Eating Disorders and the Narcissist

By Sam Vaknin

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Patients suffering from eating disorders binge on food and sometimes are both anorectic and bulimic. This is an impulsive behaviour as defined by the DSM (particularly in the case of BPD and to a lesser extent of Cluster B disorders in general). Some patients develop these disorders as a way to self-mutilate. It is a convergence of two pathological behaviours: self-mutilation and an impulsive (rather, compulsive or ritualistic) behaviour.

The key to improving the mental state of patients with dual diagnosis (a personality disorder plus an eating disorder) lies in concentrating upon their eating and sleeping disorders.

By controlling their eating disorders, patients assert control over their lives. This is bound to reduce their depression (even eliminate it altogether as a constant feature of their mental life). This is likely to ameliorate other facets of their personality disorders. Here is the chain: controlling one's eating disorders controlling one's life enhanced sense of self-worth, self-confidence, self-esteem a challenge, an interest, an enemy to subjugate a feeling of strength socialising feeling better.

When a patient has a personality disorder and an eating disorder, the therapist should concentrate on the eating disorder. Personality disorders are intricate and intractable. They are rarely curable (though certain aspects, like OCD, or depression can be ameliorated with medication). Their treatment calls for the enormous, persistent and continuous investment of resources of every kind by everyone involved. From the patient's point of view, the treatment of her personality disorder is not an efficient allocation of scarce mental resources. Also personality disorders are not the real threat. If a patient with a personality disorder is cured of it but her eating disorders are aggravated, she might die (though mentally healthy)…

An eating disorder is both a signal of distress ("I wish to die, I feel so bad, somebody help me") and a message: "I think I lost control. I am very afraid of losing control. I will control my food intake and discharge. This way I control at least ONE aspect of my life."

This is where we can and should begin to help the patient. Help him to regain control. The family or other supporting figures must think what they can do to make the patient feel that he is in control, that he manages things his own way, that he is contributing, has his own schedules, his own agenda, matter.

Eating disorders indicate the strong combined activity of an underlying sense of lack of personal autonomy and an underlying sense of lack of self-control. The patient feels inordinately, paralysingly helpless and ineffective. His eating disorders are an effort to exert and reassert mastery over his own life. At this stage, he is unable to differentiate his own feelings and needs from those of others. His cognitive and perceptual distortions (for instance, regarding body image – somatoform disorders) only increase his feeling of personal ineffectiveness and his need to exercise even more self-control (on his diet, the only thing left).

The patient does not trust himself in the slightest. He is his worst enemy, a mortal enemy, and he knows it. Therefore, any efforts to collaborate with HIM against his disorder – are perceived as collaboration with his worst enemy against his only mode of controlling his life to some extent.

The patient views the world in terms of black and white, of absolutes. So, he cannot let go even to a very small degree. He is HORRIFIED – constantly. This is why he finds it impossible to form relationships: he mistrusts (himself and by extension others), he does not want to become an adult, he does not enjoy sex or love (which both entail a modicum of loss of control). All this leads to a chronic absence of self-esteem. These patients like their disorder. Their eating disorder is their only achievement. Otherwise they are ashamed of themselves and disgusted by their shortcomings (expressed through shame and disgust directed at their bodies).

There is a chance to cure the patient of his eating disorders (though the dual diagnosis of eating disorder and personality disorder has a poor prognosis). This – and ONLY this – must be done at the first stage. The patient's family should consider therapy AND support groups (Overeaters Anonymous). Recovery prognosis is good after 2 years of treatment and support. The family must be heavily involved in the therapeutic process. Family dynamics usually contribute to the development of such disorders.

Medication, cognitive or behavioural therapy, psychodynamic therapy and family therapy ought to do it.

The change in the patient IF the treatment of his eating disorders is successful is VERY MARKED. His major depression disappears together with his sleeping disorders. He becomes socially active again and gets a life. His personality disorder might make it difficult for him – but, in isolation, without the exacerbating circumstances of his other disorders, he finds it much easier to cope with.

Patients with eating disorders may be in mortal danger. Their behaviour is ruining their bodies relentlessly and inexorably. They might attempt suicide. They might do drugs. It is only a question of time. Our goal is to buy them time. The older they get, the more experienced they become, the more their body chemistry changes with age – the better their prognosis.

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Grandiosity Bubbles by Sam Vaknin

As one Source of Narcissistic Supply dwindles, the narcissist finds himself trapped in a frantic (though, at times, unconscious) effort to secure alternatives. As one Pathological Narcissistic Space (the narcissist's stomping grounds) is rendered "uninhabitable" (too many people "see through" the narcissist's manipulation and machinations) – the narcissist wanders off to find another.

These hysterical endeavors sometimes lead to boom-bust cycles which involve, in the first stage, the formation of a Grandiosity Bubble.

A Grandiosity Bubble is an imagined, self-aggrandizing, narrative involving the narcissist and elements from his real life – people around him, places he frequents, or conversations he is having. The narcissist weaves a story incorporating these facts, inflating them in the process and endowing them with bogus internal meaning and consistency. In other words: he confabulates – but, this time, his confabulation is loosely based on reality.

In the process, the narcissist re-invents himself and his life to fit the new-fangled tale. He re-casts himself in newly adopted roles. He suddenly fancies himself an actor, a guru, a political activist, an entrepreneur, or an irresistible hunk. He modifies his behavior to conform to these new functions. He gradually morphs into the fabricated character and "becomes" the fictitious protagonist he has created.

All the mechanisms of pathological narcissism are at work during the bubble phase. The narcissist idealizes the situation, the other "actors", and the environment. He tries to control and manipulate his milieu into buttressing his false notions and perceptions. Faced with an inevitable Grandiosity Gap, he becomes disillusioned and bitter and devalues and discards the people, places, and circumstances involved in the bubble.

Still, Grandiosity Bubbles are not part of the normal narcissistic mini-cycle (see the resources in the section titled "Also Read" below). They are rare events, much like trying on a new outfit for size and comfort. They fizzle out rapidly and the narcissist reverts to his regular pattern: idealizing new Sources of Supply, devaluing and discarding them, pursuing the next victims to be drained.

Actually, the deflation of a grandiosity bubble is met with relief by the narcissist. It does not involve a narcissistic injury. The narcissist views the bubble as merely an experiment at being someone else for a while. It is a safety valve, allowing the narcissist to effectively cope with negative emotions and frustration. Thus cleansed, the narcissist can go back to doing what he does best – projecting a False Self and garnering attention from others.

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