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Though in this paper I deal with anorexia as it is best known, namely as an eating disorder, anorexia is more accurately a metaphor. I have never encountered a patient who was not in some degree enthralled with his or her capacity to do without. To say this is to say that anorexia, or anhedonia, is at once a kind of mastery and a special way of coping with envy.

Envy, of course, is what the have-nots feel in respect to the haves. When we are envious, it is of the other's wherewithal. The anorectic does not envy food or drink; she envies the capacity of the Other to manufacture and supply it. This is what incites the anorectic to a kind of hostile takeover. The anorectic's refusals become for the Other a kind of bad and empty breast, a no-thing from which only pain and frustration flow. The mother of the anorectic wants her daughter to "Take a little chicken, try a little…" not only because she wishes her daughter well, but because her skinny daughter represents a breast that excites her longings, frustration, hatred, and envy. The tables have been turned. The daughter can now imagine it is she who owns and controls the wherewithal.

The capacity to do without shows up in the therapy situation in many forms, among which wanting fewer sessions, coming late and leaving early, being indifferent to or forgetting what the analyst may have to say are commonplace. Because these behaviors are also manifestations of the patient's need to regulate the "volume" of the therapeutic encounter, the analyst needs to distinguish regulatory activity from the enactment of devaluative role reversals. When he or she begins to feel resentful of the patient and begins, for example, to make interpretations that start with the sentiment, "It is easier for you to…", envy has likely come into it.

The truly envious do not, despite their need, seek therapy. They do not like the would-be therapist to have something to offer. One of the reasons for the success of self-help groups like AA and its derivatives is because there is no one to envy. Alcoholics, after all, have substituted the booze for the supplier often precisely out of unbearable envy, and cannot be expected to seek a cure that throws them headlong into what with such effort and pain they have barely evaded.

But the pain of envy is everywhere, even in people who do submit to becoming patients. The "anorexia" of the patient who hasn't an eating disorder is also over the issue of supply: Who develops and supplies the material? Who develops and works up the insights? Many people long to have given birth and life to themselves. However flawed they feel, they are at least their own work of art and science. In the "Treatment" paper to follow this one, I note that the therapy will be tolerated only insofar as the patient can feel essential to the treatment. This may seem an odd thing to say; nevertheless it is true that there are times in even the best of work when one finds oneself telling rather than discovering with the patient what the interpretation is. Or explaining without demonstrating.

About what anorexia nervosa consists as a disease entity there is little disagreement. Since Morton—in 1689, and Gill—in 1874 (Piazza et al. 1980), the description is much the same: self-starvation to a loss of 20-30 percent of the body weight previous to the onset of the illness; cessation of the menses (sometimes before the weight loss or, in bulimia, not always explicably attached to nutrition or weight); and an indifference, approximating the "la belle,"

to the fatal consequences of the programme of weight loss. Traditionally, too, the sufferer has been (85:15 percent) female in gender, and more often than not identified with upper-middle-class backgrounds (Bruch 1973; cf. Piazza et al. 1980; Thoma 1967). Alarmingly, the incidence of the illness appears to be on the increase: up to 200 percent in the last decade (cf. *Life Magazine* 1982).

I say "alarmingly" both because the illness is serious (a 10-15 percent estimate of fatality) and because the long-term prognosis is not satisfactory. People make symptomatic recoveries, but it is not clear that many go on to flourish (Hsu 1980).

If there is agreement about the nature of the symptoms, however, there is by no means a consensus about what the symptoms mean. What is it, exactly, that is being compromised in the compromise-formation that Freud regarded symptoms as embodying?

Part of this uncertainty may arise from the assumption that anorexia nervosa is the same manifestation in all sufferers. As I shall attempt to demonstrate, there is a grave anorexia and a more transitory—even faddish—one. They are related to the same conflicts, but one is temporary, phase specific, later in arriving, and often as spontaneously surrendered as it was adopted. At its worst it does not reach the proportions of the more serious illness and indeed may be present in the form of a fastidiousness about food intake in people whom one would not at first blush see as belonging to the same nosology: some—not all—vegetarians or health food devotees, people with concerns about exercise and training, and so on. (Men may show up in these areas escaping notice as anorectics.) Here one may note one of the other paradoxes that confound this problem: anorexia nervosa is a misnomer; anorexia means loss of appetite. Only in certain cases or at certain times is this true. Usually the anorectic feels ravenous. In bulimia, a variant of anorexia, this leads to "binge" eating.

The other cause of the uncertainty as to the nature of the illness is its relatively refractory quality when psychoanalysis as a psychotherapy is applied. A major reason is this: the analyst, in so far as he maintains his neutrality, is considered by his anorectic patient a superior sort of anorectic! I shall elaborate this point presently; for now I will simply register it as one reason for the entry into the treatment field of family therapists, behavior modification engineers and psychotherapists of less classical dispositions. Bruch, to whose careful amassing of data I am otherwise indebted, puts it this way:

> It seems that many therapists in approaching an anorectic patient are tied to outmoded psychoanalytic

> treatment, even those who otherwise work with contemporary concepts. Many stress the symbolic meaning of the noneating and the unconscious problems, fantasies and dreams and interpret their meaning to the patient.... It does not matter whether or not an interpretation is correct; what is harmful is that it confirms a patient's fear of being defective and incompetent and doomed to dependence. [Bruch 1978]

Bad psychoanalysis is not "good" for anyone. And it is true that, as I indicated, anorectics, because what we call their symptoms they call their salvation (the religious connotation is deliberate), make for tough patients. But since an interest of mine is distinguishing the baby and the bathwater, anorectics, precisely because they are often so difficult to treat, repay my effort by helping me to see what helps, methodologically speaking, and what doesn't and why. Then, too, I was a finicky eater as a child, only partly consequent to celiac syndrome, and my own analytic work had perforce to attend to those areas of experience. Since it is necessary to ask especially little of anorectic patients, food for thought for these two areas of my interest sustain me when the going is particularly difficult or chaotic.

At some point, usually at the onset of puberty or, thereafter, at a time of separation like going off to school, camp, or college, some people develop a desperate need to control their intake of food. This may start off as an attempt to diet in the usual way, but it presently becomes tantamount to an obsession with amounts eaten, amounts lost, amounts gained. Holding aside the "choice" of obsession for a moment, the obsessiveness itself, like other obsessions, lends a certain density (as novas called black holes have density) to the world of experience. Everything that has dimensionality and depth is condensed into a peculiarly flat, unsensuous singlemindedness concerning intake and weight, calories and pounds.

This is the achievement of envy. The object whose value is heightened by the imminence of separation—whether that of pubescence or that of distance—is denuded of value. It does not seem to exist. When one might otherwise expect yearning or loneliness or the fright of aloneness, one sees instead a world narrowed to a pin-prick of light: the obsession with looks and weight. The object—mother, father, breast, penis, feces—is "gone."

What happened, then, to appetite and greed, to longing and object love? They are there, of course, in such measure, indeed, that the anorectic feels imperiled by them. Hence the attempt at repression. But such longings made all the more powerful by suppression of satisfaction and repression of the knowledge of what it is that is satisfying, cannot be ignored. It is imperative that as the repression fails, projections take its place. As the anorectic will in the analysis resist the transference by stimulating the countertransference, so in the family her refusal to eat "sensibly" excites (or reexcites) longings, tantamount in their intensity to transferences, from the parents. By

concentrating her attention to her parents' wants the anorectic can become relatively oblivious of her own.

We think of a projection as a sleight of mind, of a fantasy in which intentions or attributes previously associated by a person with himself, as his own, are assigned new authorship. And, indeed, when necessary, people do imagine such a deportation. But what if the other to whom the reassignments are made fails to act consonantly with them? Either the projection fails or the projector must put such distance between him and the unaltered reality as to fail to observe it as unaltered, or he must interfere with his powers of observation—the observing ego. The last is the road to psychosis. The anorectic generally manages by her refusals to project her wishes for food and all it symbolizes (I shall come to that) "successfully." That is, parents and doctors do want her to eat in the precise measure she seems not to want to eat. At times these others will feed her through nasogastric tubes or I.V.s, or compel her submission with powerful antidepressant or antipsychotic medications. The others, in accepting the anorectic's projections, convert the projections into projective indentifications.

Such family therapists as Minuchin understand something of this. That is, they seem to understand that such "collusion" is necessary and that once in place, it is expedient to work with the family "system" that holds it in place (Minuchin et al. 1978).

Minuchin, for example, attempts to redefine the anorexia as adolescent rebellion. He stages a confrontation of which the centerpiece is a luncheon meeting with several of the rest of the family and what he calls the "designated" patient. The task he sets is for the parents, first together then individually, to make the anorectic eat. Generally speaking, they cannot. There is tension between the two parents, which they resolve by appealing to their daughter. He calls this "triangulation." For my present purposes, it is enough that they want more from her than for her. When each parent separately has failed (more or less) to "make" their child eat, Minuchin displays to them and herself the tyranny of the patient, and in balance, at the same time the parents' contribution to foiling "rebelliousness" in respects other than in matters of food intake.

In this he agreed with Bruch (1978), who also places great emphasis on the remarkable co-operativeness of the anorectic in her "pre-morbid state": she is what is generally thought of as "a good child," submissive to what ambitious parents in the bourgeois Western World often ask of their children.

My own experiences construe these data differently. The preanorectic history reveals the same dynamic as the post. Throughout, the anorectic does not wish to want: she wishes to be the object of others' wants. What earlier

she achieved by docile cooperativeness, later she will achieve by stimulating people to want her to eat. Her repressions (so strong are her longings) will continue to need buttressing by projections.

These longings and their strength must now occupy us. They consist of a greed akin to gluttony. The very ruthlessness of this gluttony, its imperiousness in mentally disassociating the mother from the breast, is what makes first the model child disposition and later the anorexia such an achievement. By the simple expedient of declaring *Less is More*, greed for the breast is metamorphosed into a gluttony for punishment, yearning into abstinence, retention into elimination (in bulimia) via each and every alimentary orifice, indeed, by exercise and sweating, through the very pores themselves.

In structural terms, the nascent ego is so helpless against the strength of the (first oral, later other) drives that it can but infuse the superego with the drive energy, projecting what is left over into the parents and reinternalizing the parents, now transformed with predatory characteristics, into a precocious superego. At puberty or thereafter the only alternative to enslavement by either the internal objects or the parents is adherence to an ego-ideal which maintains the asceticism in look and deed in its core of autonomy.

Here is an example from one of Bruch's patients:

> "Sometimes I hear voices or feel things in my head and sometimes I get frightening mental images." The voices seemed to be in the conflict, some telling her to "eat, eat, eat" and others, "don't, don't, don't." These food thoughts filled her mind so completely that they drowned out her former interests.... At times she felt full of her mother—"I feel she is in me—even if she isn't there." [Bruch 1978, p.53]

(1) *I* do not want. (2) She, He, It wants. And (3) They shall not have what they want. The first asseveration leads to martyrdom, even sainthood. The world is safe from the subject's depredations. It is a statement of renunciation. The second also has a religious air; in earlier days, it might have been Satan who wants, working through others or through "It" the body, loathsome and corrupt. The third is more overtly spiteful.

The "Breast" is *so* desirable that its power cannot be forgiven. There is a detonation in the simultaneity of desire and envy. Somehow people who become anorectic (though it is not limited to anorectics) cannot get resigned to receiving. They want to possess. The very act of reception "reminds" them that they do not possess, and that is intolerable. The solution is obvious. Do not receive, do not take. Do not let them know they have what you want. Spoil it for them so they cannot revel in their possession of what is so infinitely desirable. The hope to possess gives over to envy, spite and revenge (for a further discussion of hope, see Boris 1976).

The hatred inspired by such envy is offset by the religious activity of renunciation and submissiveness. These latter, as I have indicated, serve also the purposes of first projecting and then experiencing desire as if one were the object, not the subject, of desire. Hence the seeming tractability of the premorbid anorectic.

But to be the object of desire, in the parsing of the anorectic, means also to be the object of admiration. Hence the strong achievement motif that predates the anorexia and finds its surreal outcome finally in the achievement of starvation and a thinness non pareil. Ordinarily, "a well lived life is the best revenge," to quote the proverb. The anorectic's envy of the breast is such that she cannot acknowledge its particular characteristics (to do so would also risk a resurgence of desire). She cannot therefore have a puberty and thereafter a breast-body the equal of or superior to her (early) mother's, as other envious children strive to have. Her breast-body-appetite is not of the positive, or actual breast, but of, as it were, a negative afterimage of it—the breast that is left after envy has negated what is desirable about it. In this respect the anorectic can episodically believe she is beautiful and not a bag of bones.

There is, of course, an alternative to enviously acquiring the breast ruined and deformed by spite. This is to spurn femininity altogether and acquire masculine characteristics. Much, indeed, has been made of the loss of the menses, the protuberance of the pubic region after all body fat has been lost, the hirsute look that accompanies these, and the undoubted admiration of masculine attributes (cf. Bruch 1978). But this, in my experience, is only partly true.

To see why, we have to begin with the anorectic's *bete noir*—desire. As desire becomes retracted from the person and possessions of the mother, due to frustration and envy, and equally ravenous, equally ruthless greed is directed to the father and his breast, the penis.

(Intercourse and conception are assumed to take place orally; eating and copulation are almost identical. One patient dreams: My roommate and her boyfriend, [once my patient's boyfriend] and my father and I are sitting around. Suddenly the lights go off. When the lights come back on they [the roommate and boyfriend] jump up and straighten their clothes. I know they have been making love. My father, all this while, was sitting around like a bump on a log. I feel disgusted. I say "C'mon into the kitchen. We may as well eat.")

The plight of the anorectic is such that the same simultaneity of desire and envy is repeated in respect to the father. But if she "acquires" her father's attributes, she also *mutatis mutandum* acquires his desires and these are for intercourse with her discredited mother. Out of the frying pan, she is back into the fire: each solution poses a fresh

problem. The anorectic's solution, as I have been saying, is to stimulate desire and envy in the other, to become object not subject. Thus as her father comes into the picture she attempts to seduce both his desire and his envy: to be worthy of his love and admiration but to foil those comfortable feelings by inciting, through her achievements, his frustration and envy. Those patients who are or have become "anorectic personalities" rather than symptomatically anorexic, develop crushes on men they scarcely know. These men are so "wonderful" that it is a "miracle" they have any interest in the patient at all. Yet in no time, the man, by his desire for her, demonstrates his fallibility. To complete the task of converting phallability into fallibility, the patient picks him apart point by point as if every defect in him is an enhancement of her.

The anorectic will not be found wanting, in both senses of that word.

The oedipal situation, re-igniting longing and adding jealousy to the already intense portion of possessiveness, accordingly produces a further crisis. The anorectic deals with this in two ways. First she changes the idea that genital sexuality of a reciprocal kind is involved: she wants to imagine the primal scene as something in which she could, if she wanted, participate. Looking is an activity open to a child which accommodates orality, anality, and genitality all at once. Once she alchemizes all longings into looking, she has only to reverse object and subject—the direction of the arrow—in the way she has become practiced at.

Here is another dream from the same patient. I am at a cocktail party. Everyone has someone to talk to. There is no way to break in. _____ , [a male colleague] though, seems to be able to get in. I feel horribly jealous. I follow after him. I want to imitate him, to see how he does it, as if by, like gluing myself to him I can acquire his technique. The scene changes. Now I am with a group of the women at the party. We are having lunch. Everyone has brought a sandwich. Mine is just plain, like peanut butter and jelly. One woman has a very elegant sandwich, maybe, I don't know, sprouts or something. Fancy. Everyone admires it. She passes it around the circle. When it comes to me, instead of looking at it, I take a big bite out of it. Suddenly I realize this is the wrong thing to have done. We are only supposed to look. Everyone is looking at me. I feel stupid and awful. Awful. In the next scene I am alone. I am starved, but it is also like I ate too much. The usual feelings I often have. I feel gross and fat and awful.

In the context of this woman's life history, I understand the dream to rework primal scene experiences successfully into the anorexic solution. More generally, it illustrates the "oralization" of experience, the all-purpose

value of looking and being looked at and, by implication, the problem of body image—for when so bad a light is cast on both mother's femininity and father's masculinity, what, at puberty, is there left to grow up into?

Obliterating everything is hunger. Elsewhere I have written of the options open to us when we do not wish to know what we experience (Boris 1976). I used the example of Aesop's "Fox and The Sour Grapes," observing that it was indeed easier for the fox to ease his frustration (he was hungry) and helplessness (he could not reach the grapes) by deeming them sour than by changing any other element in the experience: "I, a hungry fox, want but cannot reach the good sweet grapes." The sweetness of the grapes, untastable, could not call him liar: his fictionalization of the experience was safe. To rid oneself of the knowledge of "I-ness," "Fox-ness," indeed hunger was much more difficult. Hunger has a way of asserting itself undeniably; one cannot repress hunger, much less the knowledge of hunger. It will, out, particularly when compared to the hypothetical quality of the sweetness of untasted grapes.

It is precisely this fact that the anorectic seizes upon. Hunger is undeniable and durable. At sufficient levels of intensity it makes one oblivious of everything else. (Accounts by people who were in concentration camps give poignant testimony of this.) For the anorectic that means everything else is obliterated. If they are not obliterated by hunger itself filling the furthest reaches of the mind, they are obliterated by the experience of eating—bingeing—and then by mortification of the spirit or, via diuretics, laxatives, or vomiting, or compulsive exercise, of the flesh. For people of a different stripe, eating consoles loneliness; for the anorectic it is precisely hunger itself that paradoxically serves as the anodyne for loneliness.

I have already alluded to how hunger serves envy and now again to how it short-circuits desire for contact with people. I have shown how this spares people enslavement by the anorectic and spares the anorectic enslavement by both people and their internalized imagos. Now I need to discuss the anorectic's relationship to the food itself.

To my mind, this is the heart of the matter. The anorectic does not have a good set of boundaries. Just as food-hunger is a ruse, the flames of which are fanned to obscure object hunger, so food itself is a counterfeit substance to substitute for a longing for fusion—for being touched by hand and eye and voice, for being held in body and mind.

Since so many writers have addressed this question of "fusion" from so many different viewpoints, I need to be clear about the sense in which I am using the term. The best approximation to what I have observed in my

patients is represented by Winnicott's ideas concerning the transitional object, or at least a variation of those ideas (Winnicott 1953).

Sometimes Teddybear, the transitional object, is a baby who wants to eat: an I-baby. Sometimes a naughty greedy teddy: a not-me baby. Sometimes it is a teddy who comforts: an other (than-myself) figure. Sometimes, sadly, it is a malignant other, who wishes to eat me. But whatever its evolution, it is a not-quite-me, not-quite-actual-other figure, and it occupies the space between where I end and the other, usually mother, begins, and vice-versa.

Though variously populated by various incarnations of teddy or Linus-blanket or whatever, the space itself is there because the boundaries have become tolerable. Indeed, separation in the sense of individuation, like a tennis net, makes certain experiences possible which might otherwise not be. The transitional space is like a buffer, a neutral zone, between two bodies (as if a demilitarized zone) which makes room for the play of imagination and the apprehension of reality—both. The painter steps back from his canvas to gain perspective and then goes close to create illusion, so the space facilitates each operation, assuring, with practice, each boundary.

The anorectic shows every indication of having failed either to establish or maintain those boundaries and hence that space. I believe this to be a by-product of the envy which wishes to deny mother her "breast"—to deny that the breast travels with mother. The result is that the transitional space that under other circumstances is fashioned or maintained (depending on one's school of thought) between two people gets fashioned or refashioned (again depending) within the boundary the anorectic regards as herself space.

Language is awkward here. What I want to say is that there is an in-myself space for the anorectic, which is not congruent with an of-myself space, sensation, or image. Food has a mystifying (and frightening) way of going from outside to inside in a hurry. Many anorectic slow that terrifying hurry down by not keeping food handy or not going where food is. The lack of transition in terms of time is made up for in space, or the other way round as when food in hand is eaten slowly, chewed many times before swallowing.

That poor space-time transition necessitates the compensatory inner space for purposes both of individuation—me/not-me, and buffering—me/you. Put in graphic terms Me | Not-me-not-you | You, which is the sort of boundary and space arrangement other people might have is for the anorectic Me-not-me | Not-you-you. Food that crosses the | boundary produces a crisis: It could so easily cross the wavering line and insecure space between in-me and of-me.

The first line of defense is a restriction of intake: with it intact, hunger takes up all one's time and space. But hunger is a chancy friend: one so wants to eat. When one does, the alien food becomes akin to a foreign object in one's being. It lodges there, in danger of being assimilated (or assimilating one) but susceptible to being vitiated or expelled before it becomes of-myself and causes one to flourish despite one's self. Thus the demonic exercising, the diuretics and laxatives, the self-induced vomiting.

The paradox in all of this is that both envy and longing erode the space: for once, these two efforts to relate work in consort. The wish to deny the mother her separateness and the longing to be at one with her cause the anorectic hatefully to destroy her sense of separateness. The feeling of being enslaved by the other follows from this. It is a relief when she is enslaved by her hunger. So, what many of us fear most, starvation unto death, becomes the best riposte to what the anorectic fears most, enslavement by the desirability of the other; and, when projected, enslavement by the desires of the other; and when dissimulated into the food-hunger condensation, enslaved by food and the effects of food, namely weight. Bettelheim's phrase for autism comes to mind: "The empty fortress."

All the same, the transformations that comprise what finally emerges as anorexia represent quite a feat, and it is no wonder that the anorectic regards her achievement as a solution to a problem and decidedly not a problem needing a solution. And in the degree to which anorexia is not ego-alien the anorectic is not a good candidate for a therapeutic alliance and for a psychoanalysis of the sort that depends on such an alliance. Nevertheless, I must take issue with those who, like Bruch and Minuchin, doubt the efficacy of interpretive work, though I should not like to be misunderstood to be saying that I question their work. What I mean to say is that anorexia is a kind of culminating response to quite early difficulties that fulminate with puberty and/or separation and fail otherwise to be resolved. This it has in common with many other psychological configurations. As such, it, like they, can be finessed as Minuchin does, or worked with in ways to support autonomy, a sense of self and self-esteem, as Bruch does. Both these workers begin with a profound respect for the achievement that anorexia represents.

But the infantile neurosis of which the anorexia, however severe or temporary, is an evolution is not susceptible of resolution without interpretation of the fantasies on which it is based. And that is the very stuff of psychoanalysis. The obstacles posed are formidable, and I leave their consideration to another communication (Boris 1984) (see chapter 12). For now I want only to address the matter of the seemingly epidemic increase of anorexia in certain segments of the population.

In a speculative turn of mind, Bion (1961) wrote of "proto-mental state," of a "dis-ease" needing somehow to find a way of becoming a disease, physical, psychological or even spiritual or political (if one allows the license of linking disease with matters sacred and sociological). The precise form it took, he speculated, might have to do with cultural availability and group sanction.

The dis-ease I have encountered at the base of what evolves into anorexia is at the fundament of the human "condition"—desire, hope and envy, repression, projection and projective identification, fusion, confusion and separation, enslavement, refuge and reaction formation, boundaries of time and spaces, salvation, reparation and guilt. Indeed some readers may feel that in all of what I said I failed to say what "caused" anorexia, so much at root has anorexia in common with other problematic conditions.

But the relationship between the dis-ease and the disease has not yet been explored from a sophisticated viewpoint. Given the raw stuff of the dis-ease, one could say with Minuchin, Laing (1967), and others that only in susceptible families could the particular disease happen—families capable of certain reciprocal transferences. Some commentators refer to our society's premium on slimness and dieting, and surely the anorectic's capacity to out-diet anyone might contribute. Surely she wishes to excite envy when admiration isn't in plentiful supply. But there is a zeal to the anorectic which in another age or a different family might take a religious turn—at least in a vocation, possibly in martyrdom. In another age or cultural corner the asceticism of the anorectic might take a turn toward political revolution, philosophical nihilism, even a time in the Peace Corps or Marine Corps.

Looked at the other way round, it is hard to think of anorexia occurring in the midst of general impoverishment, though one could certainly see it as a response to enforced starvation.

With the anorectic, I am inclined to think anorexia a solution—a way of breaking away by doing without, a way of coming into one's own, a way of doing penance for unremembered sins, a way of achieving mastery over greed. It permits a way of separating from the thrall of the parent via an alliance with a group that repudiates succor and ease. The group, as Sullivan (1953) and Redl (1945) noted, is the way clear of the parent: and if the group is a "Me generation," as sociologists have characterized today's young people, then the negative group (counterculture) is a Not-me group, based on renunciation of previously valued achievements. Alliance with and allegiance to that group permits the dis-ease of the earliest months and years to become the respectable disease of adolescence and young adulthood. If only people knew!

Still, it is for some, not all, a disease that is not a passage but a stopping point, and it needs the sort of treatment that, for all our limitations, only psychoanalysis can supply.

REFERENCES

Bion, W. R. (1961). *Experiences in Groups*. New York: Basic Books.

Boris, H. N. (1976). On hope: its nature and psycho-therapy. *International Review of Psycho-Analysis*. 3:141-150.

_____ (1984). On the treatment of anorexia nervosa. *International Journal of Psycho-Analysis*. 65:435-442.

Bruch, H. (1973). *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within*. New York: Basic Books.

_____ (1978). *The Golden Cage*. Cambridge, MA: Harvard University Press.

Hsu, K. G. (1980). Outcome of anorexia nervosa: a review of the literature (1954-1978). *Archives of General Psychiatry*. 37:1041-1046.

Laing, R. D. (1967). Family and individual structure. In *The Predicament of the Family*, ed. P. Lomas, pp. 107-125. New York: International Universities Press.

Life Magazine (1982). February, pp. 63-76.

Minuchin. S., Rosman. B. L., and Gailer, L. (1978). *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge, MA: Harvard University Press.

Piazza, E., Piazza, N., and Rollins, N. (1980). Anorexia nervosa: controversial aspects of therapy. *Comprehensive Psychiatry* 21:177-189.

RedI, F. (1945). The psychology of gang formation and the treatment of juvenile delinquents. *Psycho-analytic study of the Child*. 1:367-377. New York: International Universities Press.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry*. New York: W. W. Norton.

Thoma, H. (1967). *Anorexia Nervosa*. New York: International Universities Press.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena. *International Journal of Psycho-Analysis*. 34:89-97.

_____ (1971). *Playing and Reality*. New York: Basic Books.