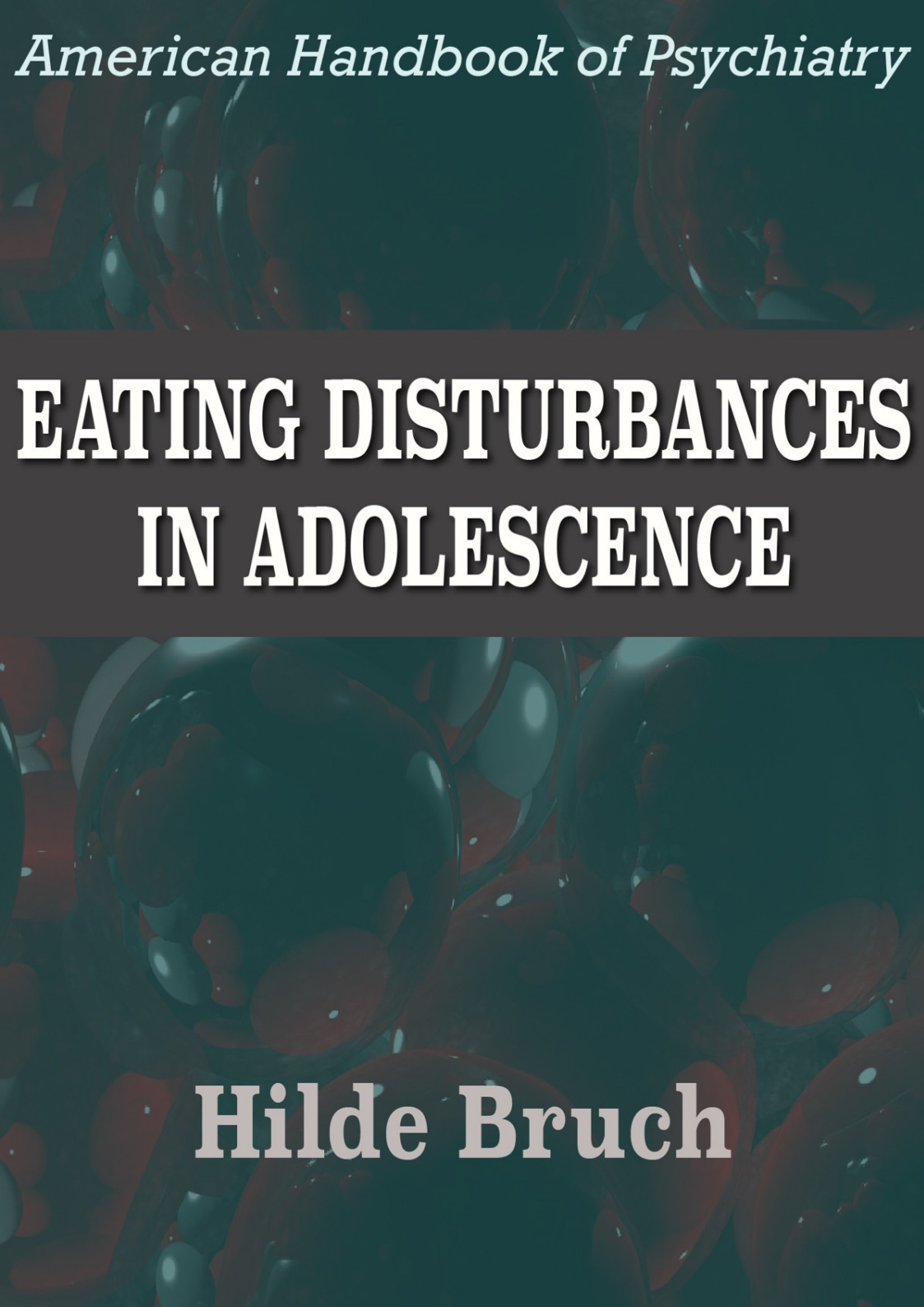
American Handbook of Psychiatry

EATING DISTURBANCES IN ADOLESCENCE



Hilde Bruch

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Hilde Bruch

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EATING DISTURBANCES IN ADOLESCENCE

Definition

The term “eating disturbances” is used here to refer to those conditions where body size and manipulation of food intake are used to solve or camouflage inner and outer adjustment problems. Clinically these disturbances are recognized as obesity, characterized by excessive accumulation of fat tissue, and psychologically by helpless ineffectiveness in the face of bodily urges and social demands, or as anorexia nervosa, extreme leanness and cachexia, representing an over-rigid effort at establishing a sense of control and identity while suffering from an all-pervasive sense of ineffectiveness. Severe psychiatric problems are also encountered in those who maintain what looks like a normal weight but who are continuously preoccupied with their appearance and dietary manipulations, a group referred to as “thin fat people.” Others alternate between phases of rigid reducing followed by rapid weight increase, seemingly unable to stabilize at any weight; they may lose and gain a total of as much as 500 pounds during the adolescent years.

There is probably no other group of people as concerned and preoccupied with their physique and appearance as adolescents, before and after pubescence. They are forever worried about their size, whether they are

too tall or too short, about the adequacy of their sexual maturation, and about their attractiveness in general; but most of all they are preoccupied with their weight. The fear of being too fat, or rated as such, parallels the weight consciousness of our society, which condemns even mild degrees of overweight as ugly, undesirable, and a sign of self-indulgence. Formerly an exceedingly rare disorder, anorexia nervosa seems to be on the increase in Western countries, where slimness is experienced by adolescents as the only respected state.

Growth in Adolescence

Adolescence, the period of active growth and maturation, is characterized by marked changes in eating habits and fluctuations in body weight. Growth during adolescence follows a specific human pattern, rigid in its sequence but varying considerably in intimate details from one individual to another. Growth in stature precedes gain in weight. The filling-out process is greater in girls than in boys and appears to be determined, more than any other factor involved in this complex process of growth, by external factors. It is not uncommon during this period of active growth for some individuals to become plump and for others to become over-slim. It is important to differentiate these normal variations from pathological disturbances of weight and size. Once growth and weight have stabilized, these normal deviations are relatively easy to correct, as is exemplified by the numerous plump adolescents who are successful with reducing programs and remain slim, though often with life-long attention to their eating habits. No information is available on the relative frequency of normal as compared to pathological weight excess. Plumpness or normal weight excess probably represents the more common form of obesity in adolescence, and such patients will not come to the attention of psychiatrists, at least not for problems related to their weight. However, under unfavorable conditions this temporary plumpness may become the starting point of progressive weight increase resulting in severe obesity, or, with excessive emphasis on dieting, it

may lead to anorexia nervosa.

Biological Aspects

There has been in recent years growing awareness that obesity is a rather complex, far from uniform, condition with disturbances in many areas. There is evidence of hereditary factors in some cases, of disturbances in deposition and release of fatty acids, of other metabolic malfunctioning or endocrine imbalance, and of variations in the number of fat cells in the adipose tissues. Another line of investigation has focused on disturbances in the central mechanisms of weight regulation. Extensive studies on animals with experimentally produced microscopic lesions of the hypothalamus and other midbrain regions have elucidated the importance of different cell groups in influencing appetite and satiation. Newer studies emphasize that not only the eating function but also spontaneous activity and motivation are affected by these lesions. The most up-to-date studies on regulation of food and water intake suggest that there are no locations for any specific behavior in any hypothalamic compartment but that the functioning of the nervous system must be approached in an integrated way. An enormous amount of information has accumulated through the study of experimental and genetic obesity in animals. Interesting as these findings are, it is not known to what extent these animal obesities are relevant for man. Their importance lies in the fact that they illustrate vividly that there are different disturbances which have a final common pathway insofar as they lead to abnormal accumulation of adipose tissue.

Clinical interest has gone through definite cycles. During the 1930's concepts of endocrine malfunctioning dominated the field, but these were conceived of in rather simplistic terms. Early psychiatric studies were as much preoccupied with proving the irrelevance of the endocrine factors as with establishing definite psychodynamic profiles. At present there is renewed emphasis on biological disturbances and a much more open-minded approach to psychiatric problems and their interaction with physiological factors. Patients who come to the attention of a psychiatrist have usually undergone exhaustive medical studies in the expectation of finding a definite organic cause. In none of the fat patients referred for psychiatric treatment had there been evidence of endocrine or metabolic disorders, and very few had obese relatives; nor have I seen a case of a thus far unrecognized tumor of the brain associated with obesity, although I have observed several young patients with postencephalitic obesity. In the latter instance, the detailed psychiatric inquiry revealed that the acute changes in weight and eating pattern, and other behavior disturbances, had followed a febrile disease which had not always been recognized as encephalitis. Such patients had developed suddenly, without relationship to an upsetting life event, an uncontrollable urge to eat; they would eat whenever food was available, unrelated to recognizable or definable emotional stress. The clinging and hostile interaction with the family, characteristic of obese patients with emotional disorders, as well as a possessive but mistrusting attitude on the

part of the parents, were absent.

In anorexia nervosa, too, opinion has fluctuated widely concerning the role of organic factors. Gull, in 1873, suggested, by naming the disorder "anorexia nervosa," that mental stress was the causative factor. Lasègue, who described the condition at the same time, ascribed it to the symptom complex of hysteria, which he conceived of as a constitutional disability. The whole discussion was thrown into new focus when Simmonds, in 1914, observed cachexia in cases of emboli in the pituitary gland; for the next two or three decades anorexia nervosa was attributed to hypopituitarism. An extensive literature developed to differentiate the psychiatric syndrome of anorexia nervosa from the effects of endocrine dysfunction. There is at present a tendency to consider all somatic manifestations as secondary to the starvation, a formulation that is not entirely satisfactory. Recent studies suggest that though most of the functions of the anterior pituitary gland are preserved, there is growing evidence that the release of gonadotropin is impaired and gonadal failure may persist even after the malnutrition has been corrected.

Social Aspects

Western culture on the whole has been critical, even contemptuous, of obesity. In the United States, preoccupation with weight, with the demand to be slim, has reached such proportions that every fat person, adolescents in particular, faces some problems in his social relations. The attitude toward obesity and the frequency of its occurrence vary inversely with social class, occurring seven times more often in lower-class women than in those of upper-class status. This suggests that an upper-class fat youngster will encounter more serious psychological and sociological problems than one growing up in a lower-class environment where the attitude toward obesity is less negative.

Though recognition of this attitude is long standing, systematic studies are of recent origin. By comparing a group of obese girls in a reducing camp with girls in a typical summer camp, Monello and Mayer illustrated, through administration of projective tests, the damaging effect of this cultural pressure on obese adolescents. The obese showed heightened sensitivity to and obsessive preoccupation with the state of being fat, combined with a tendency to be passive and to withdraw in the face of group isolation. In evaluating the body image of obese people, the positive or negative attitude toward their own appearance, Stunkard and Mendelson found that obese adults who had been of normal weight during adolescence felt much less

derogatory toward their appearance than those who had been exposed to social rejection and blame for being fat during childhood and adolescence.

Cahnman conducted a sociological study focused on the stigma of obesity and concluded that the obese teenager is discriminated against and made to understand that he deserves it, and thus he comes to accept this treatment as just. As a result, he is unable to escape his condition and settles down to live with it. He becomes timidly withdrawn, eager to please, and tolerant of abuse. Whatever avenues of escape he chooses, he interprets himself in the way that is indicated to him and responds to expectations by accepting the dominant negative attitudes regarding his obese condition.

In my experience, based on several quite distinct population groups, individual obese youngsters will react to this widespread social prejudice according to their sense of competence and independence. The first observations were made during the Depression years on fat children coming from lower-middle- and lower-class homes, often of immigrant background. Conspicuous was the bewilderment of the mothers who could not understand why anybody should object to a child being big and plump. Part of this group was followed into early adulthood; the figures are incomplete and give only approximate percentages of the outcome. Less than one-third outgrew the condition during adolescence, with the encouragement of friends or by separation from their homes. A few made a good general adjustment, though

they remained moderately overweight. Reevaluation of the early records showed that those who had done well in the long run had been accepted by their parents as being heavy, and had not been exposed to relentless pressure to reduce. Those who remained fat or became super-obese had been literally persecuted for being fat by their families and had shown evidence of serious emotional disturbances as children; quite a few became frankly psychotic. They had arrived at adolescence with a low self-esteem and a sense of helplessness, and they reacted with guilt and depression to the critical cultural attitude. Observations in private practice, on middle- and upper-class obese adolescents, led to the same conclusion, that an individual's security and competence were the determining factors for the way he reacted to the damaging social pressure.

Psychiatric Aspects

Psychiatrically, too, obesity and anorexia nervosa are not uniform conditions. In anorexia nervosa two distinct syndrome groups can be recognized. The first is the typical or primary syndrome with relentless pursuit of thinness as a final step in a desperate struggle for control, for a sense of identity and effectiveness. These patients are not primarily anorexic, though frantic preoccupation with food and the most bizarre eating habits may develop in the course of their illness. Many indulge in enormous eating binges with subsequent vomiting, alternating with periods of starvation. Characteristically, they are hyperactive to an unusual degree and deny their cachexic appearance. Less frequent is the atypical or secondary form where weight loss is incidental to some other problem and is often complained of or valued only for its coercive effect. The eating function itself is disturbed, and food is endowed with various symbolic dangerous meanings. The conflicts of conversion hysteria and other psychoneuroses prevail in some cases; in other cases these conflicts are manifest symptoms of schizophrenic reaction or severe depressive illness. These atypical cases vary considerably in the severity of illness and the accessibility to treatment. When these patients have been sick for a long time they look deceptively like cases of true anorexia nervosa and are often labeled with this diagnosis.

It is more difficult to subdivide the enormous number of obese patients.

The psychiatrist will rarely see patients from probably the largest group, those who are overweight on a constitutional basis or exhibit temporary fluctuation in weight. If they suffer from a psychiatric illness, it is not related to the weight, except that in periods of stress such patients are apt to use the excess weight as a focus for self-belittling, or an alibi for difficulties. This is commonly observed in overweight adult patients. The pattern of reactive obesity is also more commonly seen in adults, with the onset of obesity directly related to a definite upsetting event, and the overeating and ensuing obesity serving as a defense against anxiety and depression. When reducing is enforced the depression will become manifest.

The characteristic form of obesity for childhood and adolescence is developmental obesity, in which disturbances in the eating and activity pattern are intrinsically related to the whole process of growth and development. There are many obese adults who are just older representatives of this type. Whether or not they have been heavy as children, concern with size and weight and inability to tolerate frustration or delay in gratification have been central issues in their total development. Many have been fat as far back as they can remember, and their size has always been an important factor in their self-concept and in the environment's reaction to them. Much as the large size is complained of, they cling to it because they fear that by losing body substance they will lose their special strength and power. These obese adolescents engage in megalomaniac daydreams of some special and

outstanding achievement. Nothing they ever achieve comes up to the exaggerated expectation of what they feel they could or are expected to do. They are quite unrealistic in their ambitions and want to be the first and best in everything. If not recognized as special, or if success does not come without effort, they will give up in sullen despair. Such dreams of glory are usually camouflaged by a façade of indifference and are revealed only in the course of therapy. In the anorexics the special achievement is the very control over the body through self-starvation, or their defying nature by staying thin though eating enormous amounts, followed by throwing up.

Not infrequently reality checks break down and a psychotic picture becomes manifest. A dramatic account of such a breakdown of a fat young girl has been told in *I Never Promised You a Rose Garden*.

In spite of the glaring differences in the outer picture, obese and anorexic patients have certain basic disturbances in common. Underlying their manifest stubbornness and negativism is a devastating sense of ineffectiveness, a feeling of being unable to control their bodies and body functions and to direct their lives in general. They often complain about feeling empty and that they are controlled by somebody else; they act and behave as if their center of gravity were not within themselves and as if they were the misshapen and wrong product of somebody else's actions. They lack discriminating awareness of the signals of bodily needs; specifically, they are

unable to recognize hunger and satiation or to discriminate between bodily discomfort and anxiety or other psychological tensions. They have failed to achieve the sense of ownership of their own bodies. They do not experience themselves as effective, separate, and self-directed beings with the ability to identify and to control their bodies. Their failure in weight regulation is not based on some organic defect, as has often been assumed in the past, but on this deficit in self-awareness.

It is this lacking sense of ownership that colors the way obese and anorexic adolescents face the problems of adolescence. Like other adolescents they must prepare themselves for self-sufficiency and independence and emancipate themselves from their families; in particular, they must overcome their dependency on their mothers. Adolescents who develop manifest eating disturbances are poorly equipped for these tasks. The more deficient an individual is in his sense of personal and bodily identity, the less equipped he is to deal successfully with these important new steps. Quite often the adolescent has been overprotected and over-controlled as a child, with few experiences outside the home, so that the need to grow beyond the family's attitudes and values becomes a threatening experience. Frequently, he is also deprived of the support and recognition from his peer group that helps the normal adolescent in his struggle for liberation.

The inability to eat normally sets fat and anorexic adolescents apart.

The question is raised as to how such a basic bodily function as eating develops so that it can be misused in such an inappropriate and distorted fashion. The abnormal eating patterns do not occur in isolation but are always associated with other difficulties in the area of active or passive self-awareness. Detailed reconstruction of the early life experiences, from patients' accounts and transference behavior, and from observations of the transactional patterns during family sessions, suggested that the individual expressions of their needs and discomforts had been disregarded. Characteristically, these patients had been given adequate, even excellent care, from a physical angle, but it had been superimposed according to the mother's concepts of what the child needed instead of being geared to child-initiated clues.

Conceptual Model of Early Development

In order to understand how this pattern of interaction would lead to inaccurate learning of hunger awareness and deficient sense of ownership and self-directiveness, a simplified conceptual model of human development was constructed, with emphasis on the underlying functional processes and transactional patterns. Two basic forms of behavior need to be differentiated from birth on, namely, behavior that is initiated within the infant and behavior in response to stimuli. This distinction applies to both the biological and the social-emotional field. Behavior in relation to the child can be classified as responsive and stimulating. The interaction between the environment and the infant can be rated as appropriate or inappropriate, depending on whether it serves the survival and development of the organism or interferes with it.

Appropriate responses to clues coming from the infant, initially in the biological field and subsequently in the social-emotional field, are essential for his diffuse urges to become organized into differentiated patterns of self-awareness, competence, and effectiveness. If confirmation and reinforcement of his initially rather undifferentiated needs and impulses have been absent, or were contradictory or inaccurate, then a child will grow up perplexed when trying to identify disturbances in his biological field or to differentiate them from emotional and interpersonal disturbances; thus an obese person

will feel “I need to eat,” instead of anger or another appropriate emotion. He will be apt to misinterpret deformities in his self-body concept as externally induced, and will be deficient in his sense of separateness, will experience his body image in a distorted way, and will feel passive and helpless under the influence of internal urges and external forces. These symptoms are also characteristic of schizophrenia; it seems that this developmental scheme offers a clue for the close association of severe eating disorders with schizophrenia.

The reconstructed early feeding histories are often conspicuous by their blandness. This applies in particular to anorexia nervosa, where parents often stress that the patient had been unusually good, happy, and normal as a child. Such parents feel that there is nothing to report, that the child had never given any trouble, had eaten exactly what had been put before him, and did not fuss about food. If a mother’s concepts are not out of line with the child’s physiological needs, he may offer the façade of normality. Obesity in a child may be a measure of a mother’s overestimation of his needs or of her indiscriminate use of food as a universal pacifier. The gross deficit in initiative, inner controls, and active self-awareness, including the inability to regulate one’s food intake, becomes manifest when the child is confronted with new situations and demands for which the misleading routines of his early life have left him unprepared. Not having developed an integrated body concept, he will feel helpless when confronted with the biological, social, and

psychological demands of adolescence. In some, progressive obesity or anorexia becomes manifest under the stress of puberty itself; in others, the illness becomes manifest only at the time of additional new demands, such as entering a new school, separation from home, or when a reducing regime is superimposed.

Though abnormal eating patterns and disturbed body size are the outstanding symptoms, developmental deficits are encountered in many other areas. Conspicuous in the obese are the poor muscular skills, the inability to derive pleasure from athletic activities, and in the anorexics, aimless hyperactivity, a symptom that usually precedes loss in weight. Though somatic pubescence may be observed as adequate, with onset at an average or even early age, one may find serious disturbances in the psychosexual maturation of the adolescent. Amenorrhea and lack of sexual desire are consistently associated with anorexia nervosa. Obese adolescents, too, suffer from confusion and concern about their sexual adequacy. According to popular prejudice, fatness in the male indicates lack of masculinity, and an obese youngster may be paralyzed by the fear of such a defect. Surprisingly few develop overt sexual deviations, such as transvestism or homosexuality; and in fact, these deviations probably occur no more frequently than among the nonobese. Though fatness in a woman looks like an exaggeration of the female form, many adolescent girls have as serious conflicts about their sexual identity as boys; in many it appears to be a more

urgent problem. Some are quite outspoken about having wanted to be a boy, and the hope lingers on that they will be changed one day, or that they will be recognized as belonging to what the Greeks called the third sex, namely, being a man and a woman at the same time.

Corroborative Evidence

The clinical deduction of a deficit in the perceptual and conceptual awareness of hunger has found support from direct observations. Through a series of ingenious experiments in which external factors were manipulated, Schachter demonstrated that obese subjects are affected in their eating habits by external cues, such as the sight of food, its taste and availability, or apparent passage of time, whereas subjects of normal weight will eat according to interoceptive determinants. Stunkard observed that fasting obese women, during contractions of the empty stomach, failed to report awareness of hunger or desire to eat, whereas nonobese women would usually report such sensations. Coddington and Bruch observed that obese and anorexic patients were significantly more inaccurate than healthy normal subjects in recognizing whether or not food had been introduced into the stomach.

The observation of numerous functional deficits in animals reared in complete isolation supports the assumption that seemingly innate functions require learning experiences for their organization. Monkeys raised on wire mothers, when fully grown, were grossly abnormal, apathetic, stereotyped in their response, and incapable of grooming behavior or of mating, though having undergone physiologic puberty. Such isolate monkeys were also deficient in regulating their food intake and exhibited hyperphagia of the

same magnitude as monkeys with hypothalamic lesions.

This model of development as circular, reciprocal transactions between parent and child is also in good agreement with other studies of infancy, though as far as I know, no one else has expressed this in quite as simple and general terms. Piaget spoke of these reciprocal processes as "accommodation," the transformations induced in the child's perceptual schemata and behavior patterns by the environment, and as "assimilation," the incorporation of objects and characteristics of the environment into the child's patterns of perception behavior. Escalona spoke of the infant's experience as the matrix of his psychological growth, and gave many details of the reciprocal transactions between mother and child. Mahler described in detail the individuation-separation processes as circular, when infants were observed in the actual presence of their mothers. While living with families who had produced a hospitalized schizophrenic child, Henry recognized the highly inappropriate ways, duplicated with monotonous sameness day in and day out, with which such mothers would superimpose their own concepts in the feeding situations. In a study aimed at defining factors involved in the development of a child's attachment to his mother, Ainsworth and Bell observed that the differentiating factors were not related to the technique of feeding but to the relevance of the mother's response to the infant's signals of his needs. Mothers who tended to treat too broad a spectrum of clues as signals of hunger, or who wanted to produce a baby who would sleep and

make little demand, would overfeed their babies, who were rated overweight at age three months and continued to be overweight at age one.

Modern neurophysiological thinking has moved in converging directions. Pribram spoke of the servomechanism type of neural organization and suggested that two reciprocally acting mechanisms of control exist and that feedback is ubiquitous in the organization of the nervous system. He proposed a model of brain function that is memory-based rather than drive-based, which means the traces of past and ongoing experiences enter into the organization of patterns. Morgane, through his studies of the regulation of the food and water intake, pointed out that the old concepts of localization and hypothalamic centers are no longer tenable and that a general system approach to several interrelated brain stem areas is necessary for a more useful understanding of brain functioning.

Therapeutic Implications

These considerations are not only of theoretical interest but also of practical importance. Treatment results, medically as well as psychiatrically, have often been unsatisfactory. My experience has been gained chiefly through psychoanalysis and intensive psychotherapy of many obese adolescents and fewer anorexics, who, though intelligent and gifted, had failed in fulfilling the promise of their talents and in achieving interpersonal intimacy; many had experienced unsuccessful psychoanalytic therapy.

Examination of the therapeutic situation as a transactional process suggested that the classical psychoanalytic setting, with the patient expressing his secret thoughts and feelings and the therapist interpreting their unconscious meaning, contained elements that implied the painful re-experience of something that had characterized their whole development, namely of being told by someone else what they felt and how to think. The recognition that a profound sense of ineffectiveness, with deficits in awareness of and control over the body and its functions, was the key issue led to a reformulation of what is essential in the therapeutic process. These patients need help in becoming alerted to any self-initiated feelings, thoughts, and behavior. Thus they may gradually develop awareness of their own participation in the treatment process and in the way they live their lives.

Discriminating awareness of sensations may be experienced in a bodily

function other than eating. It may be as trivial as putting on a sweater because the patient, not mother, feels chilly, or in some small scene in which he recognizes that his own behavior has an effect on other people. Some may never achieve true awareness of physiological hunger. As they learn to discriminate other emotional states and body sensations, and feel more in control of their behavior, the frequency of their misinterpreting various psychological situations as urge to eat will gradually diminish. With increasing competence they may become capable of following a dietary regime.

Case Illustrations

Case 1

This history will serve as an example of normal adjustment in an upper-class obese girl who at age eighteen, five feet one inch tall and weighing 175 pounds, was seen in consultation on request of her mother who complained that her daughter always regained the lost weight after she had put her on a diet. This was an attractive girl who wore clothes flattering to her figure and who felt that her mother tried to run everybody's life. She had always had a supportive friend in her grandmother, from whom she felt she had inherited her makeup, her quiet and considerate temperament, and her short stocky figure. The girl realized that being plump had not been the same social handicap fifty years ago as it is now. However, she had found out that she functioned better, did better in her studies, and was socially more responsive when she had what she felt was her natural weight. When she tried to reduce, and she has repeatedly lost ten or twenty pounds, she felt so tense and uneasy that she had decided that it was better for her to maintain her present stable weight.

She was grateful for the support of her view that her general functioning was more important than her weight. About a year later she became engaged to an attractive young man with whom she shared many interests. When she raised the question that her weight might be socially embarrassing, he replied

that he was marrying a person not a figure. Their marriage turned out well. Ten years and two pregnancies later her weight was exactly what it had been at age eighteen, too plump by contemporary fashionable standards but not interfering with an active and meaningful life.

Case 2

In this case, obsessive concern with weight and figure was a camouflage for deep-seated self-doubt and confusion. This eighteen-year-old girl, a senior in high school, had become so depressed that she had to interrupt her studies. She had always felt she was destined to lead a lonely life because no man could love her because she was "too fat" and a brilliant student. She was tall, five feet eight inches. Her weight had never been above 135 pounds, but since age fifteen she had been obsessed with dieting. She had forced her weight down to 110 pounds but then was acutely unhappy and embarrassed by remarks about her being too skinny. She tried to be less conscientious about her school work in a effort to be like everybody else, but then was unhappy when her grades dropped. For a while she dated a young man and took part in social activities. She became alarmed and severely depressed when she gained some weight, to about 125 pounds, and now missed the remarks about how thin she looked.

Though extreme, concern like hers is akin to that of many modern

adolescents who feel attractiveness is measured in pounds and inches, and who will use any degree of plumpness as alibi to avoid social, in particular sexual, contacts.

Case 3

In anorexia nervosa the picture is usually so complicated by the severe problems that self-starvation provoke in a family that it is often difficult to recognize the dynamic constellation at the time of its development. Situations with information before the illness are of particular interest. In the case of a socially prominent upper-class family, there had been a consultation about an older daughter, who was markedly obese at age eighteen, when the younger, anorexic girl was only twelve years old. The mother asked for help because she resented her daughter s obesity and was aware that her own concern was excessive. She spoke in glowing terms about her younger daughter, who was the ideal child. Her teachers would refer to the latter as the best balanced girl in school, and relied on her warmth and friendliness when other students had social difficulties. After the anorexia developed it could be recognized how the anxious and often punitive concern with the older sister's obesity had influenced the younger girl's thinking and self-concept, convincing her that being fat was an almost shameful and deplorable fate. The rapid weight increase during puberty horrified her, and she felt she was deserving of respect only by being thin. This conviction precipitated a starvation regime,

and her weight dropped from 125 pounds to 80 pounds. This coincided with her beginning to realize that life was not just filling the mold into which her parents had poured her, but that she was expected to be master of her fate. The frantic preoccupation with her weight and body was an effort to establish mastery, at least in one area.

Case 4

This sixteen-year-old fat boy, only 61 inches tall and weighing over 200 pounds, threatened to drop out of school because he felt he was not able to be as good as he should or wanted to be. He had been sickly as a child, and he had often heard it said that he owed his life to his mother's devoted efforts. She had been outraged when he grew fat as an adolescent, and it was a crowning insult when his school record went down. After he had made considerable progress in therapy he confessed one day, "What's the use of going to school and studying if you cannot be the best in everything?" This preoccupation interfered with his studying. When he sat down to do his homework, the question flashed through his mind, "Even if I tried hard, who guarantees that somebody else will not do it better?" In his frustration he would eat whatever he could find, though he hated being fat. He wished that he were six years old again, starting first grade; then he could make A's all through the school years, and he would not need to worry. Even if he tried now, it would not be good enough, because he had not been the best student

throughout school, and his life was ruined.

Once this topic had been touched on he revealed the most amazing overambitious plans which would make his life worth living. He had seen a movie about the first ascent of the highest mountain. “That movie shows exactly how I feel. The only one who counts is the one who goes on a mountain for the first time. That is something special. The rest, all those mountain climbers, they just do exercise, they don’t count.”

From then on he spoke by the hour about his dreams of achievement. To be known, to have a famous name, and to be remembered, that was what counted. There were two main ambitions: one was to do something so great, something so helpful for mankind, that his name would be remembered even after 500 years. But he would not hesitate to commit a crime in order to get his name in the papers. In his dreams of doing something spectacular he compared himself to great people of the past. Galileo was his hero. “If you are not doing something great, if your name is not remembered, then I don’t see why we should live at all. One day you will die, you will get buried; it would be much better not to have lived at all.”

If he could not be remembered for having done something great, then he would not mind being remembered as the most vicious or the most conceited person, just as long as he were to become well known. “I would be glad to be

remembered if it were only for being conceited," and he spoke of Wagner, the composer. His therapist agreed that Wagner had this reputation, but added, "But that is not why he is remembered. In addition he was a superb musician: he is remembered for his music; he delivered the goods." This comment touched on what troubled him the most: He was afraid that he could not deliver the goods; his deepest fear was not being good enough in anything, and he had tried to build himself up with all these glorious daydreams. Nothing but the extraordinary and spectacular could protect him against this terror of being nothing, of not feeling really alive.

Mention was made of his great size making him outstanding and conspicuous. He hesitated and then admitted that his fatness was something special; it did set him apart. Though he said he hated it, there was a certain gratification in having his family continuously talk and worry about his enormous size; being so large was something extraordinary. Such pride in size is expressed by many fat people, all the embarrassment and humiliation notwithstanding.

Case 5

The discrepancy between unrealistic aspirations and inner conviction of incompetence may result in psychosis. A sixteen-year-old boy, who had been obese most of his life, suffered an acute psychotic episode shortly after

entering a liberal boarding school of his own choosing. There had been continuous conflicts at home about his insolent behavior and his greedy and unmannered eating. He expected to make friends at this school where no one remembered him as fat and awkward, which he felt had made him lonely and friendless. He hoped to become a member of the football team. He had lost some weight during the preceding summer, and his muscles had developed. He was confident that his large size, which until then had been the source of his suffering, would now become an asset.

The first day of practice was a terrible disappointment. The workout was hard and demanding, and there was no glory in it at all. He stumbled on the staircase and sprained his ankle, and thus was dropped from the team. This was a great relief to him, but it also meant the end of his dreams of glory.

The many rules and regulations at the school were disturbing to him. He had built up a case against his father for insisting on punctuality, cleanliness, and courtesy, and now he discovered that the rules at home had been lax in comparison with the rules at school. This insight, however, did not give him any relief, for it left him without justification for his hostile feelings and hatred. He could not concentrate on his studies and became increasingly worried about failing. Then he began to worry about his mental state and became really panicky.

He made some efforts to participate in group activities, but he could not make real contact. He withdrew more and more into a fantasy life in which he was the leader of a group of boys who, as a kind of people's court, controlled the student body. He was the chief executioner and dealt out the punishments. He loved the position of power, but was afraid that he might abuse his power and that the others might take revenge. It frightened him that he would like to kill someone and get away with it, but it also delighted him that he had this feeling of power over life and death. He was unable to differentiate between fact and fantasy, and when recounting this would insist that he really had been head man, the most respected boy in school.

Actually he had spent most of the time in the infirmary with vague complaints, chiefly headaches and abdominal pain. He became furious when it was suggested that his stomach pains might be related to the enormous amounts he ate; his weight had risen to approximately 280 pounds. He became more and more involved in his aggressive notions, and one evening staggered to the house of the headmaster, telling a gruesome tale about a bloody fight between two other boys in which he had interfered to prevent them from killing each other. He was afraid that they would now turn against him, and he no longer felt safe. The delusional nature of this story was recognized, and he was sent home. He was admitted to a psychiatric hospital where he made a recovery after a lengthy treatment. His weight stabilized at 200 pounds, somewhat heavy for his height but not as conspicuously fat as he

had been as a young adolescent.

Case 6

This history is given as an example of a schizophrenic reaction with extreme passivity and helplessness in a young girl who had been perfect in her parents' eyes until age fourteen, when she became plump. The father, a self-made man, was obsessively concerned with appearance and position and insisted that his wife and daughter should be slim. When fifteen years old she was persuaded to go on a diet with her mother, who subsequently maintained her weight loss. However, for the patient a period of weight fluctuation of between 105 and 170 pounds began. After entering college she soon returned to her parents' home, sleeping constantly and desiring to be left severely alone. After a course of electro-convulsive therapy (ETC) she became extremely antagonistic, suspicious, and threatening toward her parents. Less than a year after she moved out of her parents' home she was admitted to a psychiatric hospital, having progressively gained weight.

Outstanding in her behavior was her conformity, her complete inability to say no to any request, her complaining of emptiness when no one told her what to do, her mentioning that in the past, "Mother always knew what I was thinking." She was preoccupied with food, felt that it had human characteristics, only it was better. "It is always there. People are not

comfortable, but with food you don't have to make excuses, you just take. With people you have to be polite all the time and you can't say No." She ate without awareness of hunger, experiencing only an undifferentiated, uncomfortable feeling. "I feel so empty, I do not know who I am." She would wake up from sleep intensely anxious. "I feel pulled down on my bed; all my muscles are pulled back. It is a horrible experience that I cannot move." Awake, too, she suffered anxiety attacks with the feeling of floating, of having no body. Often she felt befuddled, not knowing whether she was asleep or awake. At times she was confused about temperature sensations, not knowing whether she felt warm or chilly.

This girl who had been raised as an exhibit for her vain parents gave the façade of normalcy until she was separated from them, when, without autonomy or self-reliance, she felt unable to protect herself against demands by any one she met. Her inability to control her weight was only one aspect of this developmental deficit, with obesity as the leading complaint.

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