ANOREXIA NERVOSA

Hilde Bruch

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Anorexia Nervosa

"Anorexia nervosa" is a misleading name for the condition to which it is applied. The severe weight loss and emaciation in a typical case are not due to a true loss of appetite; on the contrary, these patients are frantically preoccupied with food and eating. Their refusal to eat stands in the service of a relentless pursuit of thinness which appears to be the driving motive. Actually, this preoccupation with the body and its size is a late step in an individual's struggle to establish a sense of control and identity. Concern with control and size are the key issues in the classical anorexia nervosa syndrome, to which I shall refer here as "genuine," or "primary anorexia nervosa."

There are other cases of psychological emaciation where the symbolic meaning of the eating function itself is interpreted in a distorted way, at times associated with a true loss of appetite. The weight loss of such patients may reach the same order of magnitude as in the genuine syndrome, but they are distinctly different in their behavior and psychological concerns. After the condition has existed for any length of time, they look deceptively like true anorexia nervosa, and the different clinical pictures have been continuously confused. Such patients exhibit an atypical picture of anorexia nervosa. It is important to make the distinction because the therapeutic needs differ, according to the underlying problems.

History of Concept

Anorexia nervosa became a modern clinical entity with the reports by Gull in England, and Lasegue in France, just 100 years ago, and the picture has remained alive in medical thinking. Occasional references to a condition of self-inflicted starvation have been discovered in the older literature. Richard Morton is commonly credited with the earliest medical report, in 1689, of what he called a "Nervous Consumption." His crisp description, "a skeleton only clad with skin," immediately evokes the most dramatic aspect of the condition. The medical literature of the eighteenth and nineteenth centuries contains occasional references to self-inflicted emaciation which have been mentioned in several recent monographs.

In spite of the rarity of anorexia nervosa and its short history, there exists an amazingly large literature. I shall refer only to a few authors who have contributed to the understanding of this enigmatic condition. Since its discovery a certain atmosphere of controversy attached itself to the discussion. Lasegue considered some hysterical disturbance in the digestive tract to be the starting symptom, and named the condition accordingly, anorexie hysterique. Gull attributed the want of appetite to "a morbid mental state—I believe, therefore, that its origin is central and not peripheral." He described as the outstanding symptom emaciation associated with amenorrhea, constipation, loss of appetite, slow pulse and respiration, and

absence of somatic pathology. He commented on the restless activity: “It is curious to note the persistent wish to be on the move, though the emaciation was so great.”

Considerable contradiction and confusion has been expressed in the literature during these past 100 years. Some of this may well be related to the tendency to explain all cases through the same mechanism, and the unwillingness to concede that the same surface picture, namely emaciation due to restricted food intake, may be a manifestation of different underlying factors. The whole issue became even more confused when Simmonds, a pathologist, reported destructive lesions in the pituitary gland of an emaciated woman who had died following pregnancy and delivery. Until then, the assumption that anorexia nervosa was caused by psychological factors had been unchallenged. Following Simmonds’ publication, in 1914, the whole approach changed and every case of malnutrition was explained as caused by some endocrine deficiency, resulting in increasing vagueness in what was considered to deserve the diagnosis, anorexia nervosa.

It was only during the 1930s that persistent efforts were made to distinguish a psychological anorexia nervosa syndrome from the so-called Simmonds disease. Once it had been reestablished that anorexia nervosa was a disease of psychological origin, publications with this orientation appeared in a steady stream, without diminishing the confusion. It was assumed that

patients with such a weight loss were “fundamentally alike clinically” and that they suffered from “concealed conflicts.” The ambition was to explain the whole complex picture through one specific psychodynamic formulation; this resulted in imposing stereotyped explanations on a condition that defies such a simplistic approach.

Some of the “key” publications, illustrating the evolution of the concept, were collected in a monograph by Kaufman and Heiman; though published in 1964, the most recent paper reviewed was originally published in 1943. I shall focus here mainly on publications of the 1960s and 1970s. Two main trends can be recognized: (1) the older approach of dealing with the chief symptom, i.e., the symbolic significance of the “oral” component; and (2) the approach concerned with the personality of the patient, disturbances in ego functions, and interpersonal relations.

Symptomatic Approach

Psychoanalytic studies with focus on the disturbed eating often included psychogenic vomiting and other forms of neurotic eating disturbances. Basically, they all rest on Freud’s assumption that impairment in the nutritional instinct was related to the organism’s failure to master the sexual excitation. This one-sided emphasis on the “oral” component, with neglect of other important aspects, has contributed to the confusion with which we are

confronted today. Classical psychoanalysis viewed the whole problem as symbolically expressing an internalized sexual conflict. The high point of this approach is a paper published in 1940, by Waller, Kaufman, and Deutsch, that "psychological factors have a certain specific constellation centering around the symbolization of pregnancy fantasies involving the gastrointestinal tract." The concept that anorexia nervosa was an expression of repudiation of sexuality, specifically of "oral impregnation" fantasies, has since dominated clinical thinking. Even today "oral impregnation" is the one psychodynamic issue most persistently looked for.

Modern psychoanalytic thinking has turned away from this merely symbolic, and often rather analogistic etiological approach, and focusses more on the nature of the parent-child relationship from its beginning. Nemiah considered the excessive dependency, unquestioning obedience, and wilted kind of passivity in anorexia nervosa to be the expected outcome of a mother's overprotective attitude. Meyer and Weinroth pointed to factors that served to precondition the eating experience in the future anorexic, and felt that the onset at the time of puberty had given rise to an erroneous evaluation of the oedipal conflicts in the genesis of anorexia nervosa, and that the problem needed to be connected with the effects of earlier preoedipal experiences.

With this increasing emphasis on early development, and on behavior

and attitudes not directly related to food, recent psychoanalytic studies are approaching the views that have been expressed by authors quoted in the next section since the early 1930s. There are, of course, still reports in the old orientation. Thomae's monograph, published in 1961, is written in the classical psychoanalytic tradition and gives the impression of belonging to a bygone era of medical and psychoanalytic thinking, claiming that "obviously it is a drive disturbance—and that oral ambivalence underlies the whole symptomatology."

Personality Problems

A few analysts recognized quite early that the focus on the eating function failed to deal with the underlying disturbances in the total personality. Meng compared the regression in anorexia nervosa to what is observed in psychosis. He focused on the deformation in the ego structure, that in neurosis the ego is essentially normal though the symptoms are an expression of inner conflicts. In psychosis, however, the ego is defective in its primary structure, even though external factors play also a role. Eissler referred to Meng's concept of "deformation of the ego" as applicable to his own observations on a patient who complained that "her mind was in the mind of other people." Eissler felt that this weak and stunted ego had evolved out of the past interactional patterns between mother and child, and that this attitude was different from the dependency on the mother so frequently

encountered in neurotics. Nicolle differentiated between true anorexia nervosa and noneating related to hysteria or other neurotic disorders. She drew attention to the potentially schizophrenic aspects of true anorexia nervosa, with shallowness of feelings and cooling off in emotional awareness, as has also been described in the early diagnosis of schizophrenia.

Probably the most detailed account of the inner experiences of an anorexic patient was given by Binswanger in his report "Der Fall Ellen West." This woman had great artistic abilities, wrote poetry, and kept a diary, before and after she became sick, and Binswanger reconstructed from this her psychological development. After graduation from high school she took up horseback riding and attained great skill, doing it in the same overintense way with which she approached every task. In her nineteenth year, she noticed the beginning of a *new anxiety,* namely the *fear of becoming fat.* She had developed an enormous appetite and grew so heavy that her friends would tease her. Immediately thereafter she began to castigate herself, denying herself sweets and other fattening foods, dropping supper altogether, and went on long exhausting walks. Though she looked miserable, she was only *worried about getting too fat* and continued her endless walks. Parallel to this fear of becoming fat, her desire for food increased. The persisting conflict between the dread of fatness and the craving for food overshadowed her whole life. After many years of illness she wrote: "It is this external tension between wanting to be thin and not to give up eating that is so exhausting. In

all other aspects I am reasonable, but I know on this point I am crazy. I am really ruining myself in this endless struggle against my nature. Fate wanted me to be heavy and strong, but I want to be thin and delicate."

Recent Contributions

There has been a definite change in the whole approach since about 1960, with convergence of opinion that a true anorexia nervosa syndrome needs to be differentiated from unspecific types. Reports in the past were usually based on a few patients only and authors would draw generalized conclusions from this limited experience. King reported in 1963 from Australia on twenty-one patients, twelve of whom exhibited great similarities, a specific syndrome of primary anorexia nervosa which needed to be differentiated from abstinence from food as a secondary symptom. In 1969 Dally reviewed the course of illness since 1940 of 140 female patients in whom the diagnosis of anorexia nervosa had been made at a teaching hospital in England. He reevaluated these patients and subdivided them into "obsessional" and "hysterical" groups, with seventy-four and thirty patients, respectively. The refusal to eat, because of fear of possible weight gain or loss of self-control, was the outstanding feature in the obsessional group. In addition, there was a group with mixed etiology, thirty-six patients representing a secondary form of the illness, with loss of appetite, complaint of abdominal fullness, decreased activity because of lack of energy. Ushakov

reporting on sixty-five patients from Moscow, considers anorexia nervosa a separate nosological entity, different from unspecific cases of food refusal in various psychiatric conditions. Leading in the psychopathology is the desire to be thin which he conceives of as an expression of a supervalent thought. The manifest picture is usually preceded by behavior changes over a year or two; after that the need to be thin, the fear of gaining weight, overshadows all other symptoms. Selvini considers the "combination of conscious and stubborn determination to emaciate herself, despite the presence of an intense interest in food" as characteristic for anorexic girls, and that this constellation distinguishes true anorexia from other forms of psychological malnutrition. Reports by Russell and Crisp in England, and Theander in Sweden, give similar definitions of anorexia nervosa, as "a morbid fear of being fat," or "a state of weight phobia," combined with "anorexic behavior." I have quoted only a few of the authors who in recent years reexamined the concept of anorexia nervosa. Independently they arrived at comparable formulations, with agreement that there is a genuine syndrome, characterized by "fear of fatness," which is related to preexisting underlying disturbances. They are also in good agreement with my own formulation of the essential aspects of anorexia nervosa.

Primary Anorexia Nervosa

Anorexia nervosa has always been considered a rare disease; there is a

general impression that it is on the increase. In my own experience, based on seventy-five cases (sixty-five females, ten males) seen between 1942 and 1972, the increase is due mainly to more cases of primary anorexia nervosa. Among the sixty-five female patients, fifteen were rated as showing the atypical picture, and fifty the primary syndrome. More than half of the atypical patients were seen before 1960, whereas the great majority (86 percent) of the primary group developed the syndrome after 1960. Somatically, there is little difference between the two groups; in both there is a significant weight loss without organic explanation. The average weight loss in the primary group was 45 lbs (36.5 percent), and 48 lbs (38 percent) in the atypical group. The age of onset in the primary group was on the average 15.9 (10-26) years, and 20.3 (13-28) years in the atypical group. There is some overlap, with the youngest in the atypical group only thirteen years old, and a few in the primary group over twenty years. In the primary group six girls were still in prepuberty. The age of menarche was approximately the same in both groups, 12.6 and 12.4 respectively, with a range from 10 to 16 years. Amenorrhea was a consistent symptom in the primary group, but occurred less regularly in the atypical group. The decisive differences are in the psychological constellation.

The leading dynamic issue in the genuine syndrome is fear of fatness; the angry refusal to eat stands in the service of maintaining an extreme degree of thinness. For a dynamic understanding, which is necessary for

pertinent treatment, it is essential to isolate in each individual case the focal point of the functional disturbances, to recognize the crucial problems with which a patient struggles, and to identify his tools for dealing with them. Such an evaluation implies a clear-cut distinction between the dynamic issues of the developmental impasse which has resulted in anorexia nervosa, and the secondary, even tertiary problems, symptoms and complications that develop in its wake. Most patients come to psychiatric attention only after they have been sick for a considerable period of time, and after various futile treatment efforts. It is necessary to reconstruct the behavior and problems of a patient, and the patterns of family interaction and concern, *before* the illness became manifest. In genuine or primary anorexia nervosa the main issue is a struggle for control, for a sense of personal identity, competence, and effectiveness. Many of these youngsters had tried for years to make themselves over, to be "perfect" in the eyes of others. Concern with thinness and food refusal are late steps in this maldevelopment. The underlying personality difficulties had been camouflaged during childhood by their over-compliant behavior.

The true syndrome is amazingly uniform. Three areas of disordered psychological functioning can be recognized: (1) a disturbance in body image and body concept of delusional proportions; (2) inaccurate and confused perception and cognitive interpretation of stimuli arising in the body, with failure of recognition of signs of nutritional needs as the most pronounced deficiency; and (3) a paralyzing sense of ineffectiveness which pervades all

thinking and activities.

Body-Image Disturbances

Of pathognomic significance for true anorexia nervosa is the vigor and stubborness with which the often gruesome emaciation is defended as normal and right, as not too thin, and as the only possible security against the dreaded fear of being fat. Cachexia may occur to the same pitiful degree in patients with the atypical syndrome, but they will complain about the weight loss. The true anorexic is identified with her skeletonlike appearance, actively maintains it, and does not "see" the abnormality.

A woman twenty years old, progressing well in therapy, admitted, "I really cannot see how thin I am. I look into the mirror and still cannot see it; I know I am thin because when I feel myself I notice that there is nothing but bones." Another girl, age nineteen, also doing well in therapy, showed her physician two photographs taken on the beach, one when she was fifteen and of normal weight, and the other when seventeen and quite cachectic, admitting that she had trouble seeing a difference though she knew there was one. When she looks at herself in a mirror she sometimes can see that she is too thin, "but I can't hold onto it." She may remember it for an hour and then begins to feel again that she is much larger; there was an inner mechanism that kept on "inflating" her self-image. Only through looking in the mirror

could she "let the air out again."

The misperception of their size is preceded by an exaggerated interpretation of any curve and increasing weight as excessive and too fat. One later anorexic girl described this process. She had experienced any bodily changes during puberty with intense discomfort, and began to deny that she had breasts or a rounded buttocks, and maintained this denial over the years, long before her anorexic symptoms began. Like many others she developed a negative phantom, *not seeing* and accepting her figure as it matured.

A realistic body image is a precondition for recovery in anorexia nervosa. Many patients will gain weight for a variety of reasons but no real or lasting cure is achieved without correction of the body image misperception. The resolution of this denial was studied through self-image confrontation in one case by Gottheil and co-workers. After repeated self confrontation this patient began to see how thin she was, more strikingly on video tape than by looking into the mirror. Gradually a change in her body image occurred so that thinness became ugly rather than comforting to her. The same change occurs in patients during psychotherapy, without such direct confrontation.

Another disturbance is the failure of experiencing the body as being their own. Not uncommonly, anorexics conceive of the whole illness as something that "happened to me," not as themselves having stopped eating.

As they come to recognize this they will make comments like, “I realize now I was hurting my parents by not eating; the more they worried about me the more I was hurting them,” without awareness that they themselves underwent this ordeal of starvation.

A male anorexic who had been sick since age twelve and who had successfully resisted all treatment efforts, weighing less than 50 lbs at age eighteen, expressed this even more clearly. Throughout this time he had struggled and fought against any effort to *make* him eat. Gradually he developed a real fear of the scale. “I feel I get evaluated by it and then I am panicky. If I gain, *they* are so proud; if I lose, my mother blows her head off. It is always somebody else’s business.” Talking about his parents he used the expression, “After all, I am their property.” It was only after considerable therapeutic progress that he began to conceive of his body and its functions as his own; only then could he let go of his longstanding symptoms. When he was transferred to an open ward he expressed his satisfaction as, “I am free, *I own my body*—I am not supervised any more by nurses or by mother.” His attitude towards his weight and what he ate underwent a complete change. “Now if I lose weight it makes me feel sick, that I am losing something that is *mine.”*

Misperception of Bodily Functions

The symptom that arouses most concern, compassion, frustration, and rage is the anorexic's refusal to eat. It is this abstinence from food which is reflected in the name, "anorexia." However, the underlying disturbance is more akin to the inability to recognize hunger than to a loss of appetite. Awareness of hunger and appetite in the ordinary sense seems to be absent, and a patient's sullen statement: "I do not need to eat" is probably an accurate expression of what he feels and experiences most of the time. This deficit in recognizing signs of nutritional need, and the confusion in hunger awareness, are part of the essential underlying personality disturbances, which are closely related to other developmental deficits.

In a study of gastric motility Silverstone and Russell found that anorexic patients, though their gastric activity was similar to that found in normal subjects, usually denied sensations of hunger, or feeling anything, though they could sense the contractions. Coddington and Bruch observed that anorexic individuals, when measured amounts of food were introduced into the stomach, were significantly more inaccurate in identifying the amounts than normal, and also obese subjects. This suggests some abnormality in the perception and interpretation of enteroceptive stimuli.

Since curtailment of the caloric intake is the outstanding clinical symptom, there have been unending discussions whether these patients suffer from a true loss of appetite, stubbornly refuse to eat, repress the

sensation of hunger, or fail to act on its urges. Much more than dietary restriction is involved. The whole eating pattern, food preferences and tastes, eating habits and manners, become disorganized, with bizarre and rather outlandish practices developing as the illness persists.

Characteristic is the paradox of food refusal while frantically preoccupied with eating. Most develop unusual, even bizarre, highly individualistic food habits, usually restricting themselves to proteins only. Invariably they will eat more and more slowly, taking hours to finish a meal, however small. This dawdling and the continuous preoccupation with food is commonly observed during starvation. In an experimental study of semistarvation, carried out during World War II on a group of healthy young men, they would "toy" with their food and dawdle for almost two hours over a meal as the starvation progressed, though there was no diminution in the desire for food which was also the dominant topic of all conversation and thinking. Much of what has been called "anorexic behavior," the obsessive ruminative preoccupation with food, narcissistic self-absorption, infantile regression, etc., appear identical with what is observed in starvation due to food shortages, though, of course, the victims will eat whatever they can find, in contrast to the starving anorexic who lives in the midst of plenty but whose fear of losing control and other internal inhibitions make him reject food that is constantly offered, even forced on him. Though without true hunger awareness the anorexic behaves like a starving organism.

Anorexics will complain of feeling "full" after a few bites of food, or even a few drops of fluid. One gains the impression that this sense of fullness is a phantom phenomenon, projection of memories of formerly experienced sensations. An eighteen-year-old girl, intelligent and articulate, but obsessed with her size and eating, felt so little differentiated from others that she would assume the identity of whomever she was with and feel "full" by watching others eat, "having people eat for me," without having eaten herself. She spoke of "keeping my mind eternally occupied with what size I am, always hoping I will become smaller. If I must eat—that takes so much mental energy to decide what, how much, and why must I."

The nutritional disorganization has two phases, absence or denial of desire for food, and uncontrollable impulses to gorge oneself, usually without awareness of hunger, and often followed by self-induced vomiting. Patients identify with the noneating phase, defending it as the realistic expression of their physiological need. In contrast, they experience the overeating as a submission to some compulsion to do something they do *not* want to do, and they are terrified by the loss of control during such eating binges. They express it as "I do not dare to eat. If I take just one bite I am afraid that I will not be able to stop." In about a quarter of the cases of primary anorexia nervosa uncontrolled eating binges and vomiting occur as leading symptoms, but fear of not being able to control their eating seems to be present in all.

In advanced stages of emaciation true loss of appetite may result from the severe nutritional deficiency, similar to the complete lack of interest in food in the late stages of starvation during a famine. This indifference to food must be differentiated from the spirited way with which the anorexic defends his noneating before the stage of extreme marasmus has been reached.

In their fight against fatness, in an effort to remove unwanted food from their bodies, many resort to self-induced vomiting and enemas, or the excessive use of laxatives, and, increasingly often, of diuretics, which may result in serious disturbances in the electrolyte balance. Although the urgent need to keep the body weight low is given as the motive, other aspects must be considered, namely that here too disturbances in the cognitive awareness of bodily sensations play a role.

Another characteristic manifestation of falsified bodily awareness is *hyperactivity,* the denial of fatigue, which impressed the earlier writers but which has scarcely been mentioned in the recent psychoanalytic literature. It has often been claimed that the actual amount of exercise may not be large but only seems remarkable in view of the severe undernutrition. Through pedometric measurements Stunkard and his co-workers could demonstrate that anorexia patients were indeed hyperactive, walking an average of 6.8 miles per day, despite their emaciation, while women of normal weight walked on the average 4.0 miles per day. Patients who continue in school will

spend long hours on their homework, intent on having perfect grades.

Drive for activity continues until the emaciation is far advanced. The subjective feeling is one of not being tired, of wanting to do things, and this stands in marked contrast to the lassitude, fatigue, and avoidance of any effort that is symptomatic for undernutrition in chronic food deprivation, and is regularly complained of by patients in the atypical group. This paradoxical sense of alertness must also be considered an expression of conceptual and perceptual disturbances in body awareness.

One might also consider the failure of sexual functioning and the absence of sexual feelings as falling within the area of perceptual and conceptual deficits, though Russell discusses the possibility of primary gonadal failure contributing to the loss of sexual interest. He observed that though most of the actions of the anterior pituitary gland are preserved during the state of starvation, there is a growing body of evidence that the release of gonadotropin is impaired and does not correct itself spontaneously after the malnutrition has been corrected.

Other bodily sensations are also not correctly recognized or responded to, and they appear also deficient in identifying emotional states. One may consider the limited range with which they describe feelings of anxiety or other emotional reactions as belonging to this failure in perception or

cognitive interpretation of feeling states. Even severe depressive reactions may remain masked.

Others will misinterpret their abilities and total functioning. A seventeen-year-old girl, who had gone on a diet when she learned that her boyfriend at college was dating other girls, felt for the first time "she was getting results" when her declining weight aroused concern. She became convinced that her body had magical qualities. She had started compulsive walking rituals and would walk whether it was hot or raining, or a thunderstorm threatened. She would walk for many miles even though she was increasingly cachectic. "My body could do anything—it could walk forever and not get tired. I have the will power to walk as far as I want any time—no matter what the weather is. I felt very powerful on account of my body. My only weakness was my mind." She felt the same about her weight: "This is something I can control. I still don't know what I look like or what size I am—but I know my body can take anything." She was rather contemptuous of people who expressed concern about her health.

A sixteen-year-old anorexic girl, when at her lowest weight, was afraid of being "strong." Her ideal was to be weak and ethereal so that she could accept everybody's help without feeling guilty. Her deepest desire was to be blind; then she would show how noble she was in the face of suffering, and would be respected by everybody for this nobility. There was no realistic

awareness of what it would be like to be blind, of not being able to see. In spite of this desire for "weakness" she was extremely active and perfectionistic, and would not permit herself to go to sleep until she had done calisthenics to the point of her muscles hurting.

Changes in this distorted self-awareness are necessary milestones on the road to recovery. To quote from one patient who was doing well, "I took a walk—not to wear myself out or to prove I could make it' but just to enjoy the bright blue sky and the pretty yellow flowers. I seemed to do it without this 'double track' thinking."

Ineffectiveness

The third outstanding feature is a *paralyzing sense of ineffectiveness,* which pervades all thinking and activity of anorexic patients. They experience themselves as acting only *in response* to demands coming from others, and *not* doing anything *because they want to.* While the two other characteristics are readily recognized, this deficiency is camouflaged by the enormous negativism and stubborn defiance of these patients. Its paramount importance was recognized in the course of extended psychotherapy. Once defined, this sense of helplessness can be identified readily early in treatment and be communicated to the patient.

This deep sense of ineffectiveness seems to stand in contrast to the

vigorous behavior and the reports of normal early development which supposedly had been free of difficulties and problems to an unusual degree. These girls were described as having been outstandingly good children, obedient, clean, eager to please, helpful at home, precociously dependable, and excelling in school work. They were the pride and joy of their parents, and great things were expected of them. After a childhood of robotlike obedience, the tasks of adolescence appear insurmountable and reveal them as deficient in initiative and autonomy. Once this lack has been defined, a detailed history will reveal many subtle indications earlier in life, though parents find it difficult to accept that their well-balanced daughter should have been so troubled and under such strain.

It had always been a puzzle that this serious illness is usually precipitated by some commonplace event or trivial remark. Most give a fairly definite time of onset and usually recall the event that had made them feel "too fat" and not respected. Frequently this occurred when confronted with new experiences, such as going to camp in the younger group, or entering a new school or going to college later. In this new situation they feel embarrassed about being "chubby" and afraid of not being able to make new friends. An early signal of something wrong with their drastic dieting is that weight loss does not lead to better social relationships, but to increasing social withdrawal, often extreme isolation.

Whenever there is a detailed examination of the factors surrounding the "sudden onset" one will find that the urgent need to lose weight is a cover-up symptom, expressing an underlying fear of being incompetent, "a nothing," of not getting or even deserving respect. In this desperate worry they gain a sense of accomplishment from manipulating their eating and weight.

Family Transactions

Patterns of disturbed interaction were recognized only through intensive therapeutic contact with these families. Crisp reviewed the older literature and found little consistency in the studies which dealt mainly with the disturbed patterns after onset of the anorexia. There was little agreement between investigators concerning the nature of the premorbid phenomena and influences, and the social background. Some authors, Crisp among them, have been impressed by the high proportion of patients coming from prosperous and professional homes. Ushakov reports the same from Russia and speaks of the prosperous and good living conditions and the highly cultural backgrounds of these adolescents. In my own observation, more than half of the primary group were of upper-class background, with more than 10 percent belonging to the "super rich." In the atypical group middle- and lower-class status was more frequent.

The families are of small size which was more pronounced in the

primary than in the atypical group, but without describable "hard-fact" characteristics, except that the age of the parents at birth of the anorexic-to-be was rather high, about thirty years, a fact also commented on by others. About half of the patients were first-born children, and the position most frequently observed was that of being the older of two daughters, with a conspicuous paucity of sons. This too has been observed by others who speak of the anorexic family as being woman-dominated. The marriages appeared to be stable, at least in formalistic terms, with only two or three instances of divorce before or at the time of onset of the illness. Most parents emphasized the stability, even happiness, of their homes.

Reconstruction of the early development revealed that they had been well cared-for children to whom many advantages and privileges had been offered. Yet, on closer contact, it could be recognized that encouragement or reinforcement of self-expression had been deficient, and thus reliance on their own inner resources, ideas or autonomous decisions had remained undeveloped. Pleasing compliance had become their way of life, and they had functioned with the facade of normalcy, which, however, turned into indiscriminate negativism when progressive development demanded more than conforming obedience. No general picture can be given for the premorbid personalities in the atypical group.

Evidence of disregard of the patient's needs and emotions could be

readily recognized in joint family sessions. With all the apparent benevolence, these parents appeared to be impervious to the emotional needs and reactions of their children. At times there was a shocking discrepancy between the bland and unobservant attitude of the parents, and the evidence of the serious physical and emotional illness in the patient.

With widely varying individual features, several common aspects could be recognized. The parents emphasized the normality of their family life, sometimes with frantic stress on "happiness," and they emphasized the superiority of the now sick child over her siblings. The fathers, despite social and financial success, which was often considerable, felt in some sense "second best," and were enormously preoccupied with outer appearances, expecting proper behavior and measurable achievement from their children. The mothers had often been women of achievement, or career women frustrated in their aspirations, but who had been conscientious in their concept of motherhood. This description applies probably to many "success-oriented" upper-middle-class families; these traits are probably more pronounced in anorexia nervosa, with greater imperviousness to a child's authentic need.

In order to visualize how a family, without dramatic signs of discord, fails to transmit to a child, an adequate sense of self-effectiveness, a simplified model of personality development was constructed. Behavior, from birth on,

needs to be differentiated into two forms, namely that *initiated* in the individual, and that *in response* to external stimuli. For a normal development it appears to be essential that there are sufficient *appropriate* responses to clues originating in the child, in addition to stimulation from the environment. If responses to child-initiated clues are continuously inappropriate or contradictory, a sense of ownership of his own body fails to develop; instead, such an individual will experience himself as not in control of his body and its functions, lacking awareness of living his own life. This is the basic psychic orientation in anorexia nervosa. The gross deficit in initiative and active self-awareness may not become manifest until puberty makes new demands, and the impact of new bodily urges provokes a feeling of helplessness, *of not owning his own sensations and his own body.*

The early feeding histories which have been reconstructed in great detail are conspicuous by their blandness. The child never gave any trouble and ate exactly what was put before him, without fussing about food. Some mothers would report how they always "anticipated" their child's needs, never permitting him to "feel hungry," that means without opportunity of developing guideposts for control from within.

Distorting feeding experiences may occur together with distortions in verbal communication, with direct mislabeling of a child's feeling states, such as that he *must* be hungry (or cold, or tired) regardless of his own sensations.

This mislabeling may also apply to a child's role in the family, and his feelings and moods. Thus he comes to mistrust the legitimacy of his own feelings and experiences; in order to maintain even an unstable equilibrium with the people on whom he is most dependent, he is obliged to accept these distorted conceptions about his body, and is thus prevented from developing a clearly differentiated body scheme and sense of competence.

Sexual Adjustment and Problems

Since puberty is the characteristic time of onset it has been generally assumed that anorexia nervosa is in some way related to sexual problems. Crisp observed that the later anorexic girl is heavier at birth than her sisters, and tends to have an early menarche, and that this premature demand for sexual adjustment precipitates the illness. In my group, menarche occurred at a normal age; in two instances of monozygotic twins the later anorexic twin had been smaller at birth, with menarche at a later age than the healthy twin.

In psychoanalytic teaching the rejection of food has been equated with the rejection of and disgust with sex, and unconscious fear of impregnation has been considered the specific conflict situation. This type of sexual anxiety may play a role in atypical cases of anorexia, but it is rarely encountered in the primary form. Selvini, too, found impregnation fantasies only rarely; when they were uncovered they were not related to true sexual fears but rather a

sexual symbol of more primitive experiences.

It is difficult, if not impossible, to evaluate reports about such unconscious fantasies. When not rigidly negativistic, these patients are chameleonlike in picking up cues from their therapist. If a therapist is convinced that feeling "full" after eating is the symbolic expression of an imagined pregnancy then a patient will reply, sooner or later, that this feels like having a baby in her stomach. There seems to be a tendency to confront a patient too early in treatment with specific sexual topics, before they have developed some sense of identity and self-directed independence. Such efforts lead to sterile and threatening discussions and account, in my opinion, for the fact that treatment so often bogs down in a stalemate. One of my patients married during a remission and, though still amenorrheic, became pregnant. She experienced the enlargement of her abdomen as something desirable, as entirely different from the hateful fear of her body being too big and fat.

My cautionary remarks about "explaining" anorexia nervosa as "caused" by certain unconscious fantasies do not imply, of course, that the attitude of the patients toward sex and adulthood is not seriously disturbed. Under the fragile facade of normality, their whole development has been so distorted that it would be inconceivable if they functioned normally in this area. The changes of pubescence, the increase in size, shape, and weight, menstruation

with its bleeding, and new and disturbing sexual sensations, represent a danger, the threat of losing control. The frantic preoccupation with weight is an attempt to counteract this fear; rigid dieting is the dimension through which they try to accomplish control.

Atypical Anorexia Nervosa

Much of the confusion about anorexia nervosa is due to the failure to differentiate between the genuine syndrome, i.e., the pursuit of thinness, and other conditions where the eating function is disturbed due to various symbolic misinterpretations. No general picture can be drawn for this group except that the loss of weight is incidental to other problems, is often complained of or valued only secondarily for its coercive effect. Often there is a desire to stay sick in order to remain in the dependent role, in contrast to the struggle for an independent identity in the primary group. The characteristic features of the primary syndrome are absent, namely the pursuit of thinness, delusional denial of the emaciation, hyperactivity and striving for perfection, and constant preoccupation with food. In no case of atypical anorexia nervosa were there episodes of bulemia.

The illness is as serious and treatment problems as difficult as in primary anorexia nervosa, with poor cooperation, frequent changes of physician, and impulsive breaking off of treatment. The duration of the illness

appears to be approximately the same, with two patients in each group having been unsuccessfully in treatment for over ten years, with sixteen years in a woman with the atypical syndrome as the longest.

Certain subgroups of the atypical cases can be recognized. In eight patients, neurotic and hysterical symptoms were predominant, and schizoid features in six; an adolescent depression was observed in a girl of fifteen, with roots in recurrent traumatic separations during childhood. A few brief sketches follow to indicate the different flavor of the atypical disorder.

A fourteen-year-old girl felt that her symptoms, i.e., her loss of appetite and disgust with eating, had some relationship to the birth of a child to a favorite aunt, an event to which she had reacted with disgust and horror. More severe symptoms developed when a girl friend was discovered to be illegitimately pregnant. The thought that her friend had had sexual relations disgusted her, and she became preoccupied with the idea of sexual intercourse. She said she hated her parents because they had performed this act in conceiving her, and she wished she had not been born.

She had many other symptoms, became aphonic, and spoke in a whisper for over three years. At another time she began to limp and was admitted to an orthopedic hospital, where there were no organic findings, but she was discharged on crutches. At another time she complained of severe abdominal

pain and a kidney stone was suspected. What was found was that she had inserted a pencil into her bladder which was removed through a super-pubic incision.

Her violent temper and behavior had kept her home in a continuous state of turmoil and excitement; she refused to eat, had vomiting spells, remained up all night, and though she had been an excellent student, she had dropped out of school. After four years of invalidism, she was finally admitted to a psychiatric service for long-term treatment.

She appeared quite depressed, tense and self-absorbed, with staying sick her main preoccupation. In her damaged self-image she was an ill, crippled, and helpless child extorting irritated attention from her parents. The intrinsic therapeutic difficulty was that throughout her life she had used illness to maintain her position in the family and thus she "needed to be sick."

A thirty-two-year-old highly intelligent professional woman had been nearly continuously in treatment since age sixteen, when she had lost a considerable amount of weight. Evaluation of her long history revealed as a major theme of her life the effort to control through weakness. The noneating was a nearly accidental symptom in a woman with the pervasive hysterical character structure. She valued her low weight for its coercive effect and had gradually learned every trick to arouse attention and concern, and to keep her

weight at a dangerously low level.

A nineteen-year-old girl lost 30 lbs. during her first term in college. When she was fourteen years old her mother had undergone major surgery. From then on the daughter could not eat, “Unless I could observe the exact amount mother ate.” As long as she lived at home nobody had noticed this. At college she lost weight rapidly because “I did not know what mother ate.” Subsequently many other phobic symptoms became manifest.

Another college student became infatuated with her physician who had suggested reducing for her when she consulted him about some other symptom. She received much praise from him for being so cooperative as her weight dropped from 160 to 110 lbs. When she consulted him again he reassured her about her weight. She felt he had rejected her, lost her appetite, and became afraid to eat, and her weight dropped to 85 lbs. Later, in psychiatric treatment, she repeated the pattern of immediate infatuation, going to great length to force her attention on her therapist and his family. She was preoccupied with being “in control,” but not as a step towards independence; it was an effort to coerce her physician into permitting her clinging dependent behavior.

A twenty-nine-year-old teacher suffered a severe weight loss after having witnessed a miscarriage. She was frightened by the amount of blood,

then became obsessed with the smell of blood, first could not eat meat because it smelled of blood, then all food smelled of it. After losing 20 lbs. she felt so weak that she took to a wheelchair, and with further loss she demanded bed care.

In the schizoid group the sense of reality and the misinterpretation of the whole eating function is more dramatically disturbed, often with delusional fears of eating, whereas others refuse food for being unworthy. Characteristically, these patients are often apathetic and indolent, usually indifferent towards the emaciation; they certainly will not express pride in it.

An eighteen-year-old girl was hospitalized with a severe weight loss and scruples about sin; she felt paralyzed in doing anything. She had been quite popular in high school, even had been class president, but she was continuously preoccupied with the fear of losing her friends. She began to have peculiar thoughts about food and her digestion; she felt that what she ate would affect others. Increasingly she became preoccupied with her sins and fear of punishment. She was quite depressed and suspicious, but when hospitalized she accepted nourishment, and her weight went up and she maintained it at around 100 lbs. She suffered another episode of weight loss, down to 82 lbs., when twenty-five years old, obsessed with delusions about her digestion and the influence of thoughts on her digestion.

A twenty-one-year-old college student was advised by her professor to see a psychiatrist, after he had noted changes in her behavior and peculiarities in her style of writing. Instead she just stayed home, ate less and less, and finally did not leave her bed. Her mother had died when she was quite young, and she felt uncomfortable about living with her father. She complained that he had "not welcomed her properly," when she came back from a summer vacation. She looked emaciated and was weak, after having lost 45 lbs. There was nothing conspicuous in her attitude towards eating and she gained weight steadily in the hospital, back to the previous level of 125 lbs. She also responded well to psychotherapy and was able to free herself of her hateful dependence on her father.

These few brief sketches serve to illustrate the great differences in the precipitating events and in the personality of these patients, who have little in common except a severe sense of inadequacy and discontent.

Anorexia Nervosa in the Male

Anorexia nervosa in the male requires a separate discussion. It is much rarer than in females, and the literature on it is even more ambiguous and contradictory. One finds side-by-side statements that typical anorexia nervosa does not occur in the male, and that it is not different from that observed in the female. It has even been doubted whether it was even

justified to make the diagnosis in the male. If amenorrhea is considered a cardinal symptom then males are ipso facto excluded. Defined in psychiatric terms the condition does occur in males, and the failure in pubertal development appears to be the parallel to amenorrhea in females. Both the genuine syndrome and the atypical form are observed. As in females, relentless pursuit of thinness is the outstanding motive in primary anorexia nervosa, representing a frantic effort to establish a sense of control and identity. In the atypical picture the eating itself is disturbed with various distortions of its symbolic meaning.

Little attention has been paid to male anorexics in the modern literature; usually they are briefly mentioned in the form of an appendix or footnote. Dally surveyed 140 females with anorexia nervosa for whom he established distinctly different groups. During the same period six male anorexics were observed, who were described by Dally as more heterogeneous. He noted that it was difficult to compare the course and outcome in the two sexes. Selvini stated, in a recent discussion of anorexia nervosa, that the cases of undereating in males, in her observations, were all cases of pseudoanorexia, with paranoid delusions and hypochronical ideas about the digestive system.

In my group of seventy-five patients, observed between 1942 and 1972, there were ten males (13 percent) who were diagnosed as suffering from

anorexia nervosa at the time of their illness. By focusing on the core dynamic issues, and by clarifying the whole life pattern, interpersonal experiences, emotional conflicts, and psychological deficits, it was possible to define the primary picture in six cases, and to differentiate them from patients with atypical food refusal (four cases) with various psychiatric disturbances and the cachexia only an incidental finding.

Atypical Picture

As in the females, the atypical cases were the first to be observed; at the time of their illness they were considered examples of the classical anorexia nervosa picture. Two of these atypical anorexics were adults, twenty-four and twenty-seven years old, respectively, when they became nervous and fearful, and began to suffer a true loss of appetite, in response to life situations which they experienced as overdemanding; the birth of the first child in one instance, and facing independent professional responsibilities in the other. Both were of good intelligence but had been "underachievers," performing below the level of their capacities, throughout their lives. One was frantic about the weight loss, the other was pathologically indifferent, not having noticed any changes in his feelings about food, and without awareness of the weight loss, except for an increasing looseness of his clothes. The older of the two men, after a seeming recovery, had a relapse six years later and died rather suddenly, without a definite cause of death being established.

The third patient, a fourteen-year-old adolescent, became preoccupied with anxieties about the body and its functions, coinciding with pubertal development. He had been an only child and somewhat obese, always clinging and extremely dependent on his mother. He complained of headaches, became depressed and moody, was irritable and became even more withdrawn than before. He developed fear of swallowing, that the food might get into his lungs and he would suffocate, and became so phobic about swallowing that he refused to eat at all. When he became a psychiatric patient he was frantic with fear about his weight loss (over 40 lbs.), and that he did not want to be skinny. He was diagnosed as suffering from a psychoneurosis, conversion type; an effort was made to contact him five years later and it was learned that he was in a state hospital with the diagnosis of schizophrenia.

In the fourth patient whose illness had begun when he was thirteen years old, immediately following his bar mitzvah, fasting was one ritual amongst many others for "atonement of his sins." This boy was completely indifferent about his body and his appearance. Like the other boy, he had stopped going to school when the symptoms developed.

None of these patients had been in psychiatric treatment before the illness, but there had been many recognized difficulties, complaints about their poor achievement, disturbances in their eating behavior, and overt sexual anxieties. The families appeared overtly disturbed.

Many case reports on individual male patients that have been published are examples of the atypical picture, though they are referred to as representing the "classical" syndrome. They are usually young adults or even middle aged, who have nothing in common except the weight loss and certain degree of "give-up-itis."

Primary Anorexia Nervosa

In contrast to the divergent atypical picture, the primary group has many features in common. The psychological issues are similar to those observed in females. Here, too, relentless pursuit of thinness is the leading motive. The youngsters are described as having done exceptionally well as children. Closer studies revealed that these accomplishments were a facade performance, an expression of compliance, and not of self-initiated and self-directed goals. In their desperate struggle to become "somebody" and to establish a sense of differentiated identity, they become overambitious, hyperactive, and perfectionistic. As in females, manipulation of their own body through noneating is a late step in this development, but the weight loss results in a desperate picture that draws attention to their plight and finally brings them into treatment.

All six boys in this group were still in prepuberty when the illness began with what looked like a deliberate decision to reduce because they felt "too

fat." If the planned lower weight had been reached, it proved "not enough," because much more than weight loss had been expected. Being and staying thin became a goal in itself. Their real fear was that of not being truly respected, of not being in control but of being a helpless product of "them." Since no manipulation of the body can possibly provide the experience of self-confidence, self-respect, and self-directed identity, the pursuit of thinness becomes more frantic, the amount of food smaller and smaller, and aimless activity, to "burn off calories," more hectic.

This acute sense of dissatisfaction had occurred, in all six cases, when there was a change of the social setting, moving to a new neighborhood, change of school or going to camp or boarding school. Throughout their lives these boys had received a great deal of praise for being outstanding from their families, and also from teachers and peers. The illness became manifest when the assured status of superior achievement was threatened, when they feared they could not obtain the same prestige in the new environment. They had been success and achievement-oriented before they became sick and four had been outstanding in athletics, greatly encouraged by their fathers. As the illness progressed, with increasing social isolation, the activities tended to become aimless, no longer integrated into athletics and group activities.

In none was there a true loss of appetite, in spite of the rigid self-starvation, which is endured without definite hunger awareness. Periods of

vigorous refusal to eat alternated with eating binges of unbelievable proportions, which were followed by self-induced vomiting. Bulemia with vomiting was present to various degrees in five of the six cases. Hyperactivity and drive for achievement were remarkable, with persisting superior intellectual achievement. The boys continued to go to school in spite of the severe emaciation, with some excelling even more than before though one, observed in 1970, dropped out of school for a while under the influence of alcohol and drugs.

During psychotherapy it was learned that, in spite of their excellent performance, they had suffered from severe doubts about their adequacy and competence. In spite of the stubborn, aggressive and violent negativistic behavior, they, too, suffered from a conviction of their ineffectiveness, the dread of not being in touch with or control of their own sensations and functions. The rigid control over their weight is like a magical touchstone, the tangible evidence of control over their body. The families appeared to be stable and well-functioning, but with a transactional pattern of a controlling mother superimposing her own concepts of his needs and desires upon a developing child, disregarding the clues originating within him. Since these mothers were well informed, what they superimposed was quite reasonable, not contrary to the child's physiological and developmental needs, and when young they were healthy children and offered the facade of adequate functioning. The serious deficits were in the area of autonomy and active self-

awareness which came into the open when life situations arose where independence, decision making, and self-initiated behavior were expected.

The underlying dynamic picture in male and female anorexics with the primary syndrome shows great similarity. There is one point of difference, namely, in the male all cases of primary anorexia nervosa occur in prepuberty; these boys did not develop sexually until after they had recovered. This is consistent with the reports by others on young male patients. Falstein and his co-workers reported on four prepubescent boys who, they felt, showed the classical picture of anorexia nervosa as the end result of diverse and multiple contributing factors. All four boys had been preoccupied with their size. Tolstrup observed four males among fourteen anorexics with onset before age fourteen; the youngest was only eight years old. He felt that they showed the typical syndrome. Ushakov found that admission rates for anorexia nervosa were five times higher for girls than boys in whom the illness had an early onset between ten to thirteen years of age.

The fact that anorexia nervosa in males is conspicuously less frequent than in females may well be related to the fact that it does not occur after pubescence. In addition, the characteristic slavelike attachment of a child to the mother is probably more frequent in girls, and efforts to solve psychological problems through manipulation of the body are also more

common in females. It is probably unusual for a boy to be caught in this developmental impasse. But even when this type of attachment had developed, the psychobiological experience of male puberty will flood a boy with such powerful new sensations, inducing a more aggressive self-awareness which makes a type of self-assertion possible that he was not capable of achieving in prepuberty. Once boys are caught in this vicious cycle of self-starvation and distorted body experience, endocrine treatment appears ineffective, even disturbing. It becomes of value only after the underlying psychological problems have been clarified.

Psychiatric Differential Diagnosis

There has been considerable controversy about the proper psychiatric classification of anorexia nervosa. As long as the focus was on unconscious conflicts about sexuality or pregnancy, the condition was conceived of as a neurosis; this was the majority opinion until fairly recently. In a survey of thirty patients, observed between 1935 and 1959, Rowland noted that the final diagnosis was a mixture of conversion hysteria, obsessive-compulsive neurosis, anxiety reactions, schizophrenia, and depressive reaction, with schizophrenia being diagnosed more often during the 1950s than during the 1930s.

Much of the old confusion was related to the fact that all cases of

psychological malnutrition were lumped together, and that psychiatric diagnostic categories were conceived of as rather fixed clinical entities. Modern psychiatric thinking has undergone many changes, and questions asked today are under what conditions will a patient react in a schizophrenic, hysterical, depressive, or obsessional *fashion,* and not whether he *has* hysteria or schizophrenia, etc. Following anorexic patients over many years brings the interrelatedness of various psychiatric syndromes into the open. Not uncommonly, an early diagnosis of neurosis, in the primary as well as the atypical group, was changed to schizophrenia as the illness persisted.

Though the concept of schizophrenia has undergone many changes, no new diagnostic concept has been formulated for clinical conditions characterized by disturbances in the symbolic processes, with *deficits* in personality integration and self-awareness, reality testing and psychosocial competence. Failure in discriminating awareness of essential bodily sensations, particularly of hunger, is an outstanding deficiency in anorexia nervosa, associated with distorted concepts of one's own body identity. It may be associated, to various degrees, with disturbances and deficiencies in the integration of other symbolic processes. Viewed from this angle, primary anorexia nervosa is more akin to potentially schizophrenic development, or borderline states, than to a neurosis, though only a few patients with primary anorexia nervosa were overtly schizophrenic at the onset of their illness, or progressed to that state of disorganization. In the beginning neurotic

mechanisms, most often obsessive compulsive defenses, stand in the foreground, efforts to ward off the frightening confrontation with their complete helplessness, the falsified awareness of their own needs, and their lack of control over their bodily functions.

Depressive features deserve special evaluation; they may indicate a true depression as a primary illness, though this is a rare occurrence; more often they express the underlying despair of a schizophrenic reaction. The earliest manifestations of something wrong, preceding the actual anorexia nervosa by months or years, may be moodiness and irritability. After the condition has existed over a long period a depressive affective state is difficult to distinguish from apathy, and the corroding effects of isolation.

Recently Selvini suggested subdividing patients suffering from primary anorexia nervosa according to the differences in their eating behavior and attitude. By evaluating Rorschach records for communication defects and deviances, according to the method described by Wynne and Singer, she observed differences in the style of thinking in patients with different eating behavior. She found more signs of disorganized thinking in those with eating binges and vomiting, or frantically preoccupied with fear of losing control; patients with this fragmented type of thinking had a poorer prognosis than those who maintained stable control. Using the same scoring technique, I was unable to establish such differences, either on Rorschach evaluation or

clinically. Two of the three girls who died had been rigid in their food restriction but never vomited, the type Selvini calls “stable anorexic.” One died directly of starvation and the other of starvation and circulatory failure. In the third in whom vomiting had been a conspicuous feature, the fatal outcome was attributed to irreversible damage due to disturbances in the electrolyte balance.

Recognition of the underlying potentially schizophrenic core is essential for effective treatment. I have seen many anorexic patients where increasing isolation had progressed to apathy and withdrawal into an autistic way of life. Unfortunately, this may even happen in patients who are in treatment, with focus on their so-called conflicts, but neglecting to deal with the underlying essential problems, the ego deficiencies and incompetence in self-awareness and human relatedness. In a misguided effort, a therapist may “support” an anorexic’s increasingly bizarre living arrangements, and thus become a collaborator towards an insidious schizophrenic development.

Prognosis

Anorexia nervosa has always been regarded as a serious condition, with, at best, a protracted course. Little, if any, relevant information is available on how to predict the outcome in an individual case. Evaluation of the prognosis on the basis of the literature is more confusing than enlightening. Often an

inaccurate picture is presented, records at a large medical center are culled from patients seen over many years and treated by many different physicians with many different approaches. One such report, supposedly based on the follow-up histories of 115 patients observed at a university medical center, actually refers to only twenty-six (21 percent) of the patients who had replied to a letter of inquiry; even for them evaluation of the long-range outcome is not based on personal contact. Nothing is known about the fate of the remaining eighty-nine (79 percent) patients. Nevertheless, the authors speak of "a significant shift back to health and maintenance of weight." In a study in which contact with patients was maintained, even though they had refused psychiatric treatment, Cremerius found that the later development of fifteen patients after fifteen to eighteen years, was highly unsatisfactory. Five showed a chronic anorexic picture, though somewhat ameliorated; five had achieved a normal, even excessive weight, and some were even menstruating, but serious maladjustment and personality disturbances persisted. One patient had died from an intercurrent illness and another was hospitalized as a chronic schizophrenic. Cremerius concluded that there is no spontaneous recovery, though five patients would have given this impression on superficial contact.

Commonly weight gain is interpreted as a sign of improvement, whereas in reality it may only be a temporary remission. This is most tragically illustrated by the histories of the five patients in my group with fatal

outcome. Sufficient weight was regained by four, that for a while they were thought of as recovered; one, a fourteen-year-old boy, died after a few months, not from inanition but from a severe infection. Death occurred in one atypical case, a man of twenty-seven, who had become sick and lost his appetite following the birth of his first child. After several years of seeming recovery he suffered a relapse and died suddenly at age thirty-three with vague symptoms of gastric distension. A young woman, anorexic since age sixteen, had gotten married during what looked like a spontaneous recovery. Though still amenorrheic, she became pregnant and developed tetany. The child was stillborn and a relapse of the anorexic picture followed. She came for psychiatric treatment only after marked physiological changes had taken place which proved to have caused irreversible damages. She died at age twenty-two from the effects of general calcinosis (vitamin D poisoning), with cardiac and renal failure.

The two other girls had become anorexic at age eleven and fourteen, respectively, and gained satisfactorily while in some form of supportive psychiatric treatment, which had not dealt with the patient's inner sense of incompetence. When a relapse occurred two or three years later, the parents postponed asking for help. When finally hospitalized, medical intervention was not active enough, and both girls died of inanition, with weights as low as 45 and 55 lbs. There had been nothing in the early picture of these patients suggesting that they suffered from a more malignant form of the illness.

In my opinion the long-range outcome runs directly parallel to the adequacy of the therapeutic intervention. Specifically, there is little relationship between the diagnostic classification, whether psychoneurosis or schizophrenia, and the final outcome. Some, in whom the diagnosis of schizophrenia had been made quite early, did well in the long run, whereas others, with a consistent psychoneurotic picture, did poorly or even died. This applies to both the typical and atypical group.

It has been assumed that the prognosis in young prepubertal children is better than in older patients. These young patients come for treatment earlier and the therapeutic approach is more comprehensive, with active involvement of the parents. If the therapeutic intervention with the whole family is not effective, young patients may be as seriously ill as the older ones. The onset in three of the patients who died had been below age fourteen. Probably the case in my group most resistant to treatment was a young man who had become anorexic at age twelve and whose weight at age eighteen was below 50 lbs. His case is also an example of the direct relationship of the prognosis to the pertinence of the therapeutic approach. With therapy designed to meet his underlying problems, he made a good recovery and was doing well, actively involved in living, when last heard of ten years after discharge. There were several others with even longer histories of unsuccessful treatment, up to eleven years, who responded well to a change in therapeutic approach. Several reports of effective therapeutic intervention

are to be found in the schizophrenia literature, namely of patients who had been grossly neglected at the time of their anorexic illness. Without effective intervention at the crucial point of conflict and maldevelopment, the outlook is poor, in particular after secondary symptoms have developed and an anorectic way of life has been adopted.

Selvini has made the same observation, that the statistical evaluation of long range results, in particular when based on weight information alone, is not only noninformative but misleading. Recovery is entirely dependent on the capacity to understand the true conflicts of the anorexic and to help him find better ways of dealing with them.

Treatment

Treatment involves two distinct tasks, the restitution of normal nutrition and the resolution of the inner psychological problems so that a patient no longer needs to abuse the eating function in futile efforts to solve his problems. For effective long-range results the two aspects should be integrated; in reality this ideal is rarely fulfilled. All too many patients are made to gain weight on a medical service, and are then discharged back to the same environment where the illness had developed. They come for psychiatric treatment only after years of such futile efforts. In others not sufficient consideration has been given to the self-perpetuating destructive

effect of the nutritional deficit itself. Psychiatrists may have the unrealistic expectation that the weight will correct itself after the psychological problems have been solved; such a wait-and-see attitude where nothing is done to correct the severe malnutrition, may unnecessarily prolong the illness. A certain degree of nutritional restitution is a prerequisite for effective psychotherapy.

Since the first description of anorexia nervosa there has been continuous debate on how to accomplish the seemingly impossible task of getting food into patients who are stubbornly determined to starve themselves. This discussion has extended to what food to offer, how to feed it, where to do it, and what medication to use. The physiological principles are very simple: increase the food intake and keep these hyperactive cachectic youngsters from exhausting themselves. The question is how to persuade, trick, bribe, cajole, or force a negativistic patient into doing something he or she is determined not to do.

It is virtually impossible to draw conclusions about the effectiveness of various regimens from the literature. The case material is extremely heterogeneous, and the reports refer to patients at various stages of their illness. One reason for the confusing reports, which is rarely openly stated, is the fact that frequently the authors themselves have little experience with such patients. Rowland's survey is based on the study of the case records of

thirty patients who were observed in different departments of the Columbia Presbyterian Medical Center in New York, between 1936 and 1959; the figures suggest that about one patient was observed per year. A variety of methods were used, such as frequent small feeding of special preparations with high protein content, or, in contrast, tempting choices from special trays, or coercion to eat the regular hospital food, or feeding by gastric tube or threat of it, all with unpredictable results. Similarly discouraging is the survey by Browning and Miller, who concluded on basis of the records of thirty-six female anorexics treated at the University Hospital of Cleveland, between 1942 and 1966, that hospitalization did little to improve the course of the disease. The deaths of three (8 percent) patients while hospitalized is reported with the implication that vigorous treatment might have hastened the fatal outcome. This might be interpreted differently, namely, that hospitalization had been postponed until the patients were in such a debilitated state that they were beyond help.

In my experience too, a brief admission to a medical service which does not have special experience in the management of anorexia, creates as many problems as it attempts to solve. The staff is as helpless and inconsistent in dealing with the deceitfulness and cunning of these patients as the family, and is apt to react with anxiety, frustration, and angry coercion. But whether hospitalization is helpful or not, in reality most patients, long before they are seen by a psychiatrist, will have been hospitalized at least once. Early in the

disease the focus is on diagnostic procedures, to recognize or exclude possible organic factors. Later on, hospitalization may be necessary as a life-saving measure, when there is progressive emaciation, or acute danger to life due to electrolyte imbalance. This is particularly apt to happen in patients who use vomiting, laxatives, and diuretics, and which many will continue to use even after they have become painfully aware of the dire consequences. Under such conditions rather heroic methods may become necessary for correction of the electrolyte imbalance. In one of my patients such help came too late; extreme calcinosis had led to wide-spread irreversible changes, with cardiac and renal failure as the cause of death.

As to the medical regimen, individualization is essential. A firm attitude that eating is necessary, combined with the reassurance "We won't let you die," may produce some gain in weight. Some find it useful to prescribe certain definite amounts of high-protein high-caloric liquid nourishment which is offered as "medication," and to leave eating ordinary food to the patient's choice. Usually such a program is reinforced by the patient's knowledge that the alternative to his eating the prescribed amounts will be tube feeding. Occasionally a patient will prefer tube feeding. The boy who fasted "as atonement for his sins" required tube feeding for several years because it was "harder" and made him feel that he performed one more ritual of atonement. Other patients, though disliking the procedure, gain a sense of reassurance that someone cares for them.

The use of various medications reflects changing concepts of the etiology of anorexia nervosa. As long as it was considered of pituitary origin it was a matter of course to attempt "replacement" therapy. Prescription of thyroid was based on the assumption that a "low" basal metabolic rate indicated deficiency. Insulin was frequently given to stimulate the appetite. Endocrine products have a legitimate use in the treatment of amenorrhea, where it is possible now to produce regular bleeding. In males, with delayed puberty, testosterone may be useful, but only after the underlying condition is sufficiently corrected that its administration will not stunt the patient's growth, or precipitate an untoward psychological reaction.

In recent years the anabolic steroids have been used as adjuncts in the rehabilitation of long-standing cases, with the achievement of impressive weight gain and greater sense of well being. However, as far as I know, no controlled studies have been reported.

The psychiatric problems have also been treated by somatic methods. Both insulin and electroshock therapy have been used, and also psychotropic drugs, in my observations with only very temporary results.

Recently a method of behavior therapy has been described, namely, permitting freely chosen activities as prompt reward for gain in weight. The immediate results appear to be good and the method is recommended with

much optimism. Yet one patient in the original report, with satisfactory weight gain, committed suicide after discharge, before the planned psychotherapy had been instituted. Though this or similar methods have been in use for a short time only, I have had consultations on patients who had gained satisfactorily while hospitalized, even maintained the weight for a brief period after discharge, but then relapsed. Nothing had been changed in the essential family relationships, or in the patient's underlying personality structure. 1

Equally enthusiastic are recent reports on crisis-induced family therapy in which the family is stimulated to change their habitual patterns of interaction. These reports deal with young patients, in the beginning of their illness, before the secondary problems have become entrenched. Thus far there have been no follow-up reports, whether these dramatic rearrangements have lasting value. In young patients equally good results can be achieved by individualized psychotherapy and more conventional work with the family. The intensity of treatment for each member, the focus and its length, vary considerably. Some of these young patients can be treated effectively while living at home; in others hospitalization may be helpful to effect a gain in weight while the underlying problems are being clarified.

In many instances, when ambulatory methods have failed, when the family problems were not resolved but have disintegrated, psychiatric

admission for long-term therapy becomes necessary; it is of use only if the service has a constructive therapeutic philosophy. It has been objected that psychiatric admission is superfluous, that weight gain could be accomplished in a medical service and be followed by psychotherapy on an ambulatory basis. This reflects an outdated concept of the function of a psychiatric hospital. Great benefits can be derived from the experience of living in the hospital "milieu" provided this is integrated into the therapeutic experience.

Psychotherapy also needs to be approached in an individualized way. Since patients with the atypical syndrome vary widely in their personalities, psychological problems, and the situational and precipitating factors, no generalized statement can be made about therapy except that it needs to fit the individual circumstances. The following statements apply to the more uniform picture of primary anorexia nervosa where many similarities of the problems have been recognized.

The literature on the value of psychotherapy and psychoanalysis is hopelessly inconclusive. Psychotherapy has been referred to as useless, or, conversely, psychoanalysis has been praised as the best method. Authors who feel that a psychotic core underlies the overt clinical picture have expressed doubts about verbal forms of treatment resulting in meaningful changes in a condition that assumedly develops during the preverbal phase. Selvini found traditional psychoanalysis ineffective and achieved increasingly better results

with a more pertinent understanding of the condition, namely as a concrete use of the body in the struggle for identity. My own experiences are similar. I have found traditional psychoanalysis and "insight" giving therapies ineffective, but that good results could be achieved, even in cases who had been considered untreatable, with an appropriate change in focus by modifying psychotherapy to meet the individual need and problems of these patients.

The intrinsic therapeutic task must aim at effecting a meaningful change in their selfconcept and sense of incompetence in areas of functioning where they had been deprived of adequate early learning. There is need to evoke awareness of impulses, feelings, and needs as originating within themselves. A patient can become an active participant in the treatment approach, and thus capable of living his life with competence, even enjoyment, and self-directed, when the therapist responds with alertness and consistency, to any selfinitiated behavior and expression.

This formulation is the outgrowth of continuous evaluation, over a period of thirty years, of the therapeutic process, in particular of the difficulties and failures encountered with the traditional psychoanalytic approach. Psychoanalysis has undergone many modifications during that time, and my emphasis on evoking a better functioning self-concept is in agreement with now widely accepted modifications, particularly those

developed for treatment of schizophrenia, borderline states, and narcissistic characters.

The more a therapist conceives of the psychological disorder as expressing oral dependency, incorporative cannibalism, rejection of pregnancy, etc., the more likely he will follow a classical psychoanalytic model. That had been the case in patients who had been unsuccessfully in treatment for many years, who came for therapy, or whom I saw in consultation. The concept that the abnormal eating is a late and secondary step in the whole development, a frantic effort to camouflage underlying problems, or a defense against complete disintegration, has only recently been formulated for anorexia nervosa, and is not widely known.

This orientation leads to a therapeutic approach with focus on a patient's failure in selfexperience and on his defective tools and concepts for organizing and expressing his own needs, and his bewilderment in dealing with others. Instead of interpreting intrapsychic conflicts and the disturbed eating function, therapy will attempt to help him deal with the underlying sense of incompetence, encourage correction of the conceptual deficits and distortions, and thus enable a patient to emerge from his isolation and dissatisfaction. The patients need help with their lacking sense of autonomy, their disturbed self-concept and self-awareness. I have been impressed how often such angry "resisting" patients, if this is communicated to them without

insult to their fragile self-esteem, will become actively interested in therapy, and even will accept the need for food, instead of fighting against it.

Inability in identifying hunger and other bodily sensations is a specific deficiency. Other sensations and feeling tones too, are inaccurately perceived or conceptualized, and this is often associated with a failure in recognizing the implications of interaction with others. These patients suffer from an abiding sense of loneliness, and feel that they are not respected by others, or are insulted and abused, though the real situation may not contain these elements. The process of exploring and examining such situations and of alternatives of interpreting and reacting to them, eventually leads to a patient experiencing himself not as utterly helpless, or the victim of compulsions that overpower him. Examining their own development in this way becomes an important stimulus for their acquiring thus far deficient mental tools. The core problems, their profound sense of ineffectiveness, their lacking self-awareness of their sensations, not feeling in control, not even owning their body and its functions, were recognized as related to deficiencies in the mother-child interaction, which had been without consistent and appropriate responses to child-initiated clues. The therapeutic situation offers the chance for new experiences, where what he has to contribute is acknowledged and reinforced.

This approach involves a reformulation of the therapeutic task, that the

therapist suspend his knowledge and expertise, and permit and encourage a patient to express what he experiences, without immediately explaining and labeling it. Some of the current models of psychiatric training emphasize early formulations of the underlying psychodynamic issues. Such formulations may tempt a therapist to impose premature interpretations on a patient, and thus stand in the way of learning the truly relevant facts. The therapeutic goal is to make it possible for a patient to uncover *his own* abilities, *his* resources and inner capacities for thinking, judging and feeling. Once he has experienced this capacity of self-recognition, the whole atmosphere surrounding therapy will undergo a complete change.

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Notes

1 A series of such therapeutic failures has been reported by H. Bruch, "Perils of Behavior Modification in Treatment of Anorexia Nervosa,"