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# Application of Psychodrama and Object Relations Psychotherapy – An Integrated Approach to the Treatment of Bulimia Nervosa Based on Selected Elements of the Theory and the Author's Own Experience

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## 1. Introduction

Bulimia nervosa is an eating disorder characterized by self-destructive behaviours which gradually affect the sufferer's mental well-being and lead to body emaciation. The results of the scientific research conducted in the past few decades point to a multitude of determinants of this disorder, including biological, familial, socio-cultural and individual factors [Mikołajczyk, Samochowiec, Kent, Waller, Dagnan, Hartt, Wonderlich, Rorty, Yager, Rossotto, Lacey, Evans].

Chronic stress and traumatic events which the person experiences in his or her life (e.g. acts of violence or sexual abuse) are considered to be significant triggering factors for bulimia nervosa [Mikołajczyk, Samochowiec, Kent, Waller, Dagnan, Hartt, Wonderlich, Rorty, Yager, Rossotto]. Traumatic experiences which bulimia sufferers are exposed to, and their emotional deficits affect the recovery process. In the therapeutic process, the patient needs to develop a cognitive and emotional insight into psychological mechanisms underlying the disorder which he or she suffers from, and to undergo a corrective emotional experience in the contact with the other person. This points to the significance of an "encounter with the other person and establishing a positive emotional bond (the therapeutic alliance) with this person". Thus, psychodrama is the therapeutic method which allows to intensify reactive actions and facilitates positive changes in the emotional structure of the patient's personality, and proves to be an effective technique of reducing bulimic symptoms.

Eating disorders belong to the category of psychopathology which is characterized by various levels of personality dysfunctions which range from neurotic disorders to psychosis. The choice of diagnostic and therapeutic interventions applied in the process of treatment should then be determined by the kind of a personality disorder identified in the given individual. Developing insight into psychological mechanisms underlying eating disorders, as well as establishing a therapeutic bond, constitute a crucial element of therapeutic interactions which can be supported by such methods as psychodrama and object relations technique.

Integrating psychodrama, which allows to gain insight into psychological mechanisms underlying bulimia nervosa, with the approach that focuses on corrective interactions in

emotional relationships with significant others (objects), proves to be an effective method of reducing destructive symptoms of this eating disorder. I witness this in my own therapeutic work. The effectiveness of various psychological therapies applied in the treatment of anorexia and bulimia nervosa has been discussed in the subject literature [Hay, Bacaltchuk, Byrnes, Claudino, Ekmeijan, Yong, Bahar, Latzer, Kreidler, Berry]. Psychoanalytic and psychodynamic psychotherapies, which include therapeutic interventions based on the theoretical assumptions of classical psychoanalysis, object relations theory and psychology of the self [Bahar, Latzer, Kreidler, Berry], are regarded as the most significant in the process of treatment. They prove to be effective especially in the long-term treatment of personality disorders in adult patients. Similarly, it has been demonstrated that application of psychodynamic therapy in the treatment of eating disorders can give positive effects [Bruch, Glickauf- Hughes, Wells, Hay, Bacaltchuk, Byrnes, Claudino, Ekmeijan, Yong]. As viewed in psychological literature cognitive therapy as well as the therapy based on eclectic approach which involves integrating various theoretical elements, can be used in the treatment of anorexia and bulimia nervosa. However, application of art therapy and psychodrama, combined with psychoanalytic and psychodynamic psychotherapy (based on object relations theory) in the treatment of eating disorders has not been thoroughly discussed in subject literature [Levens, Jay]. It applies mainly to Polish references.

According to early psychoanalytical conceptions concerning the origins of an eating disorder, bulimia nervosa is a psychosomatic illness [Bruch]. Conversion symptoms have primitive symbolic significance (e.g. oral fantasies where the mouth is symbolically equated with vagina, and eating is accompanied by the fear of "oral impregnation") [Bruch]. The etiology of eating disorders is also related to such factors as the person's psychopathological personality structure and disturbances in the process of solving internal conflicts by the bulimia sufferer. The conflicts are predominantly related to destabilization occurring during such processes as development and emotional experiencing of sexuality, and accepting one's own femininity (in case of female patients). Bulimia sufferers attempt to solve the conflicts by distorting their body image and making a cognitive interpretation of their body stimuli [Bruch]. An appropriate relationship between a caregiver (a mother) and a child (which means that a caregiver adjusts to the child's experiences) is considered to have a significant impact on the development of pathological mechanisms which underlie the aforementioned dysfunctions. Thus, eating disorder symptoms, including bulimic patterns, constitute a substitute of affect regulation.

Broadly defined object relations theories represent a significant contribution to a new understanding of eating disorder psychopathology, viewed from the perspective of the significance of object relations and the characteristics of internal object representations developed in the later stages of the person's mental life [Glickauf- Hughes, Wells]. On the basis of the subject literature [Bruch, Izydorczyk] as well as my own experience, gathered in the course of therapeutic work with bulimic patients, I can state that these individuals resort to certain "external measures", or activities (such as eating) in order to cope with their internal emotional conflicts. The specific life experiences which bulimia sufferers (predominantly women) tend to report in an anamnestic interview include:

1. Playing the role of the so called "responsible child", who takes over the parents' duties such as taking care of younger siblings or running the house. The child learns how to recognize and satisfy other people's needs, which consequently leads to suppressing his or her own needs. Such childhood experience usually takes its toll on the life of a female who finds it difficult in her adult life to accept the feeling of anger in her relationship

with parents, who “cast” her in the role of “a responsible child”. The anger is directed mainly towards the mother, who the person, as a child, was trying to protect against experiencing negative emotions.

2. Playing the role of “a good child”, causing no troubles, thereby meeting expectations set by parents who encourage the desired behaviour and reward the child for it. This gradually hinders the child’s ability to express alternative feelings and pursue behaviours which their parents regard as “bad=wrong” and “needy”. The child feels he or she is a disappointment to the parents. A child lives, as it were, in the world which is merely “good” or “bad”, and this bipolar view of the world affects his or her self-perception. As a result, the child denies the “bad”, “needy” aspect of his or her personality to gain his or her parents’ approval. In this respect, bulimia nervosa can serve as a means of externalizing (e.g. through eating) and denying undesirable aspects of personality. However, despite the fact that eating is considered to be an “external activity”, it has a direct impact on the feelings and emotions which bulimic individuals have towards themselves. When a bulimic has a good day, because she or he has eaten only “good” food, the individual feels good. Such a condition lasts until the bulimia sufferer decides to consume “bad” food, which results in reversing the process of self-evaluation. It proves that self-assessment is influenced by external factors. When talking to my female patients suffering from bulimia nervosa, I notice that they often use such expressions as: “I should” or “I shouldn’t”. The need for approval, which goes hand in hand with failure to comply with self-set standards, makes it difficult for bulimia sufferers to establish social relationships. When selecting partners, bulimics oscillate between individuals who need to be taken care of and those who need to take care of others. Due to their low self-esteem bulimia sufferers find it difficult to acknowledge that their partners perceive them as attractive. The fact that bulimic individuals disapprove of and reject their own bodies triggers problems in the sexual sphere. Alcohol and drug abuse turns out to be a common coping strategy.

Recent scientific research demonstrates that the pathomechanisms underlying eating disorders, particularly bulimia nervosa, develop in response to such difficult life experiences as acts of violence or sexual abuse, which an individual is exposed to either during childhood or adult life [Mikołajczyk, Samochowiec, Kent, Waller, Dagnan, Hartt, Wonderlich, Rorty, Bruch, Izydorczyk]

A number of personality profile studies conducted on bulimia sufferers prove that they display the following personality disorders: borderline and histrionic personalities, impulse control disorders, impulsivity, or an obsessive-compulsive disorder. Bulimics tend to be quick-tempered, and have low frustration tolerance and frequent dysphoric moods. They also display a tendency to withdraw and to get depressed [Mikołajczyk, Samochowiec].

Lacey and Evans defined the notion of a “Multi-Impulsive Personality Disorder” and specified its characteristic behaviours (such as psychoactive substance abuse, repeated self-harm, compulsive dozing of substances, shoplifting and gambling), placing bulimia nervosa among them [Lacey, Evans]. Inadequate impulse control, present in bulimic patients, leads to regular episodes of binge eating, vomiting, using drugs, drinking alcohol, compulsive smoking, repeated self-harm and indulging in a variety of impulsive, tension-releasing behaviours. Such behaviours are frequently accompanied by the feelings of self-loathing and disgust towards one’s own body, guilt and shame. By contrast with patients suffering from anorexia nervosa, who tend to deny their illness, bulimic individuals go through their illness

accompanied by pain and the feeling of shame. They are filled with great remorse for their behaviour towards themselves as well as others, their nearest and dearest. That is why it happens quite frequently that they do not reveal their illness for a long time. The need for control plays an important role in the life of a bulimic, who makes attempts to keep control of food intake (the person controls the quality and quantity of food, performs compulsive eating rituals, etc.), weight, as well as his or her internal experiences and external behaviours. A bulimic individual finds it difficult to accept the fact that he or she is not able to control all aspects of his or her life. In order to become aware of it, the person has to undergo psychotherapy, which is aimed at unblocking the bulimia sufferer's creativity and spontaneity.

Exposure to social situations provokes anxiety in patients with bulimia nervosa, since it triggers the fear of loss of control, or reveals its lack. Once a bulimia sufferer realizes that he or she is unable to control his or her impulses or compensatory behaviours, or even other reactions in the person's life, the individual becomes frustrated and tends to experience intense emotional states (e.g. depression), which the person wishes to avoid. This implies that patients suffering from bulimia nervosa find it difficult to ask for help and seek psychological support. Making a decision to participate in psychotherapy might be the first step in strengthening the bulimic's motivation for introducing changes into his or her life.

Theoretical fundamentals of psychoanalytic and psychodynamic psychotherapy point to the fact that the development of these impulsive (psychopathological) symptoms is underlain by incorrect (destructive) psychological (unconscious) mechanisms which function within the structure of the bulimic individual's personality.

An object relations approach to psychotherapy emphasizes great significance of human relations which play a key role in the recovery process and replace drives as the main determinant of the person's mental development. The approach focuses on the possibility of making changes within these relations [Mikołajczyk, Samochowiec, Kent, Waller, Dagnan]. Object relations theories are based on an assumption that the patterns of relationships with significant others (objects) formed during early childhood (the early interactions between a child and the most important objects such as the mother, father, or a caretaker) significantly affect the individual's adult relationships and the person's social and emotional functioning (the phenomenon of transference) [Mikołajczyk, Samochowiec, Kent, Waller, Dagnan, Glickauf- Hughes, Wells]. This correlation seems to relate the object relations theory to Moreno's concept of psychodrama, according to which the key to understanding the genesis of the person's emotional problems should be sought in psychological background related to social relationships, which engenders dysfunctions in the sphere of an individual's reactions and behaviours. Hence integrating the approach which utilizes the corrective influence of "good" object relations therapy with psychodrama techniques such as surplus reality, might prove to be an effective method in the treatment of eating disorders, including bulimia nervosa.

Based on a review of subject literature, and drawing from my own experience gained in the course of individual and group therapy conducted on patients suffering from bulimia nervosa, I wanted to stress in this paper the importance of integrative approach to diagnosis and treatment of bulimia nervosa. My intention was to demonstrate the basic similarities between psychodrama and the object relations theory, and point to the fact that these two therapeutic approaches may complement each other.



## **2. The psychopathology of bulimia nervosa – as viewed from the perspective of the object relations theory and J.L. Moreno's psychodrama**

In my psychotherapeutic work with patients suffering from bulimia nervosa, I refer to a psychoanalytic and psychodynamic paradigm of the psychopathology of this disorder, grounded on the concepts of object relations. Taking into account the psychodynamic principles and the structure of the therapeutic process (e.g. conducting the unconscious input analysis; applying verbal therapeutic interventions including clarification, confrontation and interpretation; taking into consideration the significance of insight, developing a therapeutic relationship, and conducting transference analysis), I have applied Moreno's psychodrama in individual and group therapy which I have been conducting for several years.

According to the fundamental assumptions of psychoanalytically oriented therapies for bulimia nervosa, which underpin the classical psychoanalytic theories based on Freudian concepts, this eating disorder is a biologically determined condition. An object relations approach to the origins of the illness is slightly different. Although the major theoreticians who employ this approach belong to various schools such the British Object Relations School (Klein, Fairbairn, Guntrip, Winnicott), the American Object Relations School (Mahler, Kernerg, Kohut), and the American School of Interpersonal Relations (Sullivan), they put forward unanimous views on the issue of the etiology of eating disorders. They maintain that the origins of the eating disorder psychopathology lay in the person's traumatic life experiences, emotional deficits and patterns (the matrix) of internalized, emotionally destructive interactions of an individual with significant objects, especially the relationships established during childhood, which are "replicated" in all social interactions in the later stages of the person's life [Glickauf- Hughes, Wells]

Identification of this internal pattern of relationships with a caregiver (object) facilitates the process of psychotherapy. A therapist is able to recognize and better understand the client's interpersonal behaviours, as well as modify the internal structure of the individual's personality (object representations, self-representations, feelings). The object relations theory is considered to be in opposition to Freud's classical theory of psychoanalysis, since the person's need for emotional relationships with other people is seen as replacing sexual drive and aggressive impulses as the original motivational system for human behaviour. Focusing on social interactions as a significant element in the development of a human being, the object relations theory resembles a psychodrama approach to an emotional difficulty and an illness symptom in the process of psychotherapy [Glickauf- Hughes, Wells].

In my diagnostic and therapeutic work with patients suffering from bulimia nervosa I refer to the fundamental assumptions of the object relations theory which provide a basis for psychotherapy for this kind of disorder. Whenever I try to diagnose bulimic symptoms (such as episodes of binge eating, self-induced vomiting or purging), I attempt to identify the current as well as the past pattern of the bulimic's relationships with a caregiver (a significant object). Most frequently, I focus on my patient's relationship with his or her mother, not disregarding the significance of the father-patient relationship [Glickauf- Hughes, Wells]. The infant-mother pattern of relationship, formed during infancy and early childhood, related to breastfeeding, proves to be an important factor determining the development of an eating disorder in the later stages of an individual's life. This can be confirmed by many years' research and clinical experiments conducted by Hilda Bruch and other authors [Bruch]. It can be stated that the object relations school emphasizes the

significance and dominance of interpersonal and emotional relationships over drives in the process of mental development of an individual [Waller, Kauffman, Teutsch]. Similarly, the major therapeutic and diagnostic assumptions of psychodrama refer to a dominant role of psychological-and-social underpinnings of an individual's behaviour and reactions. In psychodrama the main stress is put on an individual's potential rather than on the specific psychopathology. However, symptoms of the pathology are not disregarded in the therapeutic work on the stage.

In both of the aforementioned therapeutic approaches, considerable significance is attached to the concept of an encounter, interpreted in psychodrama as the phenomenon of "being together; a reciprocal encounter; empathy and sharing; mutual understanding; intuitive insight" [Glickauf- Hughes, Wells, Jay, Blatner, Goldmann, Morrison]. Such an interpretation corresponds to the role that an encounter plays in psychodynamic psychotherapy, which relies on empathy and the so called "authentic patient-therapist relationship", as well as on the therapist's intuition used to develop insight and to take corrective action aimed at establishing an emotional relationship. Thus, the concept of encounter is considered to be equally significant in both therapeutic approaches.

### **3. Characteristics of psychodrama applied in psychodynamic psychotherapy for patients suffering from bulimia nervosa – a psychological diagnosis of the self-image and self-feelings**

Some of the core psychodrama techniques, applied to investigate bulimic symptoms and psychological mechanisms of this disorders include role reversal, role training, doubling, mirroring and surplus reality.

In role reversal, the protagonist reverses his or her role with another person (an auxiliary ego) on the psychodrama stage. This gives the patient-protagonist a chance to enact particular situations, inner thoughts, behaviours or other states from his or her life which are related to the significance of food, body parts and feelings in the patient's life. Thus, role reversal allows the individual to increase his or her self-awareness, and gain insight into how the person reacts in such life situations as feeding, eating, or the mother-child interaction. Role reversal provides invaluable experiential insight through seeing oneself from the perspective of another. The auxiliary ego helps the protagonist explore his or her unconscious conflicts. The role of an auxiliary ego (in monodrama the role is assigned to an object or a director) is to "give voice" to inner thought and feelings the protagonist does not yet feel able to express. It is through a dialogue with the auxiliary ego, accompanying the further role reversals, that the protagonist explores his or her unconscious mind and is able to make corrections to the dysfunctional behaviours. The protagonist enters into a dialogue with him/herself on the psychodrama stage. Reversing roles with his or her stomach or other important body part, a bulimia sufferer has a chance to find out about the unconscious feelings towards these parts, and recognize the destructive behaviours the person tended to engage in. Consequently, as a result of this powerful confrontation technique, the patient is able to introduce positive changes into his or her behaviour.

The mirror technique involves another member of the group mirroring the protagonist's postures, gestures, and words as they appeared in the enactment. The protagonist observes his or her own behaviour as reflected by another person, watches the enactment of him/herself from outside, adopts the so called metaposition of an audience member, an observer, and his or her role on the stage is acted out by a double. The mirror and double

techniques prove to be effective therapeutic instruments in the process of releasing the repressed feeling of rebellion (anger) or other emotions which a young patient fears or does not notice. Doubling occurs when a member of the group – the therapist-director – takes on the physical stance of the protagonist and attempts to enter his or her internal world by speaking the person's inner thoughts and feelings. Thus, the director is referred to as the unconscious or "inner voice" of the protagonist who might prefer to keep "hidden" [Bruch, Blatner, Goldmann, Morrison]. The technique allows a bulimic patient to become more aware of buried and partially obscured and hidden negative emotions which very often include the feelings of shame for their weakness, and an intense fear of gaining weight.

Doubling is the technique which is designed to support the protagonist (it stimulates the protagonist's response); it involves confrontation (provokes the patient to express his or her feelings and thoughts), and reveals the protagonist's ambivalent feelings (contradictory emotions, thoughts and conflicts). The director is able to express the protagonist's unvoiced thoughts and emotions (e.g. the hidden feeling of anger, the fear of maturity, responsibility and separation), thereby helping the patient deepen insight into psychological mechanisms underlying the bulimic symptoms which the individual suffers from.

A surplus reality technique, frequently applied in psychodrama, provides a patient with corrective emotional experience which the person desired in his or her life but did not have a chance to get due to his or her emotional family deficits (the individual's fundamental needs are not satisfied in the family environment).

Psychodrama techniques may be applied in the preliminary stages of individual psychodynamic psychotherapy, when a therapist builds therapeutic alliance with a client. In this phase, props (objects) assume the role of an auxiliary ego. Reversing roles with the auxiliary ego, the patient explores his or her unconscious emotions. It applies also to the preliminary stage of psychodrama - the so called warm-up phase. The warm-up technique applied in the early phase of individual psychodynamic therapy is a dialogue with a patient. During an early individual session, the client is asked such questions as: "How are you today?", "How is it going?", "What would you like to talk about today?". Such exploratory questions and therapeutic interventions prepare the patient for further stages of psychodramatic work aimed at exploring the person's feelings, attitudes, beliefs, and social relationships. Since the warm-up phase of the individual psychodynamic therapy session involves verbal communication, and lasts for a relatively short period of time, it is difficult for the patient to get prepared for the role of a protagonist. A protagonist, who displays certain characteristic personality traits (which was scientifically proven), uses a variety of defence mechanisms which include emotional blockage, dissociation, denial, rationalization, cognitive distortions concerning body image and self-assessment [Kent, Waller, Dagnan].

The techniques and exercises which a therapist employs in the warm-up phase of the session, must be carefully selected, since they are designed to develop a sense of safety, a foundation of trust, which would facilitate the process of self-exploration. The techniques applied in the therapy for bulimia sufferers, who regard their bodies as "bad objects which should be destroyed", should facilitate the gradual process of making the patient acquainted with work on the stage (it refers both to group and individual therapy), and making it easier for him or her to get accustomed to physical contact, through teaching the individual how to touch various body parts. If the techniques are applied to fast, it might result in deepening the patient's trauma, especially if the person had experienced body boundary violation before. Taking into account the psychological profile of a bulimic, I seldom employ typical



protagonist games. Applying the game therapy might be particularly risky in case of patients who reveal symptoms of personality pathologies such as psychosis, impulsive personality disorder or borderline personality disorder.

It is a frequent occurrence that when bulimic patients start their treatment, their first and primary objective is to eliminate the uncomfortable compensatory behaviours that they exhibit (such as regular cycles of binge eating and purging, self-induced vomiting, or taking laxatives), which very often cause embarrassment, guilt and even self-disgust. During the very early stage of treatment, when I try to develop a therapeutic alliance with the patient, and establish a contract which specifies the goals and procedures concerning the verbal dialogue and the treatment of psychopathology, based on theoretical assumptions of psychodynamic psychotherapy, I usually apply such psychodramatic techniques as role reversal and the mirror. The psychodrama stage is not only the physical space in which the patient-protagonist enacts situations from his or her life, but it also represents symbolically the client's internal world of feelings and emotions which the individual experiences when coming for therapy.

In the first-contact sessions I tend to use visualization and the technique which involves setting up particular scenes on the stage. If a patient resists participating in psychodrama work on the stage (e.g. the person is silent or flatly refuses to act on the stage), I resort to therapeutic dialogue with the person, trying to identify the source of the patient's resistance. In the next phase, I suggest that the patient should try to set up a scene without getting up from his or her chair. I encourage the individual to create certain scenes from his or her life, to show on the stage what hindered his or her decision to take up treatment and seek therapist's help earlier. At this stage, I introduce an auxiliary ego, whose task is to take on the so called symbolic roles (e.g. the roles of the props chosen by the patient to represent symbolically the elements of the scene he or she is attempting to create). The props used in the session include sheets of colourful paper, or scarves, and help the resistant, silent, or impulsive patient who is often full of self-disgust, describe what he or she really sees, or even feels. However, the person is not encouraged to judge his or her experiences as "good" or "bad", which makes the patient feel that he or she is engaged in setting up his or her own scene.

The interview the therapist-director conducts with the patient-protagonist prior to the therapeutic game, when the individual is sitting on the chair, describing what he or she sees and feels, setting up his or her scene using symbolic objects, allows the therapist to prepare the next phase of the session which is aimed at identifying the factors affecting the patient's motivation for treatment, and discovering the genesis of the illness (the therapist explores the patient's repressed feelings, and internal conflicts which underlie the symptoms of the illness). Once the patient becomes more active (i.e. he or she responds to the director's questions, chooses props and arranges them in such a way that helps the person visualize what he or she sees or feels), I usually invite the individual-protagonist to stand up and analyze the sequence of scenes set up on the stage. The realism of the scene setting promotes maximum opportunity for warming up, for expression of actions, thoughts and feelings. The scenes created by the protagonist bring out the reasons of the person's delayed decision to approach a therapist, the obstacles which the individual had to overcome in order to start therapy, and the current inner world of the patient's feelings and emotions. It is frequently at this stage that the patient reveals his or her self-feelings, concerns over body image, and his or her approach to an illness. The therapeutic technique I usually apply in this situation is the use of symbols, which is designed to help the patient work through the aforementioned issues.

From subject literature as well as my own clinical experience, it appears that patients (especially females) with bulimia nervosa very often bring up the issue of negative (auto-destructive) feelings they have towards their bodies such as self-disgust, embarrassment, anger, anxiety, and a desire to overcome those feelings [Lacey, Evans]. If the issue of self-disgust, which is related to the problem of binge eating and self-induced vomiting, occurs during the therapy, I often encourage the patient to use one of the props (e.g. one of the colourful scarves) to represent his or her self-disgust. When holding an object which is a symbol of the person's self-disgust, the bulimic patient is able to take a closer look at it as well as feel it, and the therapist-director can enquire about the person's experience (the therapist tries to find out whether it is intense, overwhelming, or strong, and to identify its length, structure and genesis, etc). Thus, the patient has a chance to overcome his or her resistance and to identify the self-feelings the person experiences, whereas the therapist is able to make a preliminary diagnosis of psychological factors determining the bulimic symptoms the patient suffers from.

When the patient-protagonist talks about his or her feelings (e.g. he or she says: "I feel ashamed and terrified"), I ask the individual to enact a scene which would represent the person's embarrassment and extreme fear. I encourage my patient to use objects (props) to show the feelings of embarrassment and terror which he or she experiences. Afterwards, I suggest that the patient should reverse roles with some chosen elements of the scene he or she has just created.

The patient-protagonist, encouraged by the therapist-director's enquiries, is thus able to reveal his or her inner contradictory thoughts and feelings concerning various aspects of the person's self (e.g. the reasons behind the patient's imprecise motivation for taking up treatment). The therapist-director interviews the patient-protagonist who is in the role of self-disgust or terror, asking him or her the following questions: "How strong and intense are you?", "When did you originate?", "What is your colour?", "What is your main characteristic feature?", and others. This allows the individual to show, using symbols, the source of his or her fear or shame.

Another feeling reported by a bulimic patient at this stage of therapy is anger. The protagonist is encouraged to reverse roles with anger and asked to answer the director's questions such as: "What is your origin?", "When did you originate?", "How strong are you?", "Who are you directed at?", "Who do you serve?", "Are you the protagonist's friend or enemy?", and others. The technique is instrumental in increasing the patient's awareness of the feeling of anger directed towards him/herself as well as towards others. Once I discover that the feelings which the patient exhibits are intense and have been lasting for a long period of time, and I find out that the person is under pressure from his or her family to recover quickly and fully from an illness, I understand why the patient-protagonist's attitude to an illness and his or her own body is dominated by the feelings of resistance, shame, anger and anxiety.

The therapeutic method which involves portraying on the stage auto-destructive feelings exhibited by the patient-protagonist, who is supported and understood by a therapist-director, allows to strengthen the bulimia sufferer, stimulate his or her greater spontaneity, and encourages the person to design possible scenarios of overcoming such pathological impulsive behaviours as binge eating or self-induced vomiting. While interviewing the psychodrama participant, the director is able to bring out the negative aspects of the patient's feelings which he or she seems to be unaware of. The therapist supports and guides the bulimic individual during the process of making a decision concerning taking up

treatment, as well as in coping with the aforementioned bulimic symptoms and destructive feelings (especially the feeling of guilt) which the person suffers from in everyday life. Application of the mirror technique allows the protagonist to observe his or her own behaviour as reflected by another person, and watch the enactment of him/herself from outside. The patient adopts the so called metaposition of an audience member, and his or her role on the stage is acted out by a double. Taking on the role of an observer helps the protagonist adopt a less emotional approach to stage enactment, fosters self-reflection, and provides the person with a cognitive and intellectual insight into the factors underlying his or her bulimic symptoms.

#### **4. Application of monodrama in individual psychotherapy aimed at investigating compensatory behaviours and bulimic symptoms**

When I manage to establish a successful therapeutic relationship with my bulimic patient, he or she gradually starts to reveal the negative, repeatedly accumulating life experiences, and uncomfortable disease symptoms the sufferer has to cope with. At this stage, the patient is frequently very reluctant to accept the fact that bulimia nervosa is a recurrent disease. A bulimic person often suffers from abnormally low self-esteem, which usually determines the individual's negative (auto-destructive) view of oneself and the surrounding world ("I am nobody, I am nothing").

When bulimics approach a therapist, seeking his or her help, they frequently talk about the feelings of pain, remorse, anxiety and shame, which are related to the compensatory behaviours that they engage in, such as binge eating or self-induced vomiting. I recall the words of my bulimic patients who tend to complain: "It is so hard for me; I didn't make it again; I went on a binge again; I'd rather disappear than live this kind of life", or they say: "I cried over myself; I could feel pain all over my body just after the binge; I stuffed myself like a pig; It won't work; I'm a looser; Each time I do it, I promise myself that it is going to be the last time, but it doesn't make sense." Other female patients often confess: "After the binge I feel like scrubbing everything out, wash and clean everything, I always wash myself after the binge to cover up all the tracks, to forget...; I have never felt such self-disgust before, I feel I am nothing when I do it, I puke, I stink and I don't know what is going to happen next". I realize that in the context of auto-destructive thoughts reported by my patients, and their denial of body image, I should make an attempt at integrating monodrama with such therapeutic approaches as a therapeutic dialogue and psychodynamic psychotherapy which focuses on conducting transference analysis and developing cognitive and emotional insight by means of verbal therapeutic interventions such as clarification, confrontation and interpretation. Monodrama is a psychodramatic technique in which there is only one participant – a protagonist, who is asked by a director to select a group of props (e.g. objects, scarves), which take on the role of an auxiliary ego. If I receive my patient's consent, I start investigating his or her bulimic symptoms (I place special emphasis on the cycle: binge eating-vomiting- the feeling of guilt), employing such monodrama techniques as role reversal, mirroring, doubling, or surplus reality. In the last of the aforementioned techniques, the director invites the protagonist to enact the unreal, "imaginary" scenes from his or her life, to act out what had never happened, but what the person would have liked to happen, to "undo" what was done, and to do what needs to be done. Thus, surplus reality helps transcend the boundaries of the "real world" of the protagonist; it is reenactment of a traumatic situation in which the protagonist can take corrective action [Tomalski,

Izydoreczek]. Below I present a short scenario of a monodrama applied in individual therapy for bulimia nervosa.

#### **4.1 Monodrama dynamics – clinical case description.**

A 23 year old patient, a single woman with no children, brought up in a two-parent family, an only child, who has been suffering from bulimia nervosa for several years. The first bulimic symptoms (such as binge eating and self-induced vomiting) appeared at the age of 17 as a consequence of desperate attempts at losing weight, and prior symptoms of anorexia nervosa. For the first time, the patient decided to undergo therapy when the number of binge eating episodes increased to more than a dozen a day. This led to physical as well as mental health deterioration (symptom worsening, stomach ache, collapse, fainting, or depression). Worsening of symptoms, accompanied by ambivalence about undertaking treatment, drove the woman's decision to approach a doctor and a psychotherapist. She did it because she was in fear for her life.

##### **The monodrama scenario – a preliminary phase: warm- up**

During the early phase of one of the sessions of psychodynamic psychotherapy (conducted on a weekly basis), when talking about what happened between the previous visit and the current session, the bulimic patient brought up the issue of shame and guilt, the feelings she had experienced two days before, when she had a binge of eating and vomiting. Sitting on a chair, the woman confessed that she felt as if she was "in the grasp of something", and complained that she felt stomach ache, and that she did not respect her own body. When I prompted her to explain what she had meant, the patient replied that she was in the grasp of emotions she had mentioned before, and added that she did not understand it. The woman openly admitted that it was hard for her to talk about what she had done and that she was ashamed of it. She added that she found it difficult to reveal her feelings and emotions which she was scared and ashamed of. When talking about disrespect for her body, the patient was sitting on a chair and clutching her stomach. I asked the woman to take notice of that fact and encouraged her to describe the feelings she was experiencing at that moment. I directed the patient's attention to that particular body part because it was the stomach that the woman touched and focused her attention on. Through direct physical contact with her stomach, the patient had a chance to feel it. I regarded this part of the therapy as a warm-up designed to prepare the patient for the further work aimed at investigating her bulimic symptoms (episodes of binge eating and self-induced vomiting). I continued the individual therapy session and received the patient's consent to apply the technique involving stage acting. Performing the role of a director, I encouraged the woman to describe the feelings she experienced when touching her stomach. She replied that she felt guilt, anger and shame. I suggested setting up a scene.

##### **Scene I: "The patient's feelings of guilt, anger and shame"**

As a director, I encouraged the patient to choose some colourful scarves to symbolize her feelings. The woman spread three scarves out on the stage: a red one - to represent shame, a black scarf symbolizing anger, and a grey one which was supposed to be the symbol of guilt. Asked about the title of the scene, the woman replied that she didn't know what it was. The patient was unable to name certain things, but the choice of symbolic colours which she had made, proved that the woman was trying to express something in a non-verbal way. Red might have symbolized intensity and ambivalence of the protagonist's



feelings. It could have represented the intensity of the feeling of shame as well as be a symbol of life (red is the colour of blood). Black might have stood for the patient's tendency towards depression, the person's sense of helplessness and aggression. Grey seemed to symbolize repressed feelings and a sense of helplessness and uncertainty.

When the patient set up the scene, I suggested that she should reverse roles with the feelings symbolized by the scarves. She refused to do so. At that moment, I realized it was too soon for the patient to confront the feelings, and the woman was not warmed up enough and needed more time. That is why I employed another technique – the mirroring. I introduced an object – a prop (a white scarf chosen by the patient-protagonist) which was supposed to take on the role of an auxiliary ego (the double), and be a component of the scene set up by the protagonist, who placed it in the middle of the stage (in the middle between shame and the feelings of anger and guilt). The protagonist had a chance to watch the scene from the perspective of the audience, which fostered her self-reflection and emotional responsiveness. The woman used the following words to comment on what she had seen: "This is my internal world, dominated by the feelings of guilt, anger and shame". Thus, the patient was able to name the unvoiced feelings which she had experienced.

Finally, I asked the woman to let the objects which she had chosen step out of the roles they were acting out. During the phases of sharing and identification feedback, the patient talked about the experienced feelings of guilt and shame which accompanied her bulimic symptoms ("now I feel ashamed of myself and of my symptoms, it is the feeling of shame that dominates my entire life"). In the final stage of the session I empowered the patient to reduce the feeling of guilt for her bulimic symptoms, and I supported her courageous decision to make an attempt to overcome her illness. I also encouraged the woman to acknowledge the feeling of guilt. I, as it were, gave my client "permission" to feel guilty, since the feeling had already occurred.

During the next few sessions of individual psychotherapy, the patient reported improvements in her mental condition (e.g. a decreased tendency towards depression, less intense feelings of guilt and shame following the cycles of binge eating and self-induced vomiting). However, the woman still suffered from bulimic episodes, occurring twice or three times a day.

At the beginning of one of the further sessions, clutching her stomach, the woman complained: "I've got enough of it, I did it again, I stuffed myself like a pig and I was throwing up. Now, I feel pain all over my body, and I have a terrible burning in my stomach". I asked her to focus on what she was feeling when touching her stomach (I also suggested that she should close her eyes in order to strengthen the body sensations). After a moment of silence, with closed eyes and her hand resting on the stomach, the patient confessed: "I can hear my stomach bubbling, I feel pain in it, and I wish I could tell my stomach that I feel awful doing this to it, but I just can't stop it". Afterwards, I asked my patient to open her eyes and participate in monodrama stage acting.

#### **4.2 Dynamics of the action stage of a monodrama focusing on the theme of a "stomach" (description of the process)**

The patient placed a brown scarf on the stage and "cast" it in the role of a stomach. Then, she stood opposite it, taking on the part of a protagonist. Holding the role of a director, I encouraged the participant to reverse roles with her stomach. Once the protagonist took on the part of her stomach, I asked the patient (her stomach): "Ms N. was throwing up



yesterday, do you know anything about it?”. Performing the role of the stomach, the patient-protagonist replied: “Yes, I know. That’s why I feel so much pain.” In the further stages of the session I was interviewing the protagonist in the role of her stomach. The main aim of the psychodrama interview in role reversal was to provide the patient with the opportunity to see the situation from the point of view of the other body part. The protagonist had a chance to explore the feelings and sensations which her own body part (a stomach) was forced to experience when she tormented it with binge eating and self-induced vomiting. Thus, the patient was able to experience ambivalent feelings: pain and suffering of her stomach, and a sense of relief following the episode of vomiting. Once the protagonist in the role of her stomach admitted that she had lost control over binge eating and vomiting (“I don’t know why I’m doing this, I am afraid of something”), I decided, holding the role of a director, to interview my patient in the role of her stomach:

DIRECTOR: “It is anxiety or vomiting that Ms N. suffers from. And what about you, stomach? What about your pain?”

PROTAGONIST-STOMACH: “Well, I will manage to put up with it, it will pass”.

DIRECTOR: “Are you helping her overcome anxiety?”

PROTAGONIST-STOMACH: “She feels relieved, so that’s how I help her”.

DIRECTOR: “Do you consider yourself to be her friend or enemy?”

PROTAGONIST-STOMACH: “Well, I want to make her feel relieved.”

DIRECTOR: “But do you think she feels relieved if she feels pain?”

PROTAGONIST-STOMACH: “At least she doesn’t feel tense or anxious, which is better than feeling pain. What is more, she maintains her weight. She is afraid of feeling anxious and being fat, which is worse than the feeling of pain.”

DIRECTOR: “Worse? Do you mean more dangerous than pain?”

PROTAGONIST-STOMACH: “Yes. She is also scared of what is going to happen to her.”

DIRECTOR: “What do you mean? Could you be more specific?”

PROTAGONIST-STOMACH: “You know, she is afraid of being fat, ugly and bad. Now, I’m empty and safe, and she is safe, too. She will not put on weight; she can eat whatever she wants and feel relieved”.

DIRECTOR: “Is it only relief that she can feel? You have mentioned also some other feelings ...”

PROTAGONIST-STOMACH: “Well...maybe she feels a bit guilty and she has some pain.”

DIRECTOR: “You are saying that you help her. How do you do it?”

PROTAGONIST-STOMACH: “She is not fat and can calm down and feel relaxed, that’s how I help her.”

DIRECTOR: “Do you think there is any other way to reduce the feeling of guilt and anxiety which she experiences?”

PROTAGONIST-STOMACH: “I don’t know. Throwing up is stronger, I can’t control it. She would have to get her feet on the ground.”

DIRECTOR: “What do you mean?”

PROTAGONIST-STOMACH: “She would have to feel safe and regain self-confidence.”

DIRECTOR: “How could she do it? What would you like to tell Ms N.?”

After a moment of silence:

PROTAGONIST-STOMACH: “You destroy me when you throw up, cut it off, think something up.”

In the next phase, I asked the protagonist to step out of the role of her stomach and become herself again, and listen to the message which her own stomach passed along to my patient (I gave voice to my patient's stomach, repeating what the protagonist had said in the role of her stomach). The protagonist listened carefully. She seemed nervous (emotionally moved), and finally said with a raised voice:

PROTAGONIST: "Damn throwing up, again! It is disgusting! I want to get rid of this habit, but I don't know how to do it, I can't control it!"

DIRECTOR: "Would you like to get to know what makes you vomit?"

After a while the patient replied:

PROTAGONIST: "It seems to be a good idea. Now I know that vomiting must denote something, but I don't what exactly. Yes, I do want to know the reason behind my throwing up, perhaps it has something to do with my unsettled affairs..."

DIRECTOR: "What affairs?"

PROTAGONIST: "I have to take a closer look at what happened four years ago, that is what gets me down, it was then that I started binge eating."

I reinforced the patient's readiness for further therapeutic work, and asked if we could complete the session. She agreed.

The final phase of monodrama -sharing

In the final phase of monodrama, I asked the patient to let the props which she had chosen, "step out" of their auxiliary ego roles. We completed the sharing phase (the stage during which the patient shared her thoughts and emotions that she had experienced during our therapeutic session) and discussed identification feedback which I gathered from the patient. The woman, having reflected upon the therapeutic work she had been involved in, declared her readiness to "encounter" her habit of vomiting and binge eating on the stage. We scheduled our next session, planning a monodrama whose main theme was supposed to be "the patient's encounter with her habit of vomiting", and we finished the session.

The author's comments on the dynamics of the psychotherapeutic process and the patient's monodrama.

During advanced stages of a therapeutic process, when the relationship between a therapist and a bulimic patient is established, the therapist's role is to focus on the patient's physical symptoms, the individual's internal conflicts and the introjected patterns of relationships with significant others, as well as on correcting developmental deficits. The psychodynamic psychotherapy which I conducted in the bulimic patient whose case I described above was aimed at bringing out the patient's internal conflicts; diagnosing and changing the pathological strategies the patient adopted in order to cope with her internal conflicts; and at interpreting the phenomenon of transference. The monodrama techniques, which utilize symbolic representation, were applied in the therapy for binge eating and self-induced vomiting, frequently followed by a sense of guilt, increasing tension and self-disgust. The method proved to be instrumental in identifying the patient's emotional conflicts and her "here and now" experiences, as well as in exploring the person's accumulated tensions and emotions (especially the negative ones), which she tended to "release" unconsciously, adopting the compulsive, unhealthy compensatory strategies. It proves that the therapy which involves stage acting "weakens" the protagonist's control and defence mechanisms. Monodrama, when applied in the advanced stages of the aforementioned individual

therapy, triggers the patient's "emotional catharsis" and leads to the release of tension. This safe and controllable method of tension reduction contributed to diminishing the number of destructive symptoms of an illness. As a result, the person's constructive schemes of perception and cognitive functioning, based on senses, intuition and feelings were developed.

In the further stages of the therapy, the protagonist agreed to experience an encounter with her compulsive habit of vomiting. The purpose of this element of therapy was to encourage the patient to find some alternative ways of coping with her bulimic symptoms. The therapeutic interventions which I undertook at that stage of treatment process were aimed at finding an alternative to the habit of self-induced vomiting which the patient regarded as a way of coping with her destructive feelings. My intention was to evoke in the bulimia sufferer the feeling of emotional ambivalence toward her symptoms. Setting up a scene on the psychodramatic stage shortly after a period of binge eating and self-induced vomiting (which was the case of my patient), allows a thorough, step-by-step analysis of the bulimic episode, facilitates identifying specific alarm signals which proceed the episode, and provides the protagonist with an opportunity to try out alternative strategies which the person might use in the future to cope with binge eating and self-induced vomiting. Encouraged by the therapist to reverse roles with the particular aspects of the situation proceeding a bulimic episode (ambivalent feelings which occur prior to the episode, situational stress, or interpersonal conflicts) as well as with her self-feelings and bulimic symptoms (binge eating or vomiting), my patient had a chance to unearth some unknown aspects of her personality. The role reversal helped the protagonist realize how destructive it was to try to control her body by engaging in bulimic compensatory behaviours. The technique proved to be useful in stimulating the patient to assume proper control over her own drives, impulses, feelings and needs.

## **5. Characteristics of group therapy for bulimia patients – application of selected elements of psychodrama**

The first sessions of the psychodynamic psychotherapy conducted in a group which is heterogeneous in terms of gender and the character of mental disturbances (neurotic and personality disturbances), are usually aimed at establishing a patient-therapist contract (under which both parties are obliged to maintain confidentiality and participate in all sessions), as well as at building a patient-therapist alliance, which allows to set boundaries and strengthens the individual's sense of security. Patients with bulimia nervosa usually adopt a characteristic attitude to therapy. They seek guidance, assistance and structure, and wish a therapist could lift the burden of emotional discomfort (impulsiveness, the feeling of shame and guilt about their bulimic symptoms) from their shoulders as soon as they take up therapy. The issue which bulimic patients usually bring up during therapy sessions is a relationship with mother and a desire to have the so called "good mother". They tend to project this desire onto a group therapist [Lacey, Evans, Levens, Jay].

In advanced stages of psychodynamic group therapy aimed at developing the patients' insight into psychological mechanisms underlying the eating disorder they suffer from, individual bulimia sufferers tend to focus on their own problems and difficulties related to their compensatory bulimic symptoms. They concentrate less on the problems of other therapy group members, which is followed by the feeling of guilt they report in the further phase of the therapy. What characterizes a psychodrama group is the fact that as a result of

working on the stage in the role of a protagonist, its participants experience an increased feeling of guilt once they realize that they “have taken up other participants’ time, focusing other group members’ attention on their own problems”. Thus they repeat a pattern of a bulimic cycle: obsessive compulsive eating and vomiting followed by a sense of guilt [Jay]. However, in the early stages of group therapy, the similar diagnostic background (the problems and difficulties related to eating disorders) of its participants allows to create a sense of group identification and build mutual trust among group members. A common feeling among group therapy members, especially when a group is just starting, is that of being isolated, unique, and apart from others. Enormous relief accompanies the recognition that they are not alone, which is a special benefit of group therapy. The phenomenon of sharing experiences among group members, which Yalom refers to as “universality”, is a major therapeutic factor which helps group therapy participants overcome their sense of isolation.

It is a common case that people suffering from bulimia nervosa spend their energy on satisfying others. The therapy group, watching the protagonist acting out the roles he or she chooses (e.g. the role of “a loving sister”, “a loyal friend”, or “a diligent student”), provides supportive witnessing and helps the individual get in touch with the denied, “needy” aspects of him/herself, as well as acknowledge those aspects of his or her personality which the person regards as satisfactory. Thus, a patient has a chance to build a more complete self-image, which is, as it were, contrary to the “bad/poor” bulimic self-representation [Jay]. Group members need the therapist’s assistance when the therapy proceeds from the preliminary stage of identification into the phase of establishing the relationships which are not related to the sphere of eating. There are certain structured exercises that the therapist might employ as an effective tool to facilitate the aforementioned process. An example might be an exercise in which the therapy participants’ task is to follow the therapist’s instruction: “Put eating aside for a while and think about two feelings which you often experience. Take on the roles of these feelings and introduce yourselves to your partners.” This exercise helps to increase group identification [Levens]. Spontaneous behaviour is regarded by bulimic patients as irresponsible and reckless, and is usually followed by a sense of guilt. Hence it is necessary for the therapist to prepare clients for such spontaneous reactions by means of exercises aimed at increasing the participants’ self-esteem and building up mutual trust within the group [Lacey, Evans, Jay]. The more structured the exercises are, the more relaxed the group becomes. As the therapy proceeds, the level of tolerance increases and it makes it possible for the therapist to gradually abandon the structured exercises. Prior to feeling accepted by other group members, the therapy participant feels he or she must take on the role of a protagonist and act out the particular bulimic aspects of his or her life, very often using symbols (e.g. a fridge, favourite food consumed during the episode of binge eating). Role reversal proves to be an effective technique aimed at facilitating the patient’s understanding of the symbolic context, which in turn allows the person to explore his or her problems concerning the issue of relationships. A bulimia sufferer has a chance to encounter his or her despair, inner emptiness, denied needs and repressed anger. The patient finds it difficult to acknowledge the fact that he or she “is given to” by others, which is followed by a sense of guilt. “Being given to”, as opposed to “giving”, is what bulimics feel uncomfortable about. According to Yalom, altruism is an important healing factor in group therapy [Yalom]. It fosters unconditional satisfaction of needs, which in turn, in case of therapy for bulimia nervosa, facilitates therapeutic investigation, e.g. it leads to discovering the roots of guilt which follows the act



of “getting” something from others. Psychodramatic techniques can considerably improve the process of investigating bulimic symptoms.

## 6. Summary

Since psychodrama is a method which utilizes a universal concept of time (the past, the present and the future), place and a scene, as well as the so called surplus reality, it can support psychodynamic psychotherapy applied in the treatment of bulimia nervosa. Psychodrama is a therapeutic method which takes into account a variety of aspects which include social relationships, personality features, internal conflicts, attitudes and beliefs. Thus, the technique provides an opportunity to intensify and accelerate the process of developing emotional and cognitive insight into the mechanisms underlying an eating disorder. Through role playing and spontaneous behaviour, psychodrama triggers constructive feedback from a patient who discovers effective problem solving strategies to replace old destructive ones, and thus finds an alternative to his or her disease symptoms. Spontaneity and creativity in the here and now, which are focused on in psychodrama sessions, allow the participant to explore his or her internal conflicts which the person tends to “transfer” onto his or her body. This proves that psychodrama is an effective therapeutic method, which can be combined with the fundamental principles of psychodynamic psychotherapy, based on the patient-therapist relationship. It can be concluded that the core idea which underpins both of the aforementioned therapeutic approaches is the patient-therapist encounter aimed at accomplishing the objective specified in the therapy contract.

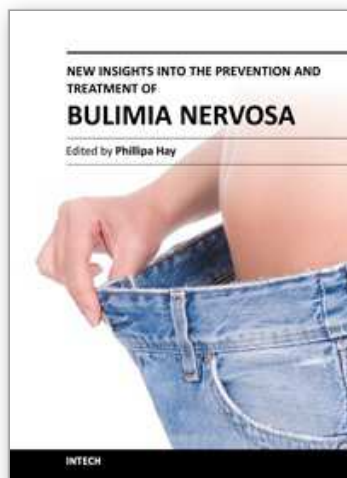
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## **New Insights into the Prevention and Treatment of Bulimia Nervosa**

Edited by Prof. Phillipa Hay

ISBN 978-953-307-767-3

Hard cover, 190 pages

**Publisher** InTech

**Published online** 03, October, 2011

**Published in print edition** October, 2011

Bulimia nervosa and eating disorders are common cause of distress and health related burden for young women and men. Despite major advances over the past three decades many patients come late to treatment and find that the therapy is incompletely addressed to the complex psychopathology and co-morbidities of the illness. The present book brings timely and contemporary understandings of bulimia nervosa to aid in current thinking regarding prevention and treatment. It will be read by therapists interested in enhancing their current approaches and those interested in earlier and more effective prevention and closing the gap between illness onset and accessing treatment. They will find practical guidance but also new ideas and ways of thinking about bulimia nervosa and the illness experience in this book.

### **How to reference**

In order to correctly reference this scholarly work, feel free to copy and paste the following:

Bernadetta Izydorczyk (2011). Application of Psychodrama and Object Relations Psychotherapy – An Integrated Approach to the Treatment of Bulimia Nervosa Based on Selected Elements of the Theory and the Author's Own Experience, New Insights into the Prevention and Treatment of Bulimia Nervosa, Prof. Phillipa Hay (Ed.), ISBN: 978-953-307-767-3, InTech, Available from: <http://www.intechopen.com/books/new-insights-into-the-prevention-and-treatment-of-bulimia-nervosa/application-of-psychodrama-and-object-relations-psychotherapy-an-integrated-approach-to-the-treatmen>

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