

Eating Disorders and Personality Disorders

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The Eating Disordered Patient

Eating disorders-anorexia nervosa and bulimia nervosa in particular-are dynamic phenomena. The eating disorder patient maintains a distorted view of her body as either too fat or somehow defective (she may have a dysmorphic disorder). Many patients with eating disorders are found in occupations where focus is placed on the body type and appearance (e.g., ballet students, fashion designers, actors).

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

(Patients with eating disorders display feelings of inefficiency, a strong desire to regulate their environment, inflexible thought, reduced social spontaneity, perfectionism, and overly controlled ambition and emotional speech (Bulimics have a greater propensity to have) impulse-control issues, alcohol abuse or other drugs, display mood lability, (have) increased suicide incidence).

Eating Disorders and Self-control

The current view of orthodoxy is that the eating disordered patient tries to reassert control of her life by ritually regulating her dietary intake and body weight. Eating disorders are similar to obsessive-compulsive disorders in that respect.

One of the first scholars to study eating disorders, Bruch, described the state of mind of the patient as a struggle for control, for a sense of identity and effectiveness." (1962, 1974).

In Bulimia Nervosa, prolonged periods of fasting and purging (induced vomiting, and misuse of laxatives and diuretics) are precipitated by stress (usually fear of social environments comparable to Social Phobia) and violation of self-imposed dietary laws. Therefore eating disorders appear to be life-long attempts to ease anxiety. Ironically, bingeing and purging anxiety the patient even more.

Masochism encompasses eating disorders. The patient tortures herself and does considerable damage to her body by abstaining ascetically from the food or purging it. Many patients cook for others elaborate meals and then refrain from eating the dishes they had just prepared, perhaps as a kind of "self-punishment" or "spiritual purge."

The Diagnostic and Statistical Manual (DSM) IV-TR (2000) (p. 584) reflects on the internal mental environment of eating disordered patients:

"Weight loss is seen as an admirable accomplishment, a symbol of exceptional self-discipline, while weight gain is seen as an unacceptable self-control failure."

But the theory of "eating disorder as a self-control practice" could be overstated. If that were so, we would have predicted the prevalence of eating disorders among minorities and the lower classes-people whose lives are dominated by others. However, the clinical picture is reversed: the vast majority of eating disorder patients (90-95 percent) are white, young (mostly adolescent) women from upper and middle classes. Eating disorders are prevalent in the working and lower classes, as well as in minorities, non-Western communities and cultures.

Refusing to Grow Up

Many researchers think the individual with eating disorder is unable to grow up. By altering one's body and preventing one's menstruation (a disorder known as amenorrhea), the patient returns to childhood and avoids the problems of adulthood (loneliness, interpersonal relationships, age, jobs, and childrearing).

Similarities with Personality Disorders

Patients with eating disorders, for example, keep a great secrecy about their condition, not unlike narcissists or paranoids. It is generally due to tangential issues when they undergo psychotherapy: having been caught stealing food and other forms of antisocial behaviour, such as anger attacks. Clinicians who are not qualified to diagnose eating disorders' subtle and misleading signs and symptoms often misdiagnose them as personality disorders or mood or affective or anxiety disorders.

Patients with eating disorders are emotionally labile, often suffer from depression, are removed from society, lack sexual desire and are irritable. Their self-esteem is weak, they are perfectionists, their sense of self-worth fluctuates. The patient with eating disorder derives narcissistic supply from the praise it garnishes for having gone down in weight and the way it looks after diet. No wonder eating disorders are frequently misdiagnosed as unstable, schizoid, avoidant, antisocial or narcissistic personality disorders.

Patients with eating disorders often mimic subjects with personality disorders as they have basic, most importantly fracturing, defense mechanisms.

The Review of General Psychiatry (p. 356):

"Individuals with Anorexia Nervosa prefer to have an absolute and completely opposite view of themselves. Conduct is either good or bad; a decision is either absolutely right or completely wrong; one is either totally uncontrollable or out of reach."

The author adds that they are unable to separate their thoughts and needs from others'.

To add confusion, all groups of patients - with eating disorders and personality disorders - have a family history which is identically dysfunctional. Munchin et al. thus (1978) defined it as "enmeshment, over-protectiveness, rigidity, lack of conflict resolution."

Both types of patients are reluctant to seek help.

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

"Individuals with Anorexia Nervosa also lose insight into the issue or have significant denial ... A large number of Anorexia Nervosa people have a personality disorder that meets requirements for at least one personality disorder."

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

A staggering 40 % of patients with Anorexia Nervosa / Bulimia Nervosa have co-morbid personality disorders (mostly Narcissistic, Histrionic, Antisocial, Borderline Cluster B). Pure bulimics tend to have a disorder of borderline personality. Binge eating is included in the Borderline Personality Disorder impulse conduct criterion.

Such rampant comorbidity raises the question of whether or not eating disorders are in fact behavioral manifestations of underlying personality disorder.

Patients with eating disorders can gorge on food or refrain from feeding, and are both anorectic and bulimic at times. It is an impulsive tendency as described by the DSM, which is often comorbid with the personality disorder of Cluster B, particularly the Borderline Personality Disorder.

Some patients develop eating disorders when two addictive habits overlap and intensify: self-mutilation and impulsive (rather, obsessive-compulsive or ritualistic) behaviour.

The key to strengthening the mental health of people dealing with both a personality disorder and an eating disorder is to focus on eating and sleeping disorders at first.

The patient reasserts control of his life by controlling his eating disorder. This newfound strength is expected to minimize, or even fully eradicate, depression as a chronic aspect of his mental life. Other facets of his personality disorder are likely to be improved too.

It is a chain reaction: controlling one's eating disorders results in better regulation of one's self-worth, self-confidence and self-esteem. Successfully dealing with one's struggle-eating disorder provides a sense of inner strength and results in improved social interaction and an increased sense of health.

When a patient has an eating disorder and a personality disorder, the therapist would do well to tackle the eating disorder first. There are complex and intractable personality disorders. These are rarely curable (although certain factors, such as obsessive-compulsive behaviors or depression may be ameliorated or changed with medication).

The diagnosis of her personality disorder from the patient's point of view is not an effective use of limited mental resources. Neither are actual threats to personality disorders. If one's personality disorder is healed but one's eating disorders remain untouched, one may die (although mentally sound) ...

An eating disorder is both a sign of depression ("I want to die, I feel so bad, someone helps me") and a message: "I think I have lost control. I'm really afraid of losing control. I'm trying to regulate my food intake and discharge, so I can control at least one part of my existence."

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