HANDOUTS

Anorexia & Cutting

Understanding and Treating Self-Harm

Presented By

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AGENDA

Monday
ANOREXIA NERVOSA

8:15 a.m. Registration (continental breakfast buffet)

9:00 **Confirming Diagnosis of Anorexia Nervosa**

- Initial consultation
- Establishing therapeutic rapport
- Reviewing medical and psychological history
- Obtaining family history

10:20 Break (coffee and tea)

10:35 **The Co-Therapy Model**

- Overview of family dynamics
- Supportive counseling for parents
- Anxiety, depression, and related family issues
- Getting parents on the treatment team

12:00 Lunch (on your own)

1:30 **Treating Anorexia Nervosa**

- Presentation of Case Study
- Nurturant-Authoritative (N-A) approach in therapy
- Relating the N-A approach to the case study
- The role of medication

2:45 Break (coffee, tea, soda, snack)

3:00 **Skills and Techniques for the Therapist**

- Becoming believable to the anorexic patient
- Understanding the value of anorexia
- Competing with anorexic thoughts
- Social re-integration of the isolated anorexic
- Overcoming road-blocks to recovery

4:30 Adjournment (pick up one-day certificates)

Tuesday
SELF-MUTILATION

7:45 a.m. Registration (continental breakfast buffet)

8:30 **Cutting (Self-Mutilation) the Disorder**

- The ritual of cutting
- Cutting as a world wide phenomena
- Differential diagnoses - is the behavior disordered or socially driven?

9:50 Break (coffee and tea)

10:05 **Treating Self-Mutilation**

- The act of cutting and other self-mutilating behaviors in isolation - a gratifying behavior creating relief
- Case study to illustrate theory and treatment
- Sub-groups - different types of cutters
- The role of medication in treatment

11:30 Lunch (on your own)

12:45 **Parental Bonding versus Cutting**

- Parent-child dynamic when the patient is a cutter
- Case study of mother-daughter dependency problems; origins of dysfunctional family
- Therapy and symptom abatement as trust develops

2:00 Break (coffee, tea, soda, snack)

2:15 **Cutting as the Tip of the Iceberg**

- Predisposing personality deficits prevalent in our society
- Discussing issues of trust, dependency and attachment
- Self-hatred, self-esteem, and alienation
- Identity and femininity

3:45 Adjournment (pick up certificates)

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Anorexia & Cutting
Understanding and Treating Self-Harm

Anorexia Nervosa:

During the past twenty-eight years since Hilde Bruch published “The Golden Cage” and I published “*The Best Little Girl in the World*” (both books coincidently in 1978), the disorder has grown from an esoteric, unknown and misunderstood illness (to professionals, the public, and the media) to the point where it has become a generic adjective.

We have come from a time (the 1970’s) when there wasn’t a single eating disorder treatment facility in the U.S., to the present, when the number of specialist books on the subject (236) and treatment facilities abound.

Still, the percentage of permanent recoveries is well under fifty per cent. The death rate from anorexia is near ten percent.

In the early years of the public’s awareness of its existence, therapists were reluctant to treat it for fear of failure, and liability. It has been written in many psychological journals that “Anorexia nervosa causes the greatest negative counter-transference (frustration and hostility on the part of therapists) of any psychological disorder.”

We are here today to develop and discuss a working description and concept of treatment based on it that will provide the best recovery rates for those diagnosed with anorexia nervosa.

Character traits:

We are all familiar with the physical and disordered eating behaviors employed by those with anorexia to lose weight. Today we will look at character traits they share in common, how they originated, and how these traits can give rise to the development of anorexia.

PART ONE

Perfectionism:

Rigidity:

Lack of Assertiveness (outside of the family):

Nurturing behavior:

Refusing nurturing offered to them:

Avoidance of interpersonal intimacy – being known to others:

Excessively independent:

Low self–esteem:

Continuous anxiety:

Superficial outgoingness:

Obsessive thinking and behavior:

Contempt for parents coupled with worry about them:

PART TWO

ORIGINS OF THESE TRAITS IN CHILDHOOD

Trust in others

Dependency on others for understanding and emotional safety

Positive emotional attachment to others

Concept of one's own identity

Comfort with femininity (gender identity)

PART THREE

FAMILY DYNAMICS AS MOTIVATION TO DEVELOP TRAITS IN PARTS "ONE" AND "TWO" (Beginning with Part Two)

Trust in others:

Factors in the developing of trust begin at birth with attention, warmth, and reliability on the part of the primary caretaker.

Dependency on others for emotional understanding and emotional safety in the toddler and older child requires that the child see the adult primary caretaker as confident, strong, emotionally substantial and able to prevail (in a reasonable manner) in disputes with child.

Positive emotional attachment to others begins with the primary caretaker. If child's attachment is welcomed warmly, the child will be able to take risks in seeking new, close relationships.

Concept of ones own identity is based on consistent "mirroring" or feedback by the primary caretaker. Three kinds of identity messages are given to the child and will be incorporated if the child trusts the primary caretaker:

- **Positive**, praising, and loving messages accompanied by attentiveness.
- **Negative** comments which far outweigh positive **messages**. Or positive messages are qualified so the compliment is *disqualified*.
- **Inferred messages** which means the absence of parental definition of the child's value. This leaves the burden of self- definition to the child. Inferred messages are always interpreted as negative.

Comfort with femininity depends on rewards, compliments and affection, given by a father to his daughter for being a little girl, as well as positive role modeling by the mother accompanied by the child's sense of emotional substantiality on the part of both parents.

Intimacy vs. Alienation: A modification of Erik Erikson's "Intimacy vs. isolation". This will develop successfully if it begins in her development in the milieu of the family.

Alienation/Isolation resulting from a failure of intimacy with at least one parent will lead to a turning inward, toward herself in order to reduce anxiety and security. This leads to obsessive thinking involving endless repetition, in an attempt to reassure her young self by her immature, insecure self. This sets her on a path to achieve **perfection,** usually through **rigidity.**

There are many factors that can cause things to go wrong in these areas of family life:

- Parents who are simply exhausted and depleted or overworked from responsibilities in their lives won't have the energy to focus on a child in the positive ways mentioned above.
- Another child may draw most of the parent's focus due to a situational, physical or mental problem.
- Alcoholism or drug addiction, depression, or another psychiatric problem on the part of a parent makes that parent unreliable, untrustworthy to the child.
- Physical or sexual abuse by any member of the family will immediately exclude trust from developing or cancel its development.
- Parents who argue, fight, or don't support each other invite a female child to attempt to nurture one or the other parent, thus reversing the natural flow of nurturance from parent to child.
- Divorce may cause any of the above.

MEDICATION

There is no known medication that cures anorexia nervosa. However, many medications can contribute to reducing genetic, chemical (not necessarily genetic), personality disorders that contribute to the development of anorexia. They include: Excessive anxiety, irritability, depression, impulsivity, bi-polar disorder, obsessive-compulsive disorder, and trauma stemming from post traumatic stress disorder.

TREATMENT

This includes individual talk psychotherapy, family therapy, and inpatient therapy in a psychiatric hospital or eating disorder unit. I have not included group therapy or leaderless self-help groups for reasons that will be discussed.

Modalities of talk therapy and their techniques: (These will be discussed at length)

Building a trusting alliance with the patient

Insight therapy

Behavioral therapy

Directive therapy

Informational therapy

Team therapy - includes physicians, dietitians, families, day programs, and school staffs communicating with each other and working together wherever possible.

Part 2
CUTTING AND OTHER FORMS OF SELF-MUTILATION

Defining "Cutting, the Disorder"

Who is **not** diagnosed as suffering from "Cutting (or self-mutilation), the Disorder?"

We don't classify those who are excessively pierced with metal ornamentation, the excessively tattooed, those who cut themselves for social reasons (like club insignias), or those who engage in competitive cutting for the largest cut/scar.

"Cutters" are almost always secretive and do not want others to know they're doing it. They tend to conceal their scars. They are 85% female and may begin as early as five years of age, but 90% of them begin between the ages of eleven and twenty-five.

What are the categories of cutting injuries?

Delicate

Gross

What do they experience during the cutting episode?

Why do they choose to cut themselves?

Reaction to sexual abuse and PTSD

Relieving Anger

Relieving undefined depression or “trapped” in unhappy circumstances

Relieve feelings of loneliness, alienation and emptiness (“I will never belong among any group-with any individual”)

The “abbreviation factor” as the work of the unconscious –“I must cut”

Low self-esteem and the pain of self-loathing

Backtracking
Looking at personality development and characteristics

Family language for communication of feelings

Permission and acceptance for expressiveness – especially negative

Healthy verbal and physical engagement among members of the family

Conflict resolution vs. winners and losers

Predatory behavior, both physical and sexual

CUTTING AS AN ADJUSTMENT TO ONGOING ADVERSITY

“The forever factor” and its relationship to cutting

Evolution of frequency

When cutting becomes an addiction

Interpreting cuts

CO-MORBIDITY
WHEN THERE ARE OTHER DISORDERS PRESENT

Other disorders may exacerbate self-mutilating behavior and create a life-threatening situation.

Borderline Personality Disorder

Obsessive-Compulsive Disorder

Major Depression

General Anxiety Disorder

Post-Traumatic Stress Disorder

Bi-Polar Disorder

- One or more of these may accompany cutting and they have to be treated simultaneously.

- In cases of co-morbidity, which is common, one or more medications must be used in conjunction with psychotherapy.

- Borderline Personality Disorder and Post Traumatic Stress Disorder suggest the use of the most groups of medications.

- Introducing the use of these medications needs to be done sensitively and thoroughly by a psychopharmacologist.

TREATMENT MODALITIES

Individual psychotherapy can be highly effective in eliminating self-harming behavior. It should involve relationship-building with a therapist who is comfortable and knowledgeable in dealing with self-inflicted injuries and their appearance. The individual therapist must also be prepared to talk to an often non-responsive patient in order to teach her a language for her feelings so she can think instead of acting against herself.

Group psychotherapy may be useful, but it may also invite “symptom pooling”. A homogeneous group of self-mutilators is often difficult to conduct because most of the group has a paucity of language for their feelings. They need to be in a mixed group.

Self-help groups may be supportive to mature adults, but need to be adjunctive to individual therapy.

Psychiatric hospitalizations are useful for protecting the cutter from lethal cutting during the peak of a crisis, but most hospitals are not prepared for long-term treatment. There are a few that specialize in this area. They can be useful for one to three months.