

## **Advanced Brief therapy for eating disorders**

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### **Abstract**

Eating disorders are a category of pathology in rapid evolution and they modify themselves according to the development of the individuals and society. For this reason these disorders need treatments which are kept updated, in order to “fit” to the different patients’ realities. The action-research carried out starting from 1993 at the CTS in Arezzo allowed to adjust the specific clinical protocols, for this kind of disorders, with a significative level of efficacy and effectiveness. On the other hand this research has allowed us to get to know better the present reality of eating disorders about their modality to generate and maintain themselves. The author analyses the main features and the main therapeutic treatments of the two “technological” innovations in the field of eating disorders: the *Vomiting* and the *Binge Eating*.

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Since 1993, at the Centro di Terapia Strategica (CTS) of Arezzo, a systemic and rigorous research project has been initiated, regarding the study of Eating Disorders relative to their modern evolution<sup>1</sup>. The adopted methodology, known as intervention-research, is the same used by the CTS in previous researches on phobic-obsessive disorders<sup>2</sup>. This modality of research has allowed us to obtain two important results. Firstly, that of putting together a specific treatment protocol which resulted to be particularly efficacious and efficient in the intervention with this type of disorders. Parallel to this, the intervention-research has permitted us to get to know better the reality in which we are intervening, thus allowing us to formulate a new discovery model relative to the formation and persistence of eating disorders. In other words, by intervening on the reality of these disorders in order to solve them, the usual perceptive-reactive systems of the persons who suffer from eating disorders, were gradually revealed.

The most surprising result of our intervention-research consists in having come to understand that the actual reality of eating disorders is quite different to that described in literature. In particular, we noticed that besides the two pathologies reported in all standard diagnostic manuals- Anorexia Nervosa and Bulimia Nervosa- progressively a third type of eating disorder was outlined, which we came to define as Vomiting syndrome.

This term refers to a type of disorder based on eating and compulsive vomiting for a number of times a day, a symptomatology that in literature is still considered a particular variant of Anorexia and Bulimia. From our empirical-experimental analysis emerged that the fact that the symptomatology of Vomiting constitutes a pathology in itself, that presents certain persistence characteristics completely different to those of Anorexia and Bulimia; making up a true and proper “technological specialization” in the field of eating disorders.

This type of disorder that appears to be essentially the most common<sup>3</sup> eating disorder, holds as a matrix Bulimia and Anorexia but once it has been formed it becomes a true and proper “emerging quality” that has nothing to do with what initially had produced it. This evolution that seems to reflect a sort of “technological advancement” of eating disorders, where an initial attempted solution meant to avoid gaining weight or losing considerable weight- i.e. induced vomiting- ends up giving rise to a completely different and autonomous problem. In fact, if in the construct of Bulimia Nervosa, typical of the usual diagnostic classifications, self-induced vomiting appears to be a simple symptomatological expression, in our definition of Vomiting Syndrome, vomiting was revealed to be, that which constitutes the true and proper syndrome. From our point of view, the persons that suffer of the Vomiting disorder are characterised by an uncontrollable impulse to eat so as to be able to vomit and not only to binge and then to proceed to vomit as a necessary means

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<sup>1</sup> For a complete and more detailed picture of the research-intervention and the protocol treatments for eating disorders, see G. Nardone, T. Verbitz & R. Milanese (1999) *Le prigionie del cibo. Vomiting, Bulimia, Anoressia: la terapia in tempi brevi*, Ponte alle Grazie, Milano; and G. Nardone (2003), *Al di là dell'amore e dell'odio per il cibo*, Rizzoli, Milano.

<sup>2</sup> Regarding the research on phobic-obsessive disorders see: G. Nardone (1993) *Paura, panico, fobie*, Ponte alle Grazie, Milano; G. Nardone (2000) *Oltre i limiti della paura*, Ponte alle Grazie, Milano; G. Nardone (2003) *Non c'è notte che non veda il giorno*, Ponte alle Grazie, Milano.

<sup>3</sup> Costin C. (1996) *The eating disorder sourcebook*, Lowell House, Los Angeles, CA.; M. Selvini Palazzoli, S. Cirillo, M. Selvini, A.M. Sorrentino (1998), *Ragazze anoressiche e bulimiche. La terapia familiare*, Cortina, Milano.

to eliminate that which had been eaten. Initially, when these young women start to eat to then vomit, vomiting is surely an attempted solution, a method used to stop putting on weight but which allows them to continue eating or to lose weight without limiting their bingeing, therefore an attempted solution that functions. However, through continuous repetition of the compulsive eating-purging sequence, it slowly transforms itself into an always more pleasant ritual, until it becomes, over a period of months, the maximum of pleasures, which certain person find difficult to renounce to.

The most relevant aspect of the this syndrome resides therefore, in the fact that what renders this compulsion uncontrollable, typical of the Vomiting Syndrome, is the pleasure given by the entire compulsive eating-purging sequence, which progressively comes to constitute a real and proper pleasure-seeking model.

Therefore, once the Vomiting syndrome has been established, the problem is no longer that of controlling one's weight but of controlling this pleasure-giving compulsion: compulsive eating and purging, which represent the "attempted solution" of Anorexia and Bulimia, become the real problem, and pleasure becomes the reason of its persistence. Therefore, it emerges as the Syndrome of Vomiting, and even though it is a product of the evolution of Anorexia and Bulimia, it can not be considered a *tout court* eating disorder, but rather a true and proper "perversion" based on food. The problem of those who start suffering of vomiting, is no longer linked to the desire to stop putting on weight or lose weight, but eating and vomiting become an extreme pleasurable compulsion, which they can not bring to an halt, even if they wanted to. And it is for this precise reason -that the syndrome resides on pleasure- that renders it particularly resistance to treatment.

From our experimentation, emerged different variants of the vomiting behaviour; each required different typologies of intervention, because they hold a different persistence modality. We have ironically defined as: ***unconscious transgressive, conscious but repentant transgressive, conscious and compliant transgressive***. The existence of these different "types" within this disorder (just like within other eating disorders) indicate that there is a marked complexity in eating disorders with respect to other types of pathologies.

The unconscious transgressive are generally young women that from a cognitive point of view are not yet aware of the intrinsic characteristic of pleasure given by the eating-vomiting ritual (approximately 20% of our cases). Generally, in such cases, it is sufficient to guide these young women to start considering what they are doing, as some sort of "sexual pervasion" in order to rapidly interrupt the symptomatology, because the women fall in crises due to her moral values. Towards this aim, we utilise interventions and provocative reframing, to put the rigid moral of these women against their same symptomatology.

Approximately 50% of our casuistry falls in the "conscious but repentant transgressive" category, or better, women who become aware that their symptomatology is a pervasion based on pleasure, but they have not yet had enough of it: they would like to stop but they feel that they can not make it on their own and thus they are generally very collaborative in therapy.

Usually, the attempted solution of these young women is that of trying to reduce or control their overeating and their vomiting, with the effect of alimentering always more the desire to carry out the ritual. This because all types of intervention aimed to control or repress lead to further exasperate the compulsion. With this type of typology, we use a tactic finalised to directly affect the pleasure given by the ritual, i.e. the interval technique. This technique consists of asking the young women to avoid trying to control their desire to

binge but to insert an interval of half an hour between the binging and the vomiting, without ingesting anything more during this interval. If we manage to make them follow the prescription, the temporal sequence -that starts off from the anticipatory fantasy, moves on to the phase of consummation and ends up with a final discharge- gets interrupted and in this way it alters the uncontrollable pleasure. In this way, we 'repossess' the symptom through a therapeutic manoeuvre which traces the structure but which at the same time, inverts its direction leading it to its self-annulment, or better, we "lead the enemy to the attic and remove the ladder"<sup>4</sup>. If the young woman accepts this prescription, through out the successive sessions the interval is increased to an hour, then an hour and a half, then two hours, until three to three and half hours, where normally they stop purging, or else, they reduce the frequency of the ritual until they arrive to gradually stop at all. *The interval technique*, by altering the spontaneity of the sequence, does not only reduce pleasure from the liberating act of purging, which is usually experienced practically as an orgasmic urgency, but by increasing the interval time, it is rendered always more irritating and unpleasant. In this way, it is transformed from a ritual based on pleasure, to a real and proper form of torture. Furthermore, at the very moment when these young women stop purging, their relationship with food gets normalised, in the sense that, since they fear of gain weight, they stop overeating and stop consuming enormous quantities of food.

The last category, that is, the conscious and compliant transgressive (approximately 30% of our studied cases) seem to be the most resistant to treatment. In fact, they are young women who are fully aware of the pure pleasurable characteristic of the symptom, but who have no intention to give up what we call their "secret lover", that is their rapport with eating and vomiting. In this case, it seems essential to progressively guide the patient to concentrate her pleasure, by constructing together with her the perfect binge, to whet her transgression even more. By teaching her to concentrate and select her pleasure, the therapist obtains important results, i.e. to make her reduce, always more the frequency of the ritual. By increasing the quality of the binging, we produce a spontaneous reduction of their quantity. This follows the Chinese stratagem, "to plough the sea unknown to the skies".

The effect of the treatment protocol put together for the Vomiting Syndrome is equivalent to 82%. Such result is highly superior to other results present in international literature (which report a mean percentage of recover that varies from 9% to 45%<sup>5</sup>) generally, with an efficiency inferior to 15 sessions.

Beyond the epidemic deluge of the Vomiting Syndrome, which turn it from an accessory disorder of the other two traditional forms of eating pathologies into a prevalent disorder, in these last years we have also witnessed an always growing diffusion of the disorder known as Binge Eating or Uncontrolled Eating Disorder.

Binge Eating, another example of the specialized technology in the field of eating disorders, is featured by alternant prolonged periods of abstinence or hyper-controlled nutritional regime and periods more or less long of intense transgression where the person would let herself go completely to the pleasure of binging. After the binging, which generally is concentrated in a limited space of time, follows another long "punitive" period

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<sup>4</sup> Regarding the therapeutic stratagems see G. Nardone (2003) *Cavalcare la propria tigre*, Ponte alle Grazie, Milano.

<sup>5</sup> Costin C. (1996) *The eating disorder sourcebook*, Lowell House, Los Angeles, CA.

of abstinence and the cycle starts off again. The perceptive-reactive system of these persons is therefore based on the continuous alternation of abstinence-binging, control-loss of control. The ability to control themselves is in fact so successful, that after awhile they are no longer able to manage it and lose control. And therefore, the prolonged abstinence from food and the continuous effort to control oneself, lead to the successive lose of control.

The manoeuvre devised to unblock this symptomatology is a reframe known as *fear of abstinence*, through which we redefine abstinence - that for these persons represent a great triumph- as something that in reality provokes that which they fear of mostly, i.e. binging. In this way, the patients are gradually brought to construct a new reality where they come to perceive what they had been attempting to do so far to protect themselves from binging, as that something that effectively produce it.

The perception of the problem is completely revolted: the attempted solution - i.e. abstinence - is no longer defined as functional but as something threatening and dangerous, because it is by restraining from food that they end up having to binge. This manoeuvre seems extremely efficacious with this type of pathology, since it traces the tendency to control - typical characteristic of these patients - and reorient it against the symptom. In fact, through the fear of abstinence, we put the tendency to control against control itself. That which conducted the persons towards a pathological behaviour- binging- is now reframed as something that leads towards a healthy behaviour, that is, one should consent oneself to eat so as not to fall victim of binging. In the majority of these cases, after such as manoeuvre, the patients start to eat regularly since they start perceiving that if they allow themselves to eat, this will permit them to control what they fear mostly i.e. binging.

As in the case of the Vomiting Syndrome, even the treatment protocol devised for Binge eating presents a high level of efficacy (88%) with an efficiency equivalent to less than 10 sessions.

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