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Case Study

Masochistic Behavioural Tendencies and Self-Mutilation in Anorexia Nervosa: A Case Evaluation

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ABSTRACT

This article presents a case evaluation of a 16-year-old female diagnosed with anorexia nervosa and its relation to her masochistic tendencies and self-harming behaviour. Her unhealthy eating behaviour was rooted to the abusive traumas of her past and her strained relationship with her parents, as a coping mechanism. Furthermore, the paper also presents an insight into the main therapeutic interventions in the "Intensive Short Term Dynamic Psychotherapy" framework. The particulars of the therapeutic relationship and the defence mechanisms used are analysed here. This case also explores the client's underlying rage and guilt developed as a result of being raised in a dysfunctional home. The discussion associates progressive changes, made during therapy, with the healing of interpersonal relationships with her parents and the development of healthier eating patterns despite the prevalence of self-sabotaging actions.

Keywords: *Anorexia Nervosa, Masochistic Tendencies, Intensive Short-term Dynamic Psychotherapy, Coping Mechanism, Defence Mechanisms*

An eating disorder is defined as a persistent disturbance of eating behaviour or behaviour intended to control weight, which significantly impairs physical health or psychosocial functioning.(2) Anorexia nervosa is an eating disorder as recognized by both ICD-10 and DSM-V. It is characterized by excessive restriction on food intake and irrational fear of gaining weight, often accompanied by a distorted body self-perception. It typically involves excessive weight loss and is usually found to occur more in females than in males (10) There are three essential features of anorexia nervosa: persistent energy intake restriction; an intense fear of gaining weight or becoming fat, core persistent behaviour that interferes with weight gain; and a disturbance in self-perceived weight or shape. This disorder is far more common in females than men, with clinical populations generally reflecting approximately a 10:1 female-to-male ratio. (2)

This study intends to gain a particular focus on the client's diagnosis of anorexia nervosa, highlighting its relation to the client's masochistic behavioural tendencies and self-harm through an intensive Short Term Dynamic Psychotherapy lens. This will lead to the

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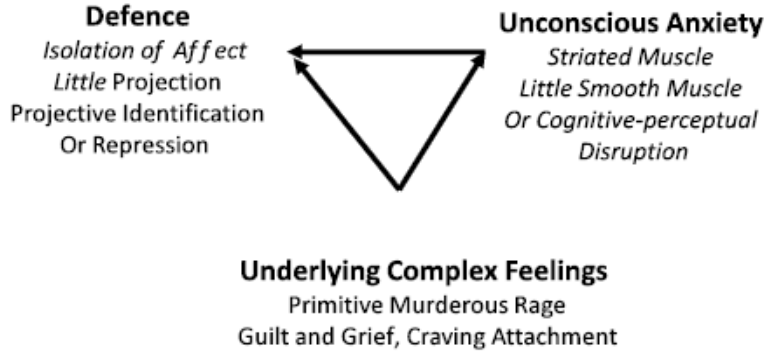
exploration of the conscious and unconscious mechanisms that produce and perpetuate self-destructive behaviours.

The anorexic is seen to protest in the act of starvation. The beliefs and desires of the anorexic appear to be grossly distorted, and it is necessary to attempt to unravel not why she starves herself but the attitude which underlies the behaviour. "To put it crudely, if anorexia is essentially a protest the crucial causal factors will be the conditions which the behaviour is protesting and the beliefs and desires of the individual making the protest."(11)

Treatment refusal and drop-out rates are high and relapse is common.(3) Most patients verbalize a desire to change, however, they seek treatment on their own terms, ideally with minimal or no weight gain. As stated by Allan Abbass in his paper on ISTDP for severe behavioural disorder: A focus on Eating Disorder, the ED symptoms serve a masochistic function, satisfying a need to self---punish, due to repressed guilt about rage towards attachment figures. Their ED symptoms are defences against the experience of anxiety, painful feelings and rage.(1)

In Intensive Short-term Term Dynamic Psychotherapy, the experience of core emotion from the past is seen as the transformative vehicle and the therapist relies on non-interpretive techniques: encouragement to feel; challenge to take responsibility to change; and confrontation of resistance to change. The therapists strive to uncover repressed emotions or "complex feelings" about past attachment failures. Many patients develop punitive self-structures to cope with these unresolved emotions during their development. ISTDP addresses these punitive structures' existence beginning with the first interview.(12)



Triangle of conflict of clients with ED according to ISTDP theory (1)

Favazza included both eating disorders and self-mutilation in his "deliberate self-harm syndrome."(8) This tendency is viewed as "a cathartic, self-purifying, function in that they modulate states of anxiety, sexual tension, anger or dissociated emptiness, and they bring about a tremendous quasi-physical sense of relief".(6) The concept of Sadorexia is a relatively new area of research on eating disorders, it is termed as a 2nd generation eating disorder characterized by a pervasive combined pattern of partial anorexic, bulimic or orthorexia behaviour and non-traditional slimming techniques like severe masochism to achieve extreme, top-model-type thinness while strongly alleviating anxiety and without raising suspicions in friends or relatives. Sadorexia is usually regarded as an 'evolution' of traditional eating disorders as well as self-injury: a result of medical smugness, prohibitionist approaches, denial of causal factors and self-bloating of those who should have been working for solutions.(4)

When individuals can uncover why they interact with food as they do, they can work on the underlying thoughts and emotions that have manifested in an eating disorder. When these thoughts and emotions are explored, disordered eating can then decrease or cease. However, when a masochistic tendency is developed through anorexia, the treatment of the same becomes limited as the client is not willing to help herself.

Case introduction

A 16-year-old female presented with problems of refusal to eat, absenteeism from school, lack of concentration in academics and excessive sleeping. She was diagnosed with anorexia nervosa and post-traumatic stress disorder, as per the Diagnostic and Statistical Manual of Mental Disorders V criteria. The client showcased self-destructive and masochistic tendencies throughout the course of therapy including self-harm (cutting and burning), suicidal ideation, missing therapy sessions and stopped coming for therapy before termination.

Presenting Complaints

Her history highlights that since age 14, she has exhibited depressed mood with anhedonia, self-harming behaviour (cutting and burning), starving tendencies and high levels of anxiety and irritability due to parent's divorce. She had constant doubts about her intellectual ability, self-deprecating thoughts about her image or person, and a desire to die or to leave school. She dwelled on painful family and personal matters, past and present. She was made a scapegoat by her parents during their divorce making her feel responsible for their failed marriage. She was exposed to physical abuse by her father and emotional, mental and verbal abuse by her mother. There was constant blaming and no sign of affection from her parents. She experiences intense anger toward her mother for betraying her and she seems to have forgiven her father.

Currently, she lives with her father, who has remarried, she refuses to attend school and has no motivation to appear for her examinations. Finally, her greatest fear is to open up to her friends and family as she has lost trust in everyone, and she does not want to experience the same deception she faced from her mother.

History

At age 14, her parents got divorced because of an unhappy marriage. She was brought up in a highly dysfunctional home, where her parents got into regular fights and were abusive. It was during this time she detested when even a little fat was shown on her body. She detested it and felt repulsed by her body. Her first traumatic incident with food was during her first day in a primary school after she had shifted from the USA. She was forced to eat the food by her teacher till she puked. Later, during the time of her parent's separation, she used to witness a lot of fights between them that involved the topic of food. Her father would refuse to eat if he got into an altercation with his wife. There were many incidents where traumatic arguments have taken place around the dining table. One prominent incident that has been embedded in the client's mind was when during a fight her mother broke a glass plate with the force of her hand, which resulted in cuts and bleeding.

Session Problems

Table 1 displays defence mechanisms manifested during sessions that served as discriminative behaviours with which the therapist intervened throughout treatment.

Defence during sessions	Examples
Rationalisation	"I understand him, he was angry he needed an outlet and I became one. "She is using rationalisation here as a defence mechanism by justifying and advocating her father's physical abuse)
Isolation of affect	Does not make eye contact with the therapist, relays messages with no affective tone, withholds information
Intellectualisation	talks about how she is well aware of her numbness rather than actually exploring her feelings
Projection	"You would think it is stupid" "You would judge me"
Somatisation	"I am feeling fatigued" "This is exhausting"

Case conceptualisation

The sessions focused on clarifying the client's explanations of and hypotheses about her problems, along with her concepts about life, parental relationship, how to achieve her goals, the self and others, and maladaptive thought patterns. She exhibited intense self-devaluation, identifying herself as the culprit for her parent's failed marriage, and also exhibited striated muscle anxiety, fragile character structure, isolation of affect, somatization and repressed guilt about rage towards attachment figures.

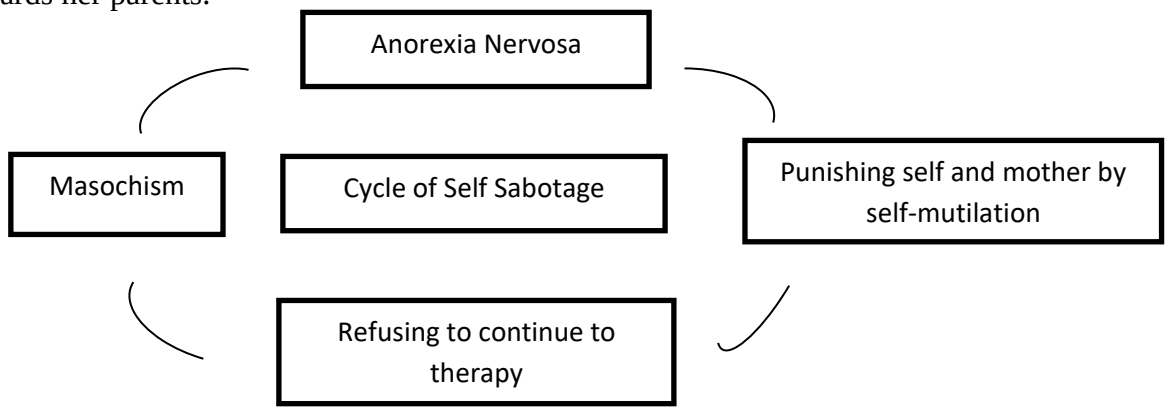
During the course of therapy, transference took place in the therapeutic relationship- the client started to identify the therapist as her mother and believed that showing her emotions would allow the therapist to use it against her, just like her mother did. She believed that showing her emotions made her vulnerable and she would be taken advantage of.

Patterns of attaching food to unhealthy emotions such as anger and situations of quarrels and arguments are something that the client has been exposed to since childhood. The parents deprived themselves of food as a way to punish their partner for starting a fight. The client unconsciously took up and developed an eating disorder to punish her parents and her anorexia is not just the client's coping mechanism but also a way to express her underlying rage and anger towards her parents. Thus, the eating disorder has a dichotomous function in the client's life proving to be a clear linkage to past attachment trauma.

The client was not able to accept her anger towards her mother. There was a great amount of resistance to expressing herself about her mother's abuse. The client rationalised her mother's actions to avoid tapping into her feelings towards her mother for beating her. One of her unhealthy thinking patterns was personalisation as she blamed herself and was taking responsibility for the incident by giving justification.

She had a breakthrough during the session when she was invited to explore her anger and rage, at that time she realised the underlying anger had been the fuel for her self-sabotaging behaviour. She was channelling the anger towards her parents onto herself leading to her refusal of food and self-mutilation. She was able to accept the anger, resentment and betrayal she felt toward her parents. She realised she wanted to hurt herself so badly because it would hurt her mother. There was a lot of self-loathing because of unresolved issues, she

was growing fat and wanted to experience pain to numb herself from feeling resentment towards her parents.



Recommendations to Clinicians and Students

There is very systematic data available on ISTDP, the processes they involve and their outcomes, and an abundance of research on the basic procedures used in these therapies such as moment-moment assessment, transference resistance assessments, ISTDP metapsychology and conflict recognition. We recommend that students and clinicians alike consider these strategies, as it can contribute to effectively treating difficult, treatment resistant patients such as those diagnosed with anorexia nervosa. These strategies are described extremely well by Allan Abbass, Dion Nowoweiski and Stephen Arthey (2013)[(1)] as well as by *Jon Frederickson in his manual* (2013)[(9).] It has become clear that these approaches can be useful in ED patients resistant to traditionally structured therapies yet, further research is required. The present case study suggests that ISTDP show great promise for intervention in treatment-resistant patients with anorexia nervosa.

Recent literature in the field of anorexia nervosa suggests the following. The study by Eddy et al. (2017)[(7)] provides valuable insights into the long-term recovery outcomes of individuals diagnosed with anorexia nervosa and bulimia nervosa. The findings highlight the importance of early detection and timely interventions in improving recovery rates. The identification of factors associated with better recovery outcomes can inform the development of targeted interventions to support individuals on their path to recovery.

The study by Treasure and Schmidt (2013) provides an updated and comprehensive overview of the Cognitive-Interpersonal Maintenance Model of anorexia nervosa. [(13)] The evidence presented in this paper supports the significance of cognitive, socio-emotional, and interpersonal factors in the development and maintenance of the eating disorder. Understanding these factors is critical for developing effective prevention and treatment strategies for anorexia nervosa, aiming to address the complex interplay between the cognitive, emotional, and social aspects of the disorder. The study highlights the need for an integrated and holistic approach to tackle the multifaceted nature of anorexia nervosa and improve clinical outcomes for individuals affected by this challenging condition. Similarly, Couturier and Lock (2019) [(5)] in their study concluded that understanding the unique challenges and needs of adolescents with anorexia nervosa is crucial for optimizing treatment outcomes and supporting sustainable recovery. The findings of this study contribute to ongoing efforts to improve the quality of care and support provided to adolescents on their path to recovery from anorexia nervosa.

These studies further prove the importance of creating a holistic plan in the treatment of anorexia nervosa by devising a therapeutic package which addresses the needs of the individual considering all necessary factors. Future studies can be longitudinal in nature addressing concerns regarding development of anorexia nervosa and related events in preceding years of the individual.

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Conflict of Interest

The author declares no conflict of interests.

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