

INPATIENT COGNITIVE-BEHAVIORAL TREATMENT OF EATING DISORDER PATIENTS WITH DISSOCIATIVE DISORDERS

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ABSTRACT

Although several investigations have noted an association between eating disorders and dissociative disorders, little work has addressed the treatment of patients with both conditions. As an inpatient service focused on severely-ill eating disorder patients, it became necessary to diagnose and treat concomitant dissociative disorders. We describe a cognitive-behavioral inpatient program developed and specifically adapted to treat eating disorder patients with dissociative disorders. Patients were identified by self-report measures (the Eating Disorder Inventory and the Dissociative Experiences Scale) and clinical interviews. Specific eating symptoms linked to post-traumatic stress or conversion disorders were approached with stimulus control and hierarchical desensitization. Individual and group cognitive therapy as well as diary techniques addressed irrational beliefs common to both disorders. Skill enhancement through relaxation training, anxiety management, and anger management, initially tailored for the eating disorder patient, required adaptation for dissociative pathology. Addressing both disorders reduced eating pathology whereas inattention to dissociative symptoms led to continued disturbed eating and purging. Identification and treatment of dissociative pathology may improve treatment outcome in the treatment-resistant eating disorder patient.

INTRODUCTION

Several recent reports have focused on the association between eating disorders and sexual abuse (Hall, Tice, Beresford, Wooley, & Hall, 1989; Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990) and, more specifically, between dissociative disorders (DDs) and eating disorders (EDs) (Torem, 1990; Demitrack, Putnam, Brewerton, Brandt, & Gold, 1990; Goodwin, Cheeves, & Connell, 1992). McCallum, Lock, Kulla, Rorty, and Wetzel (1992) found a 29% incidence of dissociative disorders in a sample of 38 women with eating disorders. Further, McCallum et al. (1992), reported a temporal relationship between dissociative phenomena and eating behaviors, an association described ear-

lier by Torem (1986).

Despite these findings, little has been written addressing treatment techniques for these "dually diagnosed" patients. Typical treatment for eating disorders has focused on a cognitive-behavioral therapy (CBT) model (Fairburn, et al., 1991). Although CBT approaches to dissociative patients (DDs) are well-known, (Andreason & Seidel, 1991; Caddy, 1985; Ross, 1989; Fine 1991a) it is unclear if these techniques are applicable when the patient suffers both disorders. Torem has described an ego-state therapy (1987; 1989a) which combines hypnoanalytic and behavioral techniques to reduce disordered eating. Although not specifically focused on the CBT model, Torem's treatment paradigm includes several of the basic features of cognitive-behavioral treatment in its overall scheme.

As an inpatient service initially focused on severely-ill EDs, our treatment program was forced to respond to the dissociative pathology uncovered in this patient population. In this paper we describe an inpatient CBT program developed to treat the "dually diagnosed" patient with an eating disorder and dissociative pathology.

In their descriptions of CBT techniques with dissociative and multiple personality disorder (MPD) patients, Ross (1989) and later Fine (1991a) highlighted the uncovering and correction of cognitive distortions. These cognitive restructuring strategies typically focused on issues such as responsibility for past abuse but neither author has described the use of specific techniques such as logging or rehearsal.

Caddy (1985) provided a case report of CBT with an MPD including goal-setting, desensitization, self-management, and relaxation exercises. Caddy appears to have employed unmodified CBT techniques developed for anxiety disorders because panic and phobic symptoms dominated in this patient and dissociative episodes did not disrupt the treatment. It is unclear if these techniques would be manageable in a more severely dissociative patient. A brief report by Andreason and Seidel (1991) described the use of CBT, goal-setting, and behavioral limits in three patients with MPD, but was not specific about techniques that were employed.

In addition to the small CBT literature for patients diagnosed with dissociative disorders, a much larger literature has described CBT techniques in post-traumatic stress disorder (PTSD), e.g., rape victims, war veterans, or disaster victims (see Saigh, 1992), and borderline personality disorder patients who were abused as children (Linehan, 1993). Although PTSD is designated an anxiety disorder in *DSM-III-R*, several authors suggest it represents a form of dissociative pathology (Braun, 1984). Conversely, dissociative dis-

orders such as MPD have been conceptualized as PTSD (Spiegel, 1984), and PTSD symptoms are usually prominent in the MPD patient (Lowenstein, 1991). Borderline personality pathology has also been recast as PTSD (Herman, 1992). CBT techniques utilized for PTSD patients such as relaxation, desensitization, and assertiveness training should be applicable to the complex dissociative patient. Our experience suggests that these techniques can be effective but require modification for the complex dissociative patient with an eating disorder.

Commonalities in cognitive and behavioral features of eating disorder and dissociative disorder patients also predict applicability of similar techniques. Both groups experience affective dysregulation including anger, depression, and anxiety, as well as the impulsive behaviors which follow, e.g., self-mutilation, substance abuse, and binge/purge cycles. McCallum et al., (1992) noted that self-mutilation was temporally related to dissociative experiences in their sample of 38 eating-disordered women. Affective dysregulation precipitating emotional flooding in both groups requires an overall focus on pacing, as described by Fine (1992b) in work with MPDs. Cognitive distortions of over-responsibility, perfectionism, and catastrophizing are well described in EDs (See Garner & Garfinkel, 1985) and DDs (Fine, 1991a). Skill deficits in time management, self-regulation, and interpersonal functioning frequently prevent proper role functioning in these two groups and exacerbate eating and dissociative pathology.

Recognition of these common themes in cognitive and behavioral function enables both the patient and treatment team to focus on specific goals for inpatient treatment and to develop long-range targets for outpatient care. At the same time, response patterns and cognitive distortions differ in several ways between uncomplicated EDs and "dually diagnosed" eating disorder patients. Failure to identify these differences may seriously undermine the treatment of the ED patient with dissociation.

THE INPATIENT SETTING

The Behavioral Disorder Unit (BDU) is a 25-bed locked inpatient unit treating adults ages 18-65 in a 100-bed private, for-profit psychiatric hospital. Patients are approximately 4:1 female, 80% with a history of child abuse, 60% with dissociative disorder (10% MPD, 20% dissociative disorder NOS, 30% post-traumatic stress disorder), 60% with substance abuse (40% active, 20% in recovery for at least 3 months), and 50% with eating disorders. Approximately 50% of EDs meet current criteria for bulimia nervosa, 10% anorexia nervosa, and 40% eating disorder NOS with most fulfilling the proposed binge eating disorder criteria (Spitzer et al., 1993). Approximately 50% of EDs are concomitantly diagnosed with a dissociative disorder. Taken together, 75% of patients admitted to the unit meet criteria for major depressive disorder, with approximately half of those with co-existing depression presenting suicidal ideation or behavior as well as self-mutilation.

All patients receive a comprehensive psychiatric evalu-

ation by an attending psychiatrist who develops diagnoses in collaboration with other team members. In addition, each patient receives a medical evaluation, the Eating Disorders Inventory (Garner, Olmsted, & Polivy, 1983), the Dissociative Experiences Scale (Bernstein & Putnam, 1986), and when appropriate, hypnotic evaluation of dissociative symptoms. CBT modalities are administered in group and individualized formats. Specific groups include problem solving strategies with daily behavioral goal-setting, relaxation training, hierarchical desensitization, cognitive restructuring, impulse control strategies, and skill development for assertiveness and anger-management. In addition to CBT, treatment modalities include pharmacotherapy, psychosocial evaluation and brief intervention, individual psychotherapy 3-4/wk, conventional group therapy, hypnotherapy, and Twelve Step Alcoholics Anonymous, Narcotic Anonymous, and/or Overeaters Anonymous as appropriate and as tolerated. During the period 1990 - 1993, the average length of stay on the BDU was 23 days, but the "dually diagnosed" EDs tended to stay 28-42 days.

GOAL SETTING AND THE BECK LOG

The techniques of goal-setting in a CBT milieu as described by Levensky and Berglas (1985) form the organizing framework of the BDU program. Patients distill presenting symptoms into a Problem/Goal/Method framework during the first three to five days of hospitalization in daily group therapy and individual sessions with their therapists and primary nurses. Problems and goals are stated behaviorally; methods entail short-term techniques to be utilized during inpatient treatment and long-term strategies for aftercare. Examples of goals for bulimic and dissociative symptoms are included in Appendix 1.

The goal-setting technique provides a specific document for the patient and therapist to utilize and amend throughout the therapy. This represents a concretization of the problem identification and patient education described in Torem (1989b) and Fine (1991a) that are the foundation for all CBT work (Beck, Rush, Shaw, & Emery, 1979). By serving as a roadmap for the treatment, the Problem/Goal/Method document permits successive approaches to the target behaviors, a process of behavioral "shaping" regarded by Linehan (1993) as critical for the patient with poor self-regulation and impulsivity. The shaping approach blends well with Fine's (1991a) overall emphasis on "pacing" in the treatment of the dissociative patient.

Most EDs with DDs are familiar with the behavioral manifestations of their ED but only partially aware of dissociative symptoms. Behavioral descriptions of dissociative symptoms such as flashbacks or amnesias de-mystify these experiences and lay the foundation for treatment. Patients are taught Beck's logging format (Beck et al., 1979) to track Situation/Thought/Feeling/Behavior for key symptoms. We have found the log to be useful in specifically elucidating experiences identified in an ongoing diary (Torem, 1989a).

RELAXATION TECHNIQUES

All patients on the BDU learn relaxation techniques to enhance mastery over disturbing physiological arousal generated by anxiety provoking thoughts. These techniques are then available for use in anxiety reduction, impulse control, and anger management. Instruction in progressive muscle relaxation and calm scene visualization initially occurs in group with individualized reinforcement by nursing staff and relaxation tapes. Selected patients are referred for individual biofeedback training.

In our experience, relaxation techniques are helpful for eating disorder patients but appear to be problematic for those with dissociative pathology. Closed-eye visualization exercises often precipitate intrusive recollections, flashbacks, and frank dissociative episodes in patients with complex dissociative disorders. Instructions to "relax" can trigger memories of similar injunctions from abusers. Beach scenes may precipitate fears of sexualized exposure or previous trauma occurring during summer months.

As a result, group participation is carefully monitored and modified. Eligibility for relaxation group is assessed during the opening diagnostic evaluation, with severely dissociative patients being excluded altogether. For those who participate in group, modified instruction sets permit maintenance of visual contact and construction of personalized scenes. Biofeedback with individual supervision is also more acceptable to these patients because it utilizes open-eye techniques.

Patients may enhance relaxation scenes by producing drawings or paintings of their "safe place" in art therapy which can be used to practice relaxation individually. As noted by Torem (1989b), self-hypnotic relaxation exercises are another method of providing mastery over arousal. BDU therapists develop a personalized self-hypnotic exercise to replace progressive muscle relaxation. Audiotaping the exercise, like the drawing of the safe place, gives the patient easy access to the experience. Patients are encouraged to practice relaxation three to five times per day and review progress regularly with the therapist and nursing staff. The dissociative patient often requires several weeks to develop a comfortable exercise and employ it on a regular basis.

MANAGEMENT OF DISSOCIATIVE EPISODES

In addition to dissociation precipitated by relaxation techniques, apparent "spontaneous" dissociation is common in this patient population and usually disrupts the patient's function. The treatment milieu promotes the formulation that dissociation is a defensive maneuver triggered by an internal or external signal of danger, and not "spontaneous" or mysterious. Dissociation is further reframed as a coping skill which was appropriate during abuse when escape was impossible but is currently no longer adaptive. Patients respond to these formulations with a sense of relief and increased alliance with the treatment team. Management of dissociative experiences thus becomes a clearly articulated goal in the treatment plan.

Once this framework is established, patients are encouraged to record dissociative experiences in diaries and apply the Beck log format to details of each experience. The therapist may employ hypnotic reconstruction to clarify events preceding dissociative episodes. Patients then learn grounding techniques to employ with early signs of dissociation such as visual field constriction, fogging, or difficulty attending to a current stimulus. Grounding techniques include maintenance of visual attention, heightening of body kinesthetic input (See Torem, 1989b), and focus on mental or written puzzles. When successful, these strategies significantly enhance the patient's sense of mastery and promote greater participation in treatment.

HIERARCHICAL DESENSITIZATION FOR FEARED FOODS

As part of our usual treatment for EDs, patients identify feared foods and relate these to cognitive distortions about their bodies and nutrition, e.g., bread is highly fattening and to be avoided. Patients must eat a prescribed diet after three days of orientation and thereby are exposed to feared foods. Failure to maintain adequate intake and completion of meals leads to progressive sanctions involving withdrawal from the community, e.g., restriction to room during free socialization time. These restrictions, not imposed during the first few days of hospitalization, prove more powerful once patients have formed bonds with peers. Most EDs are able to overcome irrational avoidance of foods (e.g., bread or pasta) with milieu support, repeated exposure, education in nutrition, and the corrective experience of weight stability.

Eating disordered patients with abuse histories often avoid specific foods for reasons unrelated to weight concerns. Exploration in psychotherapy, often assisted by hypnoanalytic techniques (Torem, 1987) in individual therapy, reveals these foods trigger abuse memories and related responses. For instance, one patient's aversion to vegetables (an unusual food for EDs to avoid) was the result of classical conditioning. During her childhood, conflicts with her parents over proper food consumption often escalated into violence against her. Similarly, classical conditioning with generalization is responsible for the aversion to certain white foods (association: semen). Patients come to recognize this first by cataloguing their aversions through the development of a "dislike" list. The dietician and therapist then formulate a plan to explore the dislikes with the patient. One approach is to have patients prepare a feared or disliked food as part of a group activity, sharing feelings with peers and staff. Following the meal patients participate in a "mood monitoring" group which serves as a debriefing. These groups are a regular part of the daily routine and receive particular emphasis after the weekly meal preparation group.

Similarly, purging often requires reconceptualization for the dissociative survivor of abuse. Whereas for the ED patient purging is an anxiety-reduction strategy in response to fears of weight gain, in the DD patient purging may represent a re-experiencing of sensations associated with the abuse. Many

survivors report nausea during or following forced oral sex. Vomiting then produced a reduction in the uncomfortable arousal (revulsion, fear, gag reflex) and nausea associated with the abuse. This response is triggered anew whenever memories of abuse produce similar arousal cues. Patients who purge in this manner often deny specific concerns about weight, instead describing purging as cleansing or relief from discomfort. Once equipped with the behavioral formulation that forced oral sex produced nausea and revulsion and that memories of abuse revive these feelings, the patient is extricated from the sexual implications and connotations of the abuse. The result is a decrease in shame and powerlessness. If the specific feelings of nausea or revulsion exist in a separate ego-state or alter then the reframing is accomplished during individual sessions with that alter.

Following this behavioral reframing, the patient develops a hierarchy of the foods with the therapist and dietician. Exposure to these foods is first done through imagination, with relaxation and hypnosis techniques to counter the anxiety response. Exposure *in vivo* begins with very small amounts of the feared food followed by post-exposure debriefing and recording of the experience in an appropriate log or diary. Subsequent exposure proceeds stepwise up the hierarchy as tolerated, usually taking 10-14 days to desensitize the patient to three to five foods. This behavioral progression provides a specific scheme to implement the process of "ratification" described in Torem's ego-state hypnotherapy (1989a). In our experience an ego-state or alter will cooperate with a stepwise approach because it permits gradual exposure to experiences, thoughts, and feelings which may trigger memories.

COGNITIVE RESTRUCTURING

Like other CBT programs for EDs (e.g., Garner & Garfinkel, 1985), the Behavioral Disorders Unit focuses on cognitive distortions about food, body image, perfectionism and over-responsibility. Distorted cognitions of food (e.g., starches cause weight gain) are addressed in nutrition education groups and exposure to these foods. Movement groups enhance the patient's ability to experience feelings expressed in body postures and to challenge typical body image cognitions. As noted earlier, enhancement of kinesthetic awareness through movement strengthens grounding skills for patients who dissociate.

In addition, for the ED with a history of abuse, interpersonal interaction with former or current abusers often triggers self-deprecation and feelings of over-responsibility which, in turn, trigger binge/purge behavior to soothe accompanying dysphoria. The patient is often unaware of the basis for the cognitive distortions which initiate the disordered eating pattern. Once ED patients are identified as victims of abuse on the BDU, they enroll in a psychoeducational group focused on the cognitive sequela of trauma, e.g., over-responsibility, perfectionism, and catastrophizing (Fine 1991a). Patients then employ the Beck log to analyze behaviors on the unit that may involve these thought patterns.

After identifying these patterns on the unit, the patient

learns to recognize these cognitive distortions in family interactions. In fact, EDs in general, and those with concomitant histories of abuse, often repeatedly choose to interact with family despite resultant feelings of worthlessness, anger, and guilt which then initiate disordered eating. To interrupt this behavioral cycle, we first ask the patient to suspend contact with family for a several-day period to uncover the thoughts and feelings involved in this behavior. The patient usually requires significant staff support to achieve only a two- to three-day hiatus in contact. The social worker may also intervene with the family (if the patient permits) to explain the temporary decrease in contact, although the rationale given is minimal, such as "this is routine procedure." Each time the patient has an urge to talk with a family member, she records the situation using the Beck format and utilizes this material for individual and group psychotherapy. Typical sequences might be as follows: (1) Situation — hearing another patient talk about her family; (2) Thought — I must keep in touch with my family or they will be angry at me; (3) Feeling — guilt and urges to gorge on desserts; (4) Behavior — binge and/or purge (hopefully blocked by decreased availability of food and monitoring of bathrooms in the milieu). Other typical cognitions include a need to reaffirm the family's affection for her despite their abuse, fear of injuring the family by withdrawing her attention and thereby provoking further abuse, or an idealized perception that the family is in fact loving and supportive so that she is selfish and unjustified in any anger toward them. The strength of these cognitions and the resultant anxiety override negative experiences and prevent the patient from modifying the baseline interaction pattern with the family despite revulsion toward them. Prior to instituting this treatment strategy we found that abused EDs were unable to interrupt disordered eating due to ongoing cognitions and feelings precipitated by family contacts.

IMPULSE CONTROL

Current data suggest that patients with histories of abuse are at increased risk for self-destructive and suicidal behavior (van der Kolk, Perry, & Herman, 1991) compared to non-abused patients. Further, both dissociative symptoms (Demitrack et al., 1990), and dissociative disorders (McCallum et al., 1992) are significant predictors of self-destructive behavior in EDs. As in any milieu treating dissociative patients, control of self-destructive behavior on the BDU assumes top priority among treatment goals. Toward this end, the patient utilizes the diary and Beck log to identify cognitive distortions underlying self-destructive behavior, bringing this material to individual and group psychotherapy.

When self-destructive feelings dominate the patient's daily function, the patient utilizes more intensive self-monitoring techniques. Self-destructive urges are registered on a 0-10 Subjective Units of Distress Scale (SUDS) at frequent intervals (15', 30', or 60' as appropriate), with staff reviewing these ratings at least twice per shift. Patient failure to perform monitoring results in restriction of movement and socialization (e.g., full-time room restriction without socialization,

or open areas restriction with no group participation). Once the log is in place, a response plan is developed for the spectrum of urge intensities. Low SUDS scores are countered with relaxation exercises, whereas higher scores signal use of the unit "safe room," contact with staff, or medication. The "safe room" is a room with minimal, comfortable furnishings where patients can write, draw, or use relaxation techniques. Patients must alert staff when they enter and depart. The room is otherwise off-limits, making it always available for patients in crisis. When self-destructive urges are complicated by dissociation the patient employs grounding techniques in the response plan. Intensive self-monitoring can also be applied to high frequency urges to purge which may occur in the dissociative ED patient during a period of frequent and severe flashbacks.

SKILLS DEVELOPMENT

Patients with EDs are usually deficient in adult management skills and victims of abuse are doubly impaired. Both individual and group modalities in our setting focus on interpersonal response strategies with specific emphasis on identification of maladaptive passive and aggressive behaviors. Patients first utilize the Beck log to identify these patterns in interactions on the unit with other patients and staff. For example, patients often report difficulty asking nursing staff for assistance when they are feeling anxious or depressed. Patients will log the situation (e.g., a difficult group session), and resultant thoughts ("I will never get better"), feelings (sadness or fear), and behavioral response (withdrawal from staff or rejection of help). The patient will then discuss this sequence with the therapist or in Assertiveness Training Group to understand how the response to staff was passive or aggressive, rather than assertive (asking for help appropriately). Patients are concurrently taught to construct assertive statements using the phrases "I think/I feel/I want" and then rehearse these prior to applying them on the unit. For example, an assertive statement might be, "I have been thinking I will never get better. I feel sad. I want someone to listen to my fears and sadness."

A unit-derived understanding of these behavioral patterns is then expanded to comprehend typical interactions with family or friends. But before attempting new strategies with the family the abuse survivor must learn how previous efforts to get empathy and support were rebuffed. This is critical to avoid unrealistic expectations of family responses to assertive behaviors. The perfectionistic thinking common to both EDs and abuse survivors is especially counterproductive in setting assertiveness goals with past or current abusers, be they family, spouses, or employers. When the patient is rebuffed anew despite more assertive behavior, she will become frustrated and hopeless.

In order to make assertiveness training more effective and reinforcing, the abuse survivor must learn to identify receptive people before applying assertive skills. Rather than attempt new, assertive behavior with family, survivors may need to mourn the wish for caring and protection from family, and lower their expectations. Appropriate goals for assertive-

ness with family are often limited to boundary strengthening, such as controlling frequency of contact and content of conversations with abusive family members. Similarly, confrontation of the abuser is usually discouraged during the hospital stay and patients are educated that this may not be helpful in the future. This contrasts with the general goal of facilitating family expression of conflict in the treatment of uncomplicated eating disorders (Garner & Garfinkel, 1985).

Lastly, because virtually all survivors maintain distorted cognitions around responsibility and blame (Fine, 1991a), assertiveness training must occur in a therapeutic context which challenges these distortions. Otherwise, patients experience skills-training as an indictment of previous responses to abusive situations. Victims must learn that passivity during childhood abuse was an appropriate response and did not reflect complicity or responsibility. Similarly, current aggressive responses can be reframed as appropriate given distorted cognitive appraisal of threats from others. Reassessment of perceived danger can then form the basis for anger-management.

ANGER-MANAGEMENT

Anger-management involves the identification of trigger situations, the thoughts and feelings they precipitate, and resultant behaviors. Patients are taught typical sequences and common cognitive distortions in group and through instructional materials. When anger is a frequent problem the patient keeps an anger log to record details of the response and its intensity. The ED patient often selects an eating behavior in response to anger whereas the patient with a dissociative disorder may utilize withdrawal, frank dissociation or self-destructive behavior. In both EDs and DDs anger is often denied or minimized. Anticipation of anger generating situations and early identification of the somatic components of anger facilitate proper labeling of feelings and enable the patient to avert negative responses. Modeling of appropriate anger expression by peers and therapists is an integral part of the learning process.

Anger responses in patients who dissociate differ from those in the non-dissociative group in two important ways. First, the dissociative patient may develop anger on the basis of a traumatic or "flashback" transference in which a person or situation in the environment triggers a re-experiencing of trauma. Cognitive appraisal of perceived threat is not consonant with the situation and the patient is unaware of the link to traumatic material. Before staff understood the nature of these distortions, angry dissociative patients were often shunned as "narcissistic" or intractable. As with feared foods, the hypnotic "affect bridge technique" (Watkins, 1971; see also Horevitz, 1991) may assist in tracing the feelings of fear and anger back to their antecedents permitting elucidation and decompression of the response.

In addition to these specific triggers for anger, the dissociative patient may present with a "victim identity" in which all situations are interpreted as victimization experiences. Therapeutic interventions are rapidly undone by this stance, making early recognition essential to preserve treatment.

The referring therapist may have magnified the victim identity as part of a need to identify or rescue victims of abuse. The inability to form a treatment alliance seen in these patients is not typical of the purely eating disordered patient, who usually wishes to please others and perform compliantly. Therapist empathy coupled with matter-of-fact cognitive exploration have been successful in correcting the distortion of victimization and maintaining the treatment. Log work focused on specific anger incidents can proceed after these initial steps.

A typical anger-management sequence runs as follows: (1) Situation — patient asked to stop smoking during non-smoking hour; (2) Thought — “staff is singling me out,” and “no one ever recognizes my needs”; (3) Feeling — anger; (4) Behavior — verbally abuses staff followed by shame and urges to hurt self. These behaviors may occur in a dissociated state. Once a treatment alliance has been developed, the patient can attempt elucidation of the anger sequence. This may require staff support over a several-day period and hypnotic exploration in the dissociated patient. A preprinted writing assignment to assist in this process is given to the patient as soon after the incident as she appears receptive. During individual review of the assignment, and in Anger-Management group, the patient learns to identify the inappropriately personalized nature of her cognitions. The survivor is often able to identify the origin of these feelings and cognitions in the family of origin. Staff and therapist then validate for the patient that cognitions of being singled out or neglected were accurate appraisals in the past. Although the patient may not be able to relinquish these responses immediately, she often can learn to identify the physical symptoms of rising anger (vocal tension, shaking, and/or palpitations) and employ a delay strategy (focus on breathing, simple counting, or withdrawal from the situation) or a grounding strategy to then permit processing. Delay averts the damaging behavioral response and grounding blocks the dissociative response, enhancing the patient's sense of mastery over an internal state which has previously made her feel helpless.

CONCLUSIONS

Eating-disordered patients with dissociative disorders represent a special group of “dually diagnosed” patients who require specifically tailored treatments. A modified cognitive-behavior therapy model which adapts to the unique cognitive distortions and re-enactment behaviors seen in this population has been successful in our hands. Prior to instituting these techniques, patients frequently left the hospital prematurely and did not develop appropriate follow-up care. More rigorous investigation of this population must identify treatment elements most effective in reducing dysfunctional eating, poor impulse and affect regulation, and self-destructive behaviors, and in enhancing adaptive functions such as stabilization of interpersonal relationships.

With increasing demand for mental health professionals to provide effective, time-limited care, cognitive-behavioral treatments are receiving greater emphasis. Goals and

methods developed during brief inpatient stays can form the framework for outpatient care. The Problem/Goal/Method approach of Levensky and Berglas (1985) not only focuses patient and clinician but is well-suited for reporting progress to monitoring agencies. A collaborative treatment directed toward measurable, achievable goals provides patient and clinician with a sense of mastery, gradually replacing the passivity and powerlessness which cripple the dissociative patient.

APPENDIX 1

I. Sample Treatment Plan for Bulimic Symptoms

A. *Problem* — I binge and purge whenever I feel anxious and overwhelmed.

B. *Goal* — To identify specific triggers for binge/purge behavior and develop alternate coping strategies.

C. *Methods*

1. Keep Situation/Thought/Feeling log of urges to binge/purge to identify three most frequent triggers.
2. Discuss triggers in Eating Disorders Group and individually.
3. Learn relaxation technique in group and practice four times a day.
4. Apply relaxation at start of binge/purge urges on unit.
5. Practice relaxation on passes to home.

II. Sample Treatment Plan for Dissociation

A. *Problem*—I dissociate and lose touch with things around me when I am reminded of my brother's abuse.

B. *Goal* — To decrease episodes of dissociation.

C. *Methods*

1. Keep Situation/Thought/Feeling log of dissociative episodes (ask staff and peers to help me remember what happened) to identify three most frequent triggers.
2. Learn about early signs of dissociation in Survivors Groups and with therapist.
3. Learn self-hypnosis with physician and how to use it to control memories and flashbacks. Practice four times a day.

4. Learn grounding techniques in Survivors Group, from nursing staff, and with therapist. Practice four times a day.
5. Explore family interactions that trigger dissociation in Family Roles Group.
6. Develop safety strategies for family interactions.
7. Practice self-hypnosis, grounding techniques, and safety strategies on pass with family. ■

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