as well as business matters" (Winnicott as cited in Phillips, 1988, p. 23). Researchers have theorized that the significant amount of time that he spent around women caused him to become more sensitive to maternal issues, including depression and withdrawal and child's dependency (Goldstein, 2001). His father was 41 years-old when Winnicott was born, and was occupied by his career as a clothing merchant, mayor of Plymouth for two terms, manager of the Plymouth hospital committee. He was eventually knighted by the British government (Phillips, 1988). It is thought that his father's success likely impacted his own motivation, while his father's lack of formal education caused Winnicott to approach his writing and theory development with an aim to, as he wrote, "design plain truth for



plain people,” espousing an affinity for simplicity (Winnicott, as cited in Phillips, p. 24). Before entering the psychoanalytic world, Winnicott practiced pediatrics and spent a great deal of time observing children and their relationships with their maternal caregivers (Mitchell & Black, 1995).

Winnicott discovered psychoanalysis by entering analysis with James Strachey, a psychoanalyst who not only translated Freud’s writings into English, but also brought Kleinian thought to England. His second analyst was Joan Riviere, one of Klein’s closest collaborators (Mitchell & Black, 1995). He worked directly under the supervision of Klein for a time, and then ultimately began practicing analysis independently. Combining his childhood experiences being raised among mostly women, his attuned observations of maternal-infant dyads in his medical work, and absorbing the beginnings of evaluation of the infant-maternal relationship initiated by Klein, he quickly focused his work on the relationship between children and their parents, ultimately conducting over 60,000 consultations between them during his career (Goldstein, 2001). After evaluating children with trauma histories, severe emotional difficulties, and deprivation, Winnicott began to evaluate more closely the relationship between infants and their environments, namely focusing on the role of the primary caregiver, very often the mother (Goldstein). Although he acknowledged that his work was highly influenced by his mentorship with Klein, Winnicott’s work was notably more “original and more radical” than others at the time (Goldstein, p. 36). “Winnicott’s writings vividly and cogently describe the mother-infant dyad, which he regarded as the center and foundation of the developmental process” (Cheschier, 1985:218, as cited in Goldstein, p. 36). For the first time, he proposed definitions for the styles of parenting that seemed to enable and disable optimal

mental health and development that many found too radical and provocative. Although he was twice elected president of the prestigious British Psychoanalytic Society, the argued leading school of psychoanalytic thinkers of the time, it is reported that his writings were considered more original than those of his colleagues at the time (Goldstein, 2001). Eventually, he became a central figure in what became known as an “‘independent,’ or middle group” of theorists that held theories newly and substantially divergent of those held by Freudians or Kleinians (Mitchell & Black, 1995, p. 113).

Winnicott’s key theories, that remain highly practiced and referenced in theory today, include his thoughts on the impacts made by *the maternal holding environment*, *the good-enough mother*, *false-self phenomenon*, *transitional objects*, and *the ability to be alone*.

*The maternal holding environment.* Winnicott believed that the infant lives in a facilitating environment, where the external environment must respond to and adapt to the child’s needs in individual ways. He viewed the mother as being the first representative of the environment (Goldstein). Winnicott’s views of the maternal holding environment were cultivated from the notion that, as infants, children are not only physically dependent upon their mother’s care for survival, but they are psychologically dependent upon their care for survival, as well. He saw the mother’s care as ego-supportive, helping the infant construct a beginning ability to experience a strength and safety in the world through their mother’s provisions of physical and emotional safety. He recognized, as Klein began to, that the infant’s existence is entirely dependent on the mother. “I once said: ‘There is no such thing as an infant,’ meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there

would be no infant” (Winnicott, 1960, p. 39). He asserted that, together, the mother and infant form “a unit,” and that “in health” they are entangled together in a way in which the infant only separates from later in development (p. 39).

This ‘unit,’ or the pairing of the infant’s and mother’s special and circumstantial participations, ultimately created what Winnicott termed the infant’s *holding environment*. He viewed infants as entering the relationship with an innate “potential” to survive, develop, and form relationships with objects in their environments, but also asserted that it cannot be realized without the support of the certain conditions created by the maternal environment (Winnicott, 1960, p. 43). The infant, in his or her *absolute dependence*, relies completely on the mother in a state of *subjective omnipotence*, or with a lack of awareness of the mother’s care due to an experience of being the center of and creator of all things in their external and internal world (Mitchell & Black).

Simultaneously, the infant is able to demand and receive this type of care due to the mother’s state of fixation on the child, or what Winnicott termed her *primary maternal preoccupation*, allowing her a biological predisposition to develop an ability to unconditionally and uncompromisingly meet the child’s needs. “The state of primary maternal preoccupation is a constructive kind of temporary madness that enables the mother to suspend her own subjectivity to become the medium for the development of subjectivity of the infant” (p. 126). Beginning during pregnancy in preparation for the child’s arrival, this state of temporary obsession with the child Winnicott not only considered a normal form of mental illness, but also one vitally important to the development of the child. Losing herself by being consumed with her baby and seeing her “own personal interests, her own rhythms and concerns fading into the background;

she adapts her movements, her activities, her very existence to the baby's wishes and needs" (Mitchell & Black, p. 125) This process allows for a merger of infant and mother in an experience considered a "bliss of oneness" where the infant's needs are met without realization (Flanagan, 2008, p. 130). It is the coupling of the infant's subjective omnipotence and absolute dependence and the mother's primary maternal preoccupation that Winnicott asserted, in optimal mental health and development scenarios, together create the infant's holding environment, "a physical and psychical space within which the infant is protected without knowing he is protected" (Mitchell & Black, p. 126), and one that helps the infant "feel related, safe, protected, and free from unwanted intrusions and that contains the infant's emotions and impulses" (Goldstein, p. 76). Winnicott considered the holding environment to exist before the infant has an awareness of "not-me objects" and living in the presence of others (Winnicott, 1960, p. 45). It is the primary stage in the overall process of what he termed "satisfactory maternal care," and recognized as ending upon the realization that objects are external to the self (pp. 43-44).

In order to maintain a state of subjective omnipotence in the infant-maternal holding environment the infant negotiates her way through three levels of dependence: *absolute dependence*, where the infant is unaware of their dependence; *relative dependence*, where the infant becomes aware of the need for maternal care; and, *towards independence*, where the infant develops memories of maternal care, an awareness for the need of care, a recognition that their actions can elicit care, and an understanding of their external environment's responsiveness (Winnicott, 1960). Winnicott later expanded by adding in two intermediary phases: Stage 3 became termed the *dependence-independence mix*, where the infant moves toward independence but returns to dependence; and, the

*independence-dependence mix*, where the infant is becoming increasingly independent (Goldstein, p. 77). As the infant meanders through these differing forms of dependence, ego organization is said to be developing as a result of the quality of care the infant receives. In the end, the infant begins to internalize an understanding of themselves and their external world by internalizing their experiences with need fulfillment.

Dependence was also seen by Winnicott to be highly relatable to the infant's ability to hide their "central self," or their true self or innate potential (Winnicott, p. 46). The ability to isolate the central self and rely completely on the mother for absolute care is vital to the infant's development. When the infant is not able to experience absolute dependence, the central self is not able to be hidden, and "impingements" are said to be created in the child's development. "The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being" (p. 47). These impingements, in turn, often result in the infant's premature implementation of defensive strategies and first emergence of the *false self*, something Winnicott saw as creating long-lasting annihilation anxiety in the individual. In health, Winnicott saw the infant's emergence from integration in the holding environment to attaining "unit status" as an individual through a gradually developed understanding of the existence of maternal care and experiencing the caregiver as the first "not-me" object (p. 45). Only in this manner, he argued, can the infant emerge from the fusion in a way that allows him or her to periodically negotiate and master anxieties that arise from disintegration (Winnicott, 1960).

Just as the infant brings requirements to the infant-maternal holding environment, the mother or caregiver was seen to be responsible for maintaining certain standards, as

well. Winnicott defined a series of characteristics that were viewed as essential qualities of maternal care in the holding phase. He viewed them as the capacity to meet the infant's physiological needs, reliably, empathically, with a protective focus, in a way that is unique to infant's specific needs, and exists during absolute infant dependence. In this manner, the infant can be completely attended to, in a way that offers nuanced care, in a time-frame that prevents infant discomfort, and where the infant can remain unaware of their own separateness. In this manner, Winnicott argued that the infant is prepared for further development. However, if the maternal caregiver fails to be attuned in some way, "impingements, or failures in adaptation" can occur, causing a reaction in the infant and a subsequent pause in his or her development (Winnicott, 1963, p. 86). Moreover, if impingements in development continue to occur in a patterned way, he theorized that the infant's entire mental health is at risk.

The holding phase of early maternal care comes to an end when the infant develops a realization of otherness. Winnicott viewed the mother as the infant's first "not-me" object, gained when the infant senses a separateness between the membrane of themselves and the beginning of their other (Winnicott, 1960, p. 45). Winnicott viewed this as a very essential stage in early infant psychological development. He believed that at the end of the merging relationship, when the infant has begun to move towards the toward independence phase of holding, they have memories of care, an ability to project needs outwardly, and a developing expectation that the environment will respond. He believed that the two final portions of this process were most essential. The ability to signal to the mother or caregiver is not only an important development for the infant in development, it is an essential way in which they can continue to experience a sense of

control within their environment. Similarly, the pattern of responses of the mother to the infant's signals will ultimately allow the infant to internalize what expectations he or she can continue to have moving forward. One of Winnicott's greatest fears during this period was of the over-involved mother disallowing her child the opportunity to signal by meeting the child's needs prematurely. "In this way the mother, by being a seemingly good mother, does something worse than castrate the infant . . . in the management of infants there is a very subtle distinction between the mother's understanding of her infant's need based on empathy, and her change over to an understanding based on something in the infant or small child that indicates need" (1960, p. 51). In this manner, the mother actually fails the infant's movement away from merger toward independence and forestalls the development of the infant's first object relationship. The environment is then viewed as no longer facilitating, and actually hindering. Winnicott viewed the ending of the holding environment, like its development, a process that also requires carefully attunement.

*Good-enough mothering.* The state of oneness developed between the infant and mother to establish an adaptive holding environment was seen by Winnicott to only be created with what has been termed *good-enough mothering*. He did not believe that the creating of an adaptive and functional holding environment required perfect mothering, she just needs to be "good-enough" (Winnicott, 1956). He argued that the most important feature of 'good-enough' parenting was the ability to develop a functional attunement with the infant; to be aware of the infant's needs and have the capability to meet those needs. "As the infant's needs and wishes emerge from the unintegrated drift of consciousness, the good-enough mother intuitively feels the child's desire relatively quickly and

shapes the world around the child so as to fulfill that desire” (Mitchell & Black, 1995, p. 126). Moreover, the mother or caregiver is recognized as needing to be able to engage in these tasks repeatedly in order to attune to the infant’s ever-changing needs (Flanagan, 2008). It was thought that good-enough mothering also allows for the development of *ego-relatedness* between the infant and the mother, or a deep emotional bond in which two individuals are intimately connected. Ultimately, such relatedness through good-enough mothering was thought to contribute to the infant’s capacity for being alone while being or recalling being with another (Winnicott, 1956).

Winnicott theorized that the ability to provide good-enough parenting was made possible by the existence of the mother’s primary maternal preoccupation with their child, as seen in emotionally healthy mothers. Housing this “deeply biological, evolutionarily honed function” to lose her own subjectivity and become engrossed in her infant’s needs and care, the mother is functionally able to re-establish her existence around her infant, enabling the development of a unit merger between infant and mother (Mitchell & Black, p.125). Conversely, Winnicott recognized that when mothers themselves were not provided with good-enough care as infants they then became unable to provide the care for their infants in the same way. Additionally, he did not view the ability to become a good-enough parent as something that could be taught (Winnicott, 1960). “There are those who can hold an infant and those who cannot; the latter quickly produce in the infant a sense of insecurity, and distressed crying” (Winnicott, 1950, p. 49). Winnicott was also clear about his theories on the outcome of good-enough or inadequate parenting: “The mental health of the individual, in the sense of freedom from psychosis or liability to psychosis (schizophrenia), is laid down by the maternal care” (p.



49). The ability for the infant to enjoy a state of absolute dependence with subjective omnipotence with a caregiver that provided good enough care, in Winnicott's conceptualization, provided the holding environment necessary to establish optimal physical and psychological maturity in the infant.

*False self phenomena.* Emergence from the holding environment, the first phase of 'satisfactory paternal development,' creates opportunities for a host of identity-forming outcomes. In optimal situations, separation from the oneness of original holding of the mother allows the infant growth from absolute dependence towards a state of developing independence. It affords them the process of recognizing their unit status, the existence of their needs, and the experience of sending messages into the environment that communicate those needs and help them achieve need gratification. However, in less than ideal parenting, the potential for impingements and failures in environmental satisfaction can also occur. Winnicott viewed the development of the *false self* as the primary defensive strategy that all individuals develop to some degree to cope with such failures of attunement, whether temporary or repetitive and seemingly permanent. The false self, or "a façade aimed at pleasing others," was seen by Winnicott to be a defensive organization that can both hide and protect the 'central self,' or true self (Goldstein, 2001, p. 77). Although having great propensity towards adaptation in one's environment, Winnicott also understood the usage of the false self as one of the primary opportunities for maladaptive mental health outcomes from the maternal holding environment. In a situation where good-enough mothering is not provided, "the infant lives, but lives falsely. The protest against being forced into a false existence can be detected from the earliest stages. The clinical picture is one of general irritability, and of feeding and other

function disturbances which may, however, disappear clinically, only to reappear in serious form at a later stage” (Winnicott, 1960, 146). As the environment becomes increasingly demanding of the infant and his or her needs to adapt to it, the false self becomes more rigidly implemented. When the true self is completely hidden by the false self, the infant loses his or her opportunity to behave spontaneously, chronically complies with its external environment, and learns to negate their own needs.

Winnicott asserted that the development of the false self occurs during the quality of the infant’s time in the holding environment. Good-enough mothering may allow for the development of a defensive hiding of the true self periodically and in an adaptive manner. However, in the context of inadequate parenting, the development of the false self takes on a more significant implementation. “The mother who is not good enough is not able to implement the infant’s omnipotence, and so she repeatedly fails to meet the infant gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant” (Winnicott, 1960, p.145). The ‘compliance’ of the infant, is said to be the development of the false self. Hiding the true self and its needs, for this type of infant, becomes more adaptive in a situation where the caregiver either is not attuned or able to be responsive to the expressed needs. The true self will not be expressed “if the child feels she must be attuned to the needs of others in the family system and if she needs to be a certain way in order to be recognized and acknowledged” (Flanagan, 2008, p. 133). Over time and frequent utilization, the false self has the propensity to become overly utilized and the true self can remain in deep hiding.

The effects of an overly utilized false self are varied. In one work, Winnicott asserts that over time the infant “builds up a false set of relationships, and by means of

introjections even attains a show of being real, so that the child may grow to be just like mother, nurse, aunt, brother, or whoever at the time dominates the scene” (1960, p. 146). In extreme examples, the true self can be so hidden that compliance dominates behavior and spontaneity is not present. Winnicott wrote of an evaluation conducted on a 6 year-old client named Bob. Arguably connected to his mother’s significant depression and panic disorders presented throughout his development, Winnicott wrote that Bob struggled with uncontrollable crying, maturational delays, socialization difficulties, and over-reliance on his mother (1965). It is likely that the unavailability of his mother during the crucial holding phases of his development may have caused Bob to rely on a false self in order to cope with repeated environmental miss-attunements. As a result, Bob continued to struggle to surpass certain impingements and struggle to adapt to the demands of his current environments. Winnicott wrote that those rigidly implementing their false self suffer in chronic ways that present symptoms throughout life. “One observes in such persons extreme restlessness, an inability to concentrate, and a need to collect impingements from external reality so that the living-time of the individual can be filled by reactions to these impingements” (Winnicott, p. 150). It seems that for such individuals, false self implementation then becomes a survival technique allowing one the ability to negotiate their participation in their social environments in a compliance-based manner, store their impingements of the true self for later review, and react in a false self way in true time. This pattern of behavior has the tendency to lead to a host of maladaptive functioning and mental health problems throughout life.

*Transitional objects.* A crucial portion of the infant’s progression from a state of absolute dependence to towards independence in the maternal holding environment is the

ability to negotiate the intermediate stage between total reliance on the caregiver object and total independence. *Transitional experience*, or the evolution of the infant's change in dependence as well as a cognitive shift from "subjective omnipotence" to greater independence and an "objective reality," was considered by Winnicott to be a central task enabling the infant the paradoxical ability to both attach in the early attachment relationships and to separate from them in maturational development (Mitchell & Black, p. 127). Not only does this process allow the infant the opportunity to differentiate from a symbiotic merger with their mother, it also was argued to provide the infant with a novel way of relating to others in the external environment onwards.

Winnicott asserted that good-enough parenting enables access to the infant's emerging ability to internalize their mother, or the elements of her that can serve soothing functions later on. "As long as the mother's unconscious wishes do not interfere with the baby's need to merge and then to differentiate, the process can go on" (Lane & Tolman, 2007, p. 41). Good-enough mothering allows infants the process of forming a unit merger with their primary caregiver, the process of differentiating from that caregiver, and ultimately through transitional experience, the process of developing a mental representation of a care-taking mother. "This lays the groundwork for the integration of the mother object in each person's inner world, a piece of that psychological apparatus that eventually allows one, through mental functioning to perform these care-giving activities for one's self" (Lane & Tolman, p. 41). Transitional experience ultimately allows the infant to hold the maternal object within when the maternal object is not present or is feared to no longer exist.

Because the straddling of symbiosis with the mother figure and the independence of separation-individuation can be such an anxiety provoking experience - even in the most healthy of holding environments, Winnicott theorized that the child takes an object representing the good-enough caregiver to help him or her hold both experiences paradoxically and simultaneously. “Sooner or later in an infant’s development there comes a tendency on the part of the infant to weave other-than-me objects into the personal pattern. To some extent these objects stand for the breast” (Winnicott, 1971, p. 3). However, the theory also asserts that the object not only signifies the mother, it “constitutes a special extension of the child’s self, halfway between the mother that the child creates in subjective omnipotence and the mother that the child finds operation on her own behalf in the objective world” (Mitchell & Black, 1995, p. 128). The process initiates with the child’s proactive search through the environment for an object to place maternal qualities onto to carry them through the separation. “In subjective omnipotence, the child feels she has created the desired object, such as the breast, and believes she has total control over it. In experience organized according to objective reality, the child feels she has to find the desired object out in the world; she is acutely aware of the separateness and distinctness of the object and her lack of control over it” (Mitchell & Black, p 127). Winnicott calls this the *original not-me possession*, a symbol of the recognition of separation from others before having the capacity for internal representations.

Winnicott believed that the development of *transitional objects*, or the process by which an object gets assigned special importance that is used by the infant to defend against anxiety due to heightened and prolonged separations, especially depressive

anxiety, allows for the bridging between infants and mothers in a manner that prepares them for a state of individuation (Winnicott, 1971, p. 4). He described the qualities that all transitional objects are required to contain: “the infant assumes rights over the object . . . the object is affectionately cuddled as well as excitedly loved and mutilated . . . it must survive instinctual loving and also hating . . . it must seem to the infant to give warmth . . . in health the transitional object does not go inside . . . it loses meaning, and this is because the transitional phenomena have become diffused” (Winnicott, p. 5). Winnicott asserted that the object becomes especially useful at bedtimes or at times “when a depressive mood threatens” (p. 4), allowing the child to experience the illusion of the mother’s presence while the mother is not actually available. “Normally, the infant substitutes security ‘blankets,’ and in doing so chooses an object that embodies the essence of the mother-her smell, her touch- but is in reality a symbol of her soothing and protective function” (Foehrenbach, Celantano, Kirby, & Lane, 1997, p. 43). As the child matures, the object often evolves from comfortable objects to be held close to objects that may more structurally represent the mother, such as a doll or a stuffed animal. Finally, the development of language is argued to allow the term “mommy” to be a final transitional object between the separating infant and mother, allowing for the internalization of the mother-object in a way that can be carried permanently. (Foehrenbach, Celantano, Kirby, & Lane).

The use of transitional objects not only allows for a healthy and adaptive separation from the mother, it also improves the individual’s capacity to be alone. Winnicott theorized that one of the most important qualities of healthy emotional development is the capacity of an individual to be contented while being in the context of

others and contented while also being alone. “He came to believe that the ability to tolerate, enjoy, and make use of healthy solitude could be developed, paradoxically, only in the presence of another” (Flanagan, 2008, p. 132). With the assistance of transitional objects and their ability to hold soothing qualities of the non-present soothing object, the infant’s inner world can become filled with object figures even when alone. In this manner, the individual grows to feel full, connected, and able to tolerate a variety of difficult emotional situations effectively. If, on the other hand, the infant has been victim to too much loneliness, isolation, or maladaptive parenting, their inner worlds can become filled with emptiness or fear (Flanagan). Once again, the importance of good-enough parenting, in Winnicott’s theoretical perspective, cannot be over-emphasized.

*Failures in Holding and Parenting, and the Development of a False Self Organization*

Since the first publications of Winnicott’s work, researchers and other theorists have expanded on his theories in an effort to better explain behaviors seen in the environment. When the maternal holding environment is inadequate and the infant’s false self is overly-implemented for defensive purposes, there are a variety of opportunities for emotional disturbance and the implementation of maladaptive behaviors. As described by Winnicott’s theories of early infant attachment and emotional development, the infant absorbs and internalizes qualities of their caregivers they perceive as useful and familiar to use during times of aloneness or distress. In the most healthful holding environments, the infant internalizes the positive and nurturing elements to use for soothing self-care.

Internalizations in environments where not-good-enough parenting is practiced, however, are conceptualized to occur in the same way. It is often mismatches between the infant and parent relationship that causes such destruction. Chronic miss-attunement,

unresponsiveness, or in more severe cases maltreatment on the part of the maternal caregiver not only threaten the efficacy of the holding environment, they have also been shown to significantly affect the infant's sense of safety in the world (Lane & Goetzl, 2007). It is said that feelings of profound helplessness and lack of protection are created by premature separations, an unresponsiveness to distress, and inconsistent interactions all during early development (Brush & Lane, 1996). The potential for impact upon the child's development and later mental health outcomes is significant. In early development, "the child omnipotently assumes responsibility for all negative events in his world and, therefore, is subject to blame not only for his own dysphoria, but also for negative paternal feelings and behavior" (Lane & Goetzl, p. 22). In this manner, the child assumes that any negativity directed toward him or her has actually been projected off and reflected back. As a result, the individual develops a mistrust of one's own needs and their likelihood of being fulfilled. Subsequently, efforts to shape oneself to the environment through the implementation of the false self become more heavily and chronically relied upon. Additionally, the primary caregiver, with the responsibility to teach the child to identify, tolerate, and regulate emotions, can also impact the strength of their child's emotional development. In inadequate holding environments, primary caregivers have been found to not only create frustration and emotional anxiety in their mismanagement or miss-attunement of needs, they can also fail to provide the necessary coping techniques for the child to endure them (Humphrey & Stern, 1988 as cited in Brush & Lane). Ultimately, an over-reliance on the false self and an inability to negotiate difficult affective states can result in maladaptive behaviors, representative of a "core affective disturbance" (Lane & Goetzl, p. 22).



Throughout development, maladaptive false self expressions can manifest in a variety of ways, such as “self-destructive behavior, provocative behavior leading to beatings, suicidal threats and attempts, sadomasochistic love objects, and a general pain-dependent life-style are common in traumatized patients” (Lane & Goetzl, 2007, p. 26). In infants, the earliest signs of miss-attunement with caregivers can be evidenced in “gaze-aversion” (Novick & Novick, 1990 as cited in Lane and Goetzl, p. 26). Masochistic tendencies, present for example in beating fantasies, are also common within groups of children suffering from the effects of maladaptive holding environments and is thought to defend against the destructive wishes the child actually feels towards their caregiver. In this manner, the aggression gets turned inwards and at the self through defenses of displacement, denial, and internalization (Novick & Novick, 1987 as cited in Lane & Goetzl). This is prime evidence of the infant’s desire to preserve the image of the caregiver, to mold themselves to the rigid needs of the environment, and to promote survival in the situation by implementing the false self. The developments of omnipotence and narcissism are also said to result from instituting the false self too early in the individual’s life. Also theorized to be a result of maternal miss-attunement and failures of the early holding environment, maintaining a delusion of omnipotence past its initial form in the phase of absolute dependence is said to be a false self implementation to protect against the actual displaced rage the infant is experiencing towards their caregiver for her/his failures and a substitution for self-esteem (Novick 1987, 1991, 1994 as cited in Lane & Goetzl).

Other theorists have focused on the manifestation of early frustrations from inadequate parenting and miss-attuned holding environments in somatic expressions.

Foehrenback, Celantano, Kirby, and Lane (2007) assert that “physical symptoms provided an avenue for individuals to express emotional distress who were unable to do so verbally or via other means” (p. 35). In health, the mother or primary caregiver helps the infant process their internal emotional states by helping them identify what emotions they are experiencing and providing them with the instruction and space to negotiate it. “This early psychic foundation will determine to a considerable extent the adult potentiality to capture and to recognize ones’ personal emotional reality and to be able then to communicate it to others” (p. 45). However, when this connection between affective states and words cannot be synthesized into one experience, feelings cannot be tolerated and are expelled, primarily through the body. “Faulty object relations that result in an individual’s continued reliance on infantile communication through the soma” has been conceptualized as one of the leading causes of these psychosomatic symptoms (p. 35). Infant insomnia, for example, is one of the first psychosomatic illnesses that appears and is said to result from the inability to either internalize or draw upon soothing images of the maternal care-giver (Foehrenback, Celantano, Kirby, & Lane).

As individuals age and implementation of the false self and somatic associations continue in a chronic way, Foehrenback, Celantano, Kirby, & Lane (2007) also argue that frequently “pathological transitional objects are created, which may take the form of addictive substances, addictive relationships, and perverse or addictive sexual behavior” (p. 47). The authors argue that the various addictive objects are used to diffuse mental pain like a mother’s care would sooth feelings. While over-eating, over-working, or dispelling of physical energies are common ways that many individuals attempt to cope, those with a history of difficulty expressing emotion have the tendency to develop a habit

of using such actions as chronic defenses to persistent emotional pain (Foehrenback, Celantano, Kirby, & Lane). Moreover, because the behaviors have been instituted for such a prolonged period of time, such individuals are generally unaware that they are evading unattended affects. Rather, they are filling their senses of loneliness and emptiness with objects, “transitional inanimate things, for self-soothing or as persons to be attacked or controlled” (p. 49).

Research has repeatedly indicated that the comfort that transitional soothing objects provide is effective, although only temporarily. Because the objects are used to quell the somatic symptoms associated with emotionality and not actually the affects themselves, they generally work for a period of time, stifling emotional instability in the moment until it rises in somatic form again, often as anxiety or uncomfortable mood states. As the affects are not being directly amended, the transitional objects are not able to be internalized (Foehrenback, Celantano, Kirby, & Lane) As a result, the transitional object is often just useful enough at temporarily quelling emotional discomfort and assisting the individual in implementing the false self to become an addictive pattern, but never truly effective. The process of over-reliance on food and binge-eating into addictive behaviors will be discussed and delineated further in the next chapter on difficult to treat binge-type eating disorders from a behavioral theory analysis.

#### *Winnicottian Treatment*

Winnicott’s ideas about effective treatment relationships directly mirror his theoretical underpinnings. The mental health struggles that call clients into treatment often relate back to the early impingements that might have occurred during early development. Often also termed as a fixation, Winnicott argued that individuals naturally

seek to work out such early developmental failures throughout their life (Fromm, 1989).

Winnicott argued that “the natural integrative thrust of human development always, under the right conditions of care, moves toward that which has been disintegrated” (p. 15).

Although the individual can continue to live with early developmental failures through false self orientations and other primitive defenses, they are argued to continue “to seek the conditions from later environmental care for the early failure to be recontacted, completed successfully, and set right” (p. 15).

In order to access a position of treatment readiness, a client must allow themselves to reach a mental status and functioning level where engaging in treatment is possible, as well as, an ability to regress to a position of dependency on the clinician. “This implies the letting go of the precocious and defensive self-sufficiency the patient has developed in holding himself” (Fromm, p. 15). In essence, removing the false self and espousing a willingness to engage in the therapeutic process exhibits a disrobing of learned defense mechanisms and a regression to an earlier psychological state. “The analytic setting, Winnicott writes, “reproduces the early and earliest mothering techniques” (1945b, p.286), and the patient, though he cannot know it as such, is functioning at the concrete level of symbolic equation” (p. 16). The clinician and the client, in their transference and countertransference, represent the earlier developmental holding environment. How difficult or easy it is to elicit the client’s actual transference and to engage with them in the environment reflects their early object interactions, their impingements, and their current relational difficulties. But, it is here in the unarmored transference, which Winnicott believed lay the opportunities for significantly effective repair. The work revolves around this level of typically unprecedented access to the

client, the success of the clinician's ability to hold the client in a safe and reliable way, and in the failures of the clinician, as well. In fact, Winnicott argued that it is in the clinician's failed ability to effectively meet the client's needs that actually brings the client closest to enacting the original impingement.

### *Food as a Maladaptive Transitional Object*

One highly implemented transitional object utilized by individuals with inadequate caretaking or deficient holding environments in order to establish a self-other boundary is food and the act of eating. It may generally go without stating that many theorists have correlated human's association of food as a warm, nurturing, and caring object with early feeding by the primary maternal caregiver. "Food is the focus of some of the earliest and most enduring parent-child interactions and it remains a symbol of mothering, nurturance, and soothing throughout the child's development" (Brush & Lane, p. 62). As a result, it is often the first object that many infants utilize in bridging the transition from merger with the mother and understanding the mother as distinct from the self (Sugarman & Kurash, 1982). "In fact, we would suggest that all infants use their body as a transitional object on the path to separation and individuation" (Sugarman & Kurash, p. 59). The innate ability to suck, the safety of close physical proximity during feeding, and the physical nourishment that results are all ways in which the interaction comes to completely satisfy the infant. This completeness, which begins with a physical satisfaction also becomes associated with emotional satisfaction throughout the infant's developmental process. Kohut (1977) asserted that the activity of eating is not only the desire for nutrients, but it is also a craving for the provider of the food. When associated together, the mother or caregiver and the food gains the ability to soothe and both are

internalized as such (Brush & Lane). Sperling (1949, 1968) also was food as “the semi-symbolic equivalent of the oral mother” (as cited in Chassler, 1998, p. 402).

Researchers have found that most individuals with BN or BED have pathological disruptions in their relationships with their primary caregivers. Most often, these individuals are thought to be in search of nurturing that was not provided during their early developmental days. Mothers of bulimics, for example, have been described throughout the literature as “passive, rejecting, and disengaged” (Johnson, 1991, p. 171). They are apparently not out-rightly neglectful, rather they appear to have the capacity to meet their child’s basic needs, although typically without emotional availability. It is thought that these women often carry their own emotional or affect regulation deficits into their next generation relationship. Their child’s infantile needs, unfortunately, prove too demanding for these individuals to cope with and failures for the child inevitably occur. The child, sensing their overwhelmed and under-involved caregiver and their insecure attachment to her, experience the rejection of their own needs and quickly look to the external environment to begin to regulate themselves independently (Johnson). Because food has powerful symbolic representations of the mother, “the bulimic repetitively turns to food in a futile effort to meet the need for nurturance, never having had a nurturing mother with whom to internalize and identify” (Sands, 1991 as cited in Brush & Lane, 1996, p. 58). Food becomes representative of the un-internalized and incomplete nurturing offered as a child and a replacement for the mother’s soothing functions. “The feeding situation becomes an attempt to make up for all the early interpersonal connections that ultimately were not there . . . The feeding takes on an endless desperation as it attempts to carry meaning that it cannot” (Johnson, 1991, p. 201)

Over time, individuals that use food as a transitional object grow to implement it, habitually and seemingly uncontrollably, to soothe negative emotional states in the absence of other affect-modulating techniques.

Sugarman & Kurash (1982) assert that without the early establishment of a soothing maternal object, the early phases of separation-individuation are said to be fundamentally difficult, in a way that is often precludes future separation phases throughout life. The development of walking and mobility, for instance, are said to be recalled by mother and grown eating disordered individual as representative of a loss within their relationship. As a result, the individual is thought to begin displaying damage to self via developmental difficulties, “specifically, a movement to external transitional objects and the concomitant development of new symbolic capacities and the more differentiated self-other boundaries associated with it” (p. 61). Because the move to traditional transitional objects cannot be made and a reliance on food and eating behaviors as objects to draw a maternal representation, the bulimic’s self-other representation does not adequately develop and separation-individuation continue to be acted out through the body (Sugarman & Kurash).

The behaviors of individuals with BN or BED can appear as a reenactment of the ungratified attachment what created in early object relations. For individuals with BED, there seems to be a symbolically frantic attempt to take in as much nurturance as possible through binge eating episodes. “It is likely that the acts of eating (in childhood) and later gorging (in adolescence) become the need-gratifying activities which allow the bulimic to develop a sensorimotor representation of the mother” (Sugarman & Kurash, 1982, p.61). Individuals with BN seem to actualize a slightly more ambivalent attempt at

seeking nurturance: bingeing can be seen as a re-enactment of the desire to take in and internalize primary caregiver's nurturance, while purging can be conceptualized as an expulsion of it in an effort to remain in complete control, to prevent fusion with and being overwhelmed by ineffective and miss-attuned external objects, or to reject nurturance out of mistrust or rage against the caregiver and their original failures (Brush & Lane; Sugarman & Kurash). Jessner and Absne (1960) also saw the bulimic behaviors as splitting, negotiating "longing for oral mothering while at the same time compelled to get rid of the introjected mother as it becomes poisoned by the rage of frustration" (Chassler, p. 402). Sugarman and Kurash, in interpreting these behaviors, saw the body as the transitional object, or a vessel for representing the maternal object and the expulsion of her. The bingeing actions of the body are argued to be a way to re-experience the moments of maternal nurturance, while the purging ones represent the terror of engulfment. Woodall (1987) also suggested that those with binge-type eating disorders develop transitional objects in food in order to replace the early caregiver and his/her frightening unreliability. In sum, the behaviors of those with BN and BED evidence the unsuccessful separation and individuation from the maternal object during transitional object development.

It is believed that individuals with BN and BED tend to develop or heighten their maladaptive eating behaviors during adolescence due to the revisited and re-emerging themes of separation and individuation. Adolescence is thought to be a time of crucial importance of the "convergence of body, cognitive, and separation issues" (Sugarman & Kurash, p.61). The increasingly sophisticated ability to understand the perspectives and expectations of others, the developing internalization of gender role expectations, and the



growing importance of friendships elucidate the importance social reputation takes on for adolescents. As a result, peer groups become the primary means individuals develop their identities, try on gender roles, and experiment with social acceptance during this time (Davis, 2004). Controlling body shape and size are primary ways the individual attempts to meet social expectations attempts to achieve group acceptance. Additionally, the adolescent is negotiating a metamorphosis as a result of cognitive, emotional, and physical changes. Consequently, the body ‘feels’ differently” than it did just a short time prior (Sugarman & Kurash, p. 61). For young women, their bodily changes tend to cause them to greater resemble their mothers, a complication during time of separation. Furthermore, Sugarman and Kurash argue that the inability for the individual to control the bodily changes that occur only heightens the original ‘not-me’ experience of the body as an object. The importance of the peer group during this time as well as the individual’s changing body both instigate a renewed urgency to separate and individuate from family and maternal object, in particular.

Not only are adolescent attempts to separate and individual often again unsuccessful for individuals with early developmental arrests, the development of binge or binge-purge behaviors is also said to represent the greatness of the original developmental arrest. Chassler (1998) writes that adolescence, because of the themes of peer group identification and bodily transformations, has the capacity to reactivate the issues developed during early failures in separation individuation: disturbances in the body, object representations, and the lack of object constancy. As a result, the attempted formation of transitional objects again becomes important. “Given the adolescent’s advanced cognitive capacities with the onset of formal operations, transitional objects can

become more diverse during adolescence than they were in childhood” (Sugarman & Kurash, p. 62). In health, items associated with peer group membership, such as clothing or music, used to set boundaries and replace the more sensory-based objects utilized in early transitional object development. However, for individuals where early object constancy and symbolization of early relational objects was not originally and successfully developed – like those with BN and BED, the ability to again create transitional objects for adolescent separation-individuation is often thwarted. “Therefore, the body becomes the playground for concrete play of separation” (Chassler, p. 403; Sugarman & Kurash), albeit a convoluted play. They assert that the individual craves the nurturing via feeding the body, while it also desires the separation and boundary development from the maternal object or the idea of the object that is achieved through the starving or emptying of it. Throughout adolescence, as other transitional objects lose meaning with healthy individuation, the individual with a difficult to treat binge-type eating disorder continues to keep theirs in focus in the absence of need fulfillment and failed healthy separation.

Finally, Barth (1988-89) also argued that the transition to college life can often serve as the triggered onset of BN and BED behaviors as they overwhelm such individuals’ needs. “College age women who have failed to resolve early conflicts over separation-individuation and who have not yet developed a stable sense of self, are not psychologically prepared to meet the demands of the college experience. They develop bulimia as a way of coping with problems of separation-individuation, self-esteem, and intimacy” (Chassler, p. 403). For those with earlier developmental arrests as a result of

miss-attuned parenting or inadequate holding environments, the pressures of adolescence often catalyze the development of disordered eating.

It is also argued that individuals that binge-eat and/or purge are not only re-enacting arrested developmental achievements associated with inadequate parenting and holding environments, but that they are also attempting to modulate their negative affective experiences, as well. The inability to self-regulate uncomfortable mood states is argued to be another result of not-good-enough mothering and inadequate holding environments. Mothers of individuals with BN or BED have been characterized in research as often capable of offering nurturance while also wildly vacillating in their delivery. They can appear “emotionally deprived,” “self-absorbed,” inconsistent, poorly attuned, and, “at times intrusive, while at other times, abandoning” (Brush & Lane, 1996, pp. 63-64). In this type of environment, children not only grow to distrust their caregiver’s ability to offer nurturance, they also begin to understand their own emotional needs as too overwhelming for their caregiver’s capabilities. As a result, they tuck them away until other methods of emotional satisfaction can be found. Because of its association with early maternal soothing techniques, food and eating quickly take the place of negotiation of or distraction from intolerable affects by providing a similar sensation of warmth, nurturance, and satisfaction (Brush & Lane). In the comfort of food, individuals “will allow themselves to behave in the presence of food in a way they would not allow any person to observe or participate in” (Johnson, 1991, p. 189). The freedom and nurturance individuals gain from food over time allows them to grow to use food to regulate tension and uncomfortable affective states (Johnson). However, as it only quells affects temporarily, prevents the ability to learn other affect-modulating techniques, and

often causes the individual physical and emotional discomfort following, the behavior is later found to be maladaptive and ultimately unsuccessful.

The developmental arrest created during failed separation and individuation from the maternal object resulting in such maladaptive eating behaviors to modulate affect has been said to lead to “a narcissistic fixation on one’s own body at the expense of reaching out to other objects in the wider world, through the use of external transitional objects” (Schwartz, 1985, p. 58). Such hyper-focus on the body, one’s own existence, and eating not only makes sustaining relationships with others difficult, it also reflects the eating disordered individual’s inability to effectively create or appropriately utilize interpersonal relationships. Much of this is the result of the tremendous conflict between the desire for dependence and the desire for autonomy in the lives of those with BN and BED (Brush & Lane). Yarock (1993), in his writings on such individuals, comments on the parallels between the way they relate to interpersonal relationships and to food: “There is a great hunger for symbiosis and anxiety over abandonment as well as a fear of loss of self with a tendency to control and push others away” (p. 10). As a result of such ambivalence and mistrust in the effectiveness of utilizing others for support coupled with an inability to effectively modulate emotional experiences, food becomes a far more trusted ally. For those that binge and purge, “the need to eat is the dissociated search of an orally approving maternal object and the need to vomit the urge to rid oneself of the monstrous creature” (Yarock, p. 10). Again, the conflict between the intense desire to fulfill unmet developmental needs and the fear of trusting objects that might fail as the primary caregiver may have is re-enacted in the binge-purge process. As a result, an over-reliance

on food rather than utilizing support from interpersonal relationships become a preferred – albeit maladaptive – coping strategy.

The desire to hide the often shameful disordered eating patterns from others also makes the process of developing, sustaining, and utilizing interpersonal relationships a trying one. More than simply wanting to mask their abnormal eating behaviors, those with BN or BED often also fear allowing others to witness the deeper meaning of their struggles. Yarock (1993) wrote of these individual's "wish-fear dilemma," or the individual's "wish for someone to identify and respond to her needs, which is juxtaposed against her fear that allowing someone to see the needy and dependent side will collapse the self-esteem and self-organization that evolved as a result of the pseudo mature behavior" (p. 12). The fragility implied in the artificial self-esteem of these individuals speaks to the weak facade they have built in order to support emotional survival, much of which is reliant upon the maladaptive use of food. Moreover, it indicates that there has been an active attempt to shield what Winnicott would call one's true self or true desires behind a carefully constructed wall of fear. In a way to protect one's true self under such circumstances, Johnson also wrote of the "distant closeness" individuals present with when relating to interpersonal relationships (p. 188). "In interacting with them, one has the illusion of relating, but overtime it becomes apparent that they are desperately protecting a separateness" (Johnson, p. 189). For individuals with BN or BED, the function of the disordered eating is often conceptualized as a way to "maintain the tenuous self-other boundary" (Chassler, p. 403).

This 'wall,' built with an over-reliance on food as a transitional object and an under-utilization of interpersonal relationships all to modulate affect due to inadequate

early holding environments of individuals with BN and BED can overall be conceptualized as the chronic implementation of the false self. Because such individuals found their primary caregivers characteristically incapable of meeting their needs after repeated failures in empathy and mirroring (Brush & Lane) or due to maternal under-involvement and over-control (Sugarman & Kurash), they grow to chronically suppress their emotional needs and mold their behavior to the given environment (Brush & Lane). As a result, “these patients tend to rely more on avoidance, denial, isolation of affect, and intellectualization” (Johnson, p. 188). Chassler (1998) argues that in their realization of their caregiver’s failures, they begin to prematurely take responsibility for their own and their environment’s self-regulation. In this manner, it is said that they develop a “pseudomature adaptation” to their emotion regulation needs and to meet the demands of their environment (Johnson, p. 188). Without the capacity to adequately meet their own infantile needs at such an early age, this adaptation – although temporarily effective and often deemed successful by the external environment, is later believed to be false or unfinished maturity. In this adaptation, individuals postpone their needs until the more demanding needs of the environment can be met.

Through this adaptation or the implementation of the false self, Chassler argues that they create a split self: “They split off and isolate their own infantile needs and over time they feel as if they are two people: one who feels desperately needy, which they experience as out of control; the other who appears to be responsible” (p. 404; Johnson). also described the experience of split selves; one the world sees as apparently competent and one the world sees as primitively needy. This ‘needy’ self represents what Winnicott would call one’s true self, while the ‘responsible’ false self presentation comes to appear

as compliant, attuned, and even caretaking to individuals in their environments. In interpersonal relationships, they seek to meet the needs of others far before their own, likely “in order to please others and secure the acceptance and understanding [they were] not able to obtain from [their] mother” (Chassler, p. 61), as well as, in an effort to ward off feared repeated abandonments. Over a period of time, these behaviors are continuously utilized in a patterned implementation and a pseudo-self-esteem is built to buttress the experience of inadequacy. However, “the discrepancy between the two states results in a self-representation of fraudulence and inadequacy” (Johnson, p. 188), and no real feelings of success or self worth are ever lasting. “They often have a veneer of adequate integration and achievement because they superficially have good social skills. Unfortunately, they discount or devalue whatever success they have experienced because they feel they are frauds. Consequently, self-esteem can never be enhanced, because any successful achievement is negated” (Johnson, p. 185).

As Winnicott argued, the chronic implementation of false self behaviors not only causes the individual to negate or postpone their own needs, it also prevents them from identifying and communicating their needs in other ways than relying upon the use of transitional objects. In individuals that use food to modulate affect, the maladaptivity of the false self implementation causes a significant postponement of affect regulation, a patterned use of food to modulate affect, a developed addiction to the behaviors over time through repetition, and an inability to utilize interpersonal relationships and other techniques for more adaptive affect regulation. It is exactly this false self implementation that often creates the most difficulty in treating BN and BED in the therapeutic context.

## *Summary*

The development of food as a maladaptive transitional object is one that begins during earliest development. Food and the act of eating, because of its inherent soothing associations, appear to be the first objects most individuals use to bridge the transition from merger with the mother to experiencing oneself as distinct. When pathological disruptions in the individual's relationship with their primary caregiver develop often as a result of an inadequate mothering or a miss-attuned holding environment, however, the reliance upon food for nurturing effects continues to be relied on in a chronic way. Without the early internalization of a soothing maternal object, the process of separation and individuation in infancy is arrested, and the desire to establish a self-other boundary becomes a somatic process, and one that is reenacted throughout development. Those with binge-type eating disorders are said to be forever in search of the soothing maternal object in food and the differentiation from it in purging or restricting behaviors. Over time, often after a second developmental arrest during adolescent separation-individuation, individuals that utilize food and eating as a transitional object grow to simultaneously use food to regulate affective states in the absence of other emotion-regulating behaviors, further reinforcing the power of food as a gratifying object. Moreover, the reliance on food to fill multiple roles coupled with early maternal failures discourages the individual's reliance on interpersonal relationships for need fulfillment and causes an over-implementation of false self presentation. Ultimately, it is the reliance on this presentation that this sub-group of eating disordered clients so difficult to treat in the therapeutic setting.



*Winnicottian Object Relations and Difficult-to-Treat Binge-Type Eating Disorders*

The thwarted developmental achievements associated with failed separation-individuation due to the inadequacies of the early holding environment seemingly produced an inability to create healthful transitional objects, the development of the maladaptive use of food and eating behaviors as objects, and an over-reliance on false-self presentations. All of these developments can amalgamate to create a population of individuals with BN and BED that is often characteristically more difficult to treat than others with similar afflictions. Johnson (1991), in his work on treating eating-disordered patients with borderline and false-self/narcissistic disorders, writes that “these patients usually do not respond to either brief cognitive-behavioral interventions or psychopharmacological treatment.” (p. 165). Because the therapeutic context revolves around the intersubjective activities that take place in the third space between the therapist and client, the themes that are most often revisited in general treatment and treatment of DTTBTEDs are related to issues of attachment. Having an early relationship with their maternal caregiver that was fraught with inconsistencies and unavailability, these individuals are typically very apprehensive about entering new relationships, trusting them, and utilizing them to better their attempts towards affect regulation. Moreover, a long-term reliance on food and eating as transitional objects has created a routine of acting out their emotion regulation and relational difficulties somatically. “Such patients do not verbalize negative feelings, might not be aware of them, or repress them so completely that the only way they can find an outlet is via their bodies” (Foehrenback, Celantano, Kirby, & Lane, 1989, p. 35). As a result, a number of a number of transference and countertransference issues arise in the therapeutic context that

make this sub-group of eating disordered clients more difficult to treat than others with similar symptoms.

One of the most difficult treatment conflicts that prove so difficult to overcome in with treatment resistant BN and BED is directly tied to the false self organization. At the beginning of treatment, they may enter them with a false-self presentation, tentative about the results of allowing themselves to enter a relationship that, by definition, requires transparency of the self. Linehan (1993), in her work on clients with borderline personality disorder, might also relate this presentation to what she terms “apparent competence” (p. 80). Apparent competence refers to the tendency of individuals “to appear competent and able to cope with everyday life at some times, and at other times to behave (unexpectedly, to the observer) as if the observed competencies did not exist” (Linehan, p. 80). For instance, at more comfortable points in treatment with individuals with a strong false self organization, Linehan argues that clients may appear confident and in control, while at times of discomfort or fear be far less able to participate in the clinical relationship. Their history of inhibited emotional expression due to an early invalidating or miss-attuned environment, a subsequent pattern of failing to communicate their emotional vulnerabilities to others, and their chronic reliance on maladaptive transitional objects to manage their emotion regulation is said to contribute to their fear of making themselves transparent and in the therapeutic setting and instead presenting themselves as more competent than they actually are. The difficulty in effectively treating this type of client is seen in the dialectical dilemma that is created in presenting as apparently competent: the client, “even though at times desperate for help, has great difficulty asking for help appropriately or communicating her needs,” causing an inability

to get needs met, and thus perpetuating the sense the invalidating nature of her external environments (Linehan, p. 84). With the establishment of a carefully attuned therapeutic holding environment, the passage of time, and a consistently validating clinician, such clients are said to then be able to develop basic trust and expose their needs and begin the actual work tied to recovery (Foehrenback & Lane, 1989).

Related to the false self organization are these clients' struggles with the 'wish-fear dilemma' in the therapeutic context. There is a significant struggle between negotiating both the great fear that allowing another to see the true neediness hidden by the pseudomature self elicits and the strong desire to overcome their relational struggles through their work in treatment. Fearing a total collapse of self coupled with the inability to trust that another can provide a safe enough holding environment to support them through creates a substantial resistance in the treatment setting. Johnson writes that for these clients in therapy, "the opportunity for involvement provokes a range of fears, from superego-based feelings of failure to more primitive concerns regarding being used and using others up" (p. 189). It is these fears amalgamated with the learned failure of their earliest caregiver to be attuned and responsive to their needs that creates a practice of "distant closeness" in their relationships (Chassler, 1998, p. 404; Johnson, 1991). In this manner, "one has the illusion of relating, but over time it becomes apparent that they are desperately protecting a separateness" (Johnson, 1991, p. 189). Theoretically, it is this type of interaction that causes the presentation of resistance in the treatment setting and forestalls any access to beliefs and behaviors that can be analyzed and processed to produce effective changes. For much of their career in treatment, working through these beliefs and their wish-fear dilemma can be a formidable piece of the work.

Johnson also asserts that there are a number of other dynamics in these clients' lives that have perpetuated the use of the false self organization, complicated the wish-fear dilemma, and created dynamics that are so characteristically difficult-to-treat. For instance, he asserts that the structure of the belief systems of many industrialized societies only adds to the struggle for female clients inherent in this dilemma. The belief subscribed to since the 1970s that women should strive to be independent and devalue their needs in exchange for sophistication has helped further define for women with this set of interpersonal struggles that relying on others would be a measurement of weakness and failure. Similarly, the individual's family unit likely chronically provided another reinforcement of the development of apparent competence. Because their pseudomature behavior so relieved their caretakers of overburdening responsibility, their apparent self-sufficiency had the capacity to be overtly or covertly applauded by the family unit and likely served to promote the family's overall stability (Johnson). In addition to their own early reliance on food as a transitional object and their under-reliance on interpersonal relationships, the additional applause individuals with binge type eating disorders receive for their independence also fuels the resistance towards exposing their true self with their clinicians and creating a difficult-to-treat situation.

As a result of these object relational deficits, Johnson asserts that these individuals typically require longer-term psychotherapy. Within the treatment, the central goal that ought to create the most effective outcomes can be conceptualized as a re-creation of early holding. "Since the central developmental disruption revolves around premature separation in response to non-malevolent caretaker under-involvement, the therapeutic task with this subgroup is to create a holding environment that allows the

patients to initially experience a regressive dependency that evolves into a mature interdependency” (Johnson, 1991, p. 189). Because this is a group of clients that were not adequately held as children, they were also not allowed to experience a range of emotions, “such as uncertainty, ambivalence, fear, selfishness, sadness, and rage” (p. 189). As a result, not only were they not taught proper management strategies, they were also not afforded the reassurance that all such feelings are normal and manageable. Similarly, Tolman (1991) asserts that an effective clinician espouses the following traits with this sub-group:

“the therapist must act as the ‘good mothering object’ to the patient, walking a fine line between allowing some dependency while encouraging autonomy and individuation; confronting maladaptive behaviors/defenses but also acknowledging their meaning and value; setting firm limits but leaving room for boundary testing and exploration; building self-esteem and the therapeutic alliance by providing support and by fostering positive transference, but allowing for the development of negative transference and confronting negative behaviors appropriately; allowing regression while encouraging maturation, etcetera” (p. 330).

Only with the establishment of a holding environment in a uniquely designed therapeutic relationship comes the ability to form basic trust, the predecessor to the processing of relational difficulties. A proposition of such a relationship is described later in this study.

Not only does the client present with a number of difficult-to-treat transferential components in therapy, they also pose several potentially overwhelming countertransferential requirements, as well. For instance, the establishment of a secure holding environment is a crucial element of successful work with individuals with difficult to treat BN and BED. Because this sub-group of eating disordered clients are so consumed by fear that their expressed needs will overwhelm or be rejected by the other, the successful clinician must continuously demonstrate an unconditional ability to

tolerate the client's needs. Moreover, once these needs are expressed, the clinician is often also pulled into a teaching mode through the creating of the client's idealizing transference. In this manner, the ability to teach the client how to live life more adaptively and affectively is generally elicited through the decoding and responsiveness of the client's needs, a process that is neither simple nor short-lived.

Secondly, because the client can generally be so skilled in the art of apparent competence and maintenance of the false self, the ability to weed through what in treatment is successful from what is actually just the client's tendency to hide their struggles or be "ostensibly compliant" is another potentially taxing assignment of a carefully attuned clinician (Johnson, p. 191). "These patients have spent their lives learning how to adapt themselves to others in order to lessen demands on significant others. Consequently, the therapist needs to be extremely attentive to communicating continuously to the patient that he or she is there to care for them as well as possible" (p. 191). Harris, Wiseman, Wagner, & Halmi (2001) also argue that inexperience in the task of recognizing exaggerated compliance with treatment recommendations and the minimization of active symptoms can result not only result in failed treatment, but more significantly in a sicker patient, as well. As a result, this proves to be another rigorous and challenging task of clinical work with this population.

Finally, Johnson (1991) argues that a clinician's ability to manage an idealizing transference without interfering with it is another task that proves to create a difficulty in effectively treating this sub-group. Because being assigned such power and influence in the therapeutic context by clients that desperately require their clinician to provide a good-enough holding environment can be experienced as uncomfortable and

disconcerting, many clinicians err on the side of discouraging such idealization. However, these are clients that need to be held by another in an omnipotent and narcissistic way. Johnson argues that “it is imperative for therapists to maintain the perspective that the patients desperately need to feel that someone else has the ability to be in charge, resilient, and powerful” (p.192). Although challenging and taxing to the clinician, the ability to tolerate these requirements in the therapeutic context with clients that have difficulty to treat binge-type eating disorders will arguably make the difference between helping the client to effectuate change and allowing the continuance of false self organization in the therapeutic context (Johnson).

### *Summary*

Because relational work is inherent in development of a therapeutic alliance any form of eating disorder treatment, from IPT to CBT, the difficulty in treating this typically resistant population due to their difficulties with interpersonal relationships is profound. As a population of clients with early and often repeated failures experienced within their attachment relationships, the process of entering new interpersonal relationships, maintaining them, and utilizing them effectively is one that they are often extremely apprehensive to take part in. They tend to present with strong false self presentations masking their true disorders and with apparent competence disguising their actual symptomatology. As evidenced in the wish-fear dilemma, they partake in treatment because they wish to be transparently be seen in an effort to improve their behaviors, while also desperately fearing that actual transparency will shatter the fragile structure of safety that they perceive they have built around themselves. It is this dilemma, the maintenance of the false self organization, and the continued reliance on

their disordered eating behaviors to buttress the entire system that together amalgamate to obviate the development of a therapeutic alliance and the effective use of treatment. Moreover, because of the time-consuming and intensive nature of effectively working with this population, there are a variety of countertransferential requirements that make the work challenging to accomplish, as well. However, with the establishment of a secure holding environment, a tolerance for the client's needs, a careful attunement to their client's apparent competence or obstinate compliance, and the allowance of an idealizing transference coupled with the client's ability to form basic trust in the clinician, this population of difficult to treat binge type eating disordered individuals can be helped.

#### *The Case of Mary*

Sugarman & Kurash (1982), in their work on the object relations of individuals with BN, illustrate a theoretically exemplary case of an individual with a difficult to treat presentation of BN as a result of the individual's object relational difficulties. At the time of treatment, "Mary" was a 24 year old, single, Caucasian graduate student that presented with recurrent episodes of bingeing and purging. She would hoard high calorie food in her dorm room, gorge on them in her room, and frequently vomit in the bathroom. Her weight would regularly fluctuate, and she would become depressed and self-deprecating following the binges. The behavior reportedly first presented itself at age 18 when she left home for college and continued on an intermittent basis throughout her college years.

The authors illustrate her developmental history as significantly affected by her early attachment relationships. When Mary was almost one year old, she suffered a dramatic shift in her primary caregiver: her mother went to work full-time, while her grandmother assumed responsibility for her care. "This change in primary caretaker,



coming at a time when her attempts to actively separate from her mother were still tenuous, had highly visible consequences in regard to Mary's ability to tolerate future separations and subsequently, to her developing motility," evidenced in her reportedly sudden sullenness and refusal to walk (Sugarman & Kurash, p. 63). Additionally, Mary's grandmother was said to regularly compare Mary to her mother, described solely as a "perfect child" and an "absolute saint" (p. 64). "It seemed that her early loss interacted with her grandmother's unidimensional description of her mother and prevented sufficient differentiation and articulation of the maternal representation to provoke evocative object constancy" (p. 64). Meanwhile, Mary's father was described to be openly hostile and critical of her weight. In sum, opportunities for developmental arrest were substantial. She is said to have developed a beginning obsession with food shortly following. Her appetite grew, she dreamt of food associated with her mother, and she began to put on weight.

During her second attempt at healthy separation and individuation during puberty, arguably already complicated with remnants of her failed first attempt, fell during a period of family uncertainty (Sugarman & Kurash). Her family was forced to uproot and move to another state for employment purposes. During this time, her caretaking shifted again, from her grandmother to her mother as the primary caretaker. It is said that the loss of her grandmother's presence and her peers at school was overwhelming, resulting in Mary feeling isolated. As a result, she is reported to have shifted a great deal of her focus on being thin and looking attractive.

The miss-attunements of Mary's holding environments, the difficulties suffered in what was perceived as not-good-enough parenting, the repeated shift in primary

caretaker, and the developmental arrests suffered at both junctures of separation-individuation speak to the significance of Mary's experience of loss. "These losses undermined the establishment of a basic sense of security, and the internalization of a stable maternal representation, leaving her emotionally hungry for love and acceptance" (Sugarman & Kurash, p. 65). When challenged by the phase of life pressures associated with leaving for college coupled with early experiences of loss, Mary's eating battles began to present as symptoms of bulimia. "Experiencing severe feelings of emptiness and panic, she lost all controls over her eating. According to her, this was the first time that she consciously 'used eating to numb my feelings and fill myself up.' . . . A pattern of gorging and vomiting, particularly at times of separation, became pronounced" (p. 65). During these episodes, it is said that Mary would envision her mother, experience the feeling of being held by her, and then strangled by her. Binging can be conceptualized as attempts to gain union with her, while purging was a violent act of maintaining separation from her.

Mary's entrance into treatment aroused her transference of the difficult object relational dynamics she experienced during her youth (Sugarman & Kurash). She reportedly quickly developed a relationship with her therapist where her feelings fluctuated between those of affection and closeness and fears of being abused or feelings of anger, culminating in binge-purge behaviors, somatically negotiating between the wish-fear dilemma. The inability to allow herself to form a basic trust with the therapist, expose her vulnerabilities, and eliminate her maladaptive eating behaviors lead a difficult to treat situation. Until she was able to cease using the act of eating as a transitional object, or "the illusion (representation) of being reunited with the needed other," she

would not be able to allow the therapeutic environment to hold her, eliminate a false self presentation, and reduce her resistance enough to effectuate necessary behavioral and relational change (Sugarman & Kurash, p.65).

### *Chapter Summary*

Individuals with DTTBTEDs not only suffer a series of more intensified, prolonged, and treatment resistant symptoms than others with differing forms of eating disorders do, they also exhibit a characteristically different object relational history. The object relations lens, more than other lenses, has the ability to portray the pattern of interaction that individuals have had with others in their environments from infancy forward, the style of interaction that they have adopted as a result, and the impact that the formulation of maladaptive interpersonal object relations has had on their affective and emotional development. Although the work of such theorists, as Bowlby, Klein, Fairbairn, Guntrip, and Mahler helped pave the way for the development of object relational thinking, many argue that Winnicott's theories not only effectively and comprehensively define how an individual's internal world is influenced by relationships in their external environments, but that his works are also often highly applicable in understanding the experience and plight of those with eating disturbances in a way no other theorist's schemas could.

Although his work was regarded as notably more radical than others at the time, his key theories have remained highly utilized and referenced today. More specifically, his ideas on the maternal holding environment, or the establishment of a series of mother-infant interactions where the infant's physiological needs are sought to be met in a reliable, consistent, empathic, nuanced, timely, and attuned way to prevent early

impingements and the development of psychological problems in the future; good-enough mothering, or the ability to functionally attune with the infant and responsively meet the infant's needs; false self phenomena, or a defensive organization to hide and protect the true self and true needs in situations where good-enough mothering or attuned parenting is not provided, and where the individual feels forced to comply with their external environment, learning to chronically negate their own needs; and, his thoughts on transitional objects, or the process of assigning maternal soothing value to external objects from which to enable the infant to hold the maternal object, in form, internally even in its absence all help clinicians to not only understand the outcomes of healthful holding environments and good enough parenting, but to also delineate the often complex processes that are inherent in maladaptive psychological development.

When chronic miss-attunements, unresponsiveness, or even maltreatment occur on the part of the early primary caregiver, not only is the integrity of the holding environment threatened, but the infant's sense of safety in the world is compromised, as well. Such a mistrust in the primary caregiver then extends itself to others in the external environment, to oneself, and to one's own needs, as well, and as a result, a powerful and chronic reliance on the false self and transitional objects often develops. Because food and the act of eating is so closely tied to the safety and nurturance offered through memories of the early maternal caregiver, many such individuals develop a chronic reliance on food in an effort to re-experience that sensation of nurturance as a transitional object. This reliance on food, over time, is not only an attempt to elicit feelings of nurturance, it also becomes inextricably tied to attempts to regulate affective states, preserving false self organization, and results in the chronic under-reliance of the

utilization of the use of interpersonal relationships for affective support in a characteristic way that is specific to the difficult to treat binge type eating disorder sub-group.

As a result of the complexities of the maladaptive use of food as a transitional object and the chronic use of the false self organization, treatment in psychological settings is challenging at best. Because relational work is an essential component of any form of eating disorder treatment, the wish to ameliorate their maladaptive eating behaviors is complicated and often stifled by the fears of transparency with the clinician in a way that might elicit repeated rejections similar to those that were perceived to occur during early development and adolescence. Consequently forming basic trust is often thwarted and reliance on binge and purging behaviors as a means of somatically negotiating their wish-fear dilemma is perpetuated, making this population of individuals with binge type eating disorders difficult to treat.

Where this chapter has been instrumental in illustrating the object relational factors that have contributed to the formation of DTTBTEDs, the following chapter will illuminate the elements of behavioral theory that are also significant in the formation and perpetuation of disordered eating patterns. More specifically, the ability of food and eating to modulate affect over time, as well as the propensity of the behaviors to take on addictive components are two other factors of binge type eating disorders that also make them highly resistant to traditional treatment models. Both will be thoroughly explored in Chapter Four.

## CHAPTER FOUR

### BEHAVIOR THEORY AND DIFFICULT-TO-TREAT BINGE-TYPE EATING DISORDERS

#### *Introduction*

Winnicottian object relations theory provides an efficient and comprehensive lens from which to view the effect that inadequate early mothering and holding environments can have on the formation of affective and emotional development, the pattern of maladaptive interactions that individuals adopt in relating to others from infancy forward, and the over-reliance on food and eating to self-soothe in individuals with DTTBTEDs. Behavior theory, on the other hand, offers an equally effective lens from which to better understand the processes that occur to solidify the use of food and eating as a temporarily successful and maladaptive affect-modulating tool. The theory not only offers an essential understanding of the mechanisms that are activated that cause eating to become a soothing activity, it also articulates the processes involved in the transformation of repeated attempts to regulate affect with external means into addictive behaviors.

#### *Overview of Behavior Theory*

Behavior theory can be classified as the study of the processes of learning that occur through experiences during one's lifetime that informs and alters the way an individual acts within their environment. Influenced by both internal biological processes and one's external physical environment, individuals' behaviors are thought to reflect the effects of both influences simultaneously, often inextricably, and repeatedly. Human

behavior is seen as shaped by both one's past and present, asserting that old experiences shaped patterns of responses exhibited in present behaviors. Similarly, the theory also asserts that current maladaptive behaviors can be altered to create improved behaviors in the future (Cooper & Lesser, 2008). "Since behaviors are learned, they can be unlearned," and behavior theory describes the basic principles involved in both (p. 162).

Behavior theorists use common terms to discuss the individual mechanisms that are involved in learning processes and the interactions between them that together constitute learning patterns. *Learning* in behavior theory is "a process of adaptive change in which people adjust appropriately as they interact with their environment" (Thorpe & Olson, 1997), bearing in mind that although some individuals exhibit behaviors that seem to be clearly maladaptive, it is highly likely that at one point the behavior was likely an adaptive effort to better survive in their environment. *Stimulus* is the terminology used to refer to an individual, object, or behavior that incites a response in another in an observable way. *Response* commonly refers to the reaction that occurs following a stimulus, and a *respondent* is an individual or object that reacts.

Many argue that there are three learning modes: *classical* or *respondent* learning, *operant* learning, and *social* learning. Classical or respondent learning involves the direct link between stimulus and response in behavioral assessment. Operant learning focuses on the individual's overt efforts and ability to change their behavior, and social learning emphasizes the influence of cognition involved in learning processes such as imitation, modeling, and observation (Lesser & Pope, 2007). Each of these modes will be delineated further in the present chapter.

## *Pavlov*

The use of behavior therapies in the clinical workplace began by a small group of clinicians in the 1950s as an alternative to psychoanalysis. However, the theoretical development of behavior theory began nearly a generation earlier (Thorpe & Olson, 1997). In an unintentional yet fortuitous series of empirical events, the foundations of behavior theory were originally stumbled upon by Russian physiological researcher, Ivan Petrovich Pavlov shortly after the turn of the 20<sup>th</sup> century. Interested in investigating salivary reflexes and digestion in dogs, Pavlov was engaged in a series of experimental procedures testing stimulus introduction and *unconditioned*, or natural, salivary responses. Pavlov arranged to have meat powder placed in the dog's mouth by white-coated laboratory assistants, he would observe the dog's salivary response, make measurements and evaluations. "The meat powder stimulus and the salivation response together form the salivary reflex, an unlearned or unconditioned reflex" (p. 35). However, as the experiments continued, Pavlov realized that the dogs would also grow to salivate prior to the introduction of the meat powder, at the sight of the white-coated laboratory assistants. Although initially thought to be an annoyance and complication to his planned experimental procedures, he quickly realized that he was actually observing something quite meaningful. In replications of the same procedure, he discovered that the *pairing* of the *unconditioned stimulus* of meat powder and the *neutral stimulus*, or a person or thing without the natural capacity to incite a particular reaction, of the white-coated laboratory assistant produced a *conditioned*, or learned, response: salivation at the sight of the white lab coat, or the newly *conditioned stimulus*. Pavlov's discovery of this phenomenon, later termed *classical conditioning*, occurred entirely accidentally (Thorpe & Olson).



To further test the validity of the conditioning process, Pavlov extended his study of conditioned salivation by pairing meat powder with other stimuli. For example, he opted for a more uncomplicated experimental measure than the white-coated laboratory assistants by pairing meat powder with the ringing of a bell, a stimulus that could be more precisely controlled and measured. As expected, the formerly neutral stimulus of the bell came to be a conditioned stimulus of salivation through the repeated pairing of bell and meat powder. The bell, in isolation, came to produce the salivary response. As a result of his series of experiments, Pavlov was not only able to solidify his theory on classical conditioning, he was also able to determine the ideal circumstances that ultimately produce conditioning, including the time interval between stimulus presentations, the duration of each stimulus, etc., findings he published in 1927. (Thorpe & Olson; Cooper & Lesser, 2008).

Just as Pavlov demonstrated that conditioning could successfully occur with the intentional pairings of unconditioned and neutral stimuli to produce a conditioned response, the reverse process can also be theoretically applied to diminish the relationship between two classically conditioned stimuli that are producing an undesired response (Thorpe & Olson). *Extinction* can be achieved by presenting the conditioned stimulus repeatedly without the unconditioned stimulus in order to reduce the conditioned response. “For example, if the laboratory assistant appears repeatedly without the meat powder being presented immediately afterwards, the appearance of the assistant will eventually fail to evoke salivation” (p. 37). Although there is some inherent discomfort assumed in the extinction process, the fading of unwanted conditioned responses is

described to be achieved successfully through this theoretical process and has become the basis for many behaviorally-oriented clinical therapies.

Pavlov's discovery of classical conditioning has had important implications for the field of psychological research and clinical treatment. "Because it can occur whenever a new stimulus is repeatedly presented together with a reflex-exciting stimulus, behavior therapists have taken classical conditioning seriously as a possible explanation for some mental health problems" (Thorpe & Olson, p. 37). In fact, the process of classical or respondent conditioning is often considered "the fundamental theoretical explanation for a variety of anxiety and phobic disorders" (Cooper & Lesser, p. 163). For instance, anxiety can be explained as a reflexive response triggering physical changes, such as heart and respiratory rates, by stimuli that naturally evoke such a response, such as surprising or shocking noises or upsetting events. However, the anxiety response can also become easily associated with another stimulus event that becomes conditioned with the unconditioned stimulus and the anxiety response by being introduced just before the unconditioned stimuli in a paired manner. For instance, children in a Haitian orphanage playing a popular board game as a massive earthquake struck might experience a heightened anxiety response to the game thereafter due to the pairing of it with the unconditioned stimulus. Treatment for victims of accidental pairings and subsequent anxiety responses "would be based on the principle of extinction; the technique would be to encourage the client to confront the conditioned stimulus repeatedly in the absence of the unconditioned stimulus" (Thorpe & Olson, p. 38).

The theories developed by Pavlov's accidental unearthing of the process of classical conditioning have made a variety of other important impacts on the field of

clinical psychology. Using the conditioning process to make a client's set of behaviors more adaptive or utilizing extinction processes to diminish maladaptive behaviors have been implemented through the years in the clinical setting by behavior therapists in a variety of treatments, such as Wolpe's assertiveness training, systematic desensitization, aversion therapy, anxiety relief therapies, and exposure therapies (Thorpe & Olson). Many behavioral treatments incorporating the principles of classical conditioning have come throughout the years to be integrated into multimodal therapies, but the basic principle of evaluating the behavior, its precursor and its successor will likely continue to be highly utilized therapeutic principles for some time (Cooper & Lesser).

### *Skinner*

Often considered "the father of behavioral theory" due to his intentional and successful study of behavior, B.F. Skinner made significant contributions to the field of behavior theory through his studies of *operant conditioning* (Cooper & Lesser, 162). Skinner, a 20<sup>th</sup> century behavior empiricist, believed that psychological research should only study measurable phenomena, thus ideas about the inner workings of the mind were inconsequential to him (Berger, McBreen, & Rifkin, 1996). He was instrumental in broadening the range of understanding of conditioning processes by evaluating *operant* behaviors, or those that involve overt activity on the environment. Moreover, his research also portrayed the modifiable nature of human behavior by exhibiting the power of consequences in relation to behavior change (Thorpe & Olson). "Whereas respondent behavior and classical conditioning are relevant in understanding reflexes and emotions, operant behavior and operant learning apply to the whole range of active human behavior – speaking, doing, working, playing, avoiding, learning new skills, and so forth" (Thorpe

& Olson, p. 58). Because he believed that humans are more a product of their environment than their natural abilities, he also believed that all behavior could be controlled by the consequences it receives (Berger, McBreen, & Rifkin). With this perspective in hand, Skinner developed convincing experiments that articulated his ideas.

In an effort to refine previous animal behavior experiments, Skinner developed what became known as “The Skinner Box” where the behavior of pigeons, for example, was evaluated (Thorpe & Olson). “The standard chamber Skinner used for pigeons consisted of a temperature-controlled rectangular box. One of the internal walls has a tray in which food (grain) may be presented and a disk that the pigeon may peck” (p. 59). When the pigeons would peck the disk, food would automatically be released into the tray. When the disk was disconnected from the food mechanism by the experimenters, pigeons quickly reduced the frequency in which they pecked at the disk. This type of behavior reflects what Skinner termed, operant behavior or *operant conditioning*.

Skinner and other behavior theorists already believed that learning involves behavioral transactions between individuals and their environment, through relationships between stimuli and responses (Berger, McBreen, & Rifkin). Through Skinner’s experiments and theory development, however, the field became able to first distinguish reflexive behavior from learned behavior. He recognized that the pigeon was reacting to a *behavioral contingency*, or the *if-then* relationship between pecking the disk and the food. Skinner saw that the delivery of food was experienced as a positive response by the pigeon, recalled by the pigeon, and continuously increased its pecking behavior. This process, where behaviors are encouraged and increased, he termed *reinforcement*. Conversely, the absence of food was experienced as a negative response, evidenced in the

pigeon's reduction of pecking behaviors. This process of disconnecting the contingency and reducing a given behavior became known as *extinction* (Cooper & Lesser). Thus, the increased frequency of pecking was not merely a reflexive activity; rather, it was one that was considered a learned response. Similarly, the reduction in pecking frequency was not necessarily a random activity; it was an effect of the pigeon's learned response that pecking the disk no longer yielding a reinforcing effect (Thorpe & Olson).

Skinner's experiments also yielded more information that detailed for researchers the processes of reinforcement and extinction. For instance, he found that the pigeon could be led towards the desired behavior by dividing the learning task into a number of smaller tasks, a process known as *shaping* (Thorpe & Olson). "For example, a first step in the shaping program could be to present food whenever the pigeon enters the half of the chamber nearer to the disk" (p. 61). As a result, moving closer to the disk would be reinforced until the pigeon was led or shaped to the disk. Skinner's theory also asserts that reinforcement can be achieved through both positive and negative means. For instance, when the pigeon is offered food for a given behavior, the reinforcement is considered *positive* because it increases a desired behavior. However, if the researchers exposed the pigeon to an uncomfortably loud noise that could be extinguished if the pigeon pecked at the disk, the reinforcement would be known as *negative*, "because the behavior increases when something (the noise) is withdrawn" (Thorpe & Olson, p.61).

Skinner's work offered the psychological clinical community a host of promising behavioral treatments on the basis of his profound operant conditioning discoveries (Thorpe & Olson). The general approach to extinguishing problematic behavior is to identify the behavioral contingency that is causing it. "Conceptually, this is as simple as

ABC: Identifying the contingency means identifying A: the antecedent events or discriminative stimuli; B, the behavior; and C, the consequences, or the reinforcers” (p.70). When applied to testing-anxiety responses in academic settings, for example, clinicians and clients could move closer to a problem-solving technique by identifying the specific situations that repeatedly induce stress (e.g. the classroom, the lecture hall, a blue book, etc.), the nature of the anxiety that the client wants to extinguish (e.g., accelerated thoughts, heart, and respiratory rates), and the consequences (e.g., errors, not finishing the exam, failing, feeling ashamed). In order to improve the anxiety, the antecedent and/or the consequences around the testing-anxiety would need to be changed depending on the specific client and situation. For instance, the situation could be altered in a way that felt more comfortable to the test taker through a step-by-step shaping way, or, the consequences, responsible for reinforcing the behavior by some means, could be altered so that they would lose their current effect. In sum, Skinner’s work in defining operant conditioning theory has made important empirical and clinical impacts on the field of psychological research and treatment.

### *Bandura*

Where Pavlov’s and Skinner’s theories of classical and operant conditioning reflected the automated nature behavior can take on, Albert Bandura is credited with expanding the link between behavior and internal processes (Cooper & Lesser). Experiencing conditioning theories as too mechanic, Bandura and his colleagues “stressed the importance of those personal factors and self-regulatory processes that intervene between stimuli and responses” (Thorpe & Olson, p. 85). Skinner identified the learning process inherent in acquired behavioral practices, but Bandura aimed to study it

as an active process, believing that the individual approaches behavior with a sense of observation, cognition, and aim towards organization. In his 1969 publication, Bandura described individuals to often mold their behavior more frequently when contingencies were observable and understood. As a result, his identification of *expectancies*, or positive reinforcements that were observable by the individual, enhanced the theories of conditioning by highlighting the power of the active processing. He did not believe that internal motivational forces were enough to cause behavior change, nor did he imagine that external stimuli were the only contributing forces either. Instead, Bandura crafted his theories of behavior change around the combination of conditioning principles and observational learning or expectancy to develop *social learning theory* (Thorpe & Olson). Bandura organized the theory into four key concepts: observational learning, reciprocal determinism, cognitive processing, and self-efficacy (Cooper & Lesser).

*Observational learning* came to be defined as the type of learning where the individual is aware of the behavior, remembers the behavior, and repeats the behavior with the expectation that the positive reinforcement will be available (Cooper & Lesser). Bandura described observational learning, also known as *modeling*, as having the ability to explain the vast host of behaviors that individuals take part in that are not taught through reinforcement, such as teaching children to swim or adolescents to drive. The theory of modeling describes how individuals observe other individuals engage in behaviors of interest, their related consequences, make an internal judgment about the process, and engage in a process of learning before doing (Thorpe & Olson).

Bandura asserted that social learning theory espoused more of an explanation for behavior than just combination of individual and environment. Rather, he felt that

“behavior, the person, and the environment all influence, and are influenced by each other” (Thorpe & Olson, p. 92). This interactional process, or *reciprocal determinism*, came to explain to a greater degree the variety of influences that can be simultaneously occurring in behavior change. More specifically, three types of interactions are said to influence each other: the person’s thoughts and emotions interact with behavior, the person’s thoughts and emotions interact with the environment, and the behavior interacts with the environment (Cooper & Lesser). As a result, when evaluating a behavior that is desired to be acquired or extinguished, all factors and their relationship with one another need to be evaluated. For example, in the example of test anxiety, evaluating the relationships between the test taker, their thoughts about the test, their feelings about the test, the testing environment, and the anxiety all need to be related to one another and evaluated thoroughly in order to better inform the efficacy of the treatment.

Bandura also identified the *cognitive processes* important in behavior acquisition and change: the ability to anticipate future behavior and consequences, the ability to symbolize and store images for future retrieval, the ability to set goals and monitor progress, and the ability to be self-reflective on one’s inner processes (Cooper & Lesser). In the example of test anxiety, evaluating the cognitive processes that are involved in quelling anxiety can broaden the understanding of the internal processes that are occurring. The ability to anticipate the test often significantly contributes to the intensifying of physical anxiety reactions, the ability to symbolize the experience of test taking and store it may provide a reinforcing component to the return of the anxiety when the test taker returns to the testing environment, the ability to set goals allows the anxiety-



ridden test taker to make detailed plans for change, and the ability to be self-reflective allows one to observe their behavior.

Finally, Bandura also recognized the importance of *self-efficacy* in social learning theory development (Thorpe & Olson). Behavior change, he argued, is more effective when the individual has a better sense of their own agency or efficacy in acquiring or overcoming a behavior (Cooper & Lesser). “Persons with high self-efficacy see challenges as something they can overcome, and each success builds further confidence. Persons with low self-efficacy doubt their abilities, and don’t perceive themselves as competent to deal with their environment” (p. 163). Thus, the strength of one’s sense of self-efficacy has a significant effect on their ability to cope with difficult situations, or the likelihood of avoiding them altogether. For instance, the test-taker’s perceived self-efficacy will have an important impact on the likelihood of facing the anxiety, making efforts to change it, and working towards maintenance of change over time. In fact, Bandura argued that the best way to increase an individual’s self-efficacy around a certain behavior is through mastery experiences, or the process of practicing a behavior until an increased comfort level is achieved (Thorpe & Olson).

The foundations of Bandura’s social learning theory have permanently altered the field of behavior theory by expanding the understandings of the detailed dynamics inherent in behavior change. More specifically, he was able to identify that, in addition to stimulus-response learning, individuals can be highly influenced by their environments and overtly make decisions about their behaviors that can influence the change process. His ideas about reciprocal determinism, cognitive processing, and self-efficacy also broadened theoretical understandings of the intricacies involved in the behavior change

process. Moreover, they create better opportunities for researchers and clinicians to address the potential psychological and motivational components that influence behavioral therapy work.

### *Summary of Behavior Theory*

The field of behavior theory has expanded dramatically during the past century, and largely as a result of the work of several theorists. Where Pavlov was instrumental in identifying the relationship between stimuli and response, Skinner was influential in identifying the active and operant activities inherent in conditioning processes. Bandura, however, was able to compound on their work and greatly expand the understanding of the various interconnected origins of behavior by extrapolating the impact of observational learning, reciprocal determinism, cognitive processing, and self-efficacy. Together, these theories have formed the fundamental principles of behavior theory that is used in a wide variety of behavioral treatments today.

### *Behavioral Treatments*

The fundamentals of behavioral treatments utilized in clinical practice invariably consist of three components: behavioral assessment, the establishment of a therapeutic relationship, and choosing the appropriate behavioral treatment modality. Behavioral assessment usually consists of a rigorous analysis of the behaviors that an individual is seeking to acquire or extinguish and has several important functions (Cooper & Lesser). “Behavioral assessment is used to (1) develop clear and specific descriptions of presenting problems, (2) identify variables related to the onset and maintenance of these problems, (3) evaluate the severity of the client’s problems, (4) identify effective treatment options and, (5) provide a means of evaluating treatment implementation,

progress, and outcome” (Thorpe & Olson, p. 150). These tasks can be achieved in a structured interview, through questionnaires or rating scales, self-monitoring techniques, or through skilled observation (Thorpe & Olson). The therapist is then “viewed as a consultant, teacher, and trainer who is there to help clients learn about themselves and change maladaptive behavior patterns” (Cooper & Lesser, p. 164). Throughout all behavioral treatments, the therapist guides the client to experience corrective learning procedures, new coping skills, improved communication, and breaking maladaptive habits. Although the relational dynamics of the therapeutic relationship are not regularly recognized or emphasized, “there is a growing empirical literature that demonstrates that clients perceive the relationship as crucial,” as well in behavioral therapies (p. 164). This very point will be addressed to a deeper degree in the next chapter.

*Classical conditioning-based treatments.* Choosing the appropriate behavioral treatment is a vital component of successful intervention. Just as there are several key concepts in behavior theory, there are also corresponding styles of behavioral treatment. For instance, in the model of classical conditioning, *confrontive exposure therapies* like *implosive therapy*, *imaginal flooding* and *exposure in vivo* are said to be utilized (Thorpe & Olson). Confrontive exposure, often termed flooding, can be described as confronting an individual with a stimuli that they have found distressing in a graduated way until they become more accustomed to them. Implosive therapy is utilized to expose individuals to the thoughts and internal imagery that have been defensively repressed and denied due to their uncomfortable or painful pairings with particular stimuli until they are able to stabilize their anxiety response and extinguish the conditioned responses (Thorpe & Olson). Imaginal flooding, much like implosive therapy, utilizes confrontive anxiety-

reducing techniques around specific stimuli without the additional fantasy material. Finally, exposure en vivo encompasses a variety of “confrontive real-life exposure,” where the individual is presented directly with the troubling conditioned stimuli, guided towards a reduced anxiety response, and eventually extinction of the stimuli’s power (Thorpe & Olson, p. 54).

*Operant conditioning-based treatments.* Where behavioral techniques based on the principles of classical conditioning are based around extinguishing the conditioned association between stimulus and response, those based on the principles of operant conditioning are based on a extinguishing the conditioned association between stimulus and response with a more active awareness (Thorpe & Olson). The ABC method of identifying the antecedent events, the behavior, and the consequences associated with a conditioned response tend to be inherent in such treatments as *habit modification*, or pairing two events repeatedly until a conditioned habit occurs, *reinforcement procedures*, geared towards shaping behavior through prescribing positive or negative responses in order to increase or decrease it, and *punishment or aversion procedures*, or implementing uncomfortable responses to behaviors that one seeks to extinguish. In each method, the process of developing awareness around the behavior and the behavioral modification process that is occurring is a significant portion of the treatments and their effectiveness.

*Social learning theory-based treatments.* Behavioral therapists that practice with the principles of social learning theory tend to invariably utilize behavioral treatments with a strong cognitive focus. Perhaps the most recognizable and widely utilized treatment is cognitive behavioral therapy (CBT) (Cooper & Lesser). “Cognitive behavior therapy resulted from an integration of three schools: behavior therapy, cognitive therapy,

and cognitive and social psychology” (p. 165). It is based on the notion that individuals can alter or simulate the environmental conditions that are most suitable for behavior acquisition or change. The treatment generally begins by identifying the problematic behavior, or the *target behavior*, and evaluating the antecedent behaviors and consequences. Applying positive reinforcement in specific ways allows behaviors to be acquired, altered, or extinguished by influencing the individual’s experience without a necessary behavior, with an insufficiently utilized behavior, or with a maladaptive behavior. There are three elements of cognitive behavioral therapy: *rational emotive therapy* challenges clients to dispute self-concepts that negatively affect them (Thorpe & Olson); *cognitive therapy* aims to correct dysfunctional thoughts and underlying cognitive distortions (Cooper & Lesser); and, *self-management strategies* rely on an individual’s ability to utilize self-efficacy and self-instructional training techniques (Cooper & Lesser). Because social learning theory asserts that environmental forces, individuals’ thoughts, and their feelings all interact to affect the target behavior, treating behavior in relation to antecedent behaviors, consequences, and responses to reinforcement in these ways is deemed the best way to effectuate change.

### *Summary*

Behavior theory and behavioral treatments have developed significantly in a short period of time. Beginning with the accidental discovery of salivary conditioning, to gaining an understanding that operant behaviors are inherent in behavior change, to developing an awareness of the reciprocity of influence between individuals, their environment, and their behaviors have all impacted the development of both the general

psychological understanding of human behavior and the application of the most effective and appropriate behavior change treatments.

### *Affect Regulation*

One particularly important area where behavior theory has significantly improved understandings of human behavior is in the study of affect regulation. The abilities individuals develop to regulate their emotional and often physiological responses to stimuli within their environments have important behavioral bases and significant mental health outcomes.

#### *Definition*

The terms *affect regulation* and *emotion regulation* have been shown to often be used interchangeably in psychological literature to simultaneously describe “the extrinsic and intrinsic processes for monitoring, evaluating, and modifying emotion reactions” (Thompson, 1994 in Goldberg, 2000, p. 134). However, other theorists interested in affect regulation have better differentiated the two and described the process of affect modulation in greater detail. For instance, Taylor, Bagby, & Parker (1997), define affect as involving the emotions individuals have and the ways in which they are experienced and expressed. Where the term emotion has tended to encapsulate more fleeting emotional experiences, many psychological researchers have come to differentiate affect as longer-lasting, pervasive, more cognitively complex, and unrelated to a particular stimulus (Bradley, 2000).

Corresponding to such broadened definitions of affect, Gross & Thompson (2007) assert that the process of *affect regulation* also encompasses a broader conceptualization than simply management of mood states. They present the processes of affect regulation

as modulating the states of coping and stress responses, emotion regulation, mood regulation, and psychological defenses, such as motivational impulses or behaviors in ways that are both extrinsically- and intrinsically-oriented. Thompson (1994) further argues that neurophysiological regulators, attention, active cognitions, emotional cues, and coping resources have also been identified as integral components of the process of affect regulation, as well (in Bradley, 2000). All are consciously and unconsciously adapted from an early age through internal conditioning and external social learning processes to continuously fine-tune adaptive affective responses (Dahl, 2003). The complexity of the regulation processes also speaks to the complicated interactions between cognitive systems, or those involved in adapting rules and consequences, and affective systems, or those involved in the actual expression of emotional arousal. Together, the systems work to help individuals to monitor, evaluate, and to implement affective responses to stimuli in self-regulating ways (Dahl, 2003).

### *Goals*

Bradley's review of affect regulation literature (2000) finds that most researchers agree that the process of regulating affect is aimed at allowing the individual to most efficiently, effectively, and flexibly respond the demands of their environment (e.g., Campos, Campos, & Barrett, 1989; Cole, Michel, & Teti, 1994; Thompson, 1994). Dahl's (2003) conceptualization is similar, proposing that affective regulation processes are generally established to better enable an individual to control their emotionality in order to accomplish certain goals. "Typically, this modulation involves inhibition, delay or altering emotional expression/behavior in ways that incorporate social rules, long-term goals, or avoiding future negative consequences" (Dahl, p. 184). Finally, Dahl

disseminated the types of goals that affect regulation is typically organized around: “appetitive” goals, or those seeking and obtaining rewards as a result of certain affective behavior and “aversive” ones, or attempts to avoid threats or punishments (p. 184).

### *Positive and Negative Affect*

It is emotion and affect that inform individuals’ ability to frame behavioral responses to external stimuli, events, affect decision making, enhance memory for important events, and facilitate interpersonal interactions (Gross & Thompson, 2007). However, emotionality and management of affective expression can prove to significantly hinder individual’s experience, as well. As a result, it is important to differentiate the experiences of differing affective states. Frijda (1993) asserts that individuals are in one of two possible affective states, pleasant or unpleasant. Each is experienced as greater than just a mood state, being comprised of longer-lasting, more cognitively, psychologically, and physiologically complex components. Clark and Watson’s work (1991b) defines *negative affect* as “the extent to which a person is feeling upset or unpleasant . . . and encompasses various affective states including *upset, angry, guilty, afraid, sad, scornful, disgusted, and worried*” (p. 321 as cited in Bradley, 2000, p 28). In contrast, *positive affect* is defined as “the extent to which a person feels a zest for life and is most clearly defined by such expressions of energy and pleasurable engagement as *active, delighted, interested, enthusiastic and proud*” (p. 321 as cited in Bradley, p.28). It is negative affect, however, that has been understood as more influential in the development of psychopathology, and as a result, more widely researched in order to better understand conceptualizations of a variety of behavior-



related mental health problems (Bradley). The implications of prolonged dysregulated affective states on mental health outcomes will be delineated in detail later in the chapter.

### *Development of Affect Regulation*

From a developmental perspective, the process of acquiring affect regulation skills begins in early childhood. As individuals grow, “links between cognitive control and affective systems to serve goals” are established and continuously become more fine-tuned in a manner that is specific to each individual’s unique set of experiences (Dahl, 2003). Many researchers have focused on the building of affective modulation processes during the period of development between infancy and adolescence because of the monumental physical and relational developments that take place. “This is a crucial period because it is a time when temperamental, neurobiological (e.g., the development of the frontal lobes), conceptual (e.g., understanding of emotional processes), and social (e.g., family, teachers, and peers) forces come together to lay the foundation for the individual differences in emotion regulation we observe in adulthood” (Gross & Thompson, 2007, p. 19). This person-in-context vantage-point enhances an understanding of the many forces that are developing and interacting with one another to influence the development of affect regulation behavior patterns during early development.

The development of affect regulation has been shown to be highly dependent upon the quality of care giving in the early years. The infant-maternal relationship in early holding environments can be characterized as a system of mutual regulation of affect: the infant sends emotion-laden messages, and the caregiver functions as a container that collects the infant’s emotions and conveys back to them what kind of affective procedures will routinely take place (Goldberg, 2000; Taylor, Bagby, & Parker,

1997; Tronick, 1989). “Recent thinking about developmental psychopathology describes the interaction between an infant and caretaker as a series of transactions in which the caretaker influences the development of the child, and the child’s behaviors affect the caretaker’s responses (Sameroof, 1989)” (Bradley, 2000, p. 30). The caregiver’s pattern of responses expresses ideas about their infant’s emotionality, especially about their distress, and about what to expect from their social support world. Over time, these messages become organized and internalized in the child, and a framework is established affect regulation behaviors and habits for future relational processes (Goldberg, 2000).

Because of the significant and pervasive impact the quality of the maternal holding environment and the attunement of the primary caregiver have on an individual’s developing strategies for regulating emotions (Bradley, 2000), many researchers have aimed to better understand the process of affect regulation development within the relationship. Initially developed by Mary Ainsworth and replicated by dozens of researchers since, the Strange Situation Experiment has been shown to perhaps best assess early infant affect regulation in the context of the early maternal care-giving relationship. In Ainsworth’s (1971) Strange Situation Experiment, infants from a variety of care-giving backgrounds and holding environments are separated from their primary maternal caregivers for a short period of time, left with friendly strangers, and reunited with their caregiver a short time later. The quality of affective response of infants before, during, and after separation is measured and compared to data on maternal responsiveness and verbal accounts of infant-maternal mental health and relationship history (Bradley, 2000; Shilkret & Shilkret, 2000). Consistently, the Strange Situation Experiment has shown infants from more adaptive holding environments and well-attuned maternal relationships

have been viewed engaging in positive affective sharing with the caregiver before separation, displaying appropriate levels of distress during separation, and experiencing a rapid return to a positive affective state upon reunion (Goldberg, 2000). Conversely, infants from less attuned maternal care-giving relationships have been viewed in the same experiment with either a more limited or constricted expression of needs, an exaggerated expression of needs, or with an unorganized or randomly varied expression of needs from the caregiver. Some infants correspondingly lack of affective expression, overly exhibit negative affect, or appear frightened or confused during all portions of the experiment, respectively. It has been hypothesized that these infants may have grown to experience as unresponsive, unpredictable, or harmful and display their affective expression correspondingly, while infants from secure maternal-infant relationships likely trust the responsiveness of their caregivers and a comfort in their affective responses (Goldberg).

#### *Sensitive Care Giving and Affect Regulation*

Since the findings of 'strange situation' experiment, family theorists have also explored the association of early maternal caretaking relationships and holding environments, and behavioral patterns of affective expression. In their research, sensitive care giving has been shown to help an infant avoid extreme and pervasive emotional states (Edme, 1989). "When the caregiver reads and responds sensitively to the infant's needs, the infant develops an expectation that distress or other states of high arousal can be moderated to allow the infant a sense of control and a sense of the environment as reasonably predictable"(Gable & Isabella, 1992; Sroufe, 1989a, 1989b as cited in Bradley, 2000). Mothers who have been identified as highly responsive and attuned to their infants have been shown to adequately respond to their child's positive and negative

affect, as opposed to infants who come from less attuned or maladaptive holding environments and where their mothers have the tendency to respond to only positive affect or overly-respond to negative affect (Goldberg, et al., 1994). This type of caretaking allows infants to feel responded to across affective states, securely express both types of affectivity, and pair positive experiences with parental responsiveness in both states of happiness and distress (Bradley). In this freedom of expression, the child is able to learn over time about their feelings in response to certain events, to label them, develop habits of expressing them freely, and ultimately learn effective coping responses (Greenberg et al., 1992). As a result, the infant is able to perceive themselves as worthy of attention, to develop an emotional openness, and willing to experience a capacity to label and share feelings as they grow and develop (Bradley).

When individuals grow out of infancy, make cognitive advancements, and gain the ability to use language, the process of affect regulation continues and the quality of the caregiver-child relationship persists to be an important factor in the process. As the child gains a better understanding of their affective states, they advance their development of self-control, their use of language to communicate their needs, and in the development of problem-solving techniques to enhance regulation (Bradley, 2000). In sensitive and attuned caretaking, the caregiver's responsibility continues to be valued throughout childhood development in such ways as being a consistently available support, a provider of language to help give words to their child's affective experience, and to help their child develop habits of utilizing the most effective problem-solving strategies (Greenberg, et al., 1992). In the process, the caregiver is not only presenting the child with a series of experiences that will be internalized as expectations of their

environment, but they are simultaneously providing their child with a narrative with which to convey their emotional expression, as well (Edgcumbe, 1984; Emde, 1984; Furman, 1992 in Taylor, Bagby, & Parker, 1997).

The type of sensitive caretaking is typically produced by a series of common affective experiences. For instance, theorists point to the caregiver's mirroring process, a practice that allows infants and children to feel that their behaviors and affect states are being monitored, followed, and recognized in a closely attuned way (Bradley, 2000). This process is said to foster the feeling of closeness and shared experience by the infant, and promote both behavioral and physiological regulation in the infant (Field, 1989 as cited in Bradley, 2000). Caregiver attunement to the infant's desensitization techniques is another important process. When over stimulated, infants exhibit innate abilities to regulate the amount of input received by limiting the amount of stimulation he or she receives. Some commonly implemented techniques include gaze-aversion, alteration of facial expression, tone of voice, emotional verbalizations, or other actions that are linked to strong feelings, and the modulation of internal states that make the external ones possible (Bradley, 2000; Dahl, 2003). "When the dyadic regulation of arousal is sensitively attuned, the caregiver responds to the infant's [attempts to self-regulate] by reducing the stimulation until the infant is ready, as indicated by a return of the infant's attention" (Bradley, p. 31). In these types of processes, a pattern of reciprocity is developed in the relationship that allows the infant to experiment with affect regulation techniques and develop a trust in their environment's ability to respond in a way that fosters adaptive coping development.

Adolescence in the context of sensitive care-giving relationships possesses another opportunity to improve the development of affect regulation skills (Bradley, 2000). With

the immense hormonal, physiological, and social developmental changes that are all simultaneously occurring, individuals are often unprepared for the surge of new positive and negative affects they experience. However, when individuals have already achieved adequate coping or social skills, the process of working with their parents to augment their existing coping mechanisms into new ones that will better prepare them to meet new affective challenges has been shown to be a far easier process when sensitive and attuned caretaking relationships already exist (Bradley, 2000).

#### *Insensitive Care Giving and Affect Regulation*

Insensitive care giving, on the other hand, has been shown to produce a differing set of characteristics in infants. For instance, research has shown that infants from misattuned or inadequate holding environments tend to display either an avoidance of negative affect, for fear that the caregiver will not be able or interested in assisting the child with their distress, or exaggerated negative affect in an effort to summon their caregiver's attention (Greenberg, et al; Shilkret & Shilkret, 2008). When infants emerge from these types of holding environments, appropriate ways of experiencing, labeling, and identifying affective states are not taught. Perhaps more importantly, opportunities for the development of patterns of adaptive coping behaviors and a language to express affective states are lost, as well (Bradley, 2000; Taylor, Bagby, & Parker, 1997). For instance, when the care-giver does not adequately mirror their child's affective experiences, provide learning experiences for them, or respond appropriately in desensitization practices, their children often grow to experience frequent negative affect states and a perceived inability to control their environments or influence their own affect regulation (Bradley). "Furthermore, adolescence intervenes before some distressed

children have achieved adequate coping or social skills, and at this point it may be harder for parents to assist their children in making up for the deficits incurred in childhood” (Bradley, 2000, p. 38). As a result, parental efforts to amend current inadequate coping mechanisms may be rejected, provoke withdrawal, create a belief that they are incompetent in affective modification, and often lead them to acting out their affective dysregulation in maladaptive behavioral ways (Bradley, 2000). Research has shown that, over the early and adolescent developmental periods, more sensitive and attuned caregiver responsiveness to their children’s affective states correlates with higher levels of positive affect, lower levels of negative affect, higher self-esteem, and higher social competence that will be displayed over the lifetime. Conversely, insensitive care giving is correlated with more negative affect, lower social competence, lower self esteem, and frequently reported as precursor to the development of psychopathology (Bradley, 2000).

In the affect regulation development research, there is general consensus across different theoretical perspectives about the development of cognitive structures “that condition an individual’s usual pattern of responding to interpersonal situations” (Bradley, p. 34). Because these structures are thought to develop out of patterns of interactions with early care-givers, the repetitiveness of individuals’ responses are thought to develop accompanied neural networking responses. These neural networks, responsible for the development, memory, and activation of cognitive and physiological responses associated with affective states, become strengthened or weakened with practice (Segal et al., 1996 in Bradley). In individuals that emerge from less adaptive early holding environments, the “associated neural networks may be composed of interlocking negative associations that, once activated, may be difficult to contain; their

continuing activation may spiral into psychopathology such as depression” (Bradley, p. 34). Additionally, it is thought that because the affective networks are so frequently activated, their cognitive and physiological responses are more readily accessed, explaining why some affect-related patterns or disorders are more difficult-to-treat over time (Segal et al., in Bradley, 2000). This theory further demonstrates the power that early caretaking has on the development of long-term behavior patterns of individuals.

#### *Establishment of Long Term Affect Regulation Practices*

As established, the internalized working models of environmental attunement and corresponding patterns of individual affective expression is thought to be associated with individual’s perceived experience of either success or failure in accurately soliciting support from objects in their environment to support their regulatory processes (Goldberg, 2000; Bradley, 2000). As a result, individuals develop long-term affect regulation practices that either include actively seeking out interpersonal relationships to assist affect regulation, otherwise known as *primary strategies*, or to turn inward to self-sooth in non-verbal and non-relational ways, otherwise regarded as *secondary strategies*. Depending upon their use, both types of strategies have the capability of becoming adaptive or maladaptive affect regulation strategies (Goldberg, 2000).

#### *Primary Strategies*

Individuals who seek out others during times of distress, are able to verbalize their affective experiences, and gain a sense comfort and regulation from their efforts are said to be using primary affect regulation strategies (Goldberg, 2000). In childhood, the individual “learns that the environment is responsive to his or her distress, and also over time learns ways of managing feelings in a reasonably adaptive fashion” (Bradley, 2000,



p. 35). Such individuals developed “an internal working model of the self as competent and of the environment as supportive,” and, as a result, experience their affect as a shared experience which can be modulated with adaptive coping mechanisms (Bradley, p. 35).

The utilization of primary strategies are normally deemed as healthy and adaptive because they involve others in the process of affect regulation and are often characterized by a range of internalized affect regulating behaviors that can be drawn upon. However, depending upon the rigidity of their utilization, primary strategies can also be used maladaptively, as well. For instance, *hyperactivation* or exaggeration of attachment to others can cause a hypervigilance of and an over-attunement to others at the cost of their own needs. When regulation of affect can *only* be produced from proximity to and support from other individuals, it is evidence that an individual was unable to internalize the skills necessary to self-soothe from their early caregivers and caused a chronic reliance on others to regulate their affect (Goldberg, 2000).

### *Secondary Strategies*

Where primary strategies utilize interpersonal relationships to regulate affect, secondary affect regulation strategies use non-human objects or behaviors to promote affect regulation. Although they can be effective and adaptive, it is the use of secondary strategies that most often take on detrimental or maladaptive forms of affect regulation, and are usually correlated with insecure attachment styles (Goldberg, 2000).

The adaptivity of the use of secondary strategies is, again, highly related to the quality of the attunement of the primary caretaking. As a result, adaptive forms of secondary strategies, such as the use of sensation objects (e.g. blanket or caregiver’s clothing) or body parts (e.g. sucking fingers, rubbing genitals, rocking) are often utilized

by infants who come from supportive early holding relationships and environments for self-soothing effects (Taylor, Bagby, & Parker, 1997). When they age, they often continue to use transitional objects, such as a favorite blanket or toy, as a symbol for the primary caregiver and the affective regulation memories of their presence represents during times of distress (Taylor, Bagby, & Parker). Research has also indicated that as they age, such individuals will continue to utilize secondary affect regulation strategies in adaptive ways and develop symbolically similar self-soothing strategies, such as religious practices, reading, music, or artistry, to regulate affect (Taylor, Bagby, & Parker, 1997).

Individuals that emerge from inadequate holding environments or miss-attuned maternal-infant primary relationships, however, tend to develop patterns of utilizing of secondary strategies in less adaptive ways. They are often less able to develop effective sensation objects early in development, and thus, ill-equipped to internalize and draw on self-soothing techniques in healthy ways (Taylor, Bagby, & Parker, 1997). When primary strategies prove ineffective, emotions and feelings of the infant become internalized and expressed in maladaptive non-verbal ways (Bradley, 2000; Goldberg, 2000). Such individuals often use *deactivating* strategies, or the suppression of attachment behaviors, and turn entirely toward secondary strategies for affective regulation, often forming chronic maladaptive practices (Goldberg, 2000). Maladaptive secondary strategies tend to use unhealthy objects, such as food, alcohol, drugs, or behaviors such as shopping, gambling, or procrastination in chronic ways (e.g., Taylor, Bagby, & Parker, 1997; Baumeister & Heatherton, 1996).

### *Persistence of Maladaptive Use of Secondary Affect Regulation Strategies*

Although the development of maladaptive affect regulation is related to early relationship styles and the quality of the early holding environment, it appears that people continue to engage in maladaptive or unhealthy behaviors for several reasons. Primarily, individuals who use secondary strategies in maladaptive ways do so in an attempt to enhance positive mood and prevent negative mood (Baumeister & Heatherton, 1996). For instance, Cooper, Agocha, and Sheldon (2000) found that some individuals tend to engage in risky or unhealthy maladaptive affect regulation strategies, such as alcohol use or non-intimate sex, in order to temporarily cope with negative mood states, whereas others did to temporarily improve or enhance positive mood states. Similarly, Tice and Bratslavsky (2000) contend that individuals engage in maladaptive behaviors, such as eating, seeking immediate gratification, and procrastination, simply because refraining from them would cause negative emotional states to follow. Research has also indicated that individuals who use maladaptive affect regulation strategies generally experience greater amounts of prolonged negative affect than other individuals (Bradley, 2000). Often these individuals cannot use adaptive forms of primary or secondary strategies to alter their affect effectively or adequately and instead direct their attention to maladaptive objects and strategies that falsely appear as effective (Bradley, 2000).

Secondly, a chronic inability to effectively regulate behavior is another reason that maladaptive secondary strategies persist to be utilized. Baumeister and Heatherton (1996) argue that self-regulation involves the ability to alter their responses to external stimuli and override their impulses when appropriate. While individuals who can use secondary strategies adaptively have the ability to control their impulses, those with a

tendency to use them maladaptively experience failures in impulse control resulting in *misregulation*, or misdirection of self-control. Such misdirected self-control is often guided by false beliefs about the types of behaviors that would lead to desired affect states, attempts to control problems in the environment that are uncontrollable, or led by a focus on the wrong part of a given problem. As a result, negative affect for these individuals is not mediated appropriately or effectively (Baumeister & Heatherton, 1996). Tice, Bratslavsky, and Baumeister (2001) found that the stress that accompanies emotional distress also contributes to breakdowns in self-regulatory processes, especially in individuals with poorly developed affect regulation skills, and can lead to misregulations of affect regulation that give priority to short-term affect regulation as opposed to long-term efforts. This style of misregulated short-term affect regulation has been empirically linked to overeating, smoking, drinking, gambling, compulsive shopping, aggression and violence, and delay of gratification (Tice, Bratslavsky, & Baumeister, 2001).

Individuals who have developed a proneness to maladaptive affect regulation also often continue to do so over the long-term because they have exaggerated alexithymic symptoms, or difficulties identifying their own emotions, the emotions of others, distinguishing between feelings and physical sensations of emotional arousal, and labeling emotions (in Taylor, Bagby, & Parker). In clinical interviews, when asked to describe feelings or emotions, many individuals with alexithymic symptoms repeatedly report ‘it’s hard to put into words’ or ‘I can’t really pin it down’ (Taylor, Bagby, & Parker, 1997, p. 32-34). Being unable to identify one’s affective states can lead to failures in managing negative affect adaptively. They generally tend to navigate away from

utilizing primary strategies or with interpersonal means, and consequently, expel their unpleasant emotional states with impulsive or compulsive activities, such as binge eating, substance abuse, perverse sexual behavior, or self-starvation (Taylor, Bagby, & Parker).

Ultimately, the variety of reasons that individuals persistently use maladaptive secondary affect regulation strategies in prolonged and rigid ways can all be attributed to the behavioral patterning consistent with conditioning and social learning theories of behavior. Over time, behaviors that may have been utilized as adaptive attempts to affectively regulate in the only way an individual may have known become conditioned and reinforced through repetition – even when maladaptive. The repetition of maladaptive methods to increase positive affect, avoid negative affect, fail to effectively utilize primary strategies, and persist to maintain alexithymic symptoms make the usage of secondary methods increasingly conditioned and increasingly difficult to give up.

*Classical conditioning theory of affect regulation.* Pavlov's accidental discovery of behavioral conditioning, or the pairing of unconditioned and neutral stimuli to produce a newly conditioned response to a previously unconditioned stimulus, and extinction, or the diminished relationship between two stimuli through repeated presentation of a conditioned stimulus without the unconditioned stimulus in order to reduce the conditioned response (Thorpe & Olson), are two theories that are evident in the development and maintenance of affect regulation. In early affect regulation learning, infant's cognitive, emotional, and physical underdevelopment render them incapable of managing their affective states (Kopp, 1989), and as a result, they rely on the process of stimulus enaction and environmental responsiveness initially to develop affect regulation skills (Gross & Thompson, 2007; Bradley, 2000). For example, the infant uses what

Kopp (1989) has termed “preadapted action systems,” or innate behavioral schemas, such as eye closing, crying, or gaze aversion, to act as affective stimulus that their caregivers respond to begin to shape their child’s regulation processes. Over time, the pairing of the infant’s affect regulation techniques and their caregiver’s responsiveness are conditioned together. Not only does this process generate an internalized expectation of the environmental demands and the effective affect regulation needs, but it also becomes a routine and habitual practice within the relationship, hardening the practice over time (e.g., Bradley, 2000; Shilkret & Shilkret, 2008; Kopp). Difficulty arises when an early association between negative affectivity and maladaptive means of regulating it, such as crying and subsequent feeding. Such an early pairing becomes closely conditioned and relied upon, over time, as a response. Although the relationship between the negative affectivity and maladaptive affect regulation method is one that begins in a way that is experienced as adaptive, with repetition over time, the behavior becomes more difficult to cease and often the maladaptivity reaches unhealthy levels. (Thorpe & Olson, 1997).

*Operant conditioning theory of affect regulation.* Skinner’s theories on operant conditioning expanded upon the stimulus-response relationship inherent in classical conditioning by asserting that learning can involve both reflexive behavioral processes, as well as observed and learned behavior. Witnessing positive or negative responses to behavior in the environment, developing corresponding cognitive expectancies, and reinforcing or extinguishing behaviors through the encouragement or discouragement of behaviors are processes that have also been found to be inherent in the process of affect regulation development (Berger, McBreen, & Rifkin, 1996; Cooper & Lesser, 2008).

In the early care giving relationship, infants not only develop a pattern of affect regulation through the conditioning of their affect and the typical response they receive, they also learn to consciously and purposefully adjust their behavioral responses as their cognitive abilities improve (Thorpe & Olson, 1997). Individuals from attuned care-giving environments are able to learn that both positive and negative affectivity can be expressed, are mirrored by their caregivers, and responded to in ways that effectively and adaptively help the individual to learn to modulate their affect (Bradley, 2000; Goldberg, 2000). Conversely, individuals that emerge from miss-attuned care giving relationships or inadequate holding environments often learn that expression of the affective stimulus in response to an internally uncomfortable state can cause either a negative response or a lack of a response entirely (Bradley, 2000; Goldberg, 2000). As a result, individuals learn to regulate their affect in ways that match their environment: freely expressing affect, inhibiting their negative affect, or exaggerating their negative affect (Bradley, 2000). With time, repetition, and reinforcement, individuals develop adaptive or maladaptive patterns of affect regulation that become difficult to extinguish (Bradley, 2000).

*Social learning theory of affect regulation.* In the development of social learning theory, Bandura theorized behavioral learning to be an active process, believing that each individual approaches behavior with a sense of cognitive awareness and with an aim towards organization (Thorpe & Olson, 1997). As individuals develop, processes of observational learning, reciprocal determinism, cognitive processing, and self-efficacy help individuals to create expectancies of their environment and establish patterns of behavior that are thought to best meet the needs of their environments (Cooper & Lesser, 2008). Kopp (1989) asserts that the process of developing affect regulation skills involves

the same social learning processes. As individuals develop enhanced cognitive, language, and memory capabilities, Kopp believed that they use the same processes to more actively experiment with behavioral responses to environmental stressors, better understand mirrored socially referenced responses from objects in their environment, experience the felt responses of their own affective regulatory systems, and learn to develop planned and organized responses to environmentally-triggered affectivity. More specifically, individuals learn through their environment to utilize *enhanced language skills* to “state their feelings to others, obtain verbal feedback about the appropriateness of their emotions, and hear and think about ways to manage them” (Kopp, 1989, p. 349); *improved social referencing skills* to measure their actions by the response of the environment (Campos, et al., 1989); and cognitively-based regulation strategies like situational *reappraisal* of a situation to diminishes negative affect in the future, *distraction*, *suppression* of thoughts and feelings, and *affective forecasting*, all in an attempt to alter affective states based on implementing varying behaviors (Loewenstein, 2007, p.180). With this variety of social learning techniques, individuals learn to consciously gain information about their behavior, evaluate typical environmental responses, and develop the most effective and efficient affect modulation procedures as possible to meet the needs of future situations. Moreover, the environment and the quality of the affect modulating techniques they were exposed to significantly impacts the ability to adaptively or maladaptively regulate their affect throughout their lives (Bradley, 2000).

*Maladaptive Affect Regulation Throughout the Lifetime*

There are important mental health implications associated with the prolonged dysregulation or misregulation of affective management and expression inherent in the



use of both primary and secondary regulation practices. As established, the quality of early maternal care-giving relationships and holding environments are instrumental in predicting emotional expression and regulation throughout an individual's life. Studies in the development of psychopathology have also suggested that early risk factors, such as loss, trauma, abuse, temperamental or stress reactivity, attachment difficulties, and family conflict, can cause higher levels of affective arousal that, over time, interfere with the development of adaptive affect regulation strategies (Bradley, 2000). Individuals that emerge from miss-attuned holding environments in infancy and early childhood are consistently more vulnerable to the development of emotion regulation problems (Bradley, 2000) and are often more susceptible to psychological problems and behaviorally reinforced affect regulation problems throughout life (Goldberg, 2000).

Maladaptive emotion regulation and poor mental health outcomes are expressed throughout various developmental periods. In infancy, children who have learned that objects in their holding environment are unresponsive, miss-attuned to their affective needs, or potentially harmful to them exhibit difficulties in self-soothing, evidenced variably in prolonged crying, lack of crying, problems with feeding and sleeping (Bates, Maslin, & Frankel, 1985 as cited in Bradley, 2000). Spangler & Grossmann (1993) also found that similar infants exhibit early affect-suppressing strategies that, when repeated and reinforced over time, have a significant impact on longer-term levels of affective arousal, styles of relating, and continued inability to regulate in future development. In toddler hood, early affective misregulations present as expressions of persistent negative affect and oppositional behaviors, perhaps as a socially referenced and environmentally reinforced technique for gaining attention (Bradley, 2000). In early childhood peer

interactions, children with misregulated affect regulation skills have continued to reinforce their behavior accordingly, evidenced as expressing social withdrawal or aggressive acting out against peers (Bradley, 2000). Such behavioral learning and reinforcement is also indicated in other studies have shown that aggressive behaviors at age two actually predicted externalizing behavior problems at age five and internalizing problems at age six (Zahn-Waxler, Iannotti, Cummings, & Denham, 1990).

Adolescence proves to be another important period in the progression of affective dysregulation. Problems developing affect-regulation skills early in life often have long-term consequences in health and well-being during the second developmental hurdle of adolescence (Dahl, 2003). Because of the physical, hormonal, social, and emotional changes that occur during puberty, adolescents are posed with an often intensified affective state that compounds the difficulty of affect regulation processes, often presenting opportunities for misregulation (Bradley, 2000). Tubman & Lerner (1994) found that patterns of negative affect and misregulation in early and middle childhood were also longitudinally linked to similar negative interactions in adolescence (in Bradley, 2000). Dishion, French, & Patterson (1995) found that individuals with poorly established early affective regulation strategies gravitated towards anti-social and self-destructive behaviors in adolescence (in Bradley, 2000). As these behaviors become conditioned with temporary improvements in affect and reinforced internally and environmentally they often become more entrenched and more difficult to change.

By adulthood, individuals with high levels of unregulated negative affectivity “are more likely to experience discomfort at all times and across situations, even in the absence of overt stress” (Watson & Clark, 1984, P. 465). Such accumulations of negative

affect and stress over time creates affective *burnout*, “an overwhelming situation that leads an individual to believe that he or she cannot cope or that the situation is hopeless” (Maier & Seligman, 1976 in Bradley, p. 159). Where brief states of negative affect permit individuals to cope through avoidance or short-term strategies, prolonged negative affect leaves individuals with few perceived ways of adaptively and effectively being able to alleviate distress. These experiences ultimately contribute to the development of chronic and more dangerous maladaptive affect regulation behaviors (Dahl, 2003; Bradley, 2000; Goldberg, 2000).

#### *Development of Addictive Behaviors*

One of the most common forms of adult psychopathology evidenced in individuals who have developed a pattern of maladaptive primary or secondary affect regulation strategies is the development of addictive behaviors. According to the DSM-IV's (2000) criteria for substance dependence, addiction is characterized as a behavior that has developed a level of tolerance, creates withdrawal symptoms when removed, involves the use of the substance longer than necessary, involves unsuccessful attempts to arrest the behavior, uses excessive time and money for the behavior, reduces the involvement of social, occupational, or extra-curricular activities, and persists even when physical or psychological problems occur (Walters, 1999). Other models that include these components have been specifically devised for gambling (DSM-IV, 1994 in Walters, 1999), sexual addiction (Goodman, 1993 in Walters, 1999) and eating disorders (Lesieur & Blume, 1993 in Walters, 1999).

Psychodynamic conceptualizations of addictions have centered on theories that all addictions share the same misguided and ineffective attempts at affect regulation, and are

often generated by deficits in an individual's self-regulatory abilities (Flores, 2001). Individuals with addictive behaviors exhibit more anxious, depressed, and angry emotions than the normal population (Walters, 1999) and significantly greater difficulty utilizing primary strategies to modulate negative affect (Flores, 2001). Because of the detrimental effects of early holding environments on affect regulation development, the addict "is seen as a victim – not a victim of a disease, but a victim of destructive learning conditions" (Thombs, 1994, p. 5). Instead of utilizing primary strategies, their attempts towards affect regulation have typically involved the repetitive use of external transitional objects that temporarily ameliorate negative affect, due to behavioral conditioning or social learning processes established earlier in life (Flores, 2001). Such substances frequently include alcohol, drugs, sex, gambling, shopping or exercise to name a few, as methods of achieving affect regulation (Thombs, 1994). Although they are originally implemented as short-term strategies to attempt to self-regulate using external objects, the continued usage of maladaptive objects or behaviors in long-term ways tend to become overly relied upon and develop into rigid and pervasive patterns (Flores, 2001; Khantzian, 1985 in Walters, 2000).

Behaviorists view addiction from a self-medication model, or as "an operantly conditioned response whose tendency becomes stronger as a function of the quality, number, and size of reinforcements that follows each drug ingestion" (Thombs, 1994, p. 80). McAuliffe & Gordon (1980) assert that reinforcements typically fall into one of three classifications: euphoria, social variables, and elimination of withdrawal (in Thombs, 1994). Theorists assert that each individual's addictive behaviors develop over time in response to specific combinations of reinforcing effects of maintaining positive affective

states, avoiding negative ones, and the amount of acceptance their behaviors receive from their social environments (Thombs, 1994). Each time an individual abuses substances their ability to resist impulses decreases as the substance grows increasingly operantly conditioned physical withdrawal effects develop (Thombs, 1994). Once the substance is removed, negative affect has been shown to rise again (Walters, 1999). As a result, the addictive behavior is again enacted to abate withdrawal symptoms and negative affect (Thombs, 1994). Langenbucher & Nathan (1990) have written of this addictive process as the “tension reduction hypothesis” (in Thombs, 1994). In alcoholic addictions, “the theory presumes that alcoholic drinking is a product of escape learning; alcoholics drink because they have been negatively reinforced for drinking in the face of life stress” (Langenbucher & Nathan, as cited in Thombs, 1994, p. 83). While the relief may be from anxiety, depression, or fear, for some examples, the regulation of these affective states still present as secondary to the original operant conditioning that occurred earlier in development between negative affect and transitional substances.

Social learning theories have also been used to explain the development and maintenance of addictive behaviors as methods of maladaptive affective regulation by asserting that negative affect and environmental reinforcements of behavior inform a decision process of affect regulation techniques that is more conscious, cognitive, and active than the automatic process in conditioning theory (Thombs, 1994). The theory asserts that the initiation of external substances to modulate negative affect can be explained by environmental modeling, and that its continued use is influenced by maladaptive self-regulation, poor self-efficacy, environmental expectancies, improved affective regulation effects, and associated punishments and reinforcements. The theory

asserts that “the person’s behavior is not random or unpredictable; it is purposeful and goal-directed. The high degree of self-regulation is clear when consideration is given to the amount of time and effort is needed (often daily) to obtain the drug, use the drug, conceal its use, interact with other users, and recover from its effects” (Thombs, 1994, p. 116). This type of behavior, which has been shown to be maintained for extensive periods of time, speaks to the conscious processing and decision making that is inherent in the utilization of addictive behaviors, as well as, the difficulty in extinguishing behaviors despite the awareness that is involved.

In sum, addictive behaviors are expressions of maladaptive affect regulation that are often established during inadequate maternal care giving relationships and misattuned holding environments early in life. Over time, the maintenance of addictive behaviors stems from the conditioned associations between temporarily altered affect and the repeatedly utilized substance, as well as and the complex decision processes involved in modulating affect in such ways.

#### *Difficult-to-Treat Binge-Type Eating as Addictive Affect Regulation Behaviors*

Binge-type eating disorders have been increasingly conceptualized in psychological literature as disorders of addiction (e.g. von Ranson & Cassin, 2007; Szmukler & Tantam, 1984; & Vandereycken, 1990). In von Ranson & Cassin’s (2007) review of the literature on eating disorders and addiction, a variety of commonalities between individuals with binge eating disorders and individuals with addictions are evidenced. These include similar expressions of addiction-like behaviors, common abuse of substances for affect regulation purposes, significantly high rates of substance abuse within family histories, and shared personality features (Davis & Claridge, 1998; Lacey,

1993; Vandereycken, 1990 as discussed in von Ranson & Cassin). Wilson's (1993) review addictive disorders also found binge eating to have behavioral similarities to other addictive disorders, such as craving likenesses, loss of control of the substance, use of the substance to regulate emotions, impairment in physical and social functioning when using the substance, and similar attempts to cease their maladaptive use of the substance. In this section, the most recent binge eating addiction research will be further delineated to improve the conceptualization of binge eating as an addictive behavior.

*Similar addiction-like behaviors.* Because individuals with binge eating disorders exhibit what has become known as characteristic addiction-like behaviors, the commonalities between binge-type eating disorders and alcohol and drug addictions have been increasingly highlighted in recent psychological literature. Victims of both types of disorders experience “denial, secretiveness, inability to discontinue the behavior, depression, and a range of physical symptoms also common in alcohol and drug disorders” (Barry, 1992, p. 303; Wilson, 1993). Physiological states characteristic to drug and alcohol use, such as cravings for the addictive substance, repeated urges to use the substance to modulate negative affect, continued use of the substance despite uncomfortable consequences, gradual return of the urge, and mounting tension until the substance is utilized, have also been increasingly identified in individuals that use binge eating in addictive ways (Gold, Frost-Pineda, & Jacobs, 2003; Marks, 1990a; Walters, 1999; Wilson, 1991; Wilson, 2000 as cited in von Ramson & Cassin, 2007). Other research has found loss of control, preoccupation with a particular substance, the use of the substance to negotiate negative affect, and negative consequences as the result of substance's use to be frequently reported features in drug and alcohol addiction as well as

binge eating addictions (Bemis, 1985 in Liebowitz, 1991; von Ranson & Cassin, 2007; Walters, 1999; Wilson, 1991; Wilson, 1993; Wilson 2000). Given these functional similarities, one set of researchers set out to better evaluate individuals with BED within the context of the DSM-IV's substance-dependence criteria and found that 92.4% met the addiction criteria (von Ranson & Cassin, 2007). Correspondingly, other recent research has also found that 26.9% of clinicians surveyed often utilized addiction-based treatments with their eating disordered clients, and an additional 15.4% eventually referred their more difficult-to-treat clients on to addictions-based treatments. (von Ranson and Robinson, 2006 in von Ranson & Cassin, 2007). Another set of researchers proposed a twelve-step program model be synthesized with traditional psychotherapy as a form of best practices treatment for individuals with binge-type eating disorders (Johnson & Taylor, 1996). It seems likely that, over time, both groups of individuals have experienced the conditioning effects of substance use and reduced negative affect.

*Similar backgrounds.* Individuals with binge-type eating disorders and alcohol and drug addictions also both exhibit similar backgrounds. In terms of family and genetic history, individuals with BN and BED tend to display family histories rife with a variety of affective disorders (e.g., Cantwell, et al., 1977; Hudson et al., 1982; Strober et al., 1982 in Taylor, Bagby, & Parker, 1997). One of the most common disorders within the family history tends to be substance abuse (von Ranson & Cassin, 2007). In fact, some research has suggested that 22% of relatives of those with binge eating disorders have affective disorders (Barry, 1992).

Their object relational histories tend to present similarly, as well. As previously discussed, psychodynamic research has widely theorized that individuals with binge-



eating behaviors that also experienced deficits in early care-giving can be attributed to impairments in affective regulation and fixations on modulating affect with the assistance of their maternal caregiver, or food-giving object. When the caregiver continues to fail them emotionally, external transitional objects, like food, becomes replaced as the equivalent to emotional nourishment and utilized in more dependent and rigid ways to regulate affect over time (Liebowitz, 1991). As a result, psychodynamic theory – like behavior theory - has come to find the maladaptive use of substances in addictive patterns as defense mechanisms (e.g., Khantzian, 1980; Wurmser, 1980 in Thombs, 1994). “Addicts abuse alcohol or drugs to protect themselves from overwhelming anxiety, depression, boredom, guilt, shame, and other negative emotions” (Thombs, p. 62). In this manner, many theorists find addictive substance use, whether drugs or binge eating, as “self-medication” (Thombs, p. 62).

Finally, individuals that exhibit binge-type eating or alcohol and drug addictions also share certain common personality features. For instance, individuals who have BED or BN and other addictions have also been found to score higher than normal on measures of impulsivity (Taylor, Bagby, & Parker, 1997), inability to control behavior, and failure to consider risks and consequences (Lacey, 1993 in von Ranson & Cassin, 2007). Similarly, individuals with binge-type eating behaviors were also found to have a higher sensitivity to reward than those who do not engage in binge-type behaviors (Davis, Strachan, and Berkson, 2004, in von Ranson & Cassin, 2007). Individuals with BN scored significantly similarly to individuals with alcohol or drug dependencies on addiction scales and addictive personality profiles (De Silva & Eyseneck, 1987 in Wilson, 1993).

*Similar affective dysregulation.* Both psychodynamic and behavior theory models assert that individuals with BN and BED exhibit the same affective dysregulation inherent in other diagnosed addictive behaviors (Hudson, Pope, Jonas, & Yurgelun-Todd, 1983; Tobin et al., 1991 in Polivy & Herman, 1993). As established, affect regulation deficits are understood to be responsible for the early development of maladaptive over-reliance on secondary affective regulation strategies, like binge-eating or other addictive behaviors (Taylor, Bagby, & Parker, 1997). In empirical research, individuals with binge-eating behaviors have consistently scored higher on clinical measures of negative affectivity (Stice, 2001), distress and tension (Taylor, Bagby, & Parker, 1997), comorbid diagnoses of depression (Polivy & Herman, 1993), perceptions of ineffectiveness (Taylor, Bagby, & Parker, 1997), difficulty discriminating their feelings and cues (Cole-Detke & Kobak, 1996), and statistically heightened rates of alexithymia (Taylor, Bagby, & Parker, 1997). Correspondingly, they are also found to be more likely than others to use food to modulate dysphoric and fluctuating affects (Polivy & Herman, 1993). Individuals with binge-type eating behaviors have also been found to abuse alcohol significantly more than those without binge-eating tendencies, indicating that both types of disorders may stem from the same substance misuse inherent in modulating affect dysregulation (Bulik et al., 2004 in von Ramson & Cassin, 2007).

The research has also detailed evidence of how, over time, the use of binge eating to regulate negative affectivity becomes a type of self-reinforcing cycle common in other forms of addiction perpetuating the existence and function of negative affect (Weiner, 1998 in von Ramson & Cassin, 2007). “Binge eaters often report eating in response to emotional stress, such as tension, anxiety, anger, boredom, loneliness, or interpersonal

conflict; binge eating is then often followed by additional negative affect or guilt, which leads to further binge eating (Abraham & Beumont, 1982; Lingswiler, Crowther, & Stephens, 1989)” (von Ramson & Cassin, 2007, p. 16). The evidenced reduction in anxiety and tension after an individual with BN or BED engages in binge-eating has been compared to similar affect modifications evidenced in individuals with alcohol abuse (Cappell & Herman, 1972 in von Ramson & Cassin, 2007).

*Similar effects of the substance.* Research has indicated that individuals with BN or BED have affective responses to the use of food and eating similar to those of individuals that use other common addictive substances. Like addiction theory, theorists of eating addiction have also described the process of using food and eating to regulate affect as the classical conditioning of repeated pairings of eating behaviors (and, eventually physical cravings and withdrawal states) with negative affective states (e.g., Booth, 1988; Jansen, 1990; Woods & Brief, 1988 in Wilson, 1993). The successful reduction in negative affect and physical withdrawal symptoms after the binge-eating behavior speaks to the sensitivity to the substance and provides a reinforcing compensatory response that further conditions the stimulus and response together.

The empirical support for such an addiction model of binge eating behavior is extensive. Individuals that use food to regulate affect and individuals that use drugs and alcohol to regulate affect commonly report similar cravings, a perceived loss of control, a preoccupation with the respective substance, a desire to quit, secrecy efforts, denial, and some degree of physical or social impairment due to the substance abuse (Wilson, 1991; Woods & Brief, 1988 in Polivy & Herman, 1993) Like individuals with drug and alcohol addictions, binge-eaters have also reported cognitions and behaviors akin to social

learning theory's assertions: that because their binge eating habits temporarily reduce negative affect, they knowingly utilize it as a self-regulating behavior despite the consequences (Polivy & Herman, 1993). Such consequences, including tolerance, physical dependence, and withdrawal symptoms, are evidenced similarly after individuals with binge-eating episodes in food-addicted individuals and after use of alcohol or drugs in alcoholics or drug addicts (Wilson, 1993, von Ranson & Cassin, 2007).

There is a significant connection between binge-eating and the temporary relief from negative affect that has been elaborated upon in the literature in order to better understand the continued use of the substance despite consequences. Research has found that binge eaters express statistically different levels of affect around meals than control participants do (Deaver, Miltenberger, Smyth, Meidinger, & Crosby 2003), that binge episodes are largely foreshadowed by negative affective states (Burton, Stice, Bearman, & Rohde, 2007; Rosen & Leitenberg, 1982 in Walters, 1999), and that negative affective periods before an eating binge are often described as overwhelming or desperate states (Sickney et al., 1999). For individuals with BN that also engage in intermittent periods of food restriction between binge episodes, research indicates that such deprivation states alone were enough to increase negative affect to preclude the likelihood of a binge episode (Mauler, Hamm, & Weike, 2006). When combined with already negative affect, the implications of the inability to control eating behavior are powerful.

While negative affect has been shown to commonly occur before a binge episode, distress reduction has also been shown to occur during. Stickney et al.'s (1999) study found that participants reported feeling relieved, less anxious, and contented while binge eating. Abraham and Beaumont (1982) found that 34% of binge eaters and bulimics felt

relieved during binge episodes, and that 66% felt free of anxiety immediately following (Taylor, Bagby, & Parker, 1997). Thus, like other addictions, binge eating has been shown to be reinforcing as it successfully serves to temporarily relieve negative affect.

However, while the behavior of binge-eating has been clearly shown to reduce negative affect during a binge episode and for a period of time following, a variety of evidence indicates that negative mood and affect ultimately increases (Hilbert & Tuschen-Caffier, 2007). As a result, many binge eaters return to the affect regulation strategy most utilized and most readily available: more binge eating. The behaviors quickly become more cyclical and, thus, more conditioned, reinforced, and entrenched.

### *Summary*

The similar ways that individuals with problematic binge-eating behaviors in BN and BED and individuals with diagnosed addictions exhibit characteristic addiction-like behaviors, display similar family/genetic and developmental histories, espouse common personality features contributing to their disordered behavior, present similar affective dysregulation and reliance on maladaptive secondary affect regulation strategies, engage in similar behaviors around their addictive behavior, and experience similar fluctuations in negative affectivity around the use of their addictive substance are all ways that better describe binge-type eating behaviors as addictive. Conceptualizing binge-eating behavior in an addiction framework better illuminates the difficult-to-treat nature of the behavior inherent in BN and BED. While it is interesting to characterize binge-eating behaviors as addictions from a theoretical perspective, the treatment implications of understanding such behaviors in a behavioral-addiction model are perhaps more important by-products of the theory. The next chapter will demonstrate the utility of a new best practices model

of BN and BED treatment given the expressed addiction-like behaviors of the disorders in conjunction with their difficult object relational histories.

### *Case of Mary*

Conceptualizing the Sugarman and Kurash's (1982) client 'Mary' from a behavior theory perspective provides a unique understanding into the more difficult-to-treat components of her disorder's behaviors. Mary's early losses and transitions in caregivers during her most sensitive developmental period were said to lead to a very early obsession with food. As with all infants, the pairing of physical nourishment and the reduction of negative affect together creates a conditioned affect modulating stimulus in food. However, it is likely that as a result of Mary's sudden early caregiver shift, she continued to crave her mother while in her grandmother's care, and grew to rely too prematurely and too rigidly on the source of nurturing she could still associate with her mother: physical nourishment. Her environment had shown her that it could not be relied upon to respond to Mary's desires for the return of her mother's care, nor could it effectively promote her sense of self-worth or self-efficacy with repeated comparisons to her mother's idealized childhood behavior. As a result, Mary likely learned to turn her needs inward and satiate them with food, a behavior that she continued to use to regulate her affect in a patterned way throughout her childhood (Sugarman & Kurash).

The challenges she faced from her family and her peers in adolescence, however, exaggerated her behavioral patterns into more severe addictive-like eating behaviors. With another abrupt shift in primary caretaking, an out-of-state move, loss of old friendships and the introduction of new peers, a transition to college life, and the social modeling of thin-as-beautiful, Mary's already deficient affect regulation strategies likely

became overwhelmed. It is said that ‘she lost all controls over eating,’ and began patterns of bingeing and purging behavior, especially pronounced when she reportedly experienced overwhelming negative affect (Sugarman & Kurash, p. 65). At this point in development, not only had Mary developed a rigidly conditioned relationship between eating and negative affect reduction, she had also gained sufficient cognitive abilities to gain insightful awareness about the purposefulness of her eating behaviors to regulate her affect, various disappointing expectancies about the inability of her environment to effectively meet her needs, and the perception of reduced self-efficacy in her own self-regulation abilities. As a result, her bulimic behaviors became more rigidly relied upon and heightened in severity until she presented for treatment (Sugarman & Kurash).

#### *Behavioral Treatments for Binge-Type Eating Disorders*

Fairburn’s (1981) cognitive-behavioral treatment for binge-eating was developed as a treatment approach for individuals, like Mary, battling BN (Fairburn, Marcus, & Wilson, 1993). The treatment is based on the classic CBT techniques of identifying the target behavior, evaluating the antecedent behaviors and consequences, and applying positive reinforcements in ways that allow behaviors to be acquired, altered, or extinguished. Over time and with the implementation of numerous controlled clinical trials, cognitive-behavioral therapy has become the standard treatment utilized with populations of individuals with BN, and BED (Wilson, Fairburn, & Agras, 1997).

The treatment emphasizes the participation of both cognitive and behavioral factors in the maintenance of binge-type eating disorders. Like traditional CBT, it is a 20 week treatment that involves individual treatment aimed at confronting current and future eating problems and devising solutions in a three-stage model. Like most behavioral

treatments, the therapist is viewed as a consultant, teacher, and trainer who assists clients in learning about themselves, their maladaptive behavior patterns, and the development and reinforcement of change strategies. The first stage focuses on behavior change through the alliance of a strong therapeutic relationship. Self-monitoring of eating, weekly weighing, devising improved self-control strategies, and designing new eating patterns are main priorities. The second stage of treatment aims to improve eating behaviors and develop more normalized routines while also focusing on developing cognitive and behavioral coping skills for resisting binge-eating behaviors. The third stage focuses on eliminating dieting practices, teaching problems solving skills, and utilizing cognitive restructuring techniques to extinguish the conditioned connection between negative and often false thoughts about oneself and behaviorally reinforced maladaptive eating behaviors (Wilson, Fairburn, & Agras, 1997).

Researchers and clinicians have found many binge-eating symptoms to be reduced substantially with CBT for binge eating disorders and that improvements can be maintained for up to one year following treatment (Fairburn, Marcus, & Wilson, 1993). However, as discussed in previous chapters, research has also indicated that there are significant populations of individuals with DTTBTEDs, with their potentially heightened difficulties developing adaptive affect regulation skills, difficult early relationships, and perhaps more entrenched behavioral disorders – all factors CBT is not designed to treat, that are unresponsive to the treatment. As a result, the call for a new, best-practices form of treatment for such individuals is strong.



## *Chapter Summary*

Behavior theory offers an effective lens from which to better understand the processes that occur within humans to solidify the use of food and eating as temporary, but successful affect-modulating tools. Through interactions with external environmental objects, individuals gain learned experiences over time that alter the way they act within their environment in patterned ways. Because these habitual behaviors can often have maladaptive effects on individual's lives, behavior theorists have been equally interested in the ways in which behaviors are adapted as they are with the ways in which they are extinguished. As a result, theoretical understandings of behavior have evolved significantly in a short time. From Pavlov's early discovery of classical conditioning processes, to understanding the learned and active behaviors that are inherent in behavior change processes gained by operant conditioning theories, to the conceptualization that social learning theory offers of the reciprocity of influence between the individual, their environment, and their behaviors, behavior theory has had sophisticated developments that better inform the processes inherent in all human behavior.

One particularly important area where behavior theory has been applied in a way that has significantly improved researchers understandings of human behavior is in the development of affect regulation. Beginning in early development and highly dependent upon the quality of caretaking in the early holding environment, affect regulation can take on adaptive or maladaptive practices that become behaviorally conditioned and reinforced through practice and from one's environment over time. The ability to effectively utilize primary strategies for regulation as opposed to maladaptively relying upon secondary external strategies for regulation has very different mental health

outcomes. Addictive tendencies often develop through persistent misregulation of negative affect with operantly conditioned responses that become intensified and reinforced by modulated affect and environmental cues over time. While most associate addictions with alcohol or drug use, binge-type eating disorders have been increasingly conceptualized in psychological literature as disorders of addiction. Those that evidence the most difficulty regulating affect, the most similarities to other forms of addictive behavior, and the most unresponsive to traditional behavioral treatments have also been understood in behavior theory terms to have DTTBTEDs.

More important perhaps than ascertaining a widely accepted labeling of DTTBTEDs as addictions is the increased conceptualization that binge-type eating disorders, like other addictive behaviors, can become behaviorally reinforced with practice and contingency management. In this manner, individuals gain temporary reward for the maladaptive use of secondary strategies, in this case with food and eating. With prolonged reliance upon the distress-relieving effects of binge eating, the behavior inevitably becomes increasingly conditioned and more difficult to regulate in adaptive ways. Individuals grow increasingly unable to utilize primary affect regulation strategies, perceive themselves to be less in control of their eating behaviors, and become far less practiced at recognizing, labeling, and modifying their negative affect states. As a result, common treatment methods fail, victims of the disorder find themselves increasingly symptomatic, and the need for a new treatment that better addresses the addictive and affect misregulation components of DTTBTEDs becomes more important.

The following chapter will synthesize the effects of early maladaptive holding environments and miss-attuned caregiver relationships and the detriments of behaviorally

conditioned and socially learned behaviors on the development of binge-eating as an addictive affect regulation strategy. Moreover, it will propose a new model of treatment for binge-type eating disorders that will address both object relations and behavior theory conceptualizations of the disorder.

## CHAPTER FIVE

### DISCUSSION: DIALECTICAL BEHAVIOR THERAPY (DBT): A SYNTHESIS OF PSYCHODYNAMICALLY- AND BEHAVIORALLY-INFORMED APPROACHES TO TREATING DIFFICULT-TO-TREAT BINGE-TYPE EATING DISORDERS

#### *Introduction*

Delineating the phenomenon of difficult-to-treat binge-type eating disorders (DTTBTEs) from a Winnicottian object relations perspective and from a behavior theory perspective provide unique understandings of their etiology and pattern of behavioral addictivity. Moreover, reviewing the typical treatments that are utilized with individuals with binge-type eating disorders by clinicians working within the two differing perspectives further illuminates the elements of the disorders that are not attended to and the sub-population of individuals for whom the treatments are ineffective. In keeping with the valued and accepted tenants of good social work practice that urge clinicians to not only remain informed of the most current and emerging clinical knowledge with which to practice, but to also assure that each client is treated with the most advanced and empirically effective treatments available, means that investigating, proposing, and applying newly and more effectively designed treatments for typically unresponsive clinical disorders seems like an essential task. As a result, this chapter aims to shed light on the complicated etiology of DTTBTEDs from the two most relevant etiological and theoretical perspectives, synthesize a uniquely amalgamated conceptualization of the disorder-type based on the two perspectives, and propose a new

method of treating them more effectively. More specifically, Dialectical Behavior Therapy (DBT) will be shown to perhaps best meet the treatment needs of DTTBTEDs as delineated by the two theoretical perspectives and in ways that have not been accomplished before.

### *Review of the Phenomenon of DTTBTEDs*

In order to better understand the need to evaluate new forms of treatment for DTTBTEDs, as well as to delineate the ways in which DBT may better impact recovery rates, reviewing the phenomena of their etiology is an important way of re-describing the group's specific needs. Individuals afflicted with binge-type eating disorders tend to exhibit a consistent and considerable core desire to fill their emotional needs with food and eating behaviors. As previously shown, individuals' needs during development were often not adequately attended to and separation-individuation from the primary care-giver resulted in an inability for the individual to incorporate adaptive self-soothing and affect regulation skills. Individuals that emerge from such situations tend to deny their own needs, lack the ability to identify their needs, and present an ambivalence about communicating them to others. As a result, they exhibit a tendency to affectively regulate with food and eating behaviors. Over time and with behavioral reinforcement, eating behaviors eventually turn into less controllable and unhealthier binge-episodes. Many also simultaneously espouse an intense desire to maintain a certain weight and body image, and as a result, implement punitive undoing behaviors, such as vomiting, fasting, or over-exercising, to defend against such fears by aiming to empty out again. What is important to recognize for both groups of binge eaters, however, is that until individuals are able to be emotionally fed and loved, the association between eating and affect

regulation remains practiced and strong. Moreover, the more intensified, prolonged, and treatment resistant symptoms that individuals with DTTBTEDs exhibit not only differentiate them from other binge-type eaters, they also cause them to be traditionally more resistant to popularly utilized treatments, such as CBT.

*Review of DTTBTEDs from a Winnicottian Object Relations Conceptualization*

An evaluation of DTTBTEDs from a Winnicottian object relations lens offers a highly useful way to understand the quality of the impact that individuals affected by often miss-attuned early maternal care-giving relationships and inadequate early holding environments. An object relations lens has better enabled theorists to evaluate the pattern of interaction individuals have with primary caretakers in their environment from infancy forward, the style of interaction that they have adopted as a result and continue to utilize with current relationships and the impact that the formation of maladaptive interpersonal object relations has had on their affective and emotional development. A Winnicottian perspective, however, allows a more precise window into the specific components of the early care-giving relationship that uniquely function to create a long-term pattern of affective dysregulation.

Winnicott's thoughts on the impacts made by the early maternal holding environment, good-enough mothering, the development of a rigidly implemented false-self phenomenon, and an over-reliance on external transitional objects are useful in better understanding the maladaptivities individuals have in their adult lives. His theories have highlighted the relationship individuals with DTTBTEDs have between their chronic and maladaptive use of food and the pathological disruptions suffered in their relationship with their early primary caregivers. The thwarted developmental achievements associated

with failed separation-individuation due to the inadequacies of the early holding environment seemingly produce an inability to create healthful transitional objects, the development of the persistent maladaptive use of food and eating behaviors as unhealthy transitional objects utilized to regulate affect, a rejection of the use of interpersonal relationships for support and soothing, and an over-reliance on false-self presentations. All of these developments can amalgamate to create a population of individuals with BN and BED that is often characteristically more difficult-to-treat than others with similar afflictions. Because relational work is inherent in development of a therapeutic alliance in any form of eating disorder treatment, the difficulty in treating this typically resistant population due to their difficulties with interpersonal relationships is profound and the call to determine a more effective treatment is essential.

*Review of DTTBTEDs from a Behavior Theory Conceptualization*

While a Winnicottian object relations lens provides a comprehensive lens from which to view the effect that miss-attuned early care taking and inadequate holding environments can have on the original development of patterns of maladaptive interactions that individuals adopt in relating to others, and the over-reliance on food and eating as self-soothing transitional objects in individuals with DTTBTEDs, behavior theory offers a conceptualization from which to better understand the behavioral conditioning processes that occur to cause eating behaviors to continue to be utilized as maladaptive affect regulating activities and ultimately solidify into addictive processes.

Behavior theory asserts that, over time, individuals mentally bookmark learned experiences through their interactions with their environments that impact the way that they continue to interact with other environments in the future. For instance, the

development of affect regulation practices begins in early development and has been shown to be highly dependent upon the quality of care taking in the early holding environment. Over time, the persistent miss-regulation of negative affect, that often results from miss-attunement and inadequate mothering that does not enable individuals to learn to identify, label, and regulate negative affective experiences in early development, becomes operantly conditioned by combining eating behaviors with temporarily modulated affect, reinforcement through practice, and ultimately developed into an addictive symptomatology. With prolonged reliance upon the distress-relieving effects of binge eating, the behavior inevitably becomes increasingly difficult to regulate in adaptive ways. Individuals grow increasingly unable to utilize primary affect regulation strategies, perceive themselves to be less in control of their eating behaviors, less effective in changing them, and become far less practiced at recognizing, labeling, and modifying their negative affect states.

#### *Review of Traditionally Utilized Treatments*

As previously discussed, there are several typically utilized treatment strategies that clinicians traditionally undertake when treating binge-type eating disorders. In particular, there are treatments that are object relationally-based and behaviorally-based as a result of the strong influences both perspectives have in the etiological development of DTTBTEDs. Elements of both types are evidenced to be somewhat effective, but neither sufficiently minimizes the symptomatology that individuals with DTTBTEDs present well enough to eradicate the disorder's debilitating effect on individuals' lives in a way that is enduring.



*Psychodynamic treatments.* Winnicott's theories about effective treatment relationships directly mirrored his theoretical object relational underpinnings. He believed that the mental health struggles that call clients into treatment often relate back to the early impingements or fixations that occurred during early development that individuals naturally seek to work out through replication of the conditions of the early care-giving environment throughout their lifetime. Given their object relational deficits and in order to access a position of treatment readiness, such individuals, like those with DTTBTEDs, typically require longer-term, psychotherapy. As previously discussed, Winnicottian treatment requires clients to allow themselves an ability to develop a position of dependency on and a basic trust in their clinician by dismantling a reliance on their false self presentation, disrobing learned defense mechanisms, and at times a regression to an earlier psychological state. An effective clinician practicing in this therapeutic relationship should house the ability to be a good-enough mothering object, allow dependency while also encouraging autonomy and individuation, develop a genuine understanding of the value of the client's maladaptive behaviors, confront maladaptive behavior patterns, set limits with the client and their behaviors, assist in the building of self-esteem, and support both positive and negative transference. In the development of such transference and countertransference, the client and clinician together represent the earlier developmental holding environment, creating an opportunity where Winnicott believed lay the most significant opportunities for significantly effective repair. The ways in which clients allow themselves to be vulnerable with their clinician, the success of the clinician's ability to hold the client in a safe and reliable way, as well as the periodic failures of the clinician to effectively meet

the client's needs are all elements of the relationship that will function to return the client closest to enacting the original damaging relationship, representing the problematic impingements, and create the most realistic opportunities for significant repair.

*Behavioral treatments.* The research has made it empirically clear that Fairburn's (1981) CBT model is the most commonly utilized treatment for individuals with binge-type eating disorders. In fact, as previously discussed, research has found that most clinicians identify CBT as their treatment of choice for individuals with BN and BED. CBT treatment is a theory-driven, manual-based treatment designed to be semi-structured, problem-oriented, and primarily concerned with the patient's present and future rather than their past. It is intended to focus on behaviors that are maintaining the problem through processes of identifying target behaviors, evaluating the antecedent behaviors and consequences, and applying positive reinforcements in ways that allow behaviors to be acquired, altered, or extinguished. The therapist is viewed as a consultant, teacher, and trainer assisting clients to learn about themselves, their maladaptive behavior patterns, and encourages the development and reinforcement of change strategies.

In CBT treatments designed for individuals with binge-type eating disorders, the proximal influences found to affect the maintenance of eating disordered behavior include an over-concern of body image difficulties, hunger, sociocultural pressures, dieting behavior that predisposes binge eating, and affective dysregulation. CBT integrates cognitive procedures designed to improve maladaptive thought distortions and beliefs around body image and eating, improve motivation for change of self-control strategies, and increase the quantity and quality of coping skills. CBT also integrates behavioral procedures designed to replace dysfunctional dieting and overeating with

more normalized eating, improved self-monitoring of behaviors and habit formation, and overtly practice the skill of monitoring cognitive processes. Ultimately, the goal of CBT's utilization with individuals with binge-type eating disorders is to implement improved cognitive restructuring techniques and behavioral improvements that together extinguish the conditioned connection between negative thoughts about oneself from behaviorally reinforced maladaptive eating behaviors.

#### *Review of Resistance to Traditionally Utilized Treatments*

Although helpful for some individuals, psychodynamic and behavioral treatments for binge-type eating disorders have consistently been shown to be ineffective or inconsistently effective for individuals with DTTBTEDs. For instance, as shown in previous chapters, empirically-based studies of psychodynamically-oriented therapies have found to be ineffective for some individuals with binge-type eating disorders. For individuals treated only with outpatient psychotherapy, abstinence rates of disordered binge-eating patterns are often low during treatment, and statistically lower during posttreatment. Because object relations-based psychodynamic treatments are aimed at re-creating the original miss-attuned early maternal relationship or miss-attuned holding environment and re-enacting the original problematic impingements in an effort towards repair without also improving maladaptive behavioral patterns, those with DTTBTEDs are often unresponsive to complete or prolonged abstinence.

As discussed in previous chapters, research has also indicated that individuals with DTTBTEDs, with their heightened affect regulation difficulties and more entrenched behavioral disorders, are often also unresponsive to CBT. Effectiveness rates among individuals with binge-type eating disorders are inconsistent, drop-out rates can be

high, and long-term abstinence rates are typically low. In fact, as previously reported, several recent empirically-based studies have shown CBT to be ineffective for about 50% of individuals with BN and BED during treatment, a significant number also continue to suffer at the treatment's end, and 30-50% of those with BN or BED fail to maintain abstinence in posttreatment (e.g., Chen, et al, 2008; Fairburn, Marcus, & Wilson, 1993; Mitchell, et al, 2004; & Wilson, Grilo, & Vitousek, 2007). Predictors of poor outcome with CBT among individuals with DTTBTEDs have been consistently identified as severity of symptoms, patterns of affective dysregulation, low self-esteem, disordered personality characteristics, and patterns of maladaptive interpersonal difficulties (e.g., Agras, 1993; Fairburn, Marcus, and Wilson, 1993; & Wisniewski, Safer, & Chen, 2007).

Because individuals with DTTBTEDs exhibit such interpersonal difficulties and affect regulation deficits, it is likely that they often fail to respond to CBT in the way that others that are not within the difficult-to-treat sub-group might not. Only treating the proximal influences presented by individuals with binge-type eating disorders without evaluating and healing the ones that originated in the process of psycho-structural and personality organization likely leave the individual with an incomplete treatment experience. Conversely, from a psychodynamic perspective, ameliorating the behavioral components of binge-eating symptoms without providing patients with an understanding of the historic and conditioned influences on their behavior is also incomplete treatment and likely contributes to rates of ineffectiveness in individuals with DTTBTEDs.

It appears that, in addition to researchers, practicing clinicians have also discovered the routine ineffectiveness of traditional single-theory psychodynamic or behavioral treatment implementation with individuals with DTTBTEDs, as evidenced in

their previously discussed attempts to layer treatments, such as adding psychopharmacology or IPT to CBT, or treating the eating disorders from eclectic or integrative approaches. However, as previously reported, those attempts were found to be ineffective with individuals with DTTBTEDs, as well (e.g., Mitchell, Halmi, Wilson, Agras, Kraemer, & Crow, 2002). Alternative forms of eclectic or integrative treatment have also been largely ineffective and require further research. What is clear is that those treating individuals with DTTBTEDs are finding traditional treatments ineffective or inconsistently effective, continuing to identify the complicated needs of the sub-group, and are in need of a more suitable treatment that their clients can be responsive to.

In sum, the limitations of the existing treatments are routinely preventing individuals with DTTBTEDs from being effectively treated in ways that will promote object relational growth or lasting behavioral abstinence. None of the currently utilized eating disorder treatments for binge-type eating disorders effectively address all the symptoms in the array of more complicated, intensified, and difficult-to-treat needs exhibited by individuals with the disorders. The severity of impulsivity, greater reported negative mood, inability to utilize primary affect regulation strategies, reliance on maladaptive secondary eating behaviors to cope with their pronounced affect regulation difficulties, and the development of addictive behavior patterns are the factors that have been identified as responsible for the greatest treatment resistance. Based on such findings, locating a more theoretically and empirically effective mode of care for individuals with DTTBTEDs that could prove to treat both the early object relational wounds and pattern of subsequent relational maladaptivities, as well as, the addictive presentation of eating behavior patterns, would not only aid the collection of literature

and improve the field of eating disorder treatment, but would also serve to better meet the needs of a specific sub-group of eating-disordered individuals typically evaded by traditional treatments. Because of the life-threatening quality of such mental health disorders, it is essential that new methods of treatment be applied and evaluated as readily as possible.

#### *Dialectical Behavior Therapy (DBT): An Overview*

Although there is some very recently evaluated research validating the promising treatment effects of transference-focused psychotherapy (TFP) on borderline personality disorder (BPD) based upon its hypothesized ability to integrate fragmented “conflicted affect-laden conceptions of self and others” that make themselves apparent in the therapeutic relationship (Levy, Wasserman, Scott, & Yeomans, 2010), Dialectical Behavior Therapy (DBT) is still currently identified as the best practices standard of care for individuals with BPD. TFP, like DBT, appears to also espouse a closely-allied highly-engaged therapeutic relationship, that is highly structured, and focuses on goals of containing suicidal and self-harming behaviors, reducing client resistance to treatment as DBT does. It will likely continue to earn more empirical investigations into its effectiveness with BPD. However, it remains less comprehensive than DBT with its focus primarily on the object relational patterns persistent in treatment without the coaching and affect regulating skills dissemination inherent in DBT. DBT, on the other hand, has earned longer-termed, consistent praise for its empirically successful ability to couple skills-based behavioral treatments with relationally-based acceptance strategies and close psychotherapy and coaching relationships in order to target life-threatening, therapy-interfering, and quality-of-life-interfering behaviors (Chen, Matthews, Allen, Kuo, &

Linehan, 2008). Because of its empirically tested ability to treat disorders of affect dysregulation from a multi-modal perspective in consistently effective ways that other treatments have failed to replicate, it remains the gold standard treatment for BPD. Because of such success in treating disorders of affect dysregulation, DBT has also been consistently applied and successfully adapted to substance abuse disorders in recent years, as well. The present study asserts that DBT has the potential to become the most effective and best practices treatment for individuals with DTTBTEDs. In order to more effectively delineate DBT and its utility, a review of BPD, the development of DBT, and the common implementation of the specialized treatment will be reviewed.

*Borderline personality disorder.* Borderline personality disorder (BPD) was originally identified in earlier psychological theoretical models as a collection of traits that was thought to position an individual's mental health status between the classic psychological categories of *neurotic* and *psychotic* (Knight, 1953). In more modern thought, however, it has come to be better understood and more specifically defined as a "behavioral, emotional, and cognitive instability and dysregulation" (Linehan, 1993, p.11). The DSM-IV-TR (2000) describes the disorder as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity," evidenced by "frantic efforts to avoid real or imagined abandonment," fluctuations of idealization and devaluation in relationships, "identity disturbance," self-damaging impulsivity, recurrent suicidal and self-harming behaviors, dysregulation of sense of self, and affective instability (p.710). As a result of such severe dysregulation, behavioral patterns of individuals with BPD tend to present with great emotional vulnerability, self-invalidation, a pattern of unrelenting crises, inhibited grieving, active

passivity and failure to engage in solving one's own interpersonal problems, apparent competence, or presenting as more highly functioning than they actually are (Linehan). Behaviorally, individuals with BPD exhibit patterns of engaging in high-risk behaviors, significant and persistent self-harming behaviors, parasuicidal behaviors, frequent suicidal ideation and suicidality, have high suicide rates, high hospitalization and multiple hospitalization rates, high turn-over rates in traditional outpatient therapy, and are stereotypically unresponsive to most traditional treatment modalities (Koerner & Dimeff, 2007; Linehan, 1993).

As is theorized with all personality disorders, individuals are thought to develop borderline personality disorder through an “interplay of internal and external factors” (Hertz, 2008, p. 321). Renowned borderline personality disorder expert and developer of DBT, Marsha Linehan (1993) describes the collision of factors that culminates to create the perfect mental health storm: “BPD is primarily a dysfunction of the emotion regulation system; it results from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction overtime.” (42). Individuals diagnosed with BPD exhibit developmental or congenital dysfunctions that cause high emotional vulnerability and innate difficulty modulating emotion (Linehan, 1993). Such intrinsic biological factors contribute to make attempts at affect regulation challenging and often unsuccessful. Over time, dysregulated and miss-regulated affect regulation develop into patterns of conditioned behaviors that become increasingly difficult to extinguish (Linehan, 1993).

Individuals with BPD also characteristically present with a history of invalidating early developmental holding environments. Roberts & Roberts (2007) argue that the early



relationships individuals with BPD typically report and evidence were often characterized by the child's need to relinquish their own dependence needs in service of the overwhelming ones of their primary caregiver, as well as a hyper-vigilance of their caregiver's needs and an attunement to them in order to maintain connection. As a result, they grow to experience their care-givers as unable to meet their affective needs and learn to expect their environment to typically respond "negatively, inconsistently, and/or inappropriately to their inner experience (e.g., beliefs, thoughts, feelings, and/or sensations)" (Safer, Telch, & Chen, 2009, p. 19). For instance, early crying might have been responded to with punishment, criticism, or neglect, while positive affect may have gone un-affirmed, invalidated, or un-acknowledged (Safer, Telch, & Chen, 2009). As a result, the overall quality of the early maternal care-giving relationship and the early holding environment were likely insufficient to support a delineation of affect modulating techniques, such as learning to label emotions, regulate arousal, tolerate emotional discomfort, or trust in emotional experiences (Safer, Telch, & Chen, 2009; Linehan, 1993). The outcome is often the development of a pervasive experience of emotional abandonment, poor separation-individuation, and a progressively intensified pattern of utilizing maladaptive defenses to attempt to maintain the original attachment relationship and secure future interpersonal relationships. Maladaptive defenses are also implemented in attempts to better cope with heightened affect dysregulation. The result of all factors is often ongoing relational difficulties; impulsive, risky, and self-harming behaviors; and, total dysregulation of one's sense of self (Roberts & Roberts, 2007; Linehan, 1993).

In the 'interplay' of innate biological predispositions and the contributions of an invalidating environmental, individuals are said to develop characteristics and patterns of

behaviors consistent with BPD. In a stress-diathesis model, Linehan (1993) asserts that the combination of environmental influences, predisposition, and a particularly stressful life event together catalyze the onset of the disordered personality organization and the maladaptive behavior patterns characteristic of BPD. Hertz (2008) concurs with Linehan's theory of personality disorder development: "biological influences in the form of heredity, events during fetal development, and the impact of trauma on the regulation of emotions, along with the impact of a pervasively invalidating environment transact over time to create the symptoms" (p.231). As a result, not only does an individual with BPD react more quickly, more intensely, and with a more narrowed focus than an individual without BPD, but they also have a far more difficult time than others modulating the already abnormally high emotional states and developing the object relational skills necessary for improving their utilization of interpersonal relationships in appropriate ways. Additionally, the interaction of one's biological predisposition and invalidating early environmental experiences not only impacts the original development of BPD, it has also been shown to perpetuate symptomatology and exaggerate patterns of emotion dysregulation throughout the lifetime (Linehan, 1993). "As adults, borderline individuals adopt the characteristics of the invalidating environment. Thus, they tend to invalidate their own emotional experiences, look to others for accurate reflections of external reality, and oversimplify the ease of solving life's problems" (Linehan, p. 42). As a result of such complicated and dramatic etiology and chronically dangerous symptomatology, interest in the disorder and models of treatment has increased significantly in recent years.

*DBT*. Because of the aforementioned patterns of chronic emotional dysregulation and repeated display of self-harming and suicidal behaviors, individuals with BPD have been found to be highly resistant to traditional forms of treatment. Single-mode treatments, such as supportive therapy, psychoanalytically- and relationally-oriented psychotherapy, and traditional forms of CBT often fail in effectively treating enough components within the plethora of BPD symptoms enough to alter their overall patterns of dysregulation (Hertz, 2008; Safer, Telch, & Chen, 2009; & Wisner & Safer, 1999). Moreover, because individuals have a patterned history of poor or damaged object relations, they also often experience great difficulty engaging in the transferential work inherent in most forms of relational therapy, evidenced by utilization of splitting, mergers, pre-mature cut-offs, and reattachments as defensive techniques (Hertz, 2008). Similarly, ill-informed therapists treating individuals with BPD often also experience great countertransference difficulty managing their clients' symptomatology, relational pushes and pulls, and struggles to relate and connect (Hertz, 2008). Linehan's (1993) work developing DBT, however, revolutionized what had been historically considered a discouraging path of recurrent treatment failures. Over time, DBT with individuals with BPD has been shown to significantly reduce maladaptive symptomatology and increase healthful ways of coping substantially, improving mindfulness practices, interpersonal effectiveness, emotion regulation, and distress tolerance abilities more than any other treatment modality (e.g., Perseus, Ojehagen, Ekdahl, Asberg, & Samuelsson, 2003; Stepp, Epler, Jahng, & Trull, 2008). Overall, the contributions of DBT as a treatment modality have dramatically improved individuals' mental health outcomes in ways unachieved by any other treatment.

Linehan (1993) originally designed DBT as a treatment for individuals with the most pervasive and dangerous parasuicidal, suicidal, and self-harming behaviors in order to help them learn to minimize their self-destructiveness and improve their ability to utilize interpersonal relationships in adaptive ways (Hertz, 2008). “In developing standard DBT, Linehan synthesized her clinical and research experience with BPD with principles and concepts from Western philosophy (dialectics), CBT, and both Eastern (Zen) and Western contemplative practices. DBT may be thought of as a synthesis of these divergent ideas” (Safer, Telch, & Chen, 2009, p. 17). DBT is also described as a treatment that “uses standard CBT interventions (e.g., self-monitoring, behavioral analysis and solution analysis, didactic and orienting strategies, contingency management, cognitive restructuring, skills training, and exposure procedures)” (Koerner & Dimeff, p.7), while also including a *dialectical* approach – or, one that reconciles between seemingly opposite desires and behaviors of the affected individual. Such a focus simultaneously prioritizes both acceptance techniques to validate the client’s experience of their symptoms with behavioral challenges aimed at encouraging the replacement of maladaptive coping skills with adaptive ones (Linehan, 1993). “Standard DBT is a comprehensive, multimodal skills-based treatment balancing behavioral strategies with acceptance-based strategies and targeting life-threatening, therapy-interfering, and quality-of-life interfering behaviors” (Chen, Matthews, Allen, Kuo, & Linehan, 2008, p. 505). Because it conceptualizes the seemingly self-destructive behavior inherent in BPD as failed attempts at affect regulation, it seeks to validate “the kernel of truth” in the individual’s perceived experience while also aspiring to exaggerate the maladaptivities of their behaviors, teach, and promote behavior change strategies

(Linehan, 1993, p. 241). Goals of treatment aim to improve the typically challenging and often poor quality of life individuals with BPD have by helping them increase behavioral control over self-harming behaviors, experience emotions in more appropriate and comfortable ways, improve relationships, and increase a sense of happiness and connectedness (Hertz; Wisner & Telch, 1999).

A complete DBT treatment program is a highly structured series of therapeutic techniques that is delivered in four methods: two hours of group skills training each week, one hour of individual psychotherapy each week, access to 24-hour telephone coaching between sessions with the primary clinician, and a therapist consultation team to support and guide the clinician (Linehan, 1993; Hodgets, Wright, & Gough, 2007). Throughout the process, the individual's self-observed affective experience, use of maladaptive behaviors, and application of newly acquired skills is recorded on a daily DBT diary card and reviewed with the individual's clinician weekly (Linehan, 1993). It is a contractual one-year therapy with four stages. *Stage 1* focuses on stabilizing the client and achieving behavioral control by decreasing the target behaviors that are most life threatening, life-interfering, and therapy-interfering, as well as increasing skills acquisition and utilization. Skills training involves educating clients to increase interpersonal skills, emotion regulation skills, distress tolerance skills, and core mindfulness skills aimed at reducing overall self dysregulation. *Stage 2* focuses on better processing past traumas and extinguishing the behavioral connection between posttraumatic memories and cognitions with maladaptive attempts at affect regulation. *Stage 3* seeks to help the individual develop improved self-esteem. *Stage 4* focuses on the

individual's maintenance of change and continuing to work towards improving experience (Linehan; Hodgetts, Wright, & Gough, 2007).

Overall, DBT is described to be “supportive,” in the therapist's aim at helping their client enhance their quality of life; “behavioral” in its analysis and targeting of patterns of problematic behaviors and replacing maladaptive ones with adaptive ones through a newly acquired skills set; “cognitive” in the therapy's focus on helping the client change maladaptive beliefs, expectations, and assumptions; “skills-oriented” in its structured skills training programming; “balances acceptance and change” throughout the treatment program through the merger of skills training and reality acceptance; and “requires a collaborative relationship” between the client and the therapeutic team in order to foster a sense of safety and progress (Linehan, pp. 442-443). With at least nine randomized controlled trials exhibiting its efficacy and numerable others currently indicating its statistically significant ability to help individuals minimize problematic symptoms, DBT is presently argued to be the most empirically successful treatment for BPD (Chen, Matthews, Allen, Kuo, & Linehan, 2008; Safer, Telch, & Chen, 2009). Because of its vast empirically-evidenced success, the development team and other researchers alike have been quick to identify a variety of other typically difficult-to-treat behavioral disorders where DBT may be successfully applied, including substance dependence (Rosenthal, Lynch, Linehan, 2005; Sher, 2002) and eating disorders (Chen, Matthews, Allen, Kuo, Linehan, 2008; Koerner & Dimeff, 2008).

#### *Similarities Between BPD and DTTBTEDs*

*Problematic object relational development.* The genesis of DBT's proposed utilization with individuals with DTTBTEDs emerges out of the marked similarities

between the disorders' etiology and symptomatological presentations. For instance, problematic object relational development and subsequent difficulties with interpersonal relationships are strongly evidenced in both groups of individuals. As previously established, an individual's pattern of relating to others is generally established through interactions in their early maternal care-giving relationship and in their original holding environment from which internal working models of future relationships and expectations of the world are generated. Through this lens, those with BPD and DTTBTEDs can be seen to evidence similar difficulties with early object relations, as evidenced in their relational difficulties, chronic struggles with affective expression and self-soothing, their over-reliance on external transitional objects, and their use of self-directed aggression to emotionally regulate. Because both groups of affected individuals evidence miss-attuned or invalidating early holding environments, they also exhibit remarkable similarities in their inability to label feelings, to trust their emotions, to tolerate distress or affectively regulate in healthy and adaptive ways, and to validate and trust one's own experience of external events and internal reactions (Safer, Telch, & Chen, 2009). As a result, both groups of individuals fail to develop an accurate sense of self and an experience of safety in relating with others in adaptive ways. Correspondingly, their reliance on objects in their environment to gain a sense of a situation to validate their emotional experiences, and even to dictate measures of eating, food, and body image tend to be consistently gathered – exclusively and at times frantically - through external sources.

*Transitional objects.* The centrality of the maladaptive use of transitional objects is also evident for individuals with BPD and DTTBTEDs. For example, one set of researchers, in their qualitative work on transitional objects in BPD, BN, and AN, found

that food functions as a transitional object for eating disordered individuals, or something that serves as “a soothing function because it is a link between an internal representation of an emotionally important object and that actual object in the external world” (Guinjoan, et al, 2001, p.462). In this case, it is argued that food represents the early feeding and responsiveness by the mother for both individuals in both groups. Similarly, it has been argued that individuals with BPD utilize suicidal gestures as “a hostile way” of attaching to an object or gaining attentional access to an object (p. 462). Early relational difficulties and conflicts during separation-individuation during early development likely contributed to a chronic over-reliance on transitional objects for need satisfaction and a rejection of interpersonal relationships for individuals in both groups.

*False self presentations.* Individuals with BPD and those with DTTBTEDs have been found to commonly present with strong false-self presentations as a result of the impact of their early invalidating or miss-attuned holding developments. Like individuals with BPD that exhibit significant difficulty with interpersonal and self-regulation skills, Chassler (1998) conceptualizes individuals with BN as maladaptively relying on the defenses of avoidance, denial, isolation of affect, and intellectualization to distance themselves from others, as well. Also like those with BPD, the author describes those with BN to have experienced damaged early care-giving relationships, suffered unmet needs, and developed an ego structure that supported the “split off and isolated . . . infantile needs” (p. 404). As a result, they begin to feel and behave as two people: “one who feels desperately needy,” in what Winnicott would term a true self expression, and one “who appears to be responsible” or in total control, as an expression of a constructed false self (p. 404). Individuals with BPD have similarly been found to be forced, through



similar exposure of biological, environmental, and interpersonal factors, to develop a split false self and true self (Roberts & Roberts, 2007). For both groups of individuals, it is the use of maladaptive ego defenses like denial of reality, displacement of emotions, and regression of attempts at affect regulation, however, that supports the structure of the split self, often leading to increasingly dangerous self-harming behaviors like bingeing, purging, over exercising, self-mutilation, and suicidality, as is routine for individuals with impulsive-type eating disorders and BPD. When coping with the overwhelming demands of their external environments with already heightened affective response levels and inadequate regulation skills, many individuals with BPD and DTTBTEDs likely avoid, deny, isolate, and postpone their affective needs until they reach a point of affective overwhelm, whereby they then presumably feel forced to engage in maladaptive regulation strategies to attempt to soothe themselves.

*Behavioral dysregulation.* The same object relational deficits suffered during early development that are thought to contribute to an over-reliance on transitional objects and false self presentations are also conceptualized to contribute to the shared experience of behavioral dysregulation that individuals with BPD or DTTBTEDs commonly exhibit, as well. It has been shown that both groups of individuals engage in maladaptive, unhealthy, risky, attention-seeking, debilitating, and often life-threatening behavior patterns in their attempts to regulate their affective states at the point of therapeutic contact. While innate biological deficits and prolonged exposure to behavioral conditioning processes have been described to significantly contribute to the development of patterns of behavioral dysregulation, shared difficulties modulating behavior are thought to all be significantly connected to invalidating or miss-attuned

earlier care-giving. Not being taught to regulate affect properly, engaging in long term patterns of conditioned and reinforced behaviors, and giving attention through dramatic displays of self-harming behaviors together cause a pattern of behavioral dysregulation. In fact, it is the severity of the behaviors they engage in and their chronic reliance on them that contributes to the conceptualization of both groups as so difficult-to-treat.

*Impulsivity.* Not surprisingly, based upon the etiological similarities of the two sets of disorders, many researchers have discovered that individuals display significant difficulties implementing consistent and adaptive attempts at affect regulation because of shared problems with impulsivity. For instance, Lilienfeld, Jacobs, Woods, and Picot (2008) discovered that individuals who were found to test positively for borderline personality features during the initial phase of their study were also significantly more likely to have developed disordered eating patterns, like BN and BED, at a 2-year follow up analysis. Lilienfeld and colleagues (1998) also identified impulsivity, an essential piece of BPD pathology, to be identified as a significant risk factor for developing disordered eating. The literature in the field of eating disorder research has also widely identified the frequent comorbidity of BPD within a sub-group of individuals with impulsive-type and difficult-to-treat eating disorders. Sansone, Levitt, and Sansone (2005), in their summary of current literature, identified 28% of participants in the studies evaluated with identified BN to also meet the criteria for BPD. Additionally, several studies identified individuals that exhibited both impulsive-type eating disorders and traits traditionally present in BPD to have significantly greater pathology and difficulties affectively regulating their behaviors (Ben-Porath, Wisniewski, & Warren, 2009; Levitt, 2005; Steiger, Thibaudeau, Ghadirian, & Houle, 1992).

*Difficulties with affect regulation.* Wisniewski (2003), in her theoretically-based piece, describes in greater detail the number of similarities in presentation individuals with eating disorders and those with BPD display in their common difficulties with affect regulation. Both diagnostic groups have difficulty regulating emotions and utilize elements within their environments, often in a maladaptive ways, to self-soothe. Both groups tend to present with biological vulnerabilities, namely temperaments that make them increasingly sensitive to emotion, exhibit a heightened emotional response, and a greater difficulty in bringing their emotions back to equilibrium. According to the theory, both groups also were raised in invalidating environments that failed to teach them the skills needed to regulate their emotions. “The result is an individual who is unable to pay attention to and trust her own responses and reactions but instead learns to rely on the environment for cues both about what to feel and what is accurate or true” (Wisniewski, 2003, p. 133). Like individuals with BPD that constantly fluctuate between states of emotion dysregulation and self-invalidation, inhibited grieving and unrelenting crisis, and apparent competence and active passivity, the author asserts that individuals with eating disordered behavior also experience the dialectic of controlled eating and absence of an eating plan, desires to change maladaptive eating behaviors and a rigid adherence to a reliance on them. Clearly, the research displays some of the similarities individuals with binge-type eating disorders and individuals with BPD have in negotiating emotion regulation skills deficits and its function as key to the experience of their disorders.

*Behavioral conditioning of maladaptive affect regulation.* Over time individuals with both types of disorders, with their innate difficulties with impulsivity, heightened affective experience, and practice of affective dysregulation and miss-regulation, likely

experience the behavioral conditioning of maladaptive affect regulation techniques and temporarily reduced negative affect. Because individuals in both groups are evidenced to emerge from miss-attuned or invalidating early developmental environments, the practice of independently regulating affect likely begins early, and consists of rejecting primary self-soothing strategies that involve the use of interpersonal relationships and relying on secondary affect regulation strategies instead. These strategies typically involve a reliance on external methods of self-regulation and often with maladaptive results. As previously indicated, individuals with BPD tend to exhibit the repeated use of a variety of impulsive behaviors, including self-harming behaviors, high-risk behaviors (e.g., substance use, sexual activity), relational fusion and dependence on interpersonal relationships, and suicidality to attempt to regulate their affective states, while individuals with DTTBTEDs repeatedly use combinations food, eating, and purging behaviors in their attempts to regulate their affective states. In both groups, the patterns of reliance on such external methods of self-soothing become increasingly relied upon through behavioral conditioning and reinforcement processes. Additionally, because attempts at affect regulation are often only temporarily effective in both groups, the experience of dysregulation arises frequently, and increases the repetition of miss-regulated affect regulation strategies. Eventually, the use of such behaviors becomes more relied upon, the ability to utilize other adaptive forms of affect regulation becomes increasingly rejected, and the problematic behaviors take on difficult-to-treat addictive presentations.

*Treatment resistance.* Because of the severity of the seemingly addictive patterns of maladaptive attempts of affect regulation exhibited in the behaviors of individuals with BPD or DTTBTEDs, individuals in both groups also commonly exhibit significant

treatment resistance. As has been previously shown, traditional psychodynamic and behavioral treatments for binge-type eating disorders have consistently shown to be ineffective or inconsistently effective for individuals with DTTBTEDs. Similarly, individuals with BPD have been found to be treatment resistant to traditional forms of supportive therapy, psychoanalytically- and relationally-oriented psychotherapy, and traditional forms of CBT. As a result, researchers and clinicians have brought the severity of the disorders' symptomatology into more prominent light and identified the need for more effective treatment models.

Evidently, there are a variety of factors that make BPD and DTTBTEDs similar in etiology, presentation, and resistance to traditional treatments. Because of such similarities, individuals that present with behavioral dysregulation that is more characteristic of one disorder over another may actually meet the diagnostic criteria for both (e.g., Wisniewski, Safer, & Chen, 2007). It is such similarities in symptomatology and etiology that make the application of DBT with these two disorders similarly appropriate. Where the effectiveness of DBT with BPD has been evidenced in numerous empirical studies since its establishment, the utility of DBT with DTTBTEDs has been applied far less often and evaluated only rarely. As a result, the remainder of this chapter will delineate the theoretically-based utility of DBT with DTTBTEDs from Winnicottian object relations and behavior theory perspectives, as well as the empirically-evidenced success that a small handful of researchers have begun to find with its implementation.

#### *Winnicottian Object Relations Conceptualization of DBT's Utility with DTTBTEDs*

From a Winnicottian object relations perspective of DTTBTEDs, there is a strong case for the application of DBT in order to treat the original object relations failures

through supportive and psychodynamically-based treatment techniques. The support for the use of DBT and the success of the treatment has been largely attributed to the treatment's ability to directly effectuate the most significant behavioral improvements in clients. However, what has not been evaluated is the potentially important and significant impact the relational experience that is created in the therapeutic relationship likely has on the client's ability to participate in all forms of treatment, allow skills acquisition, and effectuate substantial behavior change. When the relationships between client, therapist, and treatment team are evaluated from a Winnicottian object relations perspective the potential impact of the relational work that is occurring simultaneous to the behavioral work appears significant.

Within a complete DBT program implementation, it is clear that a substantial amount of interpersonal and relational work is required. Not only is a strong therapeutic alliance necessary for individual outpatient therapy sessions each week, but relational work is also necessary for participation in two hours of group work, and the opportunity to have after-hours telephone coaching support. For individuals with BPD that have historically had great difficulty both maintaining interpersonal relationships or embracing appropriate boundaries within them, participating in closely-allied therapeutic relationships in consistent ways is a challenge in and of itself. Similarly, individuals with DTTBTEDs that have grown accustomed to the utilization of strong false self presentations and exhibited greater ease in attempting to regulate affect through the secondary strategy of eating, participating in closely-allied therapeutic relationships in consistent ways is also challenging.

However, what seems especially significant about participation in the therapeutic relationship inherent in a DBT program for both groups of individuals is that it has the propensity to remedy original object relational failures. Like Winnicott envisioned, “psychoanalytic treatment must provide the physical and human conditions that resemble the maternal holding environment and that support the development of the self”(Goldstein, 2001, p. 37). Flanagan’s (2008) recent review of object relational treatment also asserts the application of his theory. “Clients, too, need the therapist to construct a holding environment that creates a safe physical and psychological space wherein they feel protected so that spontaneous interactions, feelings and experiences can occur. As it is for children, that space must be created in such a way that clients benefit from it without necessarily being aware that it is being created for them” (p. 131). The establishment of a close therapeutic relationship that exceeds the traditional therapeutic space and time constraints, the peer benefits of group participation, and the assistance consultation teams can be for the primary clinician can all be viewed as a re-creation of the original maternal holding environment. In this manner, the client is enabled an opportunity to form an idealized view of their primary clinician, disengage their false self presentations, reduce their efforts at apparent competence, and re-visit the original struggles of early object relations and work towards amending them in a permanent way.

*Individual Outpatient Therapy.* The establishment of a closely-allied therapeutic relationship with a clinician on an outpatient basis with after-hours coaching is perhaps the most substantial way that the original early holding environment is created in DBT. In her overview of treatment, Linehan writes that “the therapist must work to establish a strong, positive interpersonal relationship with the patient right from the beginning” as,

“similar to many schools of psychotherapy, DBT works on the premise that the experience of being genuinely accepted and cared for and about is of value in its own right, apart from any changes that the patient makes as a result of therapy [Linehan, 1989]. Not much can be done before this relationship is developed” (Linehan, 1993, p. 98). Immediately following the establishment of a trusted therapeutic alliance, Linehan asserts that the therapist communicate to the client that the therapist will be asserting the control in the relationship in order to effectuate life-improving and potentially life-saving strategies for change that will ultimately enhance the client’s eventual freedom and self control. In this manner, the therapist’s care, support, authority, and control closely mimic the positions espoused by parents in adaptive and well-attuned holding environments during early development, offering the client the opportunity to be placed in a regressed object-relational position and an opportunity to form an idealizing transference.

The attitudes and perspectives that clinicians are advised to make at the outset of therapy about their clients also contribute to the experience of a replicated early caregiving relationship. Linehan asserts that clinicians assume that their clients are “doing the best they can,” “want to improve,” “need to do better, try harder and be more motivated to change,” “are in a living hell,” and that they “may not have caused all of their own problems, but have to solve them anyway,” (Linehan, 1993, pp.106-108). In this manner, the clinician is not only asked to unconditionally appreciate the perspective of the client and the quality of their life as most psychodynamic orientations to clients practice, they are also recommended to continue to be assertive with them and their process of recovery, nonetheless. Linehan also writes on the power of “cheerleading” in the DBT therapeutic process: “In cheerleading, the therapist is validating the inherent ability of the



patient to overcome her difficulties and to build a life worth living . . . A key therapist attitude is ‘I believe in you.’ . . . For some patients, this will be their first experience of having someone believe in and have confidence in them” (p. 243). Once again, through the acceptance and cheerleading techniques, the clinician is able to offer the client a holding environment and good-enough parenting strategies that validates their experience and supports it with a sense of challenge and encouragement, just as a parent might.

DBT also requires the primary clinician to carefully apply “problem-solving strategies balanced by validation strategies” (Linehan, 1993, p. 99). Linehan asserts that it is essential that two forms of validation are practiced: one that communicates to the client that the therapist “finds the wisdom, correctness, or value in the individual’s emotional, cognitive, and overt behavioral responses” and, one that communicates the therapist’s belief in the client’s abilities to effectuate healthful changes (Linehan, 1993, p.99).

Validation can come in the form of “active observing,” or the process of gaining information about an event that has occurred for the client, and observes the client’s feelings, thoughts, and behaviors (Linehan, 1993, p. 223). With a third ear, the therapist makes psychological sense of the situation at hand and is able to offer additional and validating insights. Validation may also come in the form of “reflection,” or the accurate mirroring back to the patient their own feelings, thoughts, assumptions, and behaviors in a way that provides the client with additional understanding of their own processes and enhances the trust in the therapeutic relationship (Linehan, 1993, p. 224). Finally, validation can also come in the form of “direct validation,” or the therapist’s identification of “the grain of wisdom an authenticity in a patient’s responses that on the whole may have been dysfunctional,” appreciating and understanding its utility for the

client, and reflecting that understanding, as well as an appreciation of the inherent capabilities for change, in a direct manner to the client (Linehan, 1993, p. 224). Again, in this manner, like a parent would with their own child, the therapist assures the client that they are observed, listened to, understood, mirrored as they may not have been before, and filled with a narrative of belief in the capability of change.

Having established a relationship that validates the client and creates a sense of safety, the client is placed in a somewhat regressive position by allowing themselves and their most problematic behavior patterns to be scrutinized by their clinician. The clinician is able to replicate early parental roles by gaining a highly detailed understanding of their client's most maladaptive behaviors and by taking management of the process of developing, instituting and overseeing behavior change strategies, including the administering of appropriate reinforcements of positive behaviors and negative behaviors (Linehan, 1993). In the problem-solving process, the client is able to begin to master better self-regulation tasks associated with early development. As they are learned, utilized, and mastered, the client often finds themselves less in need of their clinician's support, a process highly paralleled to that of earlier separation-individuation.

The therapeutic relationship offered in DBT makes allowances for individuals that are not offered in typical psychotherapeutic relationships. For instance, Linehan (1993) writes that although therapy sessions are normally held once a week, "at the beginning of therapy and during crisis periods, sessions may be held twice a week" (p. 102). Additionally, sessions can be tailored individually to the client to last for the duration of one session to a longer session of 90-110 minutes based upon the client's ability to make themselves emotionally open and transparent in session (Linehan, 1993). When in crisis

or in need of additional support or coaching, Linehan's design also provides the opportunity for the clinician to offer after-hours "telephone consultation," typically deemed to be characteristically outside the boundaries of traditional psychotherapy (Linehan, 1993, p.104). The impetus behind the additional therapeutic contact is rooted in the notion that those who require the intensified treatments, like those with BPD and DTTBTEDs, often have difficulty asking for help effectively, feel too fearful, shameful, undeserving, or comfortable enough getting their needs met through adaptive self-soothing behaviors. Individuals also may be in need of generalizing newly acquired DBT skills to their everyday lives (Linehan, 1993). Extending the parameters of clinical work to accommodate the more intensified object relational needs is thought to improve the experience of a replicated early holding environment.

Finally, an important allocation that clinicians practicing in a DBT program have that other forms of traditional psychotherapy typically do not is the practice of utilizing contingency management procedures, or positive or negative reinforcements, to maintain firm limits in their work. Linehan asserts that every interpersonal interaction that occurs between client and therapist has the potential to reinforce or extinguish a behavior pattern. When skills acquisition is successful and negative behaviors are being abated, the therapist is allowed to apply positive reinforcements. When negative behaviors are increasing, despite adequate skills acquisition, the clinician is afforded the opportunity to implement aversive contingencies, such as "disapproval, confrontation, withdrawal of warmth, vacations from therapy when necessary, or termination as a last resort," as a result (Linehan, 1993, p. 298). Although the therapist is encouraged to carefully evaluate the necessity of aversive contingencies, their likely effects, and to allow natural

consequences whenever possible and appropriate instead (Linehan, 1993), the ability of the clinician to apply punishment techniques and promote limit-setting in order to promote client progress is another obvious parent-like therapeutic technique unique to DBT. It may not only may function to improve object relations through a more closely engaged therapeutic relationship and also exist as evidence of one, it also practically functions to generate more adaptive behavioral outcomes, as well.

In sum, if clients are able to allow themselves to engage in a closely allied relationship and participate with full transparency with their primary clinician they will be more likely to be able to take full advantage of the opportunity to amend early object relational problems. As previously evidenced in individuals with DTTBTEDs, their relationships with early caregivers were often ones that prevented complete trust, reliance upon, internalization of affect regulation skills from, and mirroring that affirmed the development of a strong sense of self. In work with a DBT-training clinician, however, these individuals are offered a pseudo-second opportunity to be in a position to be taught affect regulation and adaptive object relation skills.

*Group Processes.* Participation in a skills group twice a week with the same facilitators and group members is another contributing factor of the simulation of the original early holding environment. Just as there were other individuals that were involved in the process of raising a child and the important relationships with peers during development, group membership during DBT allows individuals with DTTBTEDs an additional opportunity to re-visit the experience of object relational development. The skills training group provides clients with the benefit of a common difficult experience, shared psychoeducation of skills, a place to commonly celebrate behavioral gains,

mutuality in working through frustrations, and the development of alliances and kinships throughout the process. Additionally, the experience of entrusting a group and the group's facilitator with one's most vulnerable life struggles enhances their practice of utilizing interpersonal relationships in ways that they may not have felt comfortable doing during previous periods of development.

*Case Consultation Meetings for Therapists.* Finally, the establishment of consultation teams to support the clinician in the process of treating individuals with DTTBTEDs not only provides the client with an enhanced therapeutic experience, it also somewhat inadvertently mimics the original primary care-giving environment. Linehan asserts that working with individuals with BDP is a uniquely challenging and draining experience. Individuals with DTTBTEDs similarly present as frustrating to treat by clinicians likely as a result of the persistent use of maladaptive and often dangerous behaviors. Individuals may also elicit frustration in their difficulty forming a transparent and closely allied therapeutic relationship because of their object relational difficulties. In order to prevent therapist overwhelm, case consultation teams afford clinicians the opportunity to gain mutuality and support from their peer clinicians experiencing similar treatment difficulties with similar clients (Linehan, 1993). In this manner, clinicians – like parents seeking parenting advice and support around difficult care-giving experiences – are also afforded similar therapy-supporting activities.

In sum, there is evidence that the various components of interpersonal relatedness that occur in the various forms of treatment have the opportunity to replicate the early maternal holding environment and reintroduce the original position of vulnerability where problems with early object relations occurred. In this replication, the client is

offered the opportunity to permanently amend those early problems by fully participating in a closely-allied individual therapeutic relationship, taking membership with peers in the skills group component of treatment, and allowing their clinician to gain support and guidance in their process of so closely managing their clients. The client with DTTBTED is, then, able to confront their persistent maladaptive use of food and eating behaviors, a rejection of the use of interpersonal relationships for support and soothing, and an over-reliance on false-self presentations in a direct manner and rely on their clinician to help them navigate through the process of change and skill acquisition. By allowing themselves the ability to be in a regressive object relational position, they will also be able to re-experience the process of separation-individuation as they master skills acquisition and implementation that enables them a more adaptive and healthy behaviors. Their development will no longer be thwarted, and they can use the relational work to improve the quality of their life to a degree they likely have not experienced before.

*Behavior Theory Conceptualization of DBT's Utility with DTTBTEDs*

While a Winnicottian object relations lens provides a comprehensive lens from which to view DBT's unique ability to reintroduce the object relational problems of early childhood during adult eating disorder treatment processes in a way that can offer new healing, a behavior theory conceptualization of DBT with DTTBTEDs offers a clear understanding of the uniquely transformative opportunity for significant and lasting behavior change offered in a full DBT program.

Like object relations theory, behavior theory of DTTBTEDs asserts that individuals have often emerged from miss-attuned early care-giving relationships and inadequate holding environments where they missed an opportunity to learn to identify,

label, and regulate their negative affective experiences during early childhood. As a result, the theory asserts that they have developed a pattern of operantly conditioned maladaptive affect regulation practices that over time become increasingly difficult-to-regulate and, ultimately, present as addictive symptomatology. DBT's significant focus on creating behavior change while also assisting the client in amending early object relational difficulties, however, also makes the application of the treatment a highly logical and promising choice.

An important component of DBT that has been shown to promote behavior change is in the process of re-teaching emotion recognition, understanding, and management. Because individuals with BPD and DTTBTEDs have both been shown to have histories of difficulty identifying and experiencing a range of emotions, their emotions are often experienced as threatening, overwhelming, shameful, and to be avoided. As a result, Linehan's design of DBT includes "emotional validation strategies" (Linehan, 1993, p.229), where the establishment of a closely-allied therapeutic context allows the client opportunities for honest emotional expression and the therapist the task of responding with a nonjudgmental and sympathetic focus. The therapist is then able to help the client observe and label their feelings, provide their own interpretation of the client's experience, and communicate that the client's feelings are valid, all enhancing the client's ability to institute significant behavior change.

Linehan asserts that the main targets of DBT are "to increase dialectical behavior patterns," or the balance in thought and cognitive functioning, while also "helping patients to change their typically extreme behaviors into more balanced, integrative responses to the moment" (Linehan, 1993, p. 120). Linehan describes dialectical thinking

akin to more balanced, constructive thinking, whereby thoughts and behavior choices are considered in relation to the environment. More specifically, it encourages individuals to view reality in its complexities, to hold multiple thoughts, to consider multiple perspectives, evaluate them, and work towards integrating them. Individuals with problematic behavior patterns are often led by polarized thought processes that frequently lead them into maladaptive behavior patterns. Instead, a DBT therapist would help the client identify the influences that have contributed to their thought processes, examine how their behaviors have been influenced as a result, and introduce new thoughts to be considered along with old ones to broaden an individual's sense of available behavioral response options (Linehan, 1993). In this manner, the DBT clinician begins amending the maladaptive behavior patterns on a cognitive level.

In this effort towards improving cognitions in order to enhance willingness for behavior change, DBT encourages a focus on “moving the patient toward more balanced and integrative responses to life situations,” and resolving various internal tension states. Some of the most problematic dialectical battles to negotiate include problem solving versus problem acceptance, skill enhancement versus self-acceptance, affect regulation versus affect tolerance, self-efficacy versus help seeking, independence versus dependence, emotional control versus emotional tolerance, and transparency versus privacy, to name a few (Linehan, 1993, p. 124). Resolving the polarities between some of these dialectical states will theoretically help the individual in treatment begin to extinguish their maladaptive behavior patterns in favor of newly acquired adaptive ones, not only in the process of being understood and validated by the therapist, but also by approaching change with a greater sense of self-acceptance.



With a goal of achieving increased balance in mind, the DBT clinician and client can better work towards integrating the core problem solving strategies of DBT. As previously described, the clinician works from a rubric of strategies aimed at creating change of the most life-interfering behaviors. The process involves behavioral analysis of the contributing factors and actions leading up to the behavior's implementation, performing a solution analysis where alternative behavior choices are offered, teaching the new skills to the client, gaining a commitment of new behavior application from the client, and overseeing the client's application of the treatment (Linehan, 1993). In this manner, the clinician is not only carefully assessing where the main contributors of the problem behavior lie, but importantly working to extinguish problematic, maladaptive, and unhealthy behaviors, as well. Once extinguished, new affect regulation strategies are developed through operant conditioning processes. For instance, a clinician's application of DBT behavior change strategies with individuals with DTTBTEDs would appear as the separating of food and eating from the process of reducing negative affect, and instead pairing the use of more adaptive primary strategies of self-soothing regulation skills with negative affective states in an overt and repetitive way until stronger associations and conditioning processes are made.

Linehan's DBT model aims to ameliorate several types of maladaptive behaviors. First and foremost, the model asserts that extinguishing the most life-threatening and life-interfering behaviors are the top priority. For individuals with DTTBTEDs, those eating or purging behaviors that appear at all parasuicidal or physically destructive would be attended to first. When the clinician is assured that their client is safe from imminent self-harm via over-eating or purging, they are then advised by the model to begin addressing

therapy-interfering behaviors, or those that compromise the ability of the client and clinician to maintain an adaptive therapeutic connection (Linehan, 1993). The success of the therapy, Linehan argues, is dependent upon the participation of client and clinician. The client must be attentive for all forms of treatment, participate in therapy in an active and collaborative manner, minimize resistance to the work, do homework assignments, comply with the agreed upon measures of behavior modification, and respect the limit setting and contingency management strategies of the treating clinician (Linehan, 1993).

Increasing a client's adaptive behavioral skill set during DBT is a significant part of the behavior change process with the understanding that extinguishing maladaptive behaviors likely becomes easier with the introduction of adaptive behaviors. As a result, DBT aims to significantly increase a client's "core mindfulness skills, distress tolerance skills, emotion regulation skills, interpersonal effectiveness skills, and self-management skills" in order to improve the variety of resources from which a client has to draw on to better negotiate their lives (Linehan, 1993, p. 144). Descriptions of each of these and their effects on the behavior change process will be further delineated below.

*Mindfulness skills.* Teaching individuals with DTTBTEDs mindfulness skills enables them to become more aware of what is occurring in their environment, more observant of their experiences in their environments, better able to describe events to increase understanding and communication, more able to participate in events completely without dissociation, and doing so non-judgmentally, focusing on one thing at a time, and in an efficient manner (Linehan, 1993).

*Distress tolerance skills.* Gaining new abilities to "accept, in a nonjudgmental fashion, both oneself and one's current situation . . . to experience one's current

emotional state without attempting to change it; and to observe one's own thoughts and action patterns without attempting to stop or control them" enables a new tolerance to distress in ways many with DTTBTEDs used to negotiate with the use of food or eating behaviors (Linehan, 1993, p. 147). In order to improve distress tolerance, techniques of distraction, self-soothing, evaluations of positive and negatives of a considered behavior, turning the mind towards acceptance of a situation, and espousing willingness to engage in adaptive behaviors despite the potential discomfort are all taught to improve the client's ability to reduce maladaptivity (Linehan, 1993).

*Emotion regulation skills.* Because of the significant affect regulation deficits individuals with BPD present with, DBT was designed with a specific focus on re-teaching clients emotion regulation skills to prevent emotions from becoming extreme or labile. Identifying and labeling affect, identifying emotions and their causes, reducing vulnerability to acting on strong emotions, increasing and sustaining positive emotional states, experiencing emotions without judgment, and applying distress tolerance techniques to negative emotions are all ways that can help clients gain better control over their emotional and affective states, thus, improving the likelihood that more adaptive behaviors will be utilized (Linehan, 1993).

*Interpersonal effectiveness skills.* Teaching interpersonal effectiveness skills, such as "assertiveness and interpersonal problem-solving" practices, also improve individuals' abilities to refine their behaviors in ways that support more adaptive and less maladaptive behavior use. Interpersonal effectiveness skills specifically enable an individual to ask for what they need without judgment, set limits with others, and cope with interpersonal conflict in ways that allow them to get their needs met, maintain relationships, and

ultimately utilize the benefit of interpersonal relationships in better implementing primary affect regulation strategies (Linehan, 1993, p. 147).

*Self management skills.* Finally, learning self management skills, such as self-control, goal-setting, environment analysis skills, accepting natural or contingency management consequences of behaviors, stimulus-narrowing techniques in overwhelming situations, are all ways that also contribute to an individual's improved sense of self-control and ability to negotiate their various environmental tasks.

The inclusion of this wide variety of behavioral skills provides the individual in treatment with a plethora of ways in which to better engage in their world and experience greater emotional and affective regulation along the way. In this manner, the opportunity to extinguish the conditioned association between uncomfortable affect and maladaptive affect regulation behaviors with food or eating is improved and able to be replaced with more adaptive and healthful self-regulation techniques.

In conclusion, the use of DBT with DTTBTEDs has great theoretical validity and clinical potential. From an object relations perspective, the various components of interpersonal relatedness that occur in the various forms of treatment have the opportunity to replicate the early maternal holding environment and reintroduce the original position of vulnerability for the client and an opportunity to amend original object relational failures. The use of an atypical and closely-allied individual therapeutic relationship with their individual therapist, taking membership and peer alliances within the skills group component of treatment, and allowing their clinician to gain support and guidance in their process of so closely managing their clients allows the individual in treatment the ability to be in a regressive object relational position from which to begin

anew. Behavior theorists would likely see this vulnerability as an opportunity for the individual to confront the damaging and maladaptive conditioned behavior patterns, like binge-eating and purging. Individuals in treatment can take advantage of being managed and held by the clinician, confronting their chronic reliance on false self presentations. Simultaneously, clients can also work towards extinguishing the conditioned pattern of using food as a transitional object as an attempt to regulate affect, learn new affect regulation skills, practice their application in their real life environments with the supervision of their clinician, and gain the opportunity to effectuate the adaptation of improved affect regulation strategies.

*Application of DBT with DTTBTEDs: Empirical Evidence and Current Examples*

Although there seem to be a deficit of empirically- or theoretically-based studies promoting the utility of DBT with DTTBTEDs based upon a compilation of Winnicottian object relations theory and behavior theory conceptualizations, there have been a handful of studies written and published for peer review that have displayed the clinical value of its application with such populations. They appear in case report format, theoretically-based studies, empirically-based studies, and a newly published manual of DBT for individuals with BED or BN as modified from Linehan's original DBT manual.

*Case Reports.* Safer, Telch, and Agras (2001) published a study of DBT as applied to a 36 year-old married Euro-American woman with an active BN diagnosis. "At baseline assessment using the Eating Disorders Examination, the patient reported 13 objective bulimic episodes, 12 subjective bulimic episodes, and 21 purging episodes over the prior 28 days" (p. 102). The client has a reported 13-year history with binge eating and purging, a history of depressive symptoms, and a 2-year experience of IPT that

reportedly helped with depressive symptoms, but was ineffective in treating her behaviors. Her bulimic tendencies presented as increased states of stress and emotional distress, increased desires to binge eat, subsequent binge-eating episodes, purging, immediate feelings of being more “centered” or “calm,” increases in feelings of shame, stress, and distress which ultimately lead to another binge/purge episode. Outside of the detail of these cyclical cognitive-behavioral patterns, no other object relational history or information was provided. After the authors instituted a DBT-based program, consisting of “20 sessions of weekly 50-min individual psychotherapy specifically aimed at teaching emotional regulation skills to reduce rates of binge eating and purging” in which the individual psychotherapy and group therapy for psychosocial skills training was combined into one treatment modality, her binge and purge symptoms dramatically and significantly decreased (Safer, Telch, & Agras, 2007, p. 103). Sessions are divided in half, the first portion being allocated to reviewing the client’s weekly practice of using DBT skills, as indicated on their weekly diary card, followed by the second half’s devotion to teaching and the acquisition of new skills to be practiced. After 5 weeks of treatment, the client in the case study evidenced no reported binges or purges, and maintained abstinence for the remainder of the 20 weeks. Additionally, at the 6-month follow-up examination, she reported only two binge/purge episodes during the period. Although the study’s success is limited by the client’s short and theoretically-narrowed treatment history, the authors reported an eagerness for the development of a randomized controlled trial to produce replicatable findings (Safer, Telch, & Agras, 2001).

Similarly, Safer, Lock, and Couturier (2007) published a case report of DBT as applied to a 16 year-old female client whose parents brought her to the Stanford

University School of Medicine's eating disorder treatment facility for help with their daughter's binge eating. The client described engaging in binge-eating episodes, in which she explained she typically ate "a whole box of cinnamon toast crunch cereal, a bag of mixed nuts, 2 Danish pastries, and several small chocolate bars" in one sitting, with a sense of loss of control, and without any compensatory behaviors, such as vomiting, laxative use, or exercise (p. 162). She espoused a history of depressed mood and anorexic tendencies several years earlier, but again, no discussion of early object relations or current relational problems was included. Using the same modified model of DBT as the previous researchers, the client was engaged in 21 weekly 60-minute sessions where individual therapy was combined with skills practice, review, and new skill acquisition. In this specific case report, certain modifications were made to better meet the more specific needs of the adolescent presentation of affect and behavior dysregulation, such as the inclusion family skills sessions when necessary and collaborative, in-session homework completion to ensure understanding of key concepts and to accommodate for additional academic homework. The authors reported that the application of DBT techniques were successful: the client reduced her baseline pre-treatment binge-eating behaviors from 22 binges in 28 days to 4 binges across several months. Additionally, at a 3 month follow-up, the client reported only 1 binge episode in 1 day and a continued ability to utilize her DBT-acquired skills to treat her affective difficulties (Safer, Lock, & Couturier, 2007). Again, the case is limited by the client's lack of reported treatment history, and yet the significance of the treatment's success remains highly persuasive.

An earlier case study out of the Stanford University School of Medicine's eating disorder facility, evaluating the use of DBT's skills of affect regulation with an individual

with BED, presented similar results (Telch, 1996). A 36 year-old, married, Euro-American woman with a diagnosis of BED, presented for treatment explaining that she routinely engaged in an average of 9 binge eating episodes on a 5-day period. She also reported a 20-year history of BN that was terminated after she became pregnant for the first time. There was no information about the client's mental status, mental health history, or object relational history. After 23 weeks of 50-minute sessions focused on the acquisition, strengthening, and generalization of affect regulation skills based on Linehan's DBT manual, the client presented with significant behavior reduction. From week 10 through the end of treatment, the client reported only 3 binge episodes, and by the end of treatment, the client no longer met the diagnostic criteria for BED (Telch, 1996). Although all case studies present with significant limitations in their single-subject design, the implications of DBT's use with individuals with difficult-to-treat binge-eating behaviors remain important for further consideration and provide clinical hope for those with DTTBTEDs that have been unassisted by other typical treatments in the past.

*Theoretically-based reports.* Several other studies have been published in recent years that have presented DBT's applicability with EDs from a theory-based perspective. For instance, Wisniewski & Kelly (2003) delineate the utility of treating individuals with a wide variety of eating disordered behaviors that are traditionally unresponsive to CBT or IPT with DBT. The author's argue that DBT's cognitive-behavioral basis, the various clinical tools it offers, its additional emphasis on acceptance strategies, emotion regulation, and its overall designation for individuals with difficult and complicated symptomatology make DBT better designed to meet those needs of individuals with DTTBTEDS in an enhanced way above all other therapeutic strategies available.



Although the study presents a thorough understanding of the etiological development of eating disorders from a biosocial theory perspective, including the impact of emotional vulnerability and an invalidating environment on affective dysregulation, it does not highlight original object relational problems, per se, nor does it assert that the relationships created in DBT have the capability to ameliorate original object relational failures through the establishment of a regressive client stance and a clinician holding environment by design. It does, however, importantly assert that addressing the same behavioral targets aimed at individuals with BPD will ameliorate the problematic eating disordered behaviors in the most effective way possible (Wisniewski & Kelly, 2003).

As early as 1999, Wiser and Telch had published a theoretically-based article suggesting the applicability of DBT specifically for individuals with BED. The authors conceptualize binge eating “as a maladaptive emotion-regulation strategy,” and suggest that offering clients the opportunity to learn and implement more adaptive and effective affect regulation strategies in a treatment might be significantly helpful.

Many individuals struggling with binge eating behavior indeed cite the distracting and emotion-dampening functions of binge as centrally linked to their use of it. If the binge itself serves as an individual’s most accessible and effective means to modulate affect, then treatment aimed at providing alternative, more functional affect regulation strategies should prove quite useful (Wiser & Telch, 1999, p.757).

The authors argue that if this shift in affect regulation strategies is successful then, ultimately, binge-eating behavior will theoretically become unnecessary and un-utilized. The authors propose an adaptation of DBT for BED that entails the teaching of the

mindfulness, distress tolerance, and emotion regulation skills in a weekly two-hour group therapy format. They assert that the group format allows members to report on practice of skills from the previous week from diary cards and evaluate them with behavioral chain analyses, followed by the application of new skills. Although there is no inclusion of interpersonal therapy described in this particular study, the authors seem to have assembled a persuasive method of teaching adaptive affect regulation skills to replace individuals' life-interfering maladaptive binge-eating ones. The statistical success of the empirically-based study derived from this theory set carried out by Telch, Agras, and Linehan in 2001 is described in the next section.

With an interest in highlighting the specific utility of telephone coaching skills with eating disordered clients, Wisniewski and Ben-Porath (2005) published guidelines delineating the process of telephone coaching sessions using DBT-like treatment strategies. The authors propose that implementing the telephone coaching tool that is so unique to DBT, especially during times of vulnerability around bingeing, purging, or restricting, might be a highly effective means of intercepting impulsive behaviors and teaching enhanced skill generalization, and coach implementation. The authors assert that DBT-based telephone coaching can be a useful singular addition to traditional treatments of eating disorders, especially when increased structure and accountability is needed for clients that are struggling. In this manner, they are able to allow the client a continued connection to the clinician, thus enhanced therapeutic and coaching relationship, an accountability to the clinician about their behaviors before they engage in them, and the opportunity to experience an in-vivo treatment experience where behavioral re-training can occur. With this study, Wisniewski and Ben-Porath(2005) highlight the significance

of the extended individual therapeutic relationship and the impact it has on the alliance and skills training.

Finally, Wisniewski, Safer, and Chen (2007) most recently published a chapter that specifically proposes an adaptation of DBT for eating disorders in a compilation of new applications of DBT programs in clinical practice across disorders and settings. Like most other reviews of traditional treatment of eating disorders, the authors recognize the problematic clinical nature of CBT and IPT only being significantly helpful for about 50% of clients. Additionally, they identify that the predictors of treatment failures, including severity of symptoms and comorbid personality disordered traits (i.e. impulsivity, affective dysregulation) make DBT, or “an approach designed for the ‘difficult-to-treat’ client,” a more viable option for individuals that have been traditionally unresponsive to other commonly utilized treatments (Wisniewski, Safer, & Chen, 2007, p. 175). Because it is based on an emotion regulation model, unlike IPT and CBT, DBT is argued to be better able to modulate the problems that dysregulated and misregulated affect, often triggered by cognitive distortions or interpersonal situations, that tend to have an the outcome of maladaptive eating behaviors. “The fact that DBT is specifically designed to teach adaptive affect regulation skills and to target behaviors resulting from emotional dysregulation provides a theoretical rationale for applying DBT to treating EDs” (Wisniewski, Safer & Chen, 2007, p. 175). The authors identify several other reasons that make DBT a particularly suitable treatment: the applicability of the use of a dialectical tension with the ambivalence that some individuals with eating disorders report in their desire to changing their maladaptive eating behaviors; the strategy of using the client as a consultant to their own treatment as a means of enhancing self-efficacy in

managing their own environments; the acknowledgment of the severity of the disordered eating's life-threatening and life-interfering nature; the enhanced understanding of the potentially therapy-interfering nature of some of the client's behaviors around protecting their maladaptive eating habits as attempts at affect regulation (Wisniewski, Safer, & Chen, 2007). These additional rationales not only prove to heighten the complicated nature of DTTBTEDs, but they also highlight the suitability of DBT with these otherwise inadequately treated disorders.

Also in their chapter, Wisniewski, Safer & Chen (2007) propose three modified DBT program models: one designed for DBT with individuals with EDs and BPD, one for individuals with difficult-to-treat EDs being treated in an inpatient or intensive outpatient setting, and a DBT model for individuals with difficult-to-treat EDs in higher functioning individuals with EDs. For the focus and purpose of the present study, the DBT programs designed specifically for individuals with difficult-to-treat EDs both in inpatient and in outpatient clinical care will be evaluated. Some of the main modifications that were made within each model to better meet the more specialized needs of individuals with eating disorders include the addition of a food diary card to monitor eating patterns and allocating extra attention be paid to treating life-threatening eating behavior and therapy-interfering behaviors, such as failing to be honest on food diary cards, inability to focus in session due to a malnourishment, refusing to be weighed, or not adhering to medical advice, etc. Additional quality-of-life-interfering behaviors, such as binge-eating vomiting, laxative use, diuretic use, diet pill use, or excessive exercise, are also adapted into the program as behavioral targets that are specific to the ED populations. Individuals participating in the DBT program in an inpatient or intensive

outpatient program are generally offered a fairly standard program with the exception of an un-standard length of time of treatment due to variable hospital stays and inconsistent individual therapy. The program for individuals in outpatient treatment is designed to follow the standard treatment plan with the exception of a combined individual therapy and skills training into one weekly session. While all adapted formats are thought to be helpful from a theoretical basis, the authors assert that the model adapted for individuals in outpatient formatting was found to have received the most support from colleagues and peers at the time of writing, as it related most closely to the original DBT format and so practically to the specific needs of clients (Wisniewski, Safer, & Chen, 2007).

*Empirically-based reports.* Perhaps some of the most promising and clinically-relevant applications of DBT with DTTBTEDs have been presented in recent randomized, controlled studies. For instance, Chen, Matthews, Allen, Kuo, and Linehan (2008), a team of researchers specializing in DBT research and design, sought to compare the application of DBT in individuals with either BED and BPD or BN and BPD in a pilot study format in order to substantiate the utility of DBT with sub-groups of more DTTBTEDs. With the results of the pilot study the authors hoped to promote the necessity of a larger study being subsequently funded and composed. Although the study does not isolate the diagnoses of BED, BN, and BPD into individual groups from which to contrast and compare, the research still presents useful findings on the applicability of DBT skills on difficult-to-treat eating behaviors.

Chen, Matthews, Allen, Kuo, and Linehan (2008) composed a group of eight women, three who met the criteria for BN and BPD, and five that met the criteria for BED and BPD. Seven clients identified as Euro-American and one as Korean-American,

ranged in age from 24-56 years, were predominantly single, had median income levels of \$25,000 to \$29,999, and identified as meeting the criteria for BN or BED in addition to BPD. Additionally, they did not meet criteria for psychotic or mood disorders. Importantly, they also generally reported not responding well to classic cognitive-behavioral treatment approaches due to the heightened severity of their symptoms along the BPD spectrum, namely greater impulsivity and negative mood states. When treated with 6 months of standard DBT with slight modifications to include binge-eating behaviors as a form of affect regulation, clients with binge-type and bulimic-type eating disorders with BPD features exhibited significant improvements in symptomatology. Namely, participants exhibited reduced self-harming behaviors, suicidal behaviors, binge eating behaviors, binge/purge behaviors, a number of eliminated non-eating disordered Axis I disorders, and improved social functioning. What is also notable and was reported as surprising to the researchers is that fact that clients with BPD and either form of eating dependence presented as difficult-to-treat and as empirically complicated as those previously studied by the same group of researchers with BPD and serious substance dependence. Although many clients reported that they found 6 months of treatment insubstantial (causing three to actually return to treatment for further assistance following the study), Chen, Matthews, Allen, Kuo, and Linehan (2008) still report significantly reduced maladaptive eating behaviors for the treated individuals. Overall, this study's results present inspiring implications for the use of DBT with DTTBTEDs.

Several years earlier, a similar group of researchers sought out to empirically investigate the statistically significant likelihood that DBT, when applied to individuals with BEDs, would contribute to reduced symptomatology. This particular study directly

followed the publication of Wisner and Telch's (1999) theoretically-based article proposing the utility of DBT with individuals with BED. Telch, Agras, and Linehan (2001) composed a pool of 44 female participants, that ranged between 18 and 65 years of age, identified themselves as 94% Euro-American, were mostly married, nearly all college educated, and all met criteria for BED. Half were randomly assigned to a wait-list control group and half to the DBT program group. After being involved in a DBT-modified 20-week treatment design, where one 20-minute weekly combined sessions of therapy, coaching, and skills teaching, researchers found that 89% of those in the DBT group had eliminated binge behaviors compared to only 12.5% of those in the control group. Moreover, at a 6 month follow-up, 56% remained free of binge behaviors. Although the findings were empirically significant and clinically promising, the authors of the study remained wary of their applicability, citing limitations of a women-only participant sample and that DBT's success was only contrasted against a control group rather than another popularized form of BED treatment, such as CBT or IPT (Telch, Agras, & Linehan, 2001). However, it seems clear that the findings do further raise the validity of DBT with such eating disordered populations.

*Treatment Manual.* The same set of researchers that recently published a chapter on the application of DBT as adapted specifically for eating disorders also published a manual on DBT for BED and BN disorders. Safer, Telch, and Chen (2009) referenced Linehan's support of the material and even acquired a forward from her asserting the importance of the treatment's use with DTTBTEDs. The authors describe their impetus for writing the book as a desire to not only respond to requests from the clinical and research communities for a specific delineation of a manualized format of DBT as

designed for difficult to treat BED and BN, but also to adapt a treatment for both BED and BN from previously investigated DBT formats for only individuals with BED. Moreover, the authors write, “the fact that a significant number of clients with BED and BN continue to suffer from their eating-disorder symptoms either at posttreatment with CBT or IPT . . . calls for other theoretical conceptualizations and/or treatment approaches for BED and BN” (Safer, Telch, & Chen 2009, p.13). Their book describes the utilization of DBT for BED and BN as based upon an affect dysregulation model of DTTBTEDs, similar to the conceptualization of DBT for BPD.

Among others, Telch [1997a, 1997b] recognized that DBT’s conceptualization of self-injury as a functional (albeit maladaptive) affect regulation behavior in patients with borderline personality disorder might provide a helpful model for understanding the function (albeit maladaptive) of binge eating and/or purging as emotion regulation behaviors in patients with disordered eating (Safer, Telch, & Chen, 2009, p.13).

As a result, a rationale for treating DTTBTEDs with the affect and behavior modifying treatment of DBT was developed.

The treatment model includes the previously described combination of individual psychotherapy and skills training in 20 weekly sessions. Treatment targets include curbing treatment-interfering behaviors, binge-eating and purging; mindless eating; cravings and preoccupations with food; capitulating, or closing off options to not binge and purge to affectively regulate; and decreasing apparently irrelevant behaviors, such as “buying binge foods ‘for company’” (Safer, Telch, & Chen, 2009, p.71). Individuals are taught mindfulness, emotion regulation, and distress tolerance techniques, however



interpersonal effectiveness skills are omitted. Unfortunately, such an omission seems to minimize the ability for individuals to receive maximum benefit of object relational healing in the treatment process. This writer hopes that future models will reintroduce the focus on interpersonal skill improvement into the full DBT program for individuals with DTTBTEDs.

In their manual, Safer, Telch, & Chen (2009) provide examples of behavioral chain analysis formats, diary cards, and skills worksheets to be utilized during weekly treatments. Chapters defining BED and BN, providing the impetus for using DBT, describing how to carry out the various stages of treatment, and delineating mindfulness, emotion regulation, and distress tolerance skills are all included. Case examples also illustrate the treatment's implementation in a more specific and detailed manner. To date, Safer, Telch, and Chen's (2009) book is the only manualized, adapted DBT treatment for BED and BN. Their conceptualization of treatment does not specifically narrativize the importance of treating the early object relational failures and the opportunity the close therapeutic relationship inherent in the DBT format has at addressing such issues. However, the treatment may inadvertently be able to provide a regressed object relational holding environment for the client to benefit from while extinguishing maladaptive eating behaviors and obtaining new affect regulation and emotion modulation skills, by design.

*Current Clinical Applications.* With such persuasive recent theoretically- and empirically-based investigations of DBT's successful application with DTTBTEDs, there have been a handful of eating disorder treatment centers that have begun to use or discuss the utilization of the treatment in their practices. For instance, the Renfrew Center Foundation, "a nonprofit organization advancing the education, prevention, research, and

treatment of eating disorders,” and in alliance with the Renfrew Center, perhaps the most nationally renowned and “the nation's first freestanding facility exclusively dedicated to the treatment of eating disorders,” is offered a seminar training clinicians in the use of DBT with individuals with eating disorders in 2009 (The Renfrew Center Foundation, 2009). Additionally, Walden Behavioral Care, another highly renowned and utilized eating disorder treatment organization in the northeastern U.S., not only offered a training on the addictive quality of eating disorders and the utility of DBT as a treatment approach to mediate them better in 2010, but also promoted the use of DBT in their eating disorder treatments, ranging from intensive outpatient to inpatient treatment (Walden Behavioral Care, 2009). The Carolina House, “a residential treatment center for women suffering with anorexia nervosa, bulimia nervosa, binge eating disorders” in North Carolina, has also made the DBT skill sets a central part of its treatment program based upon the theoretical and empirically-based notoriety it is increasingly receiving (Carolina House, 2009). Numerous other private clinics and clinicians can also be found around the country increasingly and regularly utilizing DBT and its principles in work with treatment-resistant eating disorders.

#### *DBT as Applied to the Case of Mary*

When reviewing Sugarman & Kurash’s (1982) “Case of Mary,” a 24 year old, single, Euro-American graduate student with active BN, it seems evident based upon her history and her current symptomatological presentation that DBT would be a useful treatment modality for her. Her developmental history detailed a miss-attunement and invalidation of needs, as evidenced by her frequent changes in caregivers, her regressive behaviors during attempts at separation-individuation, and her grandmother’s frequent

comparisons of Mary's mother as a more 'perfect child.' Her early reliance on food as an overly-utilized transitional object with which to attempt to feel closer to the security her mother's care continued to be relied upon in heightened ways as she aged, experienced additional losses and shifts in care givers encountered, difficulties during later separation-individuation. It is likely that association between eating and negative affect reduction became increasingly conditioned and reinforced over time. Ultimately, the rigidity of the use of eating behaviors to regulate her affect, disappointing expectancies about the inability of her environment to effectively meet her needs, and the perception of reduced self-efficacy in her own self-regulation abilities solidified her reliance on her eating behaviors and gave them an addictive quality. Additionally, her inability to connect with her psychotherapist or develop a basic trust during treatment caused her symptomatology to persist, likely in resistant ways.

DBT's dialectical focus on the validation of symptoms coupled with the encouragement of change strategies, as well as the ability to re-create a relationship between client and clinician based upon trust, transparency, and reliance would appear useful in Mary's treatment. Affording her the opportunity to develop an emotionally regressed state of dependence and attempt to heal old object relational wounds in the closeness, heightened availability, skills teaching, and coaching that is offered by the clinician would likely bring about healing of her original abandonment and inadequate care giving. Moreover, the adaptation of mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness skills would theoretically help Mary to disentangle more easily from her maladaptive attempts at affect regulation through binge eating and purging behaviors. The availability of 24-hour coaching would help her learn

skill adaptation in-vivo, group participation would provide her with a cohort and sense of support, her successes in skill use would improve her perception of self-efficacy, and the overall experience would afford her the relational work to improve the quality of their life to a degree that she has not experienced before.

### *Summary*

Based on the compelling findings evidenced in popular research of DBT's utility with DTTBTEDs and the theoretical conceptualizations that perhaps best explain the etiology and corresponding treatment goals of DTTBTEDs, DBT may be the most advanced and most effective treatment for DTTBTEDs. A Winnicottian object relations lens has better enabled researchers and theorists to conceptualize how the invalidation or miss-attunement of individuals' needs during development that were often exacerbated during separation-individuation processes often results in an inability for the individual to incorporate adaptive self-soothing and affect regulation skills. Individuals that emerge from such situations tend to deny their own needs, lack the ability to identify their needs, and present ambivalence about communicating them to others. As a result, they exhibit a tendency to affectively regulate with food and eating behaviors as prolonged transitional bonds to the feeding maternal object, while also rejecting the offerings of support from interpersonal relationships.

Similarly, a behavior theory lens supplements the understanding of the maladaptive use of food for affect regulation purposes by illuminating the behavioral conditioning and reinforcement processes that occur over time that solidify a rigid association between affective dysregulation and eating behaviors. Individuals with DTTBTEDs that missed an opportunity to learn to identify, label, and regulate their

negative affective experiences during early childhood develop a pattern of maladaptive affect regulation practices, as a result. Over time, the persistent miss-regulation of negative affect becomes operantly conditioned by temporarily modulated affect, reinforced through practice, and ultimately developed into an addictive symptomatology. Eating behaviors eventually turn into less controllable and unhealthier binge-episodes. With prolonged reliance upon the distress-relieving effects of binge eating, individuals grow increasingly unable to utilize primary affect regulation strategies, perceive themselves to be less in control of their eating behaviors, feel less effective in changing them, and become far less practiced at recognizing, labeling, and modifying their negative affect states. All of these developments can amalgamate to create a population of individuals with BN and BED that is often characteristically and statistically more difficult to treat than others with similar afflictions.

However, the use of DBT with DTTBTEDs has great theoretical validity and clinical potential. The various components of interpersonal relatedness that occur in the DBT's differing forms of treatment have the opportunity to replicate the early maternal holding environment and reintroduce the original position of vulnerability for the client and an opportunity to amend original object relational failures. Individuals in treatment can take advantage of being managed and held by the clinician, confronting their chronic reliance on false self presentations. Simultaneously, clients can also work towards extinguishing the conditioned pattern of using food as a transitional object as an attempt to regulate affect, learn new affect regulation skills, practice their application in their real life environments with the supervision of their clinician, and gain the opportunity to effectuate the adaptation of improved affect regulation strategies.

### *Limitations of the Present Study*

The information provided in this study make compelling arguments for the utilization of object relational and behavior theories to form a unique conceptualization of DTTBTEDs and promote the use of DBT with individuals with DTTBTEDs based upon their object relational development and behavioral conditioning processes. Yet, the study's theoretical framework poses a potential limitation to the treatment's immediate application in the clinical setting. In clinical environments, where evidence-based practices are becoming the more popularly relied upon methods of treatment, having empirically based research confirming DBT's effectiveness with the DTTBTED population based upon its opportunity for object relational and behavioral re-adjustments would likely make its utility more readily promotable to treating clinicians and treatment facilities. Although the theoretical vantage points seem to persuasively communicate the most significant areas of concern and opportunities for healing among individuals with DTTBTEDs, until they are statistically validated through empirical means they remain speculative. When specific empirical support is gained for DBT's specific utilization with DTTBTEDs, however, it is suspected that DBT's application will be very readily, easily, and widely implemented.

While Winnicottian object relations theory and behavior theory seem to be two of the most pertinent perspectives from which to develop a heightened understanding and conceptualization of the etiology and treatment difficulties inherent in DTTBTEDs, the strict adherence to these two theoretical approaches in this study also may be limiting in nature. Other psychodynamically-based psychologies, such as ego psychology and self psychology, and other theoretical organizations, such as family theory and substance

abuse theories also offer important conceptualizations of the problems inherent in eating disorders and may also be evaluated for further understanding.

*Statement of Perspective.* This researcher's orientation to the subject matter plays an important role in the present study's potential strengths, limitations, and biases, as well. As a 31 year-old, Caucasian, female student training in a psychodynamically-oriented clinically-focused graduate degree program, and with experience working with young women with eating disorders in a college-based setting, individuals with borderline personality disorder in respite-level care, and trained in DBT, this researcher is particularly motivated to draw together the three subject areas in ways that will benefit this particularly difficult-to-treat group of eating disordered individuals. Moreover, further fueled and persuaded by the popular literature on similarities between etiology and presentation of BPD and DTTBTEDs, and the newly evidenced effectiveness of DBT with DTTBTEDs, this researcher approaches the subject area espousing strong opinions about the utility of DBT techniques to effectively treat individuals with what has been widely identified as uniquely challenging, complex, and dangerously self-harming eating disorders. The study's establishment was not only intended to exemplify the relationships between the disorder and the two theories, but was also made in an effort to promote greater awareness of the treatment's effectiveness with the given population. While the researcher's orientation to the topic may be taken into account when evaluating the study's objectivity, the level of interest brought to the research can also serve as a strength in the creation of rich and informative research.

### *Implications for Clinical Social Work Practice*

The present research not only highlights the option of DBT as an effective option for treating individuals with DTTBTEDs, but also has the potential to contribute to the larger pool of eating disorder literature by providing a more detailed conceptualization of DTTBTEDs from an object relations and behavior theory perspective. Furthermore, the present research not only promotes the use of DBT with DTTBTEDs because of its focus on skills-based behavior change, it also importantly validates for the first time the potentially therapeutic impact that DBT could have with the population based upon the closely-allied therapeutic relationship inherent in the treatment, as well. Valued tenants of good social work practice urge clinicians to “critically examine and keep current with emerging knowledge” in order to acquire an expertise in development of knowledge as a means of upholding the integrity of the profession and assuring that each client is treated with the most advanced and empirically effective treatments available (NASW, 1996, p. 22; SCSSW Mission Statement, 2003). Bearing in mind these professional values coupled with DBT’s effectiveness in treating individuals with BN and BED as evidenced in empirical research, the present study aims to substantiate and draw attention to the possibility of DBT’s effective cross-implementation with DTTBTEDs as a newly identified tool in eating disorder treatment to improve the common practices of professional social work and clinical education.

Given the conceptualizations provided in the present study, the field of psychological research could find great utility in conducting further investigations into the statistical significance of DBT’s utilization with DTTBTEDs. Controlled empirical investigations could yield the evidence needed to identify the effectiveness of the



treatment, isolate the particular elements that work most effectively, or flesh out the ones that are ineffective with the particular population. In this manner, DBT could be authenticated as the highly useful treatment it is suspected to be, and clinicians in the field of clinical social work could be persuaded to more frequently utilize it as a best practices method of treatment for individuals with DTTBTEDs. Investigations could also yield negative results, causing investigations into more relevant practices to be promoted and conducted in order to better treat this difficult-to-treat population.

Implications of the present investigation's various theoretical perspectives could benefit the field in a number of ways. For instance, the conceptualization of object relational difficulties inherent in DTTBTEDs will likely not only deepen practicing clinicians' understandings of the disorder's development, it may also importantly draw attention to the importance of the healing potential of the relational qualities of the therapeutic relationship. Additionally, for clinicians that are most familiar with traditional supportive or psychoanalytically-based treatments for eating disorders, the behavioral conceptualization of DTTBTEDs as addictive disorders in nature can serve to better inform their practices and treatment styles. Finally, the detailed analysis of DBT and the variety of skills that are proposed to be most helpful and effective in teaching affective regulation offers practicing clinicians the impetus to begin implementing some or all elements of the treatment with a wide variety of clients in appropriate or useful ways if a full DBT program is not currently available or appropriate.

## REFERENCES

- Agras, W.S. (1993). Short-term psychological treatments for binge eating. In C.G. Fairburn, & G.T. Wilson (Eds.). *Binge eating: Nature, Assessment, and treatment*. (270-286). New York, NY: The Guilford Press.
- American Psychiatric Association. (2000). Eating disorders. In *Diagnostic and statistical manual of mental disorders, fourth edition, text revision* (pp 583-595). Arlington, VA: American psychiatric association.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, N.J.: Prentice-Hall.
- Baumeister, R.F. & Heatherton, T.F. (1996). Self-regulation failure: An overview. *Psychological Inquiry*, 7(1), 1-15.
- Ben-Porath, D., Wisniewski, L., & Warren, M. (2009). Differential treatment response for eating disordered patients with and without a comorbid borderline personality diagnosis using a dialectical behavior therapy (DBT) informed approach. *Eating Disorders: The Journal of Treatment & Prevention*, 17(3), 225-241.
- Berger, R.L., McBreen, J.T., & Rifkin, M.J. (1996). *Human behavior: A perspective for the helping professions, fourth edition*. White Plains, NY: Longman.
- Bowers, W.A., & Ansher, L.S. (2008). The effectiveness of cognitive behavior therapy on changing eating disorder symptoms and psychopathy or 32 anorexia nervosa patients at hospital discharge and one year follow-up. *Annals of clinical psychiatry*, 20(2), 79-86.
- Bradley, S.J. (2000). *Affect regulation and the development of psychopathology*. New York, NY: Guilford Press.
- Brazelton, T.B. & Yogman, M.W. (1986). *Affective development in infancy*. Norwood,

NJ: Ablex.

- Brenner, D. (1983). Self-regulatory functions in bulimia. *Contemporary Psychotherapy Review, 1*(1), 79-96.
- Brush, M.A. & Lane, R.C. (1996). Bulimia: A comprehensive critical object relational review of the literature. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 55-87). Victoria, BC, Canada: Trafford.
- Burton, E., Stice, E., Bearman, S.R., & Rohde, P. (2007). Experimental test of the affect-regulation theory of bulimic symptoms and substance use: A randomized trial. *International Journal of Eating Disorders, 40*(1), 27-36.
- Carolina House: North Carolina Eating Disorder Treatment. (2009). *Treatment programs*. Retrieved on March 25, 2010 from <http://www.carolinaeatingdisorders.com>.
- Cassin, S.E. & von Ranson, K.M. (2007). Is binge eating experienced as an addiction? *Appetite, 49*. 687-690.
- Chassler, L. (1998). "Ox hunger:" Psychoanalytic explorations of bulimia nervosa. *Clinical social work journal, 26*(4), 397-412.
- Chen, E.Y., Matthews, L., Allen, C., Kuo, J.R., Linehan, M.M. (2008). Dialectical behavior therapy for clients with binge eating disorder or bulimia nervosa and borderline personality disorder. *International Journal of Eating Disorders, 41*(6), 505-512.
- Cole-Detke, H. & Kobak, R. (1996). Attachment processes in eating disorder and depression. *Journal of Consulting and Clinical Psychology, 64*(2), 282-290.
- Cooper, M.G., & Lesser, J.G. (2008). *Clinical social work practice: An integrated approach, third edition*. Boston, MA: Pearson.

- Cooper, M.L., Agocha, V.B., & Sheldon, M.S. (2000). A motivational perspective on risky behaviors: The role of personality and affect regulatory processes. *Journal of Personality, 68*(6), 1059-1088.
- Davis, D. (2004). *Child development: A practitioner's guide*. New York, NY: Guilford Press.
- Dahl, R.E. (2003). The development of affect regulation: Bringing together basic and clinical perspectives. *Annals of the New York Academy of Sciences, 1008*, 183-188.
- Fairburn, C.G., & Wilson, G.T. (1993). Binge eating: Definition and classification. In C.G. Fairburn, & G.T. Wilson (Eds.). *Binge eating: Nature, Assessment, and treatment*. (3-14). New York, NY: The Guilford Press.
- Fairburn, C.G., Marcus, M.D., & Wilson, G.T. (1993). Cognitive-behavioral therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. In C.G. Fairburn, & G.T. Wilson (Eds.). *Binge eating: Nature, Assessment, and treatment*. (361-404). New York, NY: The Guilford Press.
- Fairburn, C.G., Hay, P.J., & Welch, S.L. (1993). Binge eating and bulimia nervosa: Distribution and determinants. In C.G. Fairburn, & G.T. Wilson (Eds.). *Binge eating: Nature, Assessment, and treatment*. (123-143). New York, NY: The Guilford Press.
- Flanagan, L.M. (2008). Object relations theory. In J. Berzoff, L.M. Flanagan, and P. Hertz (Eds.), *Inside out and outside in* (pp. 189-204). New York: Aronson.
- Flores, P.J. (2001). Addiction as an attachment disorder: Implications for group therapy. *International Journal of Group Psychotherapy, 51*(1), 63-81.

- Friedmand, A. & Tolman, M.D. (2007). Anorexia as a form self-mutilation. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 141-154). Victoria, BC, Canada: Trafford.
- Foehrenbach, L.M. & Lane, R.C. (1989). Bulimia: Its dynamics and treatment: The case of an adolescent male. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 88-105). Victoria, BC, Canada: Trafford.
- Fromm, M. G. (1989). Winnicott's work in relation to classical psychoanalysis and ego psychology. In M.G. Fromm & B.L. Smith (Eds.). *The facilitating environment: Clinical applications of Winnicott's theory*. (pp.3-26). Connecticut: International universities press, Inc.
- Goldberg, S. (2000). *Attachment and development*. London: Arnold Publishers
- Goldstein, E.G. (2001). *Object relations theory and self psychology in social work practice*. New York, NY: The Free Press.
- Gross, J.J. & Thompson, R.A. (2007). Emotion regulation: Conceptual foundations. In J.Gross (Ed.) *Handbook of emotion regulation*, (pp. 3-24). New York, NY: Guilford Press.
- Guinjoan, S.M., Ross, D.R., Perinot, L., Maritato, V., Jorda-Fahrer, M., & Fahrer, R.D. (2001). The use of transitional object in self-directed aggression by patients with borderline personality disorder, anorexia nervosa, or bulimia nervosa. *Journal of the American Academy of Psychoanalysis*, 29, 457-467.
- Hertz, P. (2008). Personality disorders with a special emphasis on borderline and narcissistic syndromes. In J. Berzoff, L.M. Flanagan, & P. Hertz (Eds.). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in*

- contemporary multicultural contexts*. New York, NY: Aronson.
- Koerner, K. & Dimeff, L.A. (2008). Overview of dialectical behavioral therapy. In L.A. Dimeff & K. Koerner (Eds.). *Dialectical behavior therapy in clinical practice: Applications across disorders and settings* (pp. 1-18). New York: Guilford Press.
- Harris, W.A., Wiseman, C.V., Wagner, S., & Halmi, K.A. (2001). The difficult-to-treat patient with eating disorder. In M.J. Dewan & R.P. Pies (Eds.). *The difficult-to-treat patient*. Washington, D.C.: American Psychiatric Publishing, Inc.
- Hilbert, A., & Tuschen-Caffier, B. (2007). Maintenance of binge eating through negative mood: A naturalistic comparison of binge eating disorder and bulimia nervosa. *International Journal of Eating Disorders*, 40(6), 521-530.
- Hodgetts, A., Wright, J., & Gough, A. (2007). Clients with borderline personality disorder: Exploring their experiences of dialectical behaviour therapy. *Counseling and Psychotherapy Research*, September 2007; 7(3): 172-177.
- Hudson, J.I., Pope, H.G., & Jonas, J.M. (1983). Treatment of bulimia with antidepressants: Theoretical considerations and clinical findings. *Psychiatric Annals* 13(12), 965-969.
- Hull, J.W. & Lane, R.C. (1990). Autoeroticism in patients with borderline personality organization: A case of wrist cutting and bulimia. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 106-119). Victoria, BC, Canada: Trafford.
- Jessner, I. & Abse, D. (1960). Regressive forms of anorexia nervosa. *British Journal of Medical Psychology*, 33, 301-342.
- Johnson, C.L. (1991). Treatment of eating-disordered patients with borderline and false-

- self/narcissistic disorders. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia*. New York: the Guilford Press.
- Johnson, C.L. & Taylor, C. (1996). Working with difficult-to-treat eating disorders using an integration of twelve-step and traditional psychotherapies. *Eating disorders*, 19(4), 829-841.
- Kopp, C.B. (1989). Regulation of distress and negative emotions: A developmental view. *Developmental Psychology*, 25, 343-354.
- Lane, R.C. (2002). Anorexia, masochism, self-mutilation and autoerotism: The spider mother. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 120-140). Victoria, BC, Canada: Trafford.
- Lane, R.C. & Goeltz, B.W. (1998). Identity confusion, bi-sexuality, and flight from the mother. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 16-34). Victoria, BC, Canada: Trafford.
- Lesser, J.G. & Pope, D.S. (2007). *Human behavior and the social environment: Theory and practice*. Boston, MA: Pearson.
- Levitt, J.L. (2005). A therapeutic approach to treating the eating disorder/borderline personality disorder patient. *The Journal of Treatment and Prevention*, 13(1), 109-121.
- Levy, K.N., Wasserman, R.H., Scott, L.N., & Yeomans, F.E. (2009). Empirical evidence for transference-focused psychotherapy and other psychodynamic psychotherapy for borderline personality disorder. In, R.A. Levy, & J.S. Ablon (Eds.). *Handbook of Evidence-Based Psychodynamic Psychotherapy*. (93-119). New York, NY: Humana Press.

- Liebowitz, E.B. (1991). Bulimia: A self-psychological study. In, A. Smaldino (Ed.) *Psychoanalytic approaches to addiction*. (96-122). Philadelphia, PA, US: Brunner/Mazel.
- Lilenfeld, L.R.R., Jacobs, C.H., Woods, A.M., & Picot, A.K. (2008). A prospective study of obsessive-compulsive and borderline personality traits, race and disordered eating. *European Eating Disorders Review*, *16*(2), 124-132.
- Linehan, M.M. (1993). *Cognitive-behavioral treatment of Borderline Personality Disorder*. New York, New York: The Guilford Press.
- Lowenstein, G. (2007). Affect regulation and affective forecasting. In J.Gross (Ed.) *Handbook of emotion regulation*, (pp.180-203). New York, NY: Guilford Press.
- Marcus, M.D. (1997). Adapting treatments for patients with binge-eating disorder. In, D.M. Garner & P.E. Garfinkel (Eds.). *Handbook of treatment for eating disorders* (484-493). New York, NY: Guilford Press.
- Mauler, B.I., Hamm, A.O., Weike, A.I., & Tuschen-Caffier, B. (2006). Affect regulation and food intake in bulimia nervosa: Emotional responding to food cues after deprivation and subsequent eating. *Journal of Abnormal Psychology*, *115*(3), 567-579.
- Mitchell, S.A. & Black, M.J. (1995). *Freud and beyond: A history of modern psychoanalytic thought*. New York, NY: Basic Books.
- Mitchell, J.E., Halimi, K., Wilson, G.T., Agras, W.S., Kraemer, H., & Crow, S. (2002). A randomized secondary treatment study of women with bulimia nervosa who fail to respond to CBT. *International Journal of Eating Disorders*, *32*(3), 271-281.
- Mitchell, J.E., & Zwaan, M. (1993). Pharmacological treatments in binge eating. In, C.G.



- Fairburn & G.T. Wilson (Eds.). *Binge eating: Nature, assessment, and treatment*. (250-269). New York, NY: Guilford Press.
- Mussell, M.P., Crosby, R.D., Crow, S.J., Knopke, A.J., Peterson, C.B., Wonderlich, S.A., & Mitchell, J.E. (2000). *Utilization of empirically supported psychotherapy treatments for individuals with eating disorders: A survey of psychologists*. Eating Disorders Research Society Meeting, Albuquerque, NM: John Wiley & Sons, Inc
- National Association of Social Workers. (approved 1996, revised 1999). *Code of Ethics of the National Association of Social Workers*. Washington, DC: Author.
- Perseus, k., Ojehagen, A., Ekdahl, S., Asberg, M. & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using dialectical behavioral therapy: The patients and the therapists' perceptions. *Archives of Psychiatric Nursing*, 17(5), 218-227.
- Phillips, A. (1988). *Winnicott*. Cambridge, MA: Harvard University Press.
- Polivy, J. & Herman, C.P. (1993). Etiology of binge eating: Psychological mechanisms. In C.G. Fairburn, & G.T. Wilson (Eds.). *Binge eating: Nature, Assessment, and treatment*. (173-205). New York, NY: The Guilford Press.
- Pollack, D.L. & Keaschuck, R.A. (2008). The object relations of bulimic women in context: An integration of two studies. *Eating Disorders*, 16: 14-29.
- The Renfrew Center Foundation (2000). *About us and Training seminars for professionals*. Retrieved on March 25, 2010 from <http://www.renfrew.org>.
- Rosenthal, M., Lynch, T., & Linehan, M. (2005). Dialectical behavior therapy for individuals with borderline personality disorder and substance use disorders. In, J. Frances, S. Miller, & A. Mack (Eds.). *Clinical textbook of addictive disorders*, 3<sup>rd</sup>

ed. New York, NY: Guilford.

- Safer, D.L., Telch, C. F., & Chen, E.Y. (2009). *Dialectical behavior therapy for binge eating and bulimia*. New York, NY: The Guilford Press.
- Safer, D.L., Telch, C.F., & Agras, W.S. (2001). Dialectical behavior therapy adapted for bulimia: A case report. *International Journal of Eating Disorders*, 30(1), 101-106.
- Safer, D.L., Lock, J., & Couturier, J.L. (2007). Dialectical behavior therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice*, 14, 157-167.
- Sansone, R.A., Levitt, J.L., & Sansone, L.A. (2005). The prevalence of personality disorders among those with eating disorders. *Eating Disorders: The Journal of Treatment & Prevention*, 13(1), 7-21.
- Schlesier-Stropp, B. (1984). Bulimia: A review of the literature. *Psychological Bulletin*, 95(2), 247-257.
- Schwartz, H.J. (1986). Bulimia: Psychoanalytic perspectives. *Journal of the American Psychoanalytic Association*, 34(2), 439-462.
- Shilkret, R. & Shilkret, C. (2008). Attachment theory. In J. Berzoff, L.M.Flanagan, and P. Hertz (Eds.), *Inside out and outside in* (pp. 189-1204). New York: Aronson.
- Smith College School for Social Work. (2005). *Mission statement*. Smith College School for Social Work: Author.
- Spangler, G. & Grossman, K.E. (1993). Biobehavioral organization in securely and insecurely attached infants. *Child Development*, 64, 1439-1450.
- Steiger, H., Thibaudeau, J., Ghadirian, A. M., & Houle, L. (1992). Psychopathological features in bulimics as a function of Axis II comorbidity: Isolation of mood-

- independent differences. *International Journal of Eating Disorders*, 12(4), 383-395.
- Stepp, S., Epler, A., Jahng, S & Trull, T. (2008). The effect of dialectical behavior therapy skills use on borderline personality disorder features. *Journal of Personality Disorders*, 22(6), 549-563.
- Stice, E., Agras, W.S., Telch, C.F., Halmi, K.A., Mitchell, J.E., & Wilson, T. (2001). Subtyping binge eating-disordered women along dieting and negative affect dimensions. *International Journal of Eating Disorders*, 30(1), 11-27.
- Stickney, M., Miltenberger, R.G., Wolff, G. (1999). A descriptive analysis of factors contributing to binge eating. *Journal of Behavior Therapy and Experimental Psychiatry*, 30(3), 177-189.
- Striegel-Moore, R.H. (1993). Etiology of binge eating: A developmental perspective. In, C.G.Fairburn, & G.T. Wilson, (Eds.). (1993). *Binge eating: Nature, Assessment, and treatment.*(Pp.144-172). New York, NY: The Guilford Press.
- Sugarman, A. & Kurash, C. (1982). The body as a transitional object in bulimia. *International Journal of Eating Disorders*, 1(4), 57-67.
- Taylor, G.J., Bagby, R.M., & Parker, J.D.A. (1997). *Disorders of affect regulation.* Cambridge, UK: Cambridge University Press.
- Telch, C. (1996). Skills training treatment for adaptive affect regulation in a woman with binge-eating disorder. *International Journal of Eating Disorders*, 22, 77-81.
- Telch, C.F., Agras, W.S., & Linehan, M.M. (2001). Dialectical behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, 69(6), 1061-1065.

- Thombs, D.L. (1994). *Introduction to addictive behaviors*. New York, NY: The Guilford Press.
- Thorpe, G.L. & Olson, S.L. (1997). *Behavior therapy: Concepts, procedures, and applications, second edition*. Boston, MA: Allyn and Bacon.
- Tice, D.M. & Bratslavsky, E. (2000). Giving in to feel good: The place of emotion regulation in the context of general self-control. *Psychological Inquiry, 11*(3).
- Tice, D.M., Bratslavsky, E., & Baumeister, R.F. (2001). Emotional distress regulation takes precedence over impulse control. If you feel bad, do it! *Journal of Personality and Social Psychology, 80*(1), 53-67.
- Tobin, D.L. (1993). Psychodynamic psychotherapy and binge eating. In, C.G. Fairburn & G.T. Wilson (Eds.). *Binge eating: Nature, assessment, and treatment*. (287-313). New York, NY: Guilford Press.
- Tolman, D.L. Adolescent girls, women, and sexuality: Discerning dilemmas of desire. *Women & Therapy, 11*(3-4), 55-69.
- Tolman, M.D. & Lane, R.C. (2007). The role of the mother on the development of restricting anorexia. In R.C. Lane & M.D. Tolman (Eds.), *Psychodynamic perspectives on eating disorders* (pp. 176-197). Victoria, BC, Canada: Trafford.
- Tronick, E.Z. (1989). Emotions and emotional communication in infants. *American Psychologist, 44*(2), 112-119.
- Vandereycken, W. (1990). The addiction model in eating disorders. *International Journal of Eating Disorders, 9*(1), 95-101.
- Von Ranson, K.M., & Cassin, S. E. (2007). Eating disorders and addiction: theory and evidence. In J.S. Rubin (Ed.). *Eating Disorders and Weight Loss Research* (pp. 1-

- 37). New York, NY: Nova Scotia Publishers.
- Walden Behavioral Care. (2009). *About us and Levels of care*. Retrieved on March 25, 2010 from <http://www.waldenbehavioralcare.com>.
- Walters, G.D. (1999). *The addiction concept*. Boston, MA: Allyn & Bacon
- Watson, D. & Clark, L.A. (1984). Negative affectivity: The disposition to experience aversive emotional states. *Psychological Bulletin*, 96(3), 465-490.
- Wilson, G. T. (1991). The addiction model of eating disorders: A critical review. *Advances in Behaviour Research & Therapy*, 13(1), 27-72.
- Wilson, G. T. (1993). Binge eating and addictive disorders. In C.G. Fairburn & G.T. Wilson (Eds.). *Binge eating: Nature, assessment, and treatment*. (pp. 97-122). New York, NY: The Guilford Press.
- Wilson, G. T., & Fairburn, C. G. (2000). *The treatment of binge eating disorder*. *European Eating Disorders Review*, 8(5), 351-354.
- Wilson, G.T., Fairburn, C.G., & Agras, W.S. (1997). Cognitive-behavioral therapy for bulimia nervosa. In, D.M. Garner & P.E. Garfinkel. *Handbook of treatment for eating disorders, second edition*, (pp. 67-93). New York: The Guilford Press.
- Wilson, G.T., Grilo, C.M., & Vitousek, K.M. (2007). Psychological treatment of eating disorders. *American Psychologist*, 62, 199-216.
- Winnicott, D.W. (1958). The capacity to be alone. In D.W. Winnicott (1965), *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. pp.29-36. New York, NY: International Universities Press, Inc.
- Winnicott, D.W. (1960). The theory of the parent-infant relationship. In Winnicott

- (1965), *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. (pp.37-55). New York, NY: International Universities Press, Inc.
- Winnicott, D.W. (1963). From dependence towards independence in the development of the individual. In D.W. Winnicott (1965), *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. (pp.83-92). New York, NY: International Universities Press, Inc.
- Winnicott, D.W., (1960). Egodistortion in terms of true and false self. In Winnicott (1965), *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. (pp.140-152). New York, NY: International Universities Press, Inc.
- Wiser, S. & Telch, C.F. (1999). Dialectical behavior therapy for binge eating disorder. *Psychotherapy in practice*, 55(6), 755-768.
- Wisniewski, L., & Ben-Porath, D.D. (2005). Telephone skills-coaching with eating disordered clients: clinical guidelines using a DBT framework. *European Eating Disorders Review*, 13, 344-350.
- Wisniewski, L & Kelly, E. (2003). The application of dialectical behavior therapy to the treatment of eating disorders. *Cognitive and Behavioral Practice*, 10, 131-138.
- Wisniewski, L., Safer, D., & Chen, E. (2009). *Dialectical behavior therapy for binge eating and bulimia*. New York, NY: Guilford Press.
- Wisniewski, L., Safer, D., & Chen, E. (2007). Dialectical behavior therapy and eating disorders. In L.A. Dimeff & K.Koerner (Eds.) *Dialectical behavior therapy in clinical practice: Applications across disorders and settings*. (pp.174-221). New

York, NY: The Guilford Press.

Woodall, C. (1987). The body as a transitional object in bulimia: A critique of the concept. *Adolescent Psychiatry, 14*, 179-184.

Yarock, S. R. (1993). Understanding chronic bulimia: a four psychologies approach. *American Journal of Psychoanalysis, 53*, 3-17.

Zahn-Waxler, C., Iannotti, R.J., Cummings, E.M., & Denham, S. (1990). Antecedents of problem behaviors in children of depressed mothers. *Development and Psychopathology, 2*, 271-291.