

TREATMENT OF EATING DISORDERS AND MULTIMODAL DYNAMIC MODEL



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With the remarkable changes in the *postmodern* individual and collective psyche, inevitably they are necessary consequential updates in the cure methods.

Every historical epoch knows the prevalence of some pathological forms that are typical of a given culture.

In the psychological field we can acknowledge that the personality disorders, first the borderline disorder, and, after that, the depressive syndromes, the obsessive-phobic forms, the panic attacks, finally, the eating disorders, are at the forefront in the Western culture.



by Giuseppe Adamo

Today it is required an “ecologic” view of cures in accordance with *the conception of an ecosystem (natural and interpersonal) in which the individual can develop a continuous exchange between the interior world and the external world and in active form because, becoming more deeply aware, has the possibility of usefully self-determining, self-adapting and, besides, participating, together with the others, in the construction of a common satisfying life-context.*



Empowerment femminile di Raffella Anania

With regard to **Eating disorders**, we can say that through feeding, we have two quite treacherous ways to damage us, in other words, to satisfy our death pulsions (or *mortido*):

- more or less complete rejection of the food up to “starvation” (condition of extreme malnutrition due to long-lasting insufficient feeding);
- bingeing in such a manner as to alter severely, over time, homeostasis and some important functions of our body.

They are two opposite behaviors, often co-present in the same subject, that unconsciously have the same end: self-destruction, self-annihilation!

Someone has said “HUNGER FOR DEATH”!

But the question is not so simple!

If we observe carefully the young child in his eating habits we can find that often he eats baby food when he wants to ingratiate himself with the parents, while obstinately refuses food when he wants to rebel against them.

Therefore, we can discover in each alimentary situation some very decisive relational dimensions, so, from the point of view of the ecosystemic psychology, the feeding behavior is also a communication.

Therefore, in the, so-called, “hunger for death” or violent attack to own survival through the waiver to feeding we can notice some paradoxical aspects: the will to exist, the desire to be as an unique individual and the need to metacommunicate to others this radical and paradoxical attempt of self-assertion!

Often I tend to emphasize that we “nourish” ourselves by our relationships with Others and that also we “nourish” the Others through our relationships with them. Obviously this is a **psychological nourishment**, intellectual but “substantial” of which the human being needs and it is also widely found throughout the animal kingdom, as it is well known to who keeps pets at home!

From this viewpoint it is easy to understand how the “hunger for death” that has been supposed in the eating disorders, in truth, is “**hunger for love**”, therefore a relational empty against which the subject unconsciously **tries to rebel with anorexia and/or to which he unconsciously attempts through the bulimic binge** followed by the effort to vomit all!

This feeding behavior over time ends up producing well remarkable clinical effects!

Physical disorders associated with extreme malnutrition: amenorrhea, constipation, abdominal pain, cold intolerance, lethargy, marked hypotension, hypothermia, dry skin, excessive fuzz growth, bradycardia, peripheral edema and, in some cases, a tendency to bleed.

Especially in those who practice usually the almost total fasting and/or frequently self-induced vomiting and/or abuse of laxatives and diuretics, often they happen general alterations that, with the passage of time, acquire some significant consequences: anemia, kidney failure, severe hypotension, cardiovascular disorders, hypocalcemia, hypokalemia, hypercortisolemia, osteoporosis, dental abnormalities, reduction of pituitary activity.

Depressed mood, irritability, excessive ideational polarization on own weight and body shape, obsessive attention to own relationship with food, social withdrawal, discomfort in eating in public, feelings of inadequacy, need to control the surrounding environment, mental rigidity, reduced spontaneity in interpersonal relationships, inhibition of emotional expressiveness are, **on the psycho-relational side**, the more frequent symptoms in the psychogenic eating disorders.



by Stefania Romano

If it is true that every disease is however psychosomatic - namely it has physical, mental, and relational components that are as different faces of a same polyhedron - in the **properly so-called psychosomatic diseases**, the clinical manifestation is corporeal but in their pathogenesis some psychological factors are fundamental along with a personality feature, called **alexithymia**, that is the difficulty to live, to mentally recognize and to verbally express emotions!

Namely, the psychosomatic patient develops specific somatic diseases due to psychological tensions and anxieties of which his conscious mind has not cognition while he is focused on own somatic troubles.

Even in the case of the **psychogenic eating disorders**, the patient does not live consciously his internal conflicts, in fact, he is negatively obsessed about own **body aspect** with consequent erroneous eating habits that cause noticeable physical alterations.

In the anorexic patients, the overriding concern is that the body remains quite thin, purified above all from alimentary "contamination", devoid of any feature which may exercise sex appeal, pure like that of a vestal: "the material body" must make room for the "spiritualized body"!



Diana and Athena are two prototypes of *virgo* in which the *libido* (vital energy) and corporeality (not sexual) have a strong presence: in *Diana* to protect the women, in *Athens* to fight the men. On the contrary, in the anorexic patients, energy is destructively self-directed, with the unconscious aim to break all relations with own earthly physicality, with own mother and with own potential generativity!

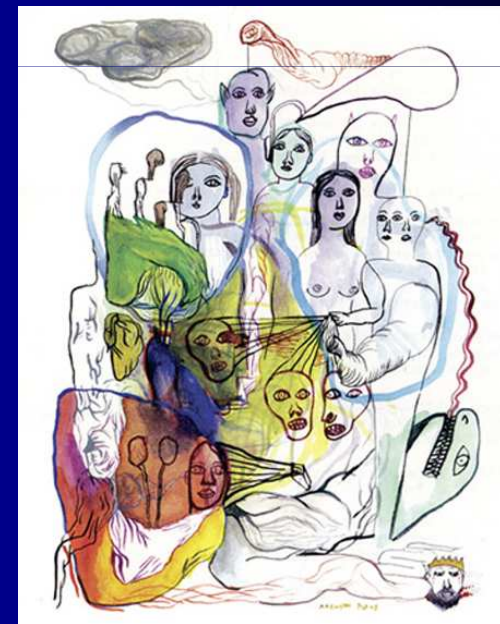
But what has happened in this pre-adolescent, teenager or young woman to get her to change her eating habits until the point to deform so showy own body, damaging tenaciously own physical health and causing high concern in people that deal with it?

The eating disorders have not symbolic meaning - as, instead, it happens in the conversion somatic symptoms of *hysteria* - on the contrary here we have a behavioral disorder that is an expression of obscure conflicting tensions of which the patient has not consciousness.



by Claudia Di Gangi

Generally, in the eating disorders, they have a great influence: **family factors** (families that are too involving, or overprotective, or intransigent, or marked by the continuing conflict between parents) and/or **factors related to own experiential world** (traumas, sexual abuse, etc.); finally, the **cultural factors** that are typical of post-modernity.



by Arrington De Dionyso

You will often have noticed, *Prof. Daniele La Barbera* says, that eminent essayists that speak to us of the great and interesting post-modern problems “they do it through a particular style, namely without never closing the discourse, leaving the perspective open, without giving definitive solutions, without answers, because this is the characteristic of the post-modern epoch. If we use this metaphor, this possibility of reading for understanding what is happening in our society, we can understand some important aspects that are part of the post-modern atmosphere in which all we are immersed; we realize it or not!”.



In my opinion, we live in the epoch of communication but our loneliness grows increasingly!

Internet, mass media, personal blogs, face-book, etc. propose an interpersonal communication more and more diffused but increasing stereotyped and at great physical distance among individuals, at the expense of the real meeting, namely not virtual.

But we must not forget that our *psychological dimensions* live and are realized mainly through the *physical body* which is also an *emotional body*, namely our *psychological being* is also realized through that *body* lived among persons that are really present in the *here and now* of their *existential* (space-temporal) *field*.



Today there is a growing isolation of the individual in his own room and a withdrawal of the body (that ultimately is our most intimate room) on itself.

The alienation from the *Other* and from the desire for the *Other* has ended up generating a growing sense of inner emptiness.



by Samuele Calabrò

So sudden, intense, temporary (ineffective in the long term) strong emotions try to find an illusory shelter to the lack of relational objects, and, from this, the search for intense sensations (*sensation seeking*), doping substances (*drugs addiction*), or even, what interests us here, the compulsive tendency to food binge “*binge eating disorder*” (**BED**).



The typical problem of post-modernity is that we live in a constant obscure anxiety for our increasingly weak, fragile, mutable identity: in other words, a growing “*dis-identity syndrome*”!

The cultural stereotypes exacerbate psychological problems of identity in the most young persons: the family and society intrude so invasively in the manner of existence of adolescents to prevent them from differentiating, reaching own autonomy and *individuation as unique and unrepeatable* person. Besides, the social psyche, through the media, hosannas skinny models but simultaneously idolizes buxom female figures that are very attractive sexually, in this context, an increasing number of adolescents seem to take the ambivalent double binary of being subdued to the cultural stereotypes but implementing a paradoxical way of rebellion against them!

Today, who more who less, we have some difficulty to recognize ourselves in our relationship with ourselves and in our relationship with the Other. An extremely fleeting “back and forth” of identifications with figures that appear and disappear within us and that, every time, tell us some new and frail truths about ourselves!

Anorexia dramatically expresses the ambiguous incapability to respond in a congruent manner to the contradictory demands of our culture, the incapability to recognize possible relational objects of identification, the refusal to accept help by therapists who would like to restore in the patient the desire and the willingness to incorporate, introject and to have relationships with objects of the outside world. The most typical response is the exacerbation of the obstinate refusal in a **closed primary** (namely pre-objectual, pre-Oedipal) **narcissism** in which the relationship with the other is near to the total detachment.

As we have seen, **Anorexia** and **Bulimia** are behavioral troubles for which it is required an interdisciplinary cooperation between various specialists from the endocrinologist to the nutritionist, the cardiologist, the psychotherapist and so on.



by Douglas Kolk

Evidently, also the family of the eating disorder patient should receive psychological support to the management of a clinical situation that is very difficult and, moreover, it must be helped to understand and remove the disturbing factors in its ecosystem that have contributed to the development in one (realistically the most fragile) of its members a food behavioral disorder that we have to consider the emerging “symptom” of a whole troubled family context.



by Brian Fahlstrom

Today it is required, previously we have said, an “ecologic” view of cures in accordance with *the conception of an ecosystem (natural and interpersonal) in which the individual can develop a continuous exchange between the interior world and the external world and in active form because, becoming more deeply aware, has the possibility of usefully self-determining, self-adapting and, besides, participating, together with the others, in the construction of a common satisfying life-context.*



Empowerment femminile di Raffella Anania

All this, however, forces us to develop models and applicative techniques, especially group models, aimed to meet the different needs to know itself by the contemporary man through more extensive and sophisticated therapeutic responses than years ago, and certainly more suitable to cure the existential complexity and the suffering that post-modernity produces.

The dual (one physician and one patient coping with the illness) classic medical model is out of date. There is need for integrated treatments through a **group of specialists that together really make operative network!**

But today, the Health Corporations have hindered rather than encouraged the group medicine and, on the contrary, have reinforced the mono-specialized model. Also in hospitals, the trend is still towards the super-specialized Divisions, I emphasize “divisions”!, without any active interdisciplinarity, because the participation of different specialists from those belonging to the department happens maximum through consultation.



by Gunter Christmann

What is missing is the *équipe* culture!

In fact, we must ask ourselves: how can we do research, prevention, cure, for instance in Eating Disorders, without putting together in the same team, internist, psychologist, psychotherapist, endocrinologist, sociologist, dietician neuropsychopharmacologist, and so on?

Besides, can we imagine that a patient that is so difficult, stubborn, driven by a rebel “hybris” and in an omnipotent challenge against everyone, like a patient with eating disorder, that is treated by a classical psychoanalyst for years in a psychoanalytic couch?

How can we get that the kind of undertaken cure is the best suited, at that moment, to the real needs of the patient rather than being centered on the specific training of the specialist consulted?

I would like to invite you to put yourself, for example, in a young patient's shoes that, to tensions connected to the common anguishes of post-modernity, adds the feelings and the frustrations tied to a specific trouble - it could be a personality disorder, a depressive syndrome, an obsessive-compulsive disorder, an eating disorder and so on - and to try to mentally trace a hypothetical psychotherapeutic run.

What form of psychotherapy should this hypothetical patient undertake? How to avoid that his choice about a determined form of therapy, with particular reference to psychotherapy - individual or group, psychoanalytic, analytically oriented, Jungian, Freudian, eco-systemic, art-therapeutic, autogenic training and so on - is fruit of case or of suggestion by the family doctor, by an aunt, by a friend, by another patient or, at last, by the attractive sagacity of the more recently appeared on TV therapist?

The real new challenge for the treatment of the more complex psychic disorders is to have the ability to find a way to take a step forward, a further progress on the therapeutic plan.

The invitation is to consider whether it would be interesting the possibility that the therapeutic itinerary of a patient does not casually or adventurously happens but instead through the preliminary valuation by a pluripotential team of specialists, namely, by a team that is able to offer - through the specialization of its different components - a plausible indication rationally centered on the case and regularly reviewed; in other words, a proper treatment planning agreed with the patient and periodically tested on the achieved results.

**I'm about to introduce the
Multimodal Dynamic Model**

Personally, I have developed a model that I presented for the first time in 2006 in a conference by the charming title “Ecology of Psychotherapy” in the University Bicocca, Milan.

MULTIMODAL DYNAMIC PSYCHOTHERAPY

by
ALFREDO ANANIA

Editor

of the Journal PSICOLOGIA DINAMICA

treatise presented in the workshop “Ecology of Psychotherapy”



*Ecologia della
Psicoterapia*

Università Milano-Bicocca 17-18
novembre 2006
aula U4-1 P.zza della Scienza 4

1. The Multimodal model of dynamic psychotherapy, 17.11.2006 @ www.psicologia-dinamica.it

Later, in 2007, I deepened epistemologically this model with a lecture given to the students of the Postgraduate School in Psychiatry, in the Psychiatric Clinic of the University of Palermo.

MULTIMODAL DYNAMIC PSYCHOTHERAPY AN EPISTEMOLOGICAL WIDENING

February 16, 2007 Seminar by *Alfredo Anania*



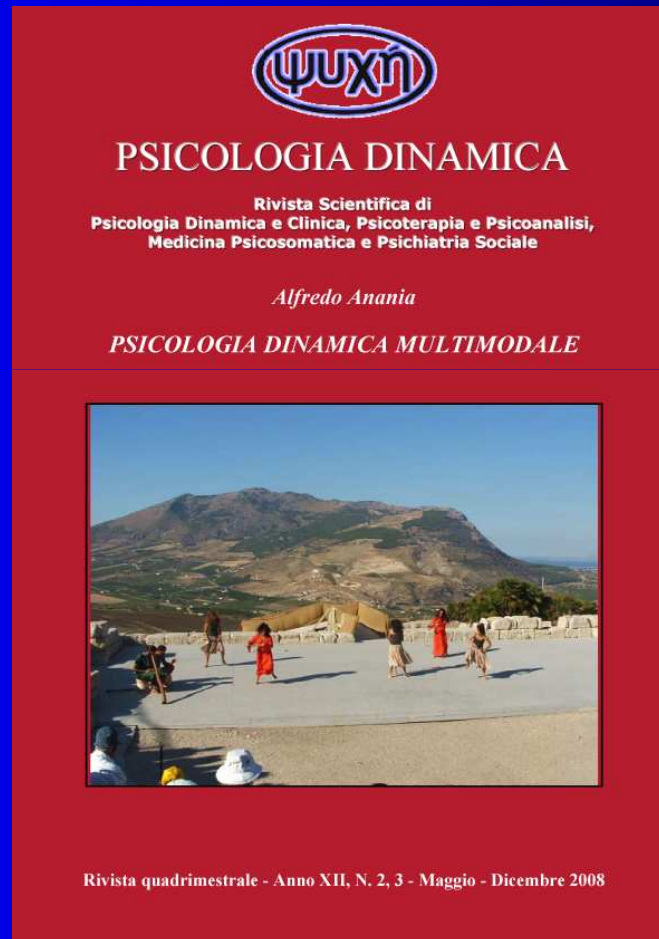
UNIVERSITY OF PALERMO
POSTGRADUATE SCHOOL
IN PSYCHIATRY

HEAD: *Prof. Daniele La Barbera*



Multimodal Dynamic Psychotherapy:
an epistemological widening
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In 2008 I published a monography in my journal **PSICOLOGIA DINAMICA**, under the title “Multimodal Dynamic Psychology”.



If there is a discipline that can perform the task of integrating quite different clinical and therapeutic approaches, many disparate research models and training schools, a discipline that can avoid a melting of models and an unbridled therapeutic inventiveness is the **Multimodal Dynamic Psychology**.

The **Dynamic Psychology** is an emergent discipline in the psychological field since, connecting itself to the traditional psychoanalytic schools, integrates them with the modern theoretical and applicative acquisitions, in particular the experimental psychology, the group therapy, the study of the transpersonal-world, the psychology of the Self and the inter-subjectivity, the relationships within the family ecosystem, the interactive influence of communication and, lastly, the various factors that have a remarkable role in the community psychology. Recently I have thought that is also necessary to include psychobiology. (A. Anania, *What dynamic psychology means*; in www.psicologia-dinamica.it, 18.03.2006).

We cannot deny that, in psychotherapy, the deep study of the unconscious can be restrictive in comparison to a **dynamical orientation** that - besides the patient's experiential world, the relationship with the parents and with the other important figures of infancy - extends the analysis to the cultural matrixes to which the individual belongs and to the problems that can rise between his subjectivity (as unique person) and the (human and natural) environmental ecosystem, the community, the contexts in which one has been formed and has lived.

It is not doubted that an expert therapist has a satisfactory **theoretical** knowledge of the most reliable clinical models, but the theoretical knowledge does not allow per se the applicability of the model without a preliminary specific training.

The **dynamic multimodal model** presupposes interventions of various (trained to a specific applicative method) therapists, because it is not plausible that a same therapist, with the same patient, now uses a setting and then another.

Ultimately, in **medical and psychological field**, we have the **necessity to transform the culture of the mono-specialized équipe** (that by now appears on the avenue of the sunset) **in a culture of the multidisciplinary équipe**, namely a culture that replaces the single therapist with **a pluri-disciplinary net of therapists.**



The Great Psychosomatic Ring
Cover of *Psicologia Dinamica* 2001

by Barnaby Furnas

In the light of what until now said, we can now trace the optimal path, in a Multimodal perspective, about the eating disorder patient, taking into consideration four basic conditions:

1) a functional structure with a polyvalent team;

2) that there is a culture of reception;

3) that the équipe meeting is mainstay of the work group;

4) the ability by all équipe-members to cooperate reciprocally in network.

1) Polyvalence of the équipe

The team should consist, at least, of the following specialized figures: internist, endocrinologist, dietician, clinical psychologist expert also in personality testing, individual psychotherapist, group-analyst, family systemic-relational psychotherapist, dramatherapist, specialist in therapy at expressive valence; art-therapist, dance-movement therapist, music therapist, specialist in psychobiology and neuropsychopharmacology; psychotherapist experienced in biofeedback and relaxation techniques.

The team obviously needs a **conductor** that is the exact opposite of a leader, a director and similar, in fact his assignment is not to have a decisional position higher than other components, but that of an expert in teamwork and with an adequate groupal training; he should help the team to function properly as a **working group**.

2) Culture of the reception

The **patient** needs a reception that make him feel welcome, put at ease, and co-participant in a treatment planning that requires the appropriate preliminary assessment based on the acquisition of all the parameters needed for a completeness clinical and textological.

The team initially intervenes also supporting the **patient's family group**; in a later stage, it should follow an ecosystemic treatment (relational-systemic family therapy) and **Large Group** opened to many families of patients.

3) The équipe meeting as mainstay of the workgroup

It is to accept the idea of using multiple treatment modalities sequentially or side by side with interventions at multiple levels modulated following the indications, in base to the clinical case, and according to a dynamic program (and from time to time agreed with the patient and/or their families) established by members of the multidisciplinary team within the team meeting. Each therapist intervenes in the overall treatment only with own specific skills and when the team considers necessary his professional work.

4) The ability by all équipe-members to cooperate reciprocally in network.

In the traditional formation of the therapists, in general, lacks a *culture of the team* and a specific *training in group work*. This probably comes from the fact that clinical practice has not been sufficiently studied in its possible multimodal evolution.

Some departments of Mental Health had developed a good familiarity with the multidisciplinary team work and, of course, have discovered the many benefits of this form of assistance organization at least in the more complex and intricate clinical situations. Today the team culture seems gradually shipwrecked!

Advantages of the Dynamic Multimodal Model

Above all it is the patient to benefit from the operative light provided by the team in the different stages of treatment. In fact, it is not secure that it is preferable to start with an individual psychotherapeutic treatment or with an experiential group or with a family therapy, without the patient's, at the same time, has the benefits the participation, for example, in a group of dance-movement therapy and so on. A team is likely more “prudent” and “wise” to evaluate and decide which, among the various plausible treatment-programs, might be the best, at a given time, and, if the verification of the results of the treatment was disappointing, to implement the necessary changes of “setting” (readjustment of the therapeutic program).

In the end, fruitful appears - especially in patients who are basically *alexithimic* and, therefore, elusive to more traditional models of therapeutic intervention - the use of applicative techniques, especially groupal, which, using symbolic-expressive moments - employing the art, the body expression and the creative expression, the world of colors and the contact with the perfumed gifts of nature - can facilitate the “*soul’s cure*” in a context that encourages the **happy marriage between nature and culture.**



Perhaps, the moment has come in which the **dynamic psychology**, after having consented to the patient to leave the sofa and to sit on armchair, can now cure also allowing to be standing, to move and to find expression through the body, the dance, the self-narration by means of the dramatization and so on!



**THANKS FOR YOUR
TOLERANT ATTENTION.
I HOPE
TO HAVE AROUSED YOUR INTEREST
AND
NOT TO HAVE ANNOYED TOO MUCH YOU!**

Alfredo Anania



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