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This is the second part of a two-part paper on anorexia nervosa for which the first, "The Problem of Anorexia," set the table.

The anorectics I have known are greedy, envious people caught in a labyrinth they constructed so early in their lives that they no longer know either the way out or the way deeper in. They know only one credo: less is more, and more is more of the same. They make deadly dull patients who are forever scaring the wits out of one by driving their weight down and their chances for dying up, for at some point the brain becomes so altered by the self-imposed starvation that it loses its capacity for signaling hunger.

As with any patient, one has to feel ready and able to go through what is necessary. It is no fair blaming the patient because he took one further than one meant to go. Anorectics, because they are too little, cannot distinguish between being found wanting and wanting: they believe that (in Beckett's words) the quantum of wantum is not negotiable: that they have only to instill all the wanting that threatens to happen into their analysts and they will feel blessedly free of want and frustration, and filled instead with serenity. Insofar as the analyst does not soak up such wanting in his countertransference, they feel him to be very disobliging and are not above punishing him, with all the brutality people who put others in starvation camps are capable of, for his lack of grace. For both these reasons they are forever not coming, not talking, not paying, not heeding contracts, if they can gull one into making or into trying to get them to make them, and forever doing (one of my patients carried a beeper and arranged to have herself paged!) whatever else they can find drives their analyst nuts. Confrontation is seldom more appealing than with anorectics, who then feel: Gotcha. Only addicts and drunks are, if possible, worse in this respect. To do any work, one has to ignore all these provocations except as they (like the emergency pages) contain meaning. The work consists in helping out with the more-of-the-same part of the credo. Differences inspire lust and also envy. People can get into a tizzy, amounting to frantic frenzy, over deciding which way they want a difference—to receive it or to own it. Any decision loses one possibility: which choice will make that loss worthwhile?

One solution, if it is one, consists of finessing those differences that are of kind by converting them into those of degree. Hence it is no longer who has which but who has more (or less). Since so much of human disputatiousness (or, alternatively, sheer and tender erotic joy) has (in the words of the limerick) to do with who does what and with which and to whom, those who simplify the terms by turning the with which into how much seem to be ahead of the game. But they miss the fun, and to keep this from gradually dawning on them as a loss to be contended with is what so much of the fuss is all about.

In the preceding chapter I attempted a formulation of the leading elements of anorexia as I have come to learn of them from the patients I have seen in individual, family, and group treatment (Boris 1984a). In this I wish to develop what in the other I could only mention in passing, namely the very particular difficulties involved in the treatment of anorectics, and what I have found useful in the way of proceeding.

Perhaps the major difficulty for analytic work is that for the anorectic his or her[1] anorexia is a solution and not a problem. And as Schafer, in particular, has emphasized, resistance is not simply a negation of material the patient

wishes to remain oblivious of or disown. It is an affirmative belief that there is another path to salvation than that of experiencing what she experiences, knowing it and resolving the conflicts involved (Schafer 1976).

For the anorectic that path to salvation is well in hand. It consists manifestly of self-starvation either through restriction or through evacuations—vomiting, diuretic-induced urination, laxative-induced defecation, constant motion exercise, or all together. The constant state of hunger is so obtrusive as to overshadow any other feelings. And the preoccupation with body size, shape, and weight is so obsessive as to crowd out any other preoccupations. At its "best" anorexia is a full-time job. I have compared it to the black hole phenomenon in astrophysics, where the mass of the star is so great as to draw everything, including its light, into itself.

The result is that the transference, in which we are accustomed to shine with borrowed light, simply does not take place. Freud noted that when a patient is in love or in mourning the transference dwindles. He also noted (1914, p. 82) that the man with a toothache cannot fall in love. The anorectic is both in love and in mourning and furthermore has a bellyache!

These positions taken together with her utter conviction that her anorexia is her last, best achievement leave little for either the transference or the therapeutic alliance. There is hardly even resistance of an active sort; just the sort of bland indifference of someone passing time between episodes of intense prayer. The anorectic is among but not of us.

If sent for analysis, the anorectic may come and be superficially co-operative; she has nothing much to lose. And since anorexia is a difficult course to pursue, she certainly would accept an appreciative recognition of that fact: she certainly does not welcome her solution, the jewel in her crown, being regarded as a problem, a flaw or defect. But for the most part the analyst feels something tantamount to the "*la belle indifference*" of the classic hysteric.

This is no accident. The anorectic is trying to cure herself of wanting, more precisely of being found wanting. Since her wants are much too intense to submit securely to repression, she distills the whole spectrum and dimensionality of them into the narrow range of occupations with intake and body image. But even that is not enough. It works intrapsychically by focusing and riveting her own attention to her fixation and obsession and rituals. But there is always the danger that someone may prove desirable—and lead her into the longing, libido, and loneliness she hates and is trying to obliterate. So she secures her intrapsychic procedures with the use of projection. If anyone is to want anything of anyone, it is the other who is to want something of her.

In the analytic situation it is at least partly the analyst's resolution and containment of his own countertransference that leaves the room for the patient's transference to occupy. Every patient to a greater or lesser degree occupies himself with what the analyst wants as a way of remaining oblivious of what he wants of the analyst. But insofar as the analyst has no mote in his own eye, the patient presently comes to see the beam in his. His projections have less and less reality to substantiate them; to continue to believe in his projections, he would have to split his ego and attack his own perceptual and memory functions—a costly procedure.

The anorectic is wanted to eat, more broadly to take. Food, care, medication, nasogastric tubes, IVs, hospitalization: something; anything. As she loses weight, her projections are fleshed out and given substance. It is the other who wants, not she. She relies on this, desperately. It can get to the point where she will die for it. She counts on "countertransferences" in both her family and, of course, her analyst.

Should the analyst not want anything for or from his anorectic patient, she will be most impressed by this. A superior sort of anorectic, she will feel, this analyst of mine. Her admiration will induce emulation. If her emulations fail, her admiration will shade over to envy and she will set out to destroy the treatment in the way Limentani and others have analysed in considering "the negative therapeutic reaction" (Limentani 1981). (See also Valenstein's [1973] work on holding on to negative affects and Brenman's [1982] elegant formulation on depression versus longing.)

All the same, it *is* necessary to want nothing for or from the anorectic, though she will spare no effort to stimulate longing in the analyst. She will want to attend less frequently, stay less long, say less, pay less—anything less. For her, of course, less is more. But in addition to this display of her substance as a person, she will count on the analyst to demand *some*thing of her. This will help support her projections, but, more, it will discredit the analyst as a person unable to cope with his greed. It will also, not incidentally, help the patient's fragile self-esteem, in the sense that it is nice to be wanted.

The analyst has to let the anorectic destroy the analysis. If it is to be destroyed, there is no point in the analyst being the one to do it. Thus no limits should be set that have to be enforced by breaking off the treatment. It is enough that the anorectic comes every once in a while, speaks every so often, and so on. What she does and how she does it has to be her business.

This is the place to note that two experienced students of the subject of the treatment of anorexia take issue

with what I have said. Bruch feels that the anorectic's bizarre eating behavior has to be the subject of treatment, particularly when she shows signs of being worrisome in regard to her body weight.

She also does not feel interpretive work does much good, a point with which I would disagree. However, a close reading suggests the interpretive work she sees as useless or worse is poor interpretive work, work that precludes self-discovery rather than aiding in it (Bruch 1978).

Minuchin has the anorectic weigh in at each session, family or individual. Otherwise he attempts to finesse the anorexia by deeming it a successful rebellion in aid of an unsuccessful search for autonomy, separation, and individuality (Minuchin et al. 1978).

The successes claimed by these two workers require our attention.

For Minuchin anorexia is a creation of the family system. With this I agree. Any fictionalization of experience —I use this term to be an arrangement of what Freud meant by the screen memory, a version enthroned to exist instead of the actual in order that the actual event or state-of-mind not be remembered or known; any fictionalization of experience, such that it is food and weight that are the matter, has to find concurrence in the others with whom the patient's fate has been cast or with whom she casts her fate. "Anorexia," for example, is itself such a fiction. It means loss of appetite. In fact, anorectics are sometimes glutted but seldom other than ravenous. It takes a willingness on the part of others to go along with a fiction and not expose it. This cooperative spirit may be unconscious, so that it is not merely going along but an active wish to believe, even to implement, a particular fiction that is at work. Laing, in his study of families, was much concerned with how the designated patient cooperated with—in his view was victimized by—fictional attributions made by the parents (Laing 1967).

Minuchin disturbs that collusion. He interferes with what he calls "triangulation" by obliging the parents to resolve the tensions between them with one another, and likewise prohibits the anorectic from reinserting herself into the twosome. Then he redefines the anorexia as at once thwarted autonomy and adolescent or childish rebelliousness and renegotiates suitable goals and better methods. The anorectic, freed of her enmeshment, her willing exploitation as a triangulating foil, and supported in her attempts to want, wants. Soon she can bear both to want and to want food.

It may be objected that little but the symptom is changed, that the anorectic personality and character structure

remain. But to dislodge a system is also to open the way to the natural development of procedures for conflict resolution and the natural processes of growth. This is no small feat. Unfortunately, Minuchin seems uninterested in the resolution of the infantile neurosis, not merely on grounds of economy of effort and expediency. As a "systems" thinker, he hasn't ideological room for intrapsychic matters, indeed regards them as a by-product of a misunderstanding. For him boldly to display to a family *there is another way of doing things; you don't need the anorexia* is most helpful, but it misses much of what the system contains (in both senses of "contain").

Bruch also sees the anorectic as a creature of her parents, a more than usually docile child obediently living out her parents' aspirations for her or for themselves. Bruch feels this subjugation can, and too often does, take place once again in psychotherapy. The anorectic, she feels, has not been allowed to discover what she wants and to arrange to get this from others. Rather, the anorectic has been anticipated so regularly that she knows nothing from within. She cannot tell whether she is hungry, full, fat, thin, energetic, exhausted—whatever. Therapy must rectify this, in Bruch's view, by permitting the anorectic to learn of herself from herself. Bruch feels that this process is facilitated when the therapist is open in his turn, so that the anorectic can learn of him from him. Bruch also talks freely of what she has learned from other anorectics, presumably as an aid to her patient in mapping and identifying her own inner experience. In this methodology it is clear that naming the dimensions of the anorexia has a clear and vital part.

Not so for Minuchin. He merely says or implies he cannot work with people who are so "childish" as not to eat. He has to be reassured by the scale that people are being sensible enough to warrant his help. That is the extent of his outpatient interest. When the anorectic has to be hospitalized, she is told what she eats is her affair but what she "spends"—the analogy is to a checking account—is the doctor's. So much in, so much out. Nothing in, bed rest. Some in, out-of-bed privileges involving exercise. In contrast to Minuchin and Bruch, I suggest that the only attention the anorexia need be given by the analyst is in terms of the use the patient is making of it in the transference. There is no contradiction in this recommendation with my earlier discussion of anorexia as preclusive of much more than a shallow transference. Indeed it is precisely that function of anorexia that needs interpretation.

The anorexia, as I have said, is designed to elicit countertransferences by stimulating substantiation for the projections the anorectic characteristically makes. The analyst is to be discovered as greedy, intemperate, enslaving. These discoveries will in turn imply defects and flaws: if the analyst wants the breast so much, he cannot therefore have one; if he hasn't a breast or penis (or whatever) of value, he needs neither to be desired or envied; he is a no-

thing. This is the anorectic solution.

The anorectic problem is the boundlessness of her desire on the one side and envy on the other and the dizzying simultaneity of the two. Within her, desire (to receive) and covetousness (to possess) war ceaselessly. Paradoxically, however, they converge in one major respect. Both combine to hate and mentally obliterate the separateness and distinctness of the object. There is no transitional space—the not-me, but yet not-other space—that transitional phenomena require (Winnicott 1953). The anorectic lives, as it were, without a skin. Others, in their incandescent desirability, impact on her with detonating force. And this is the problem.

To solve it, the anorectic creates an "inner" space: in-me but not of-me. She sets all her soldiers of vigilance to monitor that space. Thus employed, they do not have time or energy to notice the presence of the object, who would otherwise excite desire and envy.

How to get food to go in but yet not become of her? Food, as part-object, necessarily also excites desire and envy. The envy is devoted to food's ability to penetrate the of-me boundary and reach into the very marrow of being. This once was an intention the anorectic experienced in respect to the body and soul of her mother. It is still a wish she "inadvertently" acts out in respect to her mother (and father). "Eat something. Eat *some*thing! You are driving me crazy. Look, look at your father. You are making him sick. He doesn't sleep. Look, let me fix you something. Whatever you'd like. A little chicken?… But the anorectic screams "leave me a-*lone*!" and proclaims the absence of her wish to own her parents while devaluing their desirability.

The analyst, then, needs to work in a transitional space. He cannot work on or in his patient. She on her part will—unwittingly—work on or in him. It has to become and remain clear that though she will, via both projections and displacement, experience him as harboring such designs in the very core of the transference fantasy, he must not lend substance to these attributions.

Two ways of proceeding have proved helpful. One is to talk to the air. One confides one's ruminations as if to an interested but otherwise occupied colleague, or as one does when one reads aloud a snippet from the morning newspaper. The idea is: this may interest you. One's words should represent musings and not be directed at some purpose. Interpretations are food for thought. It is best that they be set out but not served. The air to which one talks is the transitional space the analyst needs to create in order to assure the anorectic her boundaries. As this becomes established, the in-me-but-not-of-me space becomes less needed. It is not so clear to me as it is to Bruch and

Minuchin that parents *do in fact* invade the space that their anorectic children require, that this is not, instead, in an important degree a function of fears of violation consequent upon projections, but I do agree with them that a neutral zone in the treatment situation is altogether necessary.

It will not remain. Either the anorectic will try to draw the analyst in or he will get the sense that his interpretations are being misinterpreted. Both require further interpretations.

The particular density of the anorectic represents a "gravitational field" tough to escape. Everything seems to have reference to matters of food, starvation, disfigurement, enslavement, and the analyst's interpretations are no exception. "When I speak to you, it is as if…" This kind of clarifying comment needs to follow almost every interpretation of what the anorectic is doing. The experience of being in the consulting room has, above all, to be tolerable.

When anorectics are in the thick of their food-weight enthrallment, they are embarrassed to talk of it. They know, as any rider of a special hobby-horse knows, that no one else could possibly have the obsessive interest in the subject they have. But, in addition, the anorectic suffers from her dread of "lapping-up" the analyst's interest. The superego, fashioned so early, is indeed an archaic creature; to it has been ascribed the terrifying predatory intentions the anorectic has struggled to rid herself of in an effort, initially, to save mother from being cannibalized. Insofar as the analyst begins to become an object of desire, the anorectic will begin to oscillate between finding his interest a consuming one and wanting to consume his interest. "Progress" in the latter direction thus poses its own problems for her. Does she prefer the devil within or the devil without? The periodic abatement of the symptom pivots on the same fulcrum. Self-starvation is a wonderful antidote for guilt and reparation—witness Lent and Yom Kippur and the taboo foods of other cultures. So is purgation; the vomiting and exercise of the bulimic is not solely to evacuate calories; they are a means of disgorging guilt. Guilt is not merely a bad feeling of feeling bad; it is a physical experience of an almost ineradicable tension. Physical means are accordingly required to expunge the feeling. There is moral relief in violent exercise, exhaustive defecation, and vomiting. There is even a kind of moral sensuality in the experience of "bingeing," when the glut of gluttony is reached. There are all so much more manageable than the awkwardness of relations with people that one can expect a resurgence of symptoms precisely when the anorectic begins to experience regard for the analyst as a good object. For when his goodness doesn't stimulate envy, it stimulates love, a love which in turn disposes the patient at once to feed the analyst and protect him from her own surging appetites. In so far as this reparative inclination meets the same fate as earlier—that the other will not accept

what she can offer, the reversion to symptomatic activity becomes all too easy.

The problem of reparation being what it is, in fantasy as well as (often) in fact, the analysis of the ceaseless, envious denuding of, and, in counterpart, the ruthless fantasies of cannibalizing the object become unbearable for the anorectic. Insofar as she cannot make up for these, except by not eating or not keeping what she eats, she feels as if she is continually being traduced—trashed. Since by taking as little as possible from the world, or, when she falters, purging herself of what she has taken, she is making, in part, an authentic attempt at sanctity, she also feels terribly misunderstood. Thus as she begins to allow herself, in oscillation, to discover in the analyst an object of value, the problem of reparation has to be given equal weight with the analysis of early greed and envy.

Having said that, however, I have now to issue a reminder. The anorectic's problems are not primarily oral; they are designed to seem so.

The obsession of the anorectic with her anorexia is reminiscent of that of the psychotic with his hallucinations. In this respect, Freud's suggestion applies: "An attempt to explain an hallucination ought not to attack the positive hallucination but rather the negative." In the all-consuming anorexia there is an absence of absence, and it is that fact and what is absent that needs analytic attention (Freud 1917, p. 232 fn. 3).

The absence of passionate longings which the anorectic achieves by her displacements and projections and reaction-formations leaves her peculiarly vulnerable to the influence of others. Her illness gives her the inner life that offsets that vulnerability. Naturally she is afraid to lose it. As she confides her anorexia to the analyst—gives it over, as it were—the absence becomes present. Not only has she now no way of getting well—for an illness is necessary for a recovery—but in the presence of the absence she fears being refilled with all of what she has projected. Laing makes this concrete: saliva that is comfortable and familiar in one's own mouth, once expectorated, even into a glass of clear, pure water, is experienced as alien and repugnant (Laing 1962). There is a terrible pain in store for the anorectic when she finds herself grotesque and her activities and rituals, previously syntonic, monstrous and malignant. Still, it is this absence that must come into being before the important work of the analysis can be done. Intuiting this, the anorectic will sometimes temporarily "give up" her anorexia in order to keep it intact for later use.

The fact that her determined use of that portion of the spectrum of development seems oral in nature is the "positive hallucination." We need, therefore, to see that the so-called regression to the developmental fixation point

is after all a function of later developmental crisis as well as conflicts at the time of fixation. In fact the point of fixation represents in some respect the last, best resolution. And indeed the anorectic has already outgrown her pregenital preoccupations by the time she hits puberty, college, divorce, or whatever part of the life cycle it is when she takes up anorexia. That is why some people spontaneously remit, or, more precisely, re-outgrow, anorectic symptomatology or are so easily "cured" by behavior modification treatment or family therapy.

When I speak of the problem of treatment, then, I have also in mind that the more carefully the elements in the anorexia are analyzed, the more the analyst is in danger of missing what the anorexia hides. Unlike certain other symptoms or characterologic malformations, anorexia *contains* in the compromise formation less of what bedevils the patient than it *obscures* it. When the anorectic finally does give way and talk of her inexhaustible occupation with food, weight, and body image, the analyst will have a Scheherazade of a patient. The occupation will conceal the preoccupation, which is oedipal-genital in nature.

The dynamics of the oedipal situation, however, are the same—profound desire competing with envious covetousness; projection as a primary defensive orientation; hypersusceptibility to stimulation and an urgent need for the release of excitement through orgasm or "displaced" orgasm.

Though writers on the subject occasionally remark positively on the facial appearance of the anorectic—childlike, angelic—the body is generally agreed to look grotesque. Moreover, the anorectic is said to think her wasted look to be beautiful. My experience does not support these assessments. To the contrary. The anorectic, by "putting" a child or angel's face on an old person's body, is attempting to complicate sexual responses in others. This is for several reasons, of which the one I want to mention here is that of inhibiting a response that will lead to the other—in the countertransference, the analyst—to thoughts of sexual intercourse. The anorectic knows she looks grotesque to others; she has certainly heard it enough. While her heroics about dieting or, at any rate, weight control are designed to stimulate admiration or, failing that, envy, the body is designed to look asexual and/or sufficiently androgynous as to evoke the most muddled sexual response in both men and women. Others, and, of course the analyst, are supposed to try to feed or fail at feeding and to coerce or fail at coercing. It is supposed to be as difficult to think about sex as it might in conjunction with a concentration camp victim or a saint.

That there is a degree of vindictive spite in this will emerge later; as some patients for periods try to excite unrequitable longing in the analyst as a means of imposing retaliatory pain, so the anorectic denies the analyst the

sensuous gratification he ordinarily gets from contemplating loveliness. But this is secondary to her effort not to "let sex come into it," as it is frequently put.

The anorectic is attempting to understand everything in certain terms. There are women, for example, who upon the break-up of a relationship—a marriage perhaps—lose weight. At first this may be due to stress, depression, worry of an essentially reactive sort. But then the weight loss becomes progressive and begins to express an "understanding" of the separation from the husband in terms of loss of mother or breast: I have been too greedy, so this is what happened. This understanding is at once "true" and "untrue." That is why it makes a good screen or cover story. So with the more extreme anorectic. Not only is she "understanding" what happened in oral and anal terms, *so must others*. One patient, for example, filled all the sessions of the week preceding a visit from her parents with ruminations concerning how she was going to see them and get any work done, how she would keep to her diet if she had to share mealtimes with them and have food in the refrigerator for them. The week of their visit gave rise to (triumphant) accounts of what dreadful, limited people they were, interspersed with (defeated) tearful accounts of "binges." The sessions of the week following their visit were devoted to (gloating) accounts of how "behind" she was in her work and how everyone was trying to get work out of her and how annoying it was to have to attend sessions. But after all these "points" were made and driven home, there was this casual, almost fleeting reference: "It's so funny, when my folks were here, how much I masturbated, as if I was almost daring them to walk in and discover me at it."

The vast fascination with sexual matters needs systematically to be noted along such lines as this: One patient says: "It's terrible on these days, like when I was walking here, wherever I look there is food—people eating, shops selling food. That's all I see."

I: "Instead of…"

Patient: (*Pause*) 'Now you mention it, I have been taking a new route over here. They have these beautiful women, soft mysterious, come hither. But it's all false. Even if you went in—I mean, what kind of women undress for people in places like that." [Note the "Now you mention it," the "over here," the "if you went in."] This notation is not simply to breach the resistance or even to help fashion the direction of the work. It is necessary, I think, to "talk to the unconscious" by way of making an alliance with the disowned sexual self. The oscillations of which I wrote earlier are the more easily stopped if, like a third leg to the stool, there is another option for the

patient to remember and use. As in growing out of pregenital orientations, developmentally speaking, so in the course of the analysis there has to be somewhere else for the patient to go.

In meditating on the Wolf Man, Freud wrote that one can think of interpretations being put, by the child, on events at the time they occurred, at a later time in the light of subsequent information or fantasy or at the time of narration or dreaming (Freud 1918). In terms of construction, anorectic patients pose just this problem more so than many. It is often difficult to tell whether they mistook genital and oedipal matters as having to do with feeding and elimination, confusing breast and penis, pregnancy and puberty because they always thought only in oral terms or because they reinterpreted everything to rid themselves of later discoveries too painful to be allowed to endure. To put it still another way, it is not easy to know when one is dealing with memories from childhood and when memories of childhood. I would like to suggest that this difficulty is expressive of a particular function in anorectic patients.

Just as the location of contents crosses, as it were, *spatially*, back and forth between self and internal object, between self and transitional space, between body and food, and projectively between self and other, so too has the anorectic shuttled the contents of her experiences back and forth through time with the same frenetic and carelessly careful ease. The result is, I suggest, a *mélange* of experiences, or rather of interpretation of experience. Prospective views, retrospective views, vision and revision, once served the same functions as the spatial ones do in the present. They protect against certainty—particularly the certainties of separation and loss and of ownership and disillusionment. And since uncertainty is itself so painful (for example, the haunting uncertainty attaching to what the body looks like or weighs after eating or purging), there has had to be created a quantity of understandings to compensate for the quality that is lost. Experience is always being attacked and lost to attack, interpreted and reinterpreted: confusion and fusion.

That this makes reconstruction inherently difficult can almost go without saying. But the difficulty is compounded by the anorectic patient who wants more interpretations to go with her own and has no intention of giving one up for another. The analyst's interpretations are valued since into him the anorectic projects the good material she craves. But they are feared, as food is, because the interpretations will add so much and have such weight that she will be lost in the confusion. She attacks interpretations with scorn and doubt and feels lost and uncertain. Then she takes an additive approach in order that no interpretation can be entirely true (or false). When this procedure causes its own difficulties, she perforce must look for certainty outside herself again. (It is

characteristic of these patients to look to their parents to remember childhood for them.)

The anorectic's relationship to the analyst's interpretation has therefore to be a concern for him, not alone in terms of how they are symbolized and with what his giving of them is analogized (food: feeding, impregnation, etc.) but in terms also of the problems posed for the patient by certainty and uncertainty, his and hers. This is the more necessary because for periods of time the anorectic takes up a paranoid stance and proceeds with deception and stealth. Where others might complain of bad, useless or "how's that supposed to help" interpretations, she may simply fight fire with fire, much as she returns silence for silence. For the anorectic patient the undoing of the "remembered" life history with the usual eye to historical accuracy engenders not only the usual resistances, but one rooted in a profound intolerance of ambiguity, uncertainty—of anything approaching Keats's "negative capability".[2] Cooperation in the interest of discovery is an infrequent state of affairs: competition in access to what is so is the more pervasive atmosphere. More than with other patients, letting matters evolve until the anorectic patient can make her own constructions is much to be desired. The anorectic's reach for simple certainty leads her to insights that are about as accurate and helpful as her nostrums for physical well-being. "It sounds like…" says one of my patients. "So it would seem that…" says another.

"*I* have to say 'seems' and 'sounds like'," I interject, "because I can only infer, can but guess. *You*, in contrast, can know, really know." But, in the end, it is the analyst's own quiet tolerance of the muddle and uncertainty, of the gradualness of approximations, of error and apology that makes it possible for his patient to come simply to be. In being resides the experience that when genuinely experienced leads to the insights with which development is facilitated. The capacity for both parties to the analysis to manage the presence of the absence of certainty is what, more than anything, I think to be or not to be the conducive factor.

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Notes

1 Since 85 percent of anorectics are female, it is estimated (Bruch 1978), I shall use the pronoun her.

2 The condition in which "man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason." *The Letters of John Keats: 1814-1821*, vol. 2, p. 193.