Barely staying alive: a case study of a male with anorexia nervosa and a survey of therapists working with anorectic patients.

Teri Pomerantz Rumpf
University of Massachusetts Amherst

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BARELY STAYING ALIVE:
A CASE STUDY OF A MALE WITH ANOREXIA NERVOSA AND
A SURVEY OF THERAPISTS WORKING WITH ANORECTIC PATIENTS

A Dissertation Presented
by
TERI POMERANTZ RUMPF

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of
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BARELY STAYING ALIVE:
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Approved as to style and content by:

Castellano B. Turner, Chairperson of Committee

Dee G. Appley, Member

Daniel Eric Fajardo, Member

Alvin Winder, Member

Seymour M. Berger, Chairperson
Department of Psychology
For Noah Clifford Pomerantz Rumpf
ACKNOWLEDGEMENTS

Arriving at the end of my graduate school career marks the end of a very important period, a time of growth and change. What I have come to know about psychotherapy and psychology represents the composite of many moments of learning, both formal and informal. I wish to acknowledge the friends and fellow students with whom I shared such moments. I also wish to acknowledge the contributions of Dr. Harold Jarmon, whose course in object relations helped me formulate some of the ideas in these pages and Dr. Harold Raush, from whom I learned a great deal about psychotherapy. I feel fortunate to have been his teaching associate. Specifically with regard to this dissertation, I wish to thank Ms. Melanie Bellenoit, whose assistance in preparing the manuscript was invaluable. I wish to thank Dr. Daniel Eric Fajardo and Dr. Alvin Winder for their participation on my committee. I want to offer special thanks to Dr. Dee G. Appley, who as a role model, teacher, friend and mentor, has offered support, encouragement, praise, criticism and affection. I want her to know that I think I have learned much of what she has tried to teach me. For Dr. Castellano Turner, special thanks and gratitude, since without his faith in me, none of this would have been possible. Finally, I wish to thank my own therapist for her support and for her contribution to my knowledge of psychotherapy, to thank my father, who has been patiently waiting for me to finish this degree, and to thank my son, Noah, for his good humor and tolerance of all the partially cooked frozen dinners.
ABSTRACT

Barely Staying Alive:
A Case Study of A Male With Anorexia Nervosa and
a Survey of Therapists Working With Anorectic Patients

Teri Pomerantz Rumpf, B.A., Syracuse University
M.A., Ph.D., University of Massachusetts

Directed by: Professor Castellano B. Turner

The subject of anorexia nervosa has received a great deal of recent attention in both the popular and scholarly literature. However, males with anorexia nervosa represent only a small minority of this population. Experienced clinicians, working with eating disordered patients over a period of years, may encounter only a few male patients, or none at all. For this reason, encountering a male with primary anorexia nervosa was considered a rare event.

This dissertation describes and analyzes the case of a twenty-two year old male with anorexia nervosa. In addition, the results of an international survey of clinicians who work with eating disordered patients are presented. The survey gathered information on males with eating disorders as well as information concerning the theoretical orientations and treatment practices of therapists who work with anorectic and bulimic patients.

Anorexia nervosa is a disorder with a long history. This history is summarized in the literature review. Also reviewed are issues of etiology and diagnosis; diverse theoretical perspectives; treatment approaches; and a summary of the available literature on anorexia
nervosa in males. Methodological considerations involved in the dissertation are presented.

The major part of the dissertation consists of the case history. Throughout the course of therapy, the primary focus was on the underlying issues: identity, autonomy and control, rather than on the pathological eating behavior. However, in any case of severe anorexia nervosa, consideration must be given to the management of pathological eating. In this case, weight was not regained until the underlying issues had been sufficiently worked through.

The data of a survey is presented. While the thirty-five participating clinicians had had contact with over two thousand anorectic patients, the number of males treated was less than one hundred.

Finally, anorexia nervosa is discussed from the theoretical perspectives of pathological narcissism.
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CHAPTER I

INTRODUCTION AND BACKGROUND

Introduction

Although a great deal of literature has recently been published on the subject of anorexia nervosa, it remains a subject of much controversy. Reading this literature, one finds much that is confusing and contradictory. Until the recent publication of the third edition of the Diagnostic and Statistical Manual (1980), there was considerable confusion about which diagnostic criteria were actually necessary for a diagnosis of anorexia nervosa. Because of this, many studies proceed from different definitions of anorexia and comparison of these studies is difficult. Even now there are considerable discrepancies, if not about what constitutes anorexia nervosa, about how it should be treated, about why it appears with such frequency at this time, and about whether anorectic patients are different from bulimic patients.

Anorexia nervosa is considered a disease of young women. The literature on males is sparse and there has been doubt about whether a true form of anorexia nervosa can really occur in a male. Only a few studies of males exist and of those, many are reports of anorexia nervosa in pre-pubescent males, while others are reports of small numbers of patients.

Although the exact figures vary, a case of anorexia nervosa in a pre-pubescent male is considered a rare event. The purpose of this
dissertation is to provide an in-depth case study of one such male anorectic and, hopefully, to add to what is known about anorexia nervosa by the analysis of this unusual case. The study provides data on the subjective world of this individual, focusing on what is common to all anorectics, the split between the body and mind, and the displacement of feelings on to food. It is also the exposition of a therapy, and of the decisions made by one clinician in training when she was unexpectedly confronted by an exceptionally thin young man.

Following the case study, there is a report of an international survey of clinicians who work with patients who have eating disorders. The survey began as an attempt to gather more information about males with anorexia nervosa by asking those people who were considered "experts" in the field, that is, people who had written about anorexia nervosa, or who worked at a center specializing in the treatment of eating disorders, or who had some sort of special training and interest in treating this population. In addition to finding out more about males with anorexia nervosa, the survey also became an attempt to see how expert clinicians dealt with problems common to eating disordered patients; when to hospitalize, how to handle issues of food and weight, etc.

At the very beginning, when first considering this kind of study for a dissertation, it was the rarity of such a patient which generated the excitement and motivation to undertake such a project. A single case made sense, since it was extremely unlikely that a single clinician would be able to collect a sample of males with
anorexia nervosa. As the study progressed, it became apparent that there was something else that was rare about this particular individual. The subject was a young man who was exceptionally insightful and articulate about his thoughts and feelings and who was therefore able to provide a unique perspective on his condition. He enables us to see what his inner world is and how his outlook changed over time—that is, during and after the course of therapy.

Writing this dissertation has enabled the author to see how she too has grown and changed over time. In this sense, the dissertation is an extremely personal statement. Listening to the tapes of the therapy sessions was sometimes pleasurable, often painful. Given hindsight, there are things I would change, but also much that I would not. At the time that the therapy began, Jeff was ready for it. It was not his first therapy, but it was the first one in which he was actually able to confront his condition and struggle with events in his life (both inter- and intrapersonal) which led to the development of anorexia, as well as his feelings about his body, his sexuality, his family and, finally, his obsession with food and weight.

Before proceeding with the actual case study, I will present a history of anorexia nervosa from the first recorded case in the 17th century to the present and review the literature on anorexia nervosa in males, as well as provide a more general review of the literature on anorexia nervosa. Chapter II discusses the methodology involved in the case. Chapter III presents the case of Jeff (a pseudonym); Chapter IV presents the survey; and Chapter V discusses issues in the etiology and treatment of anorexia nervosa.
Historical Perspective

Anorexia nervosa is not a new disorder. It has a history which is long and interesting. While descriptions of anorexia nervosa have changed little since the 17th century, the interpretations used to explain it have paralleled the development of psychological thought. In studying anorexia nervosa from a historical perspective, we find a microcosmic view of the development of etiological attribution beginning in the descriptions of 17th century physicians and proceeding to the object relations perspective currently used to explain the origins of the anorectic conflict. A variety of authors (Bliss and Branch, 1960; Bruch, 1973; Sours, 1980) have written detailed histories of anorexia nervosa. Casper (1983) details the history of bulimia in connection with anorexia nervosa.

Bliss and Branch (1960) begin their discussion with a cross-cultural perspective on fasting in primitive societies. Fasting has historically been connected with taboos and cultural prohibitions; the mourning process, food preparation and eating have been part of ascetic religious practices. In religions which espouse a dualism between the "evil body and the pure soul," asceticism and fasting have been linked together. In such religions, the "evil body was not to be pampered and abstinence from all excessive and often normal bodily desires was a virtue" (Bliss and Branch, 1960, p. 3).

Crisp (1980) contrasts fasting with feasting, and says that the "fasting associated with Christianity provides us with a wealth of cultural background information relevant to our own present day
society and ... therefore ... related to anorexia nervosa" (p. 9). He notes that in cultures such as ours, where the dualism of the mind and body predominate, the body is always seen as the corruptor of the mind and men have always reacted with self control and self punishment. Punishments have varied, including those that have to do with fasting and the infliction of pain or mutilation on the self, or sexual abstinence, but the idea behind the punishment is always the control of passions and of the body.

Both Crisp (1980) and Mogul (1980) contrast the Eastern and Western forms of asceticism. Historically, Eastern asceticism has been associated with attempts to transcend the cycle of mortality. Mogul says that the "Hindu myth provides an idealized image that helps visualize the anorectic's psychology in pursuing power through fasting" (p. 167). In western civilization, the emphasis has been on morality, on good and evil, and on atonement and punishment for sin. Crisp (1980) argues that both the desire for a higher purpose inherent in the Eastern philosophy and the desire for placation and atonement in the Western forms of asceticism are important mechanisms in anorexia nervosa.

While Bliss and Branch (1960) describe some earlier case reports, there seems to be general agreement that the first case accounts of anorexia nervosa appeared in 1689 by a British physician, Sir Richard Morton. One of Morton's documented cases was published in 1689, an account of an eighteen year old boy. Morton called the syndrome "phthisis nervosa." His description of the symptoms sounds strikingly modern and familiar: food avoidance, amenorrhea in females, lack of
appetite, constipation, extreme emaciation and overactivity (Sours, 1980).

Other cases were reported in the 18th century by Whytt, an English physician who published in 1767, and Nadeau, writing in 1789 (Palazzoli, 1978). Sours (1980) describes these early case reports as very similar to current cases being reported in the literature with symptoms of relentless starvation, eating binges followed by vomiting and an unpredictable outcome, leading either to recovery or to death.

In the 19th century reports of anorexia nervosa began to appear with increasing frequency. In 1868, Gull published several case reports in the Lancet. One of these was the history of a young man and Gull made the point that anorexia nervosa was not limited to young women (Sours, 1980). Gull first used the term "apepsia hysteria" and then in 1874 changed the name to anorexia nervosa, a term which could be applied to both sexes. He described it as a psychological disorder and recognized early on the significance of the family in the disorder, saying that "relatives made the worst possible attendants" (as quoted by Sours, 1980).

About the same time in France, LaSègue characterized the origin of anorexia nervosa as hysterical, and said that the illness was marked by denial and optimism. The description given by LeSègue, as quoted in Palazzoli (1978), sounds quite up to date:

After a few months, the ill patient finally arrives at a state that can rightly be called hysterical anorexia. The family is in turmoil. Persuasion and threats only produce greater obstinacy. The patient's mental horizon and
interests keep shrinking and hypochondriacal ideas or delusions often intervene. The physician has lost his authority; medicaments have no effects, except for laxatives, which counteract the constipation. The patients claim that they have never felt better; they complain of nothing, do not realize that they are ill and have no wish to be cured. This description would, however, be incomplete without reference to their home life. Both the patient and her family form a tightly knit whole, and we obtain a false picture of the disease if we limit our observations to the patients alone. (Palazzoli, 1978, p. 5)

As the 19th century progressed, the conceptualizations of anorexia became increasingly sophisticated. Gilles de la Tourette differentiated primary and secondary forms of anorexia in 1895, and Freud mentioned anorexia with regard to the Dora case in 1905. Janet documented several cases of anorexia between 1903 and 1909. He differentiated between a hysterical and an obsessive form of the disease (Sours, 1980).

In 1914, a German doctor named Morris Simmonds described a patient with anterior pituitary damage and weight loss. From this point on, many anorectics were thought to suffer from a form of panhypopituitarism and were treated with various extracts of the pituitary gland, confounding things considerably. It was not until the late 1930s that anorexia nervosa became a distinct psychiatric syndrome once again.

In the 1940s and 1950s the psychoanalytic formulations were largely in terms of specific unconscious fantasies, such as the rejection of pregnancy wishes and the reaction formation against oral sadistic impulses. Anorexia nervosa was also regarded as a disturbance of drives (Gero, 1953; Kernberg, in Sours, 1980). A
hallmark study by Keys (1950) on the biology of starvation showed that there were biological effects of starvation which were independent of any form of psychopathology. Keys put 36 male subjects on semi-starvation diets for a period of six months. When their bodies began to feel the effects of starvation, these men began to show many behaviors currently associated with anorexia nervosa: intense preoccupation with food and eating; eating strange combinations of food; spending hours planning how they would eat their food; and interest in recipes and cooking. They also drank larger amounts of coffee and tea, as many anorectic patients do (Garfinkel and Garner, 1982). This study is unique, since ethical prohibitions now protect human subjects from starvation, but it remains outstanding in that it separates the biological effects from the psychological ones, and reintegrates them to give a better understanding of anorexia nervosa.

In the 1960s and 1970s the work of Hilde Bruch focused on the interpersonal aspects of anorexia nervosa as well as the perceptual and cognitive errors made by anorectic patients. Bruch's work is largely developmental in nature and parallels the trend away from classical Freudian concepts in psychoanalysis in favor of the neo-Freudian theories of the Sullivanians and the ego psychologists. Bruch (1973) differentiated primary and atypical forms of anorexia nervosa. In the primary or true form, there is a disturbance in body image which reaches delusional proportions; a misperception of bodily functions, such as the feeling of hunger, and a pervasive sense of ineffectiveness. In the atypical form, there are no such common
characteristics. Weight loss occurs, but it is secondary to other psychiatric problems—hysterical or affective disorders or even schizophrenia. Bruch believes that it is possible for both forms of anorexia nervosa to occur in males as well as females, although primary anorexia nervosa is likely to be more common in pre-adolescent males (1977). She sees the anorectic's struggle as a battle for identity, with the issues of autonomy and control as paramount.

Both Bruch (1973) and Sours (1980) note that the diagnosis of anorexia nervosa is often difficult and that anorectics must be differentiated from patients in whom weight loss is secondary to a thought disorder or affective illness. Bruch (1973) cites the Case of Ellen West (Binswanger, 1944) as an example of a woman who was anorectic although she was diagnosed schizophrenic. Hsu, et al. (1981) describe three patients who developed schizophrenic symptoms after they had apparently recovered from periods of anorexia nervosa.

Most of Palazzoli's early work, written in the 1970s, is based on the work of the object relations theorists, with special emphasis on Fairbairn (1952). She saw the anorectic patient as one with a split between her mind and body, where the body represented the introject of the bad mother. If the real self or mind was to survive, the body would have to be rigidly controlled. Palazzoli (1978) and Minuchin (1978) have both espoused family treatment as the treatment of choice in cases of anorexia nervosa, emphasizing the interpersonal nature of the pathology.

Recent works by Masterson (1977), based on the developmental theories of Margarett Mahler, present evidence of borderline
functioning and narcissistic personality disorders in the anorectic patient and focus on the pervasive issues of autonomy and control that these patients present.

Garfinkel and Garner (1982) do not endorse the concept of a specific personality type among individuals with anorexia nervosa, especially when the onset occurs early in adolescence before personality features are fully developed. However, they consider borderline personality organization frequently manifested among bulimic individuals and note that bulimic anorectics often have labile affect, loss of control and a sense of emptiness described ... as typical of borderlines. They do not feel pleasure from their bodies but rather a sense of intolerance and a need to control their bodies. Their behavior is characterized by poor impulse control which ... may take may forms beyond the bulimic episodes themselves ... Their interpersonal relationships fluctuate between transient, superficial ones and intense dependent ones that lead to further personal devaluation and anger.

They continue to say that the finding of borderline personality structure in bulimic individuals may not in itself improve our understanding of the disorder. "However, if one views such borderline patients as frequently having marked problems with emotional separation and autonomy and if the latter are predispositions to anorexia, it may help explain why this group is vulnerable to the illness" (1982, pp. 54-55).

Masterson (1977) attempts to supplement Bruch's developmental perspective by adding the intrapsychic one. Much of the recent literature reflects the trend toward object relations theory and the
shift away from emphasis on oedipal issues and impregnation-castration fantasies as a cause of anorectic psychopathology. Although there is agreement that anorexia nervosa developmentally originates in the pre-oedipal period, there is little agreement about the underlying personality structure of the anorectic patient. Anorexia nervosa in relation to depression is discussed by Sugarman, Quinlan, and DeVenis (1981) who see the anorectic as an individual who is vulnerable to separation experiences and the depression that often accompanies feelings of intense loss. The anorectic symptomatology is seen as a defense against these experiences and the loss of self-other boundaries which may accompany them.

In addition to its relationship to schizophrenia, borderline personality, and affective disorder, Rizzuto, et al. (1981) presents anorexia nervosa as a disorder which occurs in patients with a schizoid personality, while Dally (1969) characterize the pathology as obsessive, hysterical, or a mixture of both.

Once again, the author wishes to highlight the theoretical shift toward object relations theory and the role of pre-genital conflicts, originating in the early mother-infant relationship, with regard to the development of anorexia nervosa. While anorexia nervosa appears to be a syndrome characterized by a severely disturbed sense of self, one must ask why we now see this kind of pathology so often and what is going on in society which causes this kind of psychopathology to occur. In short, in order to understand the psychopathology underlying anorexia nervosa, it is necessary to understand the cultural changes which have set the stage on which the psychopathology
develops. Without a sense of the interface between the macro- and microspheres, our understanding is incomplete, especially since it is likely that any kind of private disorder is a reflection of disorder in the larger society (Marcuse, 1966). Thus an understanding of anorexia nervosa encompasses its history, the psychodynamic perspective, and the familial and socio-cultural perspectives as well. These discussions follow in subsequent sections of this chapter.

Diagnosis and Subtypes of Anorexia Nervosa

and Bulimia

The third edition of the Diagnostic and Statistical Manual of Mental Disorders (1980) lists anorexia nervosa (307.10). The diagnostic criteria for a diagnosis of anorexia nervosa are:

1. an intense fear of becoming obese, which does not diminish as weight loss progresses;
2. disturbance of body image, e.g., claiming to "feel fat" even when emaciated;
3. weight loss of at least 25% of original body weight plus projected weight gain expected from growth charts may be combined to make the 25%;
4. refusal to maintain body weight over a minimal normal weight for age and height, and
5. no known physical illness that would account for the weight loss.

For bulimia (307.51), a patient must manifest at least three of the following criteria:

1. consumption of high caloric, easily ingested food during a binge,
2. inconspicuous eating during a binge,
3. termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting,

4. repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics, and

5. frequent weight fluctuations greater than ten pounds due to alternating binges and fasts, plus

A. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily,

B. Depressed mood and self depreciating thoughts following eating binges, and

C. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Before the DSM-III did much to standardize these diagnostic criteria, many studies used the criteria of Feighner, et al. (1972) as the basis of their diagnosis. These are similar to the DSM-III criteria but differ with respect to age, attitude toward food, and requirement of specific physical symptoms. According to Feighner and his associates, a diagnosis of anorexia nervosa could be made if the following factors were present:

1. age of onset prior to 25,

2. anorexia with accompanying weight loss of at least 25% of pre-morbid body weight,

3. a distorted attitude toward food, eating or weight that overrides hunger ... e.g., there is a denial of illness with a failure to recognize nutritional needs, an apparent enjoyment of weight loss, a desired body image of extreme thinness, unusual hording or handling of food,
4. no other known medical illness that could account for the anorexia and loss of weight,

5. no other known psychiatric disorder (affective disorders, schizophrenia, obsessive-compulsive disorders and phobic neuroses), and

6. at least two of the following must be present: amenorrhea, lanugo, bradycardia, hyperactivity, bulimia, vomiting (which may be self induced).

Bruch's (1973) differentiation of primary and atypical anorexia nervosa has already been discussed. She says (1966) that it is necessary to differentiate the different forms of psychological manifestations and psychodynamics in the clinical course of eating disorders; and that meaningful understanding of the condition and effective treatment strategies can only be possible once this kind of clear cut diagnosis is possible. In a study of 43 patients (37 females, 6 males), she found 30 with a true or primary form of anorexia nervosa characterized by body image distortions, disturbances in perceptual accuracy when the body is involved (including failure to recognize hunger), and a pervasive sense of ineffectiveness. In the other thirteen patients, food refusal was in the service of neurotic or schizophrenic conflicts.

Dally (1969) makes amenorrhea of at least three months duration a criteria for the diagnosis of anorexia. His other criteria include: a loss of weight due to active refusal to eat, such that the patient must have lost a minimum of 10% of her previous body weight; lack of evidence of schizophrenia, lack of organic illness, and onset between 11 and 35 years. He notes that although the
presence of amenorrhea in the diagnostic criteria automatically excludes men, a condition similar to anorexia nervosa does occur in males, with homosexual conflicts prominent in some male patients. He also notes that emaciated males lose their sexual interest even more rapidly than females but that libido returns when weight increases.

Dally also describes five conditions which resemble anorexia nervosa. These are: anxiety-depression, anxiety-hysteria, anorexia tardive (late onset) psychotic depression, and phobic anxiety. He notes that it is possible for the anorectic to subsequently become schizophrenic and for manic depression to occur subsequent to anorexia nervosa. He differentiated three groups of anorectic patients: those he called hysterical; those who were obsessional; and those whose pathology was neither clearly one nor the other, whom he called mixed.

Hogan (1983) says that the anorectic who restricts her diet is more likely to have an underlying obsessional character structure, while the gorger-vomiter is more apt to present with a hysterical character structure.

Palazzoli (1978) differentiates three forms of anorexia nervosa: primary, chronic, and secondary neurotic. She stresses that the term anorexia nervosa should really be only applied for females. According to Palazzoli, anorexia nervosa in its primary form is "associated with a deliberate and increasing refusal to eat enough, which eventually causes severe emaciation (though there is never a total rejection of food); amenorrhea, constipation, and neuro-muscular overactivity"
Chronic anorexia nervosa differs from primary anorexia nervosa because the onset occurs in childhood or infancy and it is characterized by intestinal disorders. Chronic anorexia continues into adulthood and is associated with other hypochondriacal ailments. In contrast, secondary neurotic anorexia nervosa can occur at any age, and is usually a response to some life trauma. Although some cases may become chronic, secondary anorexia nervosa is usually not characterized by the extreme emaciation of the primary form and is usually not complicated by other emotional disturbances. Palazzoli further differentiates secondary neurotic anorexia nervosa by saying that there is no attempt to gain control over the body and to master psychological difficulties through the pursuit of thinness, as there is in the primary form of anorexia.

Sours (1980) emphasizes the diversity within anorexia nervosa. He notes that criteria such as weight loss, distortion of body image, sense of inadequacy, and ineffectiveness may all be characteristic of other psychiatric disturbances as well as anorexia nervosa. What he finds which is both specific to and pathognomonic of anorexia nervosa is the relentless pursuit of thinness for the pleasure of being thin, and the all-consuming effort invested in all things concerned with food, eating, and weight.

According to Sours (1980) the diagnosis of anorexia nervosa must be differentiated from schizophrenia, psychotic depression, phobic disorders such as fear of swallowing, and from various forms of hysterical and obsessive character disorders. It is possible for
anorectics to have severe borderline personality disorders. Anorexia nervosa must also be clinically differentiated from panhypopituitarism, which results in anorexia and emaciation, as well as from cerebral tumors, hypothyroidism, and pernicious anemia.

Sours divides anorectics into four subgroups. Group I is composed of adolescent girls who develop fears of eating and gaining weight. This group represents the core syndrome and presents with the typical configuration of criteria for anorexia nervosa. Group II is composed of older adolescent girls and women. Sours says that this group "shows serious defects in ego structure and organization, along with strong pre-genital fixation and infantile dependency" (1980, p. 343).

Males are in the third group. Males present more heterogenously in terms of their symptoms than do females; they tend to have worse prognoses and tend to be more schizoid and compulsive than their female counterparts. Hypochondriacal and obsessional preoccupations are more often present than in females. Males are also more suspicious and boast more about their fasting than do females. In addition, males with anorexia nervosa usually do not deny their hunger. Because males carry a more pessimistic prognosis, the possibility that the anorectic symptomatology may be a precursor to psychosis must be considered. Male anorectics are usually "prepubertal, passive boys who fear phallic and aggressive feelings" (Sours, 1980, p. 348). Their fear of aggression is particularly strong when the aggression is directed at their mothers, and there is often mutual hostility between fathers and sons.
Group IV consists of those who do not starve themselves, but who binge and vomit, i.e., bulimics. Sours also describes a mixed group of anorectics with bulimia who both restrict their diet and binge and purge. Bruch (1977) estimates that bulimia is present in about 25 percent of all anorectics. It is to this mixed group of anorectics with bulimia (sometimes called bulimarexics) that Jeff belonged.

Rollins and Piazza (1978) compared their own diagnostic criteria for anorexia nervosa with the criteria of Russell (1970) and Feighner (1972). They found that the three sets of criteria differed on nearly all the significant points: the weight loss, amenorrhea, and psychopathology necessary for a diagnosis to be made. When they applied these three sets of criteria to 36 patients with the presumptive diagnosis of anorexia nervosa, they found that the numbers of patients who could be diagnosed anorectic varied according to which criteria were applied. When the Russell criteria were applied, 53 percent of the patients had anorexia; when Feighner's criteria were applied, 23 percent did; and, according to the criteria applied by Rollins and Piazza, 90 percent of the patients could be diagnosed anorectic. Their study gives what is probably the best indication of just how much confusion has been present in this area and how difficult a cross comparison of studies can be.

Garfinkel, et al. (1980) argue that bulimia with anorexia nervosa is an indication of poor prognosis. From 1970 to 1978 they studied 68 patients who were bulimic anorectics and 73 who only restricted their diets, in an effort to distinguish one group from another. Results of their study showed that the bulimic patients (66 females and 2
males) were more likely to use alcohol and drugs than the restricting patients (69 females and 4 males). A significantly higher incidence of stealing was reported among the bulimics. Suicide attempts and attempts to inflict harm on the self were also higher among this group.

In this study, bulimics were also reported to be more labile than restrictors, and had a history of weighing more at the onset of their illnesses. The authors concluded that bulimia represented a distinct subgroup of anorexia nervosa. The bulimic group appeared to manifest a greater lack of impulse control and less mastery of sexual and aggressive drives than did the group of primary anorectics.

Herzog (1982) found significant differences between bulimic and anorectic patients in terms of marital status, religious denomination, family income, and family history of obesity and chronic illness. Bulimic patients in his study ($N = 30$) were more likely to be married, Jewish, and have a family income of over $45,000, as well as more likely to have a family history of chronic physical illness or obesity than did the anorectic patients in the study ($N = 30$).

Casper, et al. (1980) contrasted restricting anorectics with bulimic anorectics and found that the restrictors were more introverted, more often denied their feelings of hunger and displayed less overt emotional distress. Bulimic anorectics were likely to be more extroverted, more frequently admitted having a strong appetite, and tended to be older. They were more frequently involved in stealing and showed greater amounts of anxiety, depression, guilt, interpersonal sensitivity, and had more somatic complaints.
Halmi and Falk (1982) found that bulimic anorectics rated themselves as having more guilt and hostility than restricting anorectics and were described by nursing staff as more sensitive to interpersonal issues, more anxious, and more prone to express somatic complaints than were the restricting anorectics. However, when the patients were followed after one year, there was a less clear distinction between the restrictors and bulimic anorectics in terms of their symptomatology, although bulimics tended to remain more sensitive to interpersonal issues and be more preoccupied with somatic complaints. At follow up, bulimics showed a higher proportion of psychotic factors than did the restricting anorectics.

Halmi (1983) found that in two large surveys ($N = 105$ and $N = 141$) half of the patients with anorexia nervosa also had a significant problem with binge eating. Bulimic anorectics in this study were more impulsive with regard to alcohol abuse, stealing, and suicide attempts.

Strober (1981) compared anorectics with and without bulimia, and found that the bulimic anorectics showed higher levels of anorectic symptomatology, and were more likely to abuse alcohol and manifest some form of affect disturbance. Families of the bulimic anorectics were characterized by less cohesion, greater conflict and negativity than the families of nonbulimic anorectics. Strober also says that bulimic anorectics experienced more stressful life changes prior to the onset of their illnesses than did the nonbulimic anorectic patients.

In contrast, a number of authors feel that there are less clear
diagnostic distinctions between the two groups of anorectics and even between anorectic and bulimic patients. Garfinkel and Garner (1982) note that anorectic-like behaviors may occur in the population as a whole, without ever developing into a full blown anorectic syndrome. They tend toward seeing anorexia as a continuum of behaviors, ranging from the near normal to the severely pathological. Swift and Stern (1982) propose that patients with anorexia nervosa are really heterogeneous groups and, like Garfinkel and Garner, see anorexia nervosa as a "spectrum disorder." They subdivide anorectic patients into three groups: the borderline, the empty, and the identity confused.

Holmgren, et al. (1983) find that with the increased number of reported cases of anorexia nervosa, the clinician is more apt to find individuals who do not conform to the typical picture. In their study of seventy-nine patients, they found overlapping symptomatologies between anorectics, bulimic anorectics, and bulimics, and found that almost half of the subjects had gone through some prior stage of the illnesses which would have necessitated an alternative diagnosis. This matches the experience of this author, who found that in a group of eight young women in a college health service setting, five of the eight had previously been anorectic but had regained weight and were currently bulimic.

When Herzog and Norman (1983) compared MMPI profiles of three groups of women with anorexia nervosa, bulimic anorexia, and bulimia, they found that all three groups had many personality features in common. Personality profiles among the groups were highly correlated
and all were characterized by depression, alienation, hostile feelings toward men, and a conventional view of femininity.

It thus seems more likely that anorexia nervosa, bulimic anorexia, and normal weight bulimia do represent a spectrum disorder and while some personality traits may well occur more frequently among bulimic anorectics and bulimics, it seems that these are less pronounced than originally thought.

**Incidence and Gender Distribution**

There is currently debate about whether anorexia nervosa is really increasing or whether we are just more aware of it because of increased media attention. A number of authors agree that the incidence of anorexia is indeed increasing (Halmi, 1974; Crisp, 1980; Jones, Fox, Babigian, and Hutton, 1980; Schwartz, Thompson, and Johnson, 1982).

Theander (1970), using statistics on hospitalized women in Sweden, concluded that in a thirty year period there was an increase from .24 to .45 cases of anorexia nervosa per 100,000 people, an increase from 1.1 to 5.8 new cases per year. However, these were only the most severe cases, which required hospitalization. Nylander (1971), also writing in Sweden, included milder cases in his study and estimated that one out of every 150 adolescents was affected. Crisp (1980) feels that the disorder has become much more common in Britain over the past ten years. He says that in private schools, it is present in one in every 100 girls aged 16 to 18. The figure is less in public schools, approximately one in 300 adolescent girls.
Dally and Gomez (1979) estimate that about one percent of bright young women over 18 has some form of anorexia nervosa, but that this may be mild, and may remit spontaneously.

A recent survey of 355 college students (Halmi, Falk, and Schwartz, 1981) indicated that 13% of the respondents experienced all of the major symptoms of bulimia. Of these, 87% were females and 13% males. Anorexia nervosa may be on the increase in older women as well (Garfinkel and Garner, 1982). Although these authors describe a bimodal peak for onset at ages 14 and 18, 17% of their patients became ill when they were over 20 and 5% experienced onset at age 25 or after.

Hospital records and a psychiatric case register were used to investigate the incidence of anorexia nervosa in Monroe County, New York (Jones, Fox, Babigian, and Hutton, 1980). These authors found a sharp increase in the incidence of anorexia from 1960 to 1979, particularly in the 15 to 24 year old age group and in families of higher socioeconomic standing.

Prepubertal onset has been reported in both sexes by Bruch, 1973, Taipale, et al., 1972, Wiener, 1976, Sreenivasan, 1978, and Palazzoli, 1978). Pre-adolescent onset has been associated with boys, but a recent study by Crisp and Burns (1983) does not agree with this finding.

Halmi (1974) studied hospital records of 94 patients with anorexia nervosa from 1920 to 1972. Of these, 88 patients were female and six were male. It is interesting to note that in this study, 43 cases of anorexia nervosa were diagnosed between 1920 and
1954. This represents an incidence of 1.3 cases a year. Between 1955 and 1971, 51 cases were documented, an increase to three cases a year. Four percent of these cases were under 10 years old, 29% were between 10 and 15 years old, and the majority of patients were aged 16 to 25 (41%). Thirteen patients (25%) were over twenty-five at onset. Kay and Leigh (1954) found that 30% of their subjects were over 25, but Theander (1970) found only 1% over 25 years old at onset.

Of 45 primary anorectics in Bruch's study (1973), average age at onset was 15.9 years, with a range from 10 to 26. This study also included six males diagnosed with primary anorexia. For the males, average age at onset was 12.5, with a range from 12-13 years.

Crisp (1980) says that the average age of onset is almost always between 17 and 18 years.

There is little agreement on the number of male anorectics in the population. Taipale, et al. (1972) estimate that males constitute from 10% to 20% of all anorectics. Halmi (1974) found males to be about 5% of the population (6 out of 94) patients and says that this figure is similar to statistics reported by Dally (1969). However, in their later study of bulimia in college students Halmi, et al. (1981) found that 13% of the bulimic population were males and that this constituted 5% of the male population as a whole. Hogan, et al. (1974) report that of 16 anorectic patients admitted to an adolescent psychiatric unit over a 14 month period, 25% were male. They then reviewed the case histories at the Mayo Clinic and found that the incidence of males there varied from 5.5% to 9.7%. Crisp and Toms (1972) report that the ratio of male to female anorectics is 1:15, or
approximately 7% males. Sours (1980) reports that the incidence of males is one in ten cases, although he notes that the exact statistics on males in the population are difficult to procure, since anorexia nervosa is diagnosed with less frequency in boys who lose weight.

Garner and Garfinkel (1982) state that males constituted 7.2% of their population from 1970 to 1975, and 3.3% from 1976 to 1981. Ushakov (1971) found a higher number of males in the Soviet Union (1:5 ratio of males to females), but a later study in the USSR (Korkina, Marilov, Tsivilko, and Kareva, 1980-81) states that the disorder occurs only nine times more frequently in females. These authors found that anorexia nervosa in males was always a manifestation of schizophrenia.

**Mortality Rates**

With regard to death from anorexia nervosa, Schwartz and Thompson (1981) reviewed twelve studies and found that the overall death rate was about 6% but that in individual studies, the death rate ranged from 0 to 25%. In a review of sixteen outcome studies, Hsu (1980) found that mortality ranged from 0 to 19%, but that in over half the studies included in this review, the death rate was below 5%. Garfinkel and Garner (1982) find that the average death rate is around 9% and that this is lower in pediatric samples. They review nine studies which have described the causes of death in their patients. Of 44 anorexia nervosa related deaths, they found that 36 were due to starvation or the complications of starvation, and eight patients committed suicide.

Suicide among anorectics is discussed by Bruch (1973), Palazzoli
(1978), Dally and Gomez (1979), Crisp (1980), Sours (1980), and Schwartz and Thompson (1981). Bruch (1973) says that although anorexia has been referred to as "suicide in refracted doses," it is usually not death which is desired, but to be in control of one's life and to be able to maintain a sense of identity. Crisp (1980) agrees, and says that when suicide occurs it is because the individual seeks relief from the endless struggle to maintain the anorectic position.

Sours (1980) sees suicide as relatively rare among anorectic patients and says that it occurs primarily among the atypical cases, i.e., those who are bulimic as well as anorectic. He finds that suicidal gestures occur primarily in older patients: "... either as their defense against bulimia fails and they become depressed over the prospects of surrender to mother, or after horrendous bouts of binging and vomiting" (p. 306).

Schwartz and Thompson (1981) find a suicide rate of only 1% in the twelve studies included in their review. However, they raise the question of whether deaths from starvation and other complications of anorexia nervosa really ought to be considered forms of suicide.

Dally and Gomez (1979) find that 11% of anorectics in the 15 to 18 year old group and 20% of those over 19 had made some sort of suicidal gesture.

The Clinical Picture of Anorexia Nervosa

While a marked loss of weight is central to the syndrome of anorexia nervosa, patients are likely to present in a variety of ways,
some related to the weight loss, others related to the depression or somatic complaints which accompany the restriction in diet and in some cases, the binging and vomiting. Garfinkel and Garner (1982) note that often when the patient herself seeks help, it is for some sequelae of the anorexia which is disturbing to her, such as constipation, sleep disturbance, impaired concentration, affect lability, or impaired interpersonal relationships. Some patients, especially younger ones living at home, are brought to their physicians by parents, who are concerned about their loss of weight.

In addition to the loss of weight, anorexia nervosa is often marked by amenorrhea once weight drops below the level necessary for menstruation. In very young anorectic patients, menarche may be delayed. Hyperactivity is often a feature of the syndrome (Sours, 1980), at least early on, before the effects of starvation cause the patient to become fatigued easily. Anorectic patients may also have dry skin, hair loss, brittle nails, the growth of lanugo hair, and are unusually sensitive to cold. The patient may have a lowered body temperature along with bradycardia and hypotension. Edema occurs, after rapid ingestion of food in severely malnourished patients or after a binge on high carbohydrate foods (Garfinkel and Garner, 1982).

Dally (1969) also mentions diarrhea, especially when laxatives are used, dehydration secondary to diarrhea, circulatory disturbances, epileptic fits or convulsions, and stealing in connection with anorexia nervosa. Dental problems, such as the wearing away of the enamel and the development of caries occur in patients after prolonged and frequent vomiting (Garfinkel and Garner, 1982).
According to Garfinkel and Garner (1982), differentiation of anorexia nervosa from other diseases which cause rapid weight loss can be distinguished on the basis of history and physical examination. What is central is the patient's desire for thinness, and often the distortion in body image which accompanies it, leading the patient to deny the fact that she is indeed extremely thin if not already emaciated. Discussions of alternative physical syndromes which present with weight loss are well presented in Sours (1980), and Garner and Garfinkel (1982). Essays on the hypothalamic and endocrine factors involved in eating disorders are included in Vigersky (1977) and the reader is referred there for further discussion.

Complications from anorexia nervosa can be serious and include death from cardiac arrhythmia or hypokalemia. Changes in renal function and in electrolyte balances can occur, especially when there is excessive vomiting and use of laxatives and/or diuretics. In addition to constipation, gastric dilatation can occur with gastric perforation. In cases of anorexia nervosa which occur before the individual has reached full height, the skeletal system may be affected, so that patients never reach their full potential height (Garfinkel and Garner, 1982). However, growth may resume when weight is recovered (Matthews and Lacey, 1983).

In understanding anorexia nervosa, it is important to be able to differentiate the biological effects of starvation from the psychopathology underlying the symptom development. As discussed earlier, many of the characteristics associated with anorexia are really due to starvation, including the preoccupation with food and
eating, so central to the core pathology of the syndrome (Dally, 1969; Garfinkel and Garner, 1982). While the physical changes noted above are due to the effects of starvation, emotional and mental changes are also manifest and it is sometimes difficult for clinicians to differentiate the personality of the patient from these effects of starvation, especially if therapy begins when the patient is in a severely emaciated state. For this reason, Bruch (1973, 1978) is adamant about that weight should be gained if therapy is to progress.

In addition to the preoccupation with food, rituals around food, food cravings, bizarre eating practices, and peculiar food fetishes are also associated with the effects of starvation (Dally, 1969; Garfinkel and Garner, 1982). After a period of starvation, the individual is likely to become tired and quarrelsome and there is lack of drive, spontaneity, and a feeling of indifference (Dally, 1969). The obsessional characteristics of the anorectics are not entirely due to starvation because they do not entirely disappear once weight has improved. These characteristics are also associated with the anorectic's need to maintain control. When memory, alertness, and concentration are decreased because of starvation, anorectic patients feel that their sense of self control and mastery are threatened, which can be extremely distressing to them (Garfinkel and Garner, 1982).

The Sense of Self

Bruch's (1962) three characteristics for anorexia are: (1) a disturbed body image; (2) a disturbance in perception such that the
feelings of hunger are not recognized as such; and (3) a pervasive sense of ineffectiveness, which may appear as negativism and/or stubborn defiance. According to Bruch (1962) "anorectic girls are haunted by the fear of ugliness and are forever concerned with their appearance, while denying the abnormality of their starved bodies" (p. 189). Not eating represents control and anorectic patients are often afraid that if they begin to eat, they will lose control and never be able to stop.

Crisp (1980) says that these patients fear obesity and fear weight gain if their diets are not strictly controlled. This fear is worse among patients who periodically do lose control and binge, who then must vomit in order to purge themselves and regain their sense of control once again.

Lack of hunger may be compounded by the inability to recognize fatigue as well. The result is restlessness, often hyperactivity which is manifested in the intensification of sports or exercise programs until the state of starvation becomes quite advanced. Anorexia is in general characterized by the inability to recognize feeling states according to Bruch. Not only is the patient unable to recognize hunger and fatigue, but there is often difficulty in recognizing other emotional states as well.

In her discussion of the sense of ineffectiveness which characterizes anorexia nervosa, Bruch says that these patients do not feel that they can do things of their own volition. In general, they lack a sense of identity, autonomy, and control over their lives. They exist as an extension of others and do things because it is
necessary that they please these others in order to survive emotionally. Thus, they are often the "good" children, pleasant and compliant until they begin to starve themselves by way of protest.

It is interesting to note that starvation is not the only response to this situation. Arieti and Bemporad (1978) discuss existing for others as a factor in the etiology of depressive psychopathology, while Miller (1981) discusses it with regard to the development of pathological narcissism.

Empirical studies have attempted to document the distortions of body image described by Bruch (1973). This research is well outlined by Garfinkel and Garner (1982). Slade and Russell (1973) found that, compared with normal subjects, anorectics were more likely to overestimate body width. Bruch (1973) makes the development of more realistic body image a criteria for recovery from anorexia nervosa.

Garfinkel and Garner (1982) compare the anorectic's avoidance of food and weight gain with that of the phobic patients, and find differences between them. For the phobic, avoidance is triggered by some external situation, while for the anorectic, it is triggered by her own internal fear of her body and weight gain. They find fears of food secondary to fears of increased size. They also note that phobics differ from anorectics in that they do not feel the anorectic's perverse pleasure in that which is forbidden (food) and are not constantly preoccupied with it the way anorectics are.

According to these authors, anorectics misperceive and distort information about food. They assume that thinness may be the basis of self worth, so that the two are erroneously equated in their minds.
They assume that total self control is necessary and desirable and assume that it is necessary to be absolutely certain about how things are to be. This kind of black-white dichotomous thinking is indeed familiar to anyone who has treated anorectic patients.

The role of the emerging self in adolescence must be considered in any discussion of anorexia nervosa. Although psychodynamically, anorexia is rooted in a much earlier period, the majority of cases begin along with the developmental crises of adolescence. Crisp (1980) finds it unclear whether the initial dieting behavior of the would-be anorectic is motivationally different from that of any other adolescent. His opinion is that it is not, rather that it is behavior which becomes disproportionately important because of other factors. Crisp finds that early sexual experiences and thoughts about pregnancy may be a precipitant of the exceptional concern with body image and shape.

Cohler (1977) says that dieting is an active way to ward off psychic disorganization and is a way for the anorectic to try to ward off a psychic decompensation, which would occur if she were to remain passive.

Women who became anorectic appeared to be disproportionately concerned with pleasing men, so that anorexia may occur in the context of the adolescent who both wishes for validation of herself from males and who fears rejection from them (Boskind-Lodahl, 1981).

Connected to this appears to be the sense of confidence that the anorectic gains from restricting her eating (Crisp, 1980). Like Bruch (1973), Crisp (1980) finds that this sense of control over the self
is an experience which is related to the developmental concerns of adolescence—control, independence, and autonomy of the self as well as the environment.

Mogul (1980) says that in order to get through the tasks of adolescent development, the ego calls on and makes use of the defenses of intellectualization and asceticism. Asceticism aids the adolescent's quest for independence by freeing her from eating meals prepared by her mother and by allowing her to go without food for long periods of time while devoting herself to more independent pursuits. However, adaptive asceticism is distinguished from the pathological variety present in anorexia nervosa by the degree to which the ascetic experience becomes an end in itself. Asceticism, according to Mogul, is used by the anorectic as a defense against libidinal drives which is carried to an extreme. It is also used as a defense against a sense of powerlessness and as an assertion of self control and self determination (Bruch, 1973, 1978). Mogul says that the anorectic's use of asceticism in this way is qualitatively different from that of other adolescents because it takes on a life of its own. Asceticism is also the attempt to distinguish the self by being able to transcend the normal human limitations. Mogul makes reference to Kafka's story, The Hunger Artist, when he says:

Anorectics generally have a sense of being concerned with the "higher things" in life and have a disdain for the worldliness of those around them. They become "hunger artists" more interested in satisfying their own standards than in expecting applause, but they are often hurt when their difficult achievement is little appreciated and even seen as "sick" by others. (p. 162)
According to Bruch (1973) the origins of the anorectic pathology lie in earliest infancy, and the model she uses is a departure from the traditional dichotomy between somatic and psychological development. Earliest feeding behavior and the interaction of mother and infant are the platform on which the rest of development is built. Confirmation and reinforcement of the infant's needs are crucial to successful development. The infant who develops without this, who lacks "mirroring," is the child who "will grow up perplexed when trying to differentiate between disturbances in his biological field and emotional and interpersonal experience, and he will be apt to misinterpret deformities in his self-body concept as externally induced" (p. 56). This is the child who cannot distinguish between hunger and satiety, who looks at others to confirm or deny the signals of her own body.

The situation is compounded when the mother responds to the child by answering her own needs, rather than the child's. This occurs because it is difficult or impossible for the parents to recognize the child as a separate individual and to recognize the uniqueness of their child's individual instinctual needs. However, the infant who signals a need which is not recognized and legitimated by the parents finds that something else is substituted in place of the need which s/he is trying to convey. This is based on the parent's projection of his or her idea of the infant's need on to the infant, and the resolution of the need based on projection, instead of actuality. Bruch says that, "the larger the area of appropriate responses to the various expressions of a child's needs and impulses, the more
differentiated will the child become in identifying his bodily experiences, and other sensations, thoughts, and feelings as arising within him, and as distinct from the human or nonhuman environment." However, "failure of regular and persistent appropriate responses to his needs deprives the developing child of the essential groundwork for acquiring his own body identity with discriminating perceptual and conceptual awareness of his own functions" (1973, pp. 56-57). This helps to explain the confusion about self and others that anorectic patients feel, why they feel and behave as if they had no independent rights and why the issues of autonomy, identity, and self control are so very important to this clinical population.

Bruch's model is primarily interpersonal and developmental in nature and has been criticized for failing to detail the structural and intrapsychic components of this process (Masterson, 1977). Older psychoanalytic interpretations have described anorexia nervosa as the desire of the child for the father's penis with the refusal to eat as the attempt to resolve this conflicted desire and as the conflictual wish to be impregnated through the mouth. Classic oedipal interpretations of anorexia are critiqued by Boskind-Lodahl (1981) and described by Rizzuto, et al. (1981). However, most interpretations now focus on the pre-oedipal origins of anorexia nervosa and while oedipal issues may be relevant, they appear to be of secondary etiological importance.

The child's original experience with the primary object is a corporeal-incorporative one (Palazzoli, 1978). All of the infant's experiences are to some extent corporeal in nature, based on the need
for food and bodily care. A good relationship with a primary object leads to a good body experience, where one's own body is felt as a source of pleasure. When the interpersonal situation becomes frustrating, this sense of good is replaced by a bad object and a correspondingly bad body experience. According to Palazzoli, the child comes to feel that it is inhabited by a bad object, or that it is a bad body. Bad body experiences which occur during this early incorporative phase remain with the child as it develops. Experiences which follow during the phase of secondary narcissism will be, in part, recapitulations of the incorporative experiences of this primary phase.

In understanding how the symptoms of anorexia nervosa develop, Palazzoli describes a split in the ego of the developing child. Based on the work of Fairbairn (1952) with schizoid pathology, Palazzoli says that anorectics experience the body as separate from the mind. The mind or ego is equated with the self, while the body is equated with the introject of the bad object. Eating is then experienced as the feeding of the body at the expense of the ego. The anorectic patient feels that being a body is equivalent to being a thing. If the thing is fed, if it is allowed to grow, the person inside is diminished. Because the phase that is recalled is that of primary narcissism, the body, which is equated with the introject of the bad object is perceived as being all powerful. There is thus an absence of aggression, rather, a feeling of helplessness which is pervasive. It is as if the anorectic feels that the object is too powerful to be destroyed.
In the defensive structure of the anorectic, there has been a split between the incorporating ego (which becomes the body) and the identifying ego (which becomes the self). Since the body has been identified with the bad object, there follows a distrust of bodily needs and a desperate need to control the body or bad object. The clinical picture is further determined by whether the individual has arrived at the anal or the phallic phase of development (Palazzoli, 1978). Self starvation is a reaction against the incorporated bad object which allows some feelings of control over the overwhelming feelings of helplessness, and which allows the anorectic to organize a self image which is split off from the image of the bad object. Of course, this happens at great expense.

If the patient has reached the anal phase of development, her defensive structure is likely to be organized around the fear of losing control over impulses and having to keep impulses under control. This differs from the phallic defenses, which create the desire to be admired, to be controlling, and to overpower the oedipal rival.

Palazzoli concludes that anorexia nervosa is a defensive position which is somewhere in between the paranoid-schizoid and depressive positions described by Melanie Klein (1975). The introject of the bad object is synonymous with the body. This allows a self which is dissociated from the body to exist as a separate entity. The tension between the two is continuous. Unlike the schizophrenic, for whom persecutors wait in the outside world, the projection of the patient with anorexia nervosa goes no further than the limits of the mind/body.
It is possible for anorexia to be a defense against schizophrenia and in some cases when the anorectic defense fails, schizophrenia develops (Hsu, et al., 1981). Anorexia resembles schizophrenia but anorectics are usually delusional only with respect to food and their body image.

In summary, the task of the anorectic according to Palazzoli (1978) is to control the introject of the bad object, which is identified with the body, and to preserve the ego, self, or mind. The body is never abandoned or decathcted. The patient continues to invest it with some libidinal energy, and treats it as something which belongs to her but which must be controlled at all costs.

Rizzuto, Peterson, and Reed (1981) suggest that anorexia nervosa is a particular manifestation of the schizoid personality structure. In their explanation, the anorectic pathology occurs because the mother is unable to see her child as a separate psychic being. Rather, "the mother relates to the child as a physical body reality, perceived in a fixed manner. The mother fails to make the child a psychic object. The child experiences utter isolation, and compensates with compliant behavior in the hope that perfection and the avoidance of any mistakes, errors, or flaws would satisfy the conditions to be allowed to exist" (p. 475).

What happens in this conception of mother-child relationship is that the child exists in accordance with the mother's performed image of her, of what she should be. The bodily appearance of the child is identified with the image of the child that has been constructed by the mother, and the "real child in her own body has little, if any, opportunity to connect her developing sense with the body self that
has been preempted by the mother" (p. 475). The child and her body grow up quite separate from each other, and under the developmental vicissitudes of adolescence become antagonistic to each other.

Rizzuto, et al. (1981) say that anorectic patients are not borderline because they are too stable, nor are they narcissistic. Rizzuto finds that these patients do not experience a symbiotic or self object period, and that these are people who have never been seen for what or who they are; they are instead the product of parents whose image is based on their own projections. The mother of the anorectic is one who has failed to be an adequate mirror to her child, and Rizzuto quotes from Winnicott's (1971) paper on the Mirror Role of the Mother (1971): "(But what of) the case of the baby whose mother reflects her own mood, or worse still, the rigidity of her own defenses. (These babies) have a long experience of not getting back what they are giving ... Their own creative capacity begins to atrophy and they look around for other ways of getting something of themselves back from the environment." (Rizzuto, 1981, p. 477)

Winnicott (1936) also says that there is an important connection between appetite and greed. Greed, as a symptom, never appears on its own, but is always secondary to anxiety. Appetite disorders are always the result of inhibited greed, of the child's sense that it cannot obtain what it wants because feelings of anxiety or aggression become too great; or because the child fears that its greedy impulses will destroy the desired object. Greed, which is defined as the longing for the good object, or the desire for good things (Klein and Riviere, 1964) may be inhibited when it is felt that it endangers
the existence of the good object, or when greedy impulses engender too much persecutory anxiety in the individual, in return for the inhibition of greed, the existence of both internal and external good objects is preserved and protected.

Masterson (1977) discusses the anorectic pathology occurring in the borderline adolescent. According to Masterson, the pathology of the borderline develops when the mother withdraws and is no longer available to the child who begins to separate and individuate. According to Masterson:

The borderline mother, herself suffering from a borderline syndrome, experiences significant gratification during her child's symbiotic phase. The crisis supervenes at the time of separation-individuation, specifically during the rapprochement subphase, when she finds herself unable to tolerate her toddler's ambivalence, curiosity, and assertiveness ... The mother is available if the child clings and behaves regressively, but withdraws if she attempts to separate and individuate. The child needs the mother's supplies in order to grow; if she grows, however, they are withdrawn from her. (p. 478)

Masterson further describes a split in the developing ego of the child. Each part consists of an object image, a self image and affect which links the two. He calls one part the withdrawing part unit and the other the rewarding part unit. The withdrawing part unit is cathected with aggressive energy, and the rewarding part unit is cathected with libidinal energy. The two are kept apart by means of splitting. Masterson says that most patients with anorexia nervosa experience this developmental arrest at the symbiotic or separation-individuation phase so that their problems include fears of loss of self or loss of object. If the arrest truly does occur
during the symbiotic phase, the patient is likely to be schizophrenic. If the arrest occurs later, during the time when the patient is closer to achieving object constancy, then the anorectic's pathology is more likely to include both the wish for and the fear of oral impregnation.

Masterson does not specifically connect his developmental theory with the pathology of anorexia nervosa. Rather, he connects anorexia nervosa with the borderline personality. Using a specific case example, he says that anorexia nervosa served to relieve the individual's anxiety about loss of the object if she separated and individuated, by causing her to restrict growth of all kinds; to substitute obsessive control mechanisms for individuation strivings, and to get rid of the aggression she felt toward the object. He also suggests that the pervasive helplessness of the anorectic, described earlier by Bruch, is a failure of separation-individuation whereby the mother rewarded the child for clinging behavior. Likewise, the patient's distrust of her own bodily sensations and feelings is a consequence of this arrest in development whereby the patient suppresses her striving towards individuation in order to preserve maternal supplies.

Like Masterson, Sours (1982) relates the anorectic pathology to a developmental crisis during the rapprochement subphase of separation-individuation. Sours sees the anorectic's mother as a parent who withdraws when her daughter begins to manifest her independence, and who supports clinging and regressive behavior as well as passivity and compliance. She controls her daughter and withdraws support when she cannot. During adolescence, when the
search for a separate identity urges disidentification with mother, the anorectic daughter becomes embroiled in a conflict with her mother for control, at the same time increasing the use of the control mechanism which she has learned from her mother. Sours says,

Defeat and control by the mother tighten the anorectic's tie to the maternal object and confront the anorectic with her aggression and resultant separation anxiety, as well as depression and fear of maternal abandonment. The combination of aggression to the mother and new challenges increases her separation anxiety. Infantilized, the anorectic is unable to make decisions. Stemming from weakness in self and object constancies, cohesive self-other and inner-outer boundaries, transient unreality feelings may occur with the sense of being amorphously different, an obscure sense of helplessness, uselessness, and ineffectuality, mixed with boredom and emptiness. Transient unreality feelings are expressive of a reactivation of feelings of oral helplessness, threatening an already weak sense of self. (p. 347)

Gaining control over significant object relations and of herself is thus at the core of anorexia. The anorectic confuses the literal and the metaphoric and confounds control and independence. Control of the body becomes more important than satisfying bodily drives. The narcissistic pleasures involved in mastering her body obscures from the anorectic her body's true ugliness and her own sensations of hunger. Her sense of ineffectiveness is overcome by her achievement—academic and physical.

Family Dynamics

Much has been written about the family of the anorectic patient and about the generation of anorexia nervosa within the family nexus
Families of anorectics have often been characterized as belonging to the upper social classes, i.e., families where the father has been in a managerial or professional position. Sours (1982) says that the earlier the onset of the disorder, the more likely this is true. He also says that when anorexia nervosa occurs among the lower socioeconomic groups, it may be the atypical or secondary form, where the psychopathology is more severe. In Dally's (1969) study of patients and their families, this finding was true for 65%, but over one third of the families involved (N = 140) belonged to lower socioeconomic groups. Of these, most fathers were skilled or semi-skilled workmen; only four fathers were unskilled workers. Dally's opinion of this "downward spread" of anorexia nervosa is that it has to do with the increased affluence of our society in general. Garfinkel and Garner (1982) are also of the opinion that anorexia is no longer limited to daughters of the well-to-do. They note that as the incidence of anorexia nervosa has increased, there has been a more equal distribution throughout all levels of society. They also feel that cultural factors relevant to the development of anorexia nervosa (attitudes about weight, achievement, and self control) now cross socioeconomic boundaries.

A generalized picture of family life in 51 primary anorectic patients studied by Bruch (1978) portrays them as well cared for, privileged, and exposed to a great many educational, artistic, and athletic opportunities. However, these were also individuals whose
development had not been encouraged or supported so that they lacked security and autonomy when making decisions, expressing their own ideas, etc. While their lives appeared normal, their achievements high, this was often only a facade of "pleasing compliance."

Minuchin (1978) says that families of anorexia nervosa patients are representative of psychosomatic families and are characterized by enmeshment, overprotectiveness, rigidity, and the inability to resolve conflict. Emotional issues are rarely discussed and somatization serves as a way of dealing with highly charged issues (Sours, 1980). Conflict is avoided, since there is no way to deal with it other than somatically, and the needs of the individual are often subordinated to the needs of the group, which fosters the anorectic patient's feelings of lack of identity, autonomy and control.

Families treated by Bruch (1973) emphasized that their lives were normal and tended to deny the anorectic illness, but would often emphasize that this child was superior when comparing her to siblings. Bruch says that this denial of anything except the weight loss suggests that past difficulties were also denied, or that they were not perceived and that the anorectic patient's previous facade of compliance was one which was accepted without question.

Dally (1969) reports that 38% of the parents in his study showed overconcern with what their children ate, whether they ate enough, and whether they ate the right kinds of food.

Palazzoli (1978) says that a sadomasochistic relationship exists between the parents of anorectic patients with more apparent sadistic behavior manifested openly by the father but with the mother exerting
more subtle "castrating" behaviors. She finds that neither spouse has really separated from their own families of origin, i.e., that husbands in these families have never really married their wives, but are still tied to their idealized mother images. Wives may be attentive and efficient, but they lack a separate identity and are there to basically cater to their husbands and families. The wife in such families sees the hateful characteristics of her own mother reflected in her husband's neediness. She has a close relationship with her mother, but it is often one which is based on dependency, hostility, and guilt. Thus, mothers act as slaves to their own mothers, as well as their husbands. Palazzoli says that at first, marriage may appear liberating to these women, but not for long. The sex lives of these couples is rarely satisfactory. It is no wonder, therefore, if such a family portrait is accurate, that these women are often depicted as depressed and that they project their own unfulfilled dreams and desires onto their daughters.

Sours (1980) presents the anorectic family as one which is vigilant to distress but which does its best to obfuscate conflict. He says that appropriate developmental strides toward independence are not encouraged in these families, and that such strivings are often viewed as disloyal and destructive to the family. The anorectic child is often involved in conflict between the parents, and one parent will attempt to form a coalition with that child against the other parent. In addition to the factors which threaten the family from within, Sours points to cultural pressures which threaten the family with discontinuity, transformation, and dissolution and says
that these may be responsible for the increased incidence of anorexia nervosa at this time.

Wilson (1983) lists six factors which characterize the families of anorectic patients. Based on a study of fifty such families, he found, like Dally, that subjects were overconcerned about weight, about being fat, and about dieting. This was present in every case. All families were perfectionists; every family manifested repressed emotions; and children in these families were infantilized in terms of decision making and were over-controlled. Parents were exhibitionistic in terms of their sexual behavior, bedroom doors were not locked, bathroom doors were left open; one child was "selected" in each of these families and treated differently than the other children. It was this child who became anorectic.

Garfinkel and Garner (1982) discuss the problems involved in investigating anorectic families. It is important for researchers to distinguish family phenomena which have etiological significance from those which are the result of anorectic pathology. According to these authors, "it is not uncommon to observe struggles between parent and child for control if the child had been starving herself seriously for the previous five years; it would be wrong to infer that such a struggle necessarily represents the pathogenic substrate of the illness" (p. 165). They further note that few studies in this area have been properly controlled; often family attitudes have been measured only by the subjective judgment of the individual clinical investigator, which introduces the strong possibility of bias. In this way, myths are perpetuated. Indeed, it seems unfair to say,
as Palazzoli (1978) has done, that she had never "come across parents (of an anorectic) with a mature emotional relationship to each other, superficial appearances to the contrary" or to speak of the domineering mother/passive father combination, which, as Garfinkel and Garner note, has been applied to may psychiatric illnesses.

Garfinkel and Garner (1982) also stress the heterogeneity within the syndrome, both in terms of research which fails to discriminate between bulimic and restricting anorectics and between fourteen year old adolescents and a twenty-nine year old married woman. This is an important contribution, since these differences have often been obscured in the literature. These authors do note, as have others (Bruch, 1973; Dally, 1969), that parents of anorectic patients often tend to be older, although by today's standards, with the current trend toward late marriages and child birth, these figures do not seem significant.

In her discussion of the mother-daughter relationship in anorectic families, Palazzoli (1978) says that the disgruntled mother described above re-establishes and recapitulates her unsatisfactory relationship with her own mother. The "chosen" daughter has a relationship with her mother which is different from that of any other child in the family. Other children are allowed more freedom and are more readily allowed to develop independently. The anorectic daughter, however, is there to satisfy her mother's expectations and fulfill her mother's needs.

Wold (1973) likewise found that the mothers of her anorectic patients were unable to separate from their own mothers and recreated
the relationship with their own mothers with their anorectic daughters. They were unable to deal with their own anger, and dealt with expressions of anger by their daughters by withdrawing, becoming depressed, or threatening to "fall apart." Like others in this review, Wold says that emotional deprivation is a necessary precondition for the development of anorexia nervosa, but says that other factors must also be present, i.e., that emotional deprivation is necessary but not sufficient.

Bruch (1978) says that mothers of anorectics are women who have sacrificed their own goals for the well-being of their families. Like Palazzoli, she sees them as women who submit to their husbands but who do not respect them.

Fathers in these families are described as financially successful and successful in their careers; as conventional, pre-occupied with appearances, and demanding of their children. Yet their self-esteem is not always high; they feel "second best" (Bruch, 1978; Sours, 1980).

Wold (1973) described the fathers of the anorectics in her study as "compulsive persons with violent tempers" (p. 1396). She thought that these fathers identified their anorectic child with their own mothers and seemed to displace hostility from their own mothers on to their daughters.

Sperling (1983) takes the position that anorectic patients regress from a position of competing with her mother for the attention of her father to "competitive rivalry" with the father for mother's attention—a shift from an oedipal to a pre-oedipal position that
coincides with changes in the behavior of the patient. This shift in attachment and regression also coincides with a negation of heterosexuality. Sperling further says that these changes often occur after some real or imagined disappointment by the father.

Dally (1969) examined the families of his anorectic patients for incidence of psychiatric disorder. He found that such disturbance was present in 33% of his patients' families; in 32 mothers and 14 fathers (from a total of 139 parents). However, he does not say what kind of disturbances these were.

More recent studies by Hudson, Pope, Jonas, and Yurgelun-Todd (1983) and Winokur, March, and Mendels (1980) find relationships between anorexia nervosa and affective disorder. Hudson, et al. studied 420 first degree relatives of 89 patients with anorexia nervosa, bulimia, and the bulimic form of anorexia and found that the risk for affective disorder in the families of the eating disorder patients was similar to that found in the families of patients with bipolar disorder and greater than that found in the families of patients with schizophrenia or borderline personality disorders. Winokur, et al. found that 22% of relatives of anorectic patients had histories of affective disorder while only 10% of the relatives of control subjects had such histories. Thus, anorexia nervosa may occur more frequently in families where there is already some history of affective disorder.
Cultural Influences

Self-starvation is a form of pathology common only to situations of economic surplus and abundance. It does not seem to exist in developing nations in the third world where there are frequent famines and starvation conditions (Bruch, 1973). Historically, in periods where food has been in short supply, the fat female figure has been interpreted as a sign of wealth, fecundity, sexuality, and distinction (Palazzoli, 1978; Garfinkel and Garner, 1982). In our society, it has become a thing to scoff at, worry about, or laugh at. Obesity is more common in our culture among the lower socioeconomic groups (Bruch, 1973).

At other times in history, cultural attitudes toward women have promoted serious physical deformities and illness, such as the custom of footbinding in China and the wearing of tight corsets (Garfinkel and Garner, 1982). As can be seen in the art of the 17th and 18th centuries, the full bodied figure was considered attractive. Today, we seem to prefer the "Twiggy" look, or women who are thin enough to have become desexualized.

Current cultural pressures may make it more common for girls to somaticize their problems, even at an early age. When girls and boys admitted to a child psychiatry unit were compared, it was found that girls were more often referred for somatic complaints. Their symptoms included abdominal pain and loss of appetite. Boys were more often admitted for conduct disorders (Stewart, Gath, and Hierowski, 1981).
Likewise, in a study of college students (318 females, 182 males) who visited a college psychiatric service, identity disorders, bulimia, and histrionic personality disorders were more often diagnosed in women. Men were more likely to have some sort of compulsive disorder (Strangler and Printz, 1980).

Being thin has become associated with self control and success, and this has become increasingly important in our society as more external controls have broken down (Garfinkel and Garner, 1982). The standards which once governed behavior so rigidly are less apparent, less clear. Because of this, greater structure is demanded from within and must develop in the absence of clear guidelines and what may be a confusing and frightening abundance of options (Crisp, 1980).

Adolescence is the time which has been designated as a period of identity formation; the onset of anorectic symptomatology has been repeatedly associated with the maturational crises of adolescent development. It is important to remember, therefore, that the concept of personal identity, with which anorexia nervosa is ultimately connected, is one that is culture bound. Crisp (1980) says that identity is a different matter in Buddhist societies than in our own, and points out that the concept of adolescence did not even exist two centuries ago. In writing about the various ages of a man's life, Aries (1962) details the concept of adolescence, saying that until the 18th century, adolescence was confused with childhood. He credits the German composer Wagner with portraying the first adolescent in Sigfried and says that the concept did not appear in France until about 1900.

Unlike the psychoanalytic authors described above, Crisp (1980)
finds that dieting fosters internal control mechanisms for adolescents, who emerge into a society which has become lax in its guidelines and codes of conduct. Garfinkel and Garner (1982) likewise agree that thinness has become associated with self control. Dieting becomes a way of asserting control over situations which seem increasingly out of control and provide the adolescent with one special area that she can have some control over.

Given a cultural perspective, there is a clear shift in emphasis when one considers the etiology of the anorectic pathology; a shift from the individual who has failed to develop a sufficient sense of identity to a culture which has failed to provide the means to facilitate the growth of such a structure in the first place. When one looks at studies of college students who have some form of eating disorder, who are preoccupied with food and weight, but in whom the level of pathology has not reached clinical proportions (D. Zuckerman, 1983; Button and Whitehouse, 1981), there is little doubt that the cultural influence is an extremely important one and one which has been given too little attention thus far.

Wilson (1983) also attributes the incidence of anorexia nervosa to "the breakdown of established societal institutions and attitudes that have afforded the female definite paths for identity formation, impulse control and sublimation" (p. 23). He continues to say that faced with leaving home, going away to college, "the anorexia prone girl has no choice but to regress and starve herself." While this does appear to be somewhat of an overstatement, he is correct to point to the social anomie that today's generation faces and the
changing values that are now placed on roles which have been traditionally valued—child bearing and motherhood, while increased demands for achievement are placed on women.

Schwartz, Thompson, and Johnson (1982) attempt to bridge the gap between the analytic and culturalist positions by stressing that there are multiple paths to any form of psychopathology. In individuals whose early life trauma establishes a tendency toward psychopathology, the exact nature is determined by later factors in the life of the individual. Cultural influences which stress thinness collude with these predisposing factors to form the symptoms of anorexia nervosa. These authors draw a parallel between the hysteria common in Freud's day and the eating disorders of today, in that both involve the formation of symptoms symbolizing a particular issues which represents the period and culture. The increase in anorexia, then, is due to the fact that individuals with certain characterological psychopathology find this configuration of symptoms supported by cultural trends.

The driving need to achieve and to take control, which has been discussed often, are manifested in the athletic capacities of the anorectic patient. While weight loss in athletes is different from that in anorexia nervosa, because both males and females appear to be at equal risk (Smith, 1980), and a differential diagnosis is sometimes difficult to make (Chipman, et al., 1983). Psychiatric evaluation may be necessary to determine whether the weight loss is complicated by disturbed body image, feelings of inadequacy, and whether other symptoms of anorexia nervosa are present.
Yeats, Leehy, and Shisslak (1983) compared patients with anorexia nervosa and male marathon and trail runners. They found that these male athletes, called "obligatory runners," resembled the anorectic women with regard to family background, socioeconomic class and personality traits such as inhibition of anger, high need for achievement, and expectations, tolerance of physical discomfort, and a tendency toward depression. They hypothesize that both could represent an attempt at identity formation.

Sours (1982) also finds parallels between the motivation of runners and anorectic patients. Like anorexia nervosa, running has captured the interest of the media; both are the subject of constant and abundant articles. Like the anorectic, the runner strives to overcome the limitations of the body, and like the anorectic, the runner forms an identity around running. Like the anorectic, the runner uses his mind to overcome the physical limitations of the body and strives to become more perfect and more enduring.

Treatment of Anorexia Nervosa

The literature on the treatment of anorexia nervosa is filled with articles advocating virtually every kind of treatment from force feeding to classical psychoanalysis. Like the literature on etiology, which offers a plethora of possible explanations, the treatment literature is also diverse and somewhat confusing. Ultimately, the clinician is left to choose the mode of treatment.

Successful treatment of anorexia nervosa includes a resumption of normal eating patterns and a resolution of the underlying conflicts
Which caused the symptoms in the first place (Bruch, 1977). These two goals may, in some instances, be incompatible, since any suggestion of weight gain may alarm the patient and initiate the development of a negative transference (Goodsitt, 1977). On the other hand, if weight falls too low, there is little use in psychotherapy, since the nutritional deficits and complications of starvation only serve to confuse the psychological situation. Loss of more than 25% of normal body weight makes it difficult for the patient to gain weight on her/his own. Weight loss of 40% or more requires hospitalization (Garfinkel and Garner, 1982). Halmi (1982) feels that if the patient does not recover weight, she is not being effectively treated. In most cases, an initial period is required to restore nutrition, she says, then outpatient treatment can be done on a continuing basis.

Garfinkel and Garner (1982) note that the patient must share in her own treatment goals and, from the inception of treatment, emphasis should be on weight restoration and on helping the patient to see that weight loss and weight control represent maladaptive solutions to other problems. The patient needs to learn that she has made weight into a metaphor for other emotional difficulties. Once this has occurred, she can be helped to face those conflicts more directly.

An excellent review of psychotherapy and treatment of patients with anorexia nervosa during the period from 1930 to 1950 is found in Bliss and Branch (1960). Other excellent discussions of treatment are found in Bruch (1973), Sours (1980), Garfinkel and Garner (1982), and Vigersky (1977).

Bruch (1978) cautions against placing a patient in a hospital
which does not specialize in the treatment of anorexia nervosa. She feels that hospitalization becomes necessary when the patient's condition deteriorates so that it is considered life-threatening, but once weight rises past the danger point, she feels that outpatient treatment is preferable. The collaboration of the therapist and medical practitioner is crucial. However, Bruch stresses that it should be the physician and not the therapist who is responsible for monitoring the patient's weight.

Sometimes various forms of therapy are combined in a multimodal approach. This is particularly feasible when the treatment involves a period of hospitalization, and therapists from different disciplines can function as a team (Hedblom, Hubbard, and Anderson, 1981). Piazza, Piazza, and Rollins (1980) provide details on a multimodal treatment program at Children's Hospital Medical Center in Boston, where milieu therapy was used to place emphasis on nutrition and help to restore weight. A parents' group provided a place for parents to release anxiety about their anorectic child and get support from other parents, as well as individual therapy and family treatment. A parents' group may be a useful alternative to family therapy when family therapy is contraindicated (Rose and Garfinkel, 1980).

Behavior therapy in anorexia nervosa has been widely discussed (Stunkard, 1972; Halmi and Larson, 1977; Agras and Werne, 1977; Pertscuk, 1977) and has been critiqued as being too simplistic (Bruch, 1978), too rigid (Goodsitt, 1977), and too likely to replicate aspects of the original life situation of the patient which were causative factors in the first place (Goodsitt, 1977). Bruch
(1978) feels that the treatment of these patients must involve not merely inducing weight gain; that a fundamental part of the therapeutic task is to illustrate to both the family and the patients that self starvation is a manifestation of complex emotional issues. Goodsitt (1977) feels that in behavior therapy, an anorectic is forced to ignore her inner states and conform to yet another rigid regimen. The split between the self and the body is once again recreated and intensified when the patient submits to the control of behavior modification.

Behavior therapy may be too mechanistic and may be applied without paying attention to the individual circumstances of the patient's life, but it may be useful when it is used toward strengthening the patient's ability to distinguish between anorectic and appropriate behaviors (Garfinkel and Garner, 1982). These authors note that even when the patient has begun to improve, anorectic behaviors such as cutting food into tiny pieces, eating alone, eating only certain foods which have been labelled "safe," etc., may remain with the patient. Behavior therapy may be used to help rid the patient of such behaviors, particularly when combined with more cognitive approaches. Garfinkel and Garner also feel that behavioral exercises may be used to provide corrective emotional experiences. A therapist may accompany a patient to a meal in order to support normal eating habits. Likewise, they advocate behavioral homework assignments and role-playing as helpful to the patient with such activities as decision making, assertiveness training, etc.

More traditional forms of behavior therapy, involving positive
and negative reinforcement are also useful to the anorectic patient (Garfinkel and Garner, 1982). Therapists' knowledge of reinforcement contingencies that determine the patient's behavior can be helpful in goal setting, while negative sources of reinforcement should be eliminated.

Stunkard (1972) treated patients hospitalized for anorexia nervosa by making the opportunity for physical activity a reinforcer for increased food intake and weight gain. Physical activity was contingent upon gaining weight. He found that results with three patients were striking, with patients averaging gains of four pounds per week during six weeks of hospital stay. In one severe case of anorexia nervosa, Stunkard decreased chlorpromazine dosage in proportion to the amount of weight gained by the patient on the previous day. Reduction of the drug was used as a reinforcer since the patient complained that the drug made her drowsy. Stunkard concludes that any suitable contingency may serve as a reinforcer in this kind of therapy.

Sours (1982) agrees that behavioral therapy can be a very effective approach with the severely anorectic patient who is hospitalized and refuses to eat; especially when these are aimed at symptom improvement and reduction in the family's preoccupation with the anorectic illness. However, he feels that it is a mistake to rely solely on this method of treatment and that results could be disastrous if the patient were allowed to leave the hospital only on the basis of weight gain. Sours also says that the anorectic patient may be alarmed by the rapid changes in her body that occur with this
kind of treatment which increases the possibility of depression and that her hopes of regaining some more genuine sense of self-control may be upset by this kind of therapy.

In a study by Halmi and Larson (1977) patients received increased privileges for gaining and maintaining weight while in the hospital. Once outside the hospital, they continued the program, using new clothes and other positive reinforcers as a basis for continued weight gain. If the patient's weight dropped below a minimum point, rehospitalization would occur. Results of their study showed that treatment which included behavior therapy was more effective in inducing weight gain in patients.

In a study which compared treatment with appetite stimulating drugs and psychotherapy with behavior therapy, Wullemier (1978) found that those patients treated with behavior therapy gained weight more rapidly during hospitalization. However, when behavior therapy was compared with total parenteral nutrition therapy it was found that the parenteral nutrition therapy resulted in more rapid weight gain (Pertschuk, Forster, Buzby, and Mullen, 1981).

Some authors (Minuchin, 1978; Palazzoli, 1978) make family therapy their treatment of choice. Using a structural approach, Rosman, Minuchin, Liabman, and Baker (1977) found that family treatment would shift the focus from the identified patient (i.e., the anorectic daughter) to the way the family members interacted and related to each other. In this method, families are thought of as a series of functionally related subsystems. In family therapy, the dysfunctional relationships may be exposed and modified so that family
members begin to relate to each other differently and the patterns of behavior underlying the symptomatology disappear. Structural family therapy emphasizes the present, the therapist works with the family as it is at that particular moment.

The first step in such a treatment program is to reduce the life threatening nature of the situation. Once the necessity to focus on food is diminished, the necessity for the family to be organized around food and eating is also reduced. When this occurs, more central conflicts can be identified. Often with Minuchin (1978) the therapy begins in the hospital setting over a lunch meeting with the family and patient. This immediately redefines eating as an interpersonal problem and allows the therapist to shift away from eating as the problem to other areas of family dysfunction as soon as possible.

Piazza, Piazza, and Rollins (1980) found that there is often a stable coalition between the patient and one of the parents in the families of patients with anorexia nervosa. While they use family therapy, they do say that this kind of therapy alone may not be sufficient and that treatment should remain flexible enough so that it can be adapted to fit the individual case.

While there are some who feel that psychoanalysis is the treatment of choice in anorexia nervosa (Wilson, Hogan and Mintz, 1983), the classical analytic approach has been criticized (Bruch, 1977) as an approach which contains elements which recall the situation responsible for the creation of the pathology in the first place. The patient is placed in a passive stance and is "given"
interpretations from the therapist. Bruch feels that this is apt to reinforce the patient's original sense of helplessness. She recommends a modified psychodynamic approach which will expose and resolve the core conflicts responsible for the pathology. According to Bruch:

...the focus is on the patient's failure in self experience, on the defective tools and concepts for organizing and expressing needs, and on the bewilderment when dealing with others. One aspect of the therapy is the effort to repair conceptual defects and distortions and to recognize the roots for the deep seated dissatisfaction and sense of isolation. This is accomplished by assisting patients to develop awareness of their own capabilities and potentials so that they become capable of handling their own problems in more competent ways. These modifications are in good agreement with modern concepts of psychotherapy...

The therapist's task is to be alert and consistent in recognizing any self-initiated behavior and expressions by the patient. He must pay minute attention to the discrepancies in a patient's recall of the past, to the way current events are misperceived or misinterpreted... (1977, p. 300)

Goals of psychotherapy with an anorectic patient are aimed at establishing a better narcissistic equilibrium and at maintaining life (Goodsit, 1977). The patient can use the therapy to establish a symbiotic transference and use the therapist for ego functions which she is not capable of. This fosters ego functioning in the patient and heals old narcissistic injuries. Goodsit cautions against the symptom of the illness and cautions that treating the symptom so that the patient puts on weight may interfere with the correction of intrapsychic pathology.

In any kind of psychodynamic psychotherapy that is undertaken,
interpretation will not be an effective tool until the patient is able to recognize her own resistance and able to begin to recognize the affects which have been split off and denied (Sours, 1980). The establishment of a therapeutic alliance is not easy with an anorectic; control of the therapeutic process may serve as a very powerful form of resistance (Sours, 1980). Sours also says that he feels that analysis is possible for anorectic patients who fall within the less severe borderline categories. In the transference, via identification with and internalization of the analyst, the patient becomes less and less fused with the mother and is able to develop stronger ego functioning and new psychic structure.

Cohler (1977) describes the significance of the therapist's feelings in the treatment of patients with anorexia nervosa. Treatment of anorectics is especially difficult because of the possibility that the patient will die during the treatment. If the patient does not gain weight, the therapist may feel that he is not successful and this feeling can be intensified by the negative transference reactions of the patient, who tells the therapist that s/he is not helpful. In addition, a therapist may be in the position of treating someone who does not really feel that she is ill, or of treating someone who says she wants to get better but then will do everything possible to resist recovery. According to Cohler (1977), it is:

...the capacity of the therapist to bear these feelings of anger, hopelessness, manipulation, and powerlessness (which) is of greatest importance for the treatment process. It is precisely when the patient can attribute these
feelings to a therapist, who can accept and endure these feelings himself, that the patient is first able to achieve personality change and to experience a greater sense of intrapsychic integration. (p. 354)

The question of how to address the issue of weight is especially important outside the hospital setting, assuming that the patient who is not hospitalized is less severely anorectic than the one who is. Garfinkel and Garner (1982) clearly state that since the process of psychotherapy is affected by the patient's nutritional state, the psychotherapist must be concerned with issues of weight. However, they continue to say that before weight and eating can be productively addressed in psychotherapy, the patient and therapist must have established a therapeutic alliance, and the patient should participate in planning her weight so that she is convinced that the therapist is not there to be in control of her, but to help her gain control of herself. They also stress that the patient's low weight should be reinterpreted to her, i.e., she should be told that she is not in control because she is so thin, rather than her thinness is a symbol of control.

In another publication, Garner, Garfinkel and Bemis (1982) detail the kinds of common errors in thinking made by anorectic patients. These are: dichotomous thinking, in which things are only all one way or all the other with nothing in between the two extremes; superstitious thinking, i.e., believing the cause-effect relationship of non-contingent events; personalization and self reference of impersonal events; magnification of the significance of events, such as gaining several pounds; selective abstraction, basing conclusions
on isolated information fragments while ignoring others; overgeneralization, formulating a rule on the basis of a single event and applying it to other situations. While these kinds of cognitive errors may apply to the thought processes of other disorders as well as anorexia nervosa, they do indeed appear to be accurate descriptions of the kinds of errors made by this population.

Use of Drug Therapies

A variety of drugs have been used in the treatment of anorexia nervosa, often as adjunct therapies. Chlorpromazine has been used to reduce the patient's anxiety around eating (Sours, 1980). However, there have been harmful side effects such as dyskinesia and fluid retention.

Needleman and Waber (1977) report the use of the antidepressant, amitriptyline, and Sours (1980) says that when antidepressants are used, they are generally one of the tri-cyclics such as amitriptyline.

Cyproheptadine, an antiserotoninergic drug, caused weight gain in children with asthma. Vigersky and Loriaux (1977) report a double blind study in a group of 24 patients with anorexia nervosa but their findings did not support the use of this drug with anorectic patients.

L-Dopa was tested on nine anorectic patients by Johanson and Knoor (1977). The patients were given low doses of the drug for periods of 16 to 27 days. Five of the nine responded with a significant gain in weight, but one later relapsed and lost weight.

Metoclopramide, an antiemetic drug, has been used to relieve the
gastric discomfort of anorexia nervosa patients (Moldofsky, Jeuniewic, and Garfinkel, 1977; Saleh and Legwohl, 1980). A preliminary report by the former indicates that this drug was helpful in relieving symptoms of flatulent dyspepsia but appeared to cause depression in two patients, which improved once the drug was discontinued. The study by Saleh and Lebwohl (1980) indicates that this drug was helpful in improving tolerance to meals, postprandial epigastric pain, belching and vomiting. They urge metoclopramide as an adjunct treatment in the therapy of anorexia nervosa patients.

The use of diphenylhydantoin is reported as helpful to anorectic patients who are also compulsive eaters by Green and Rau (1977). While the actual mechanism of this drug was not known at the time of this report, these authors suggest that it may reduce the excitability of the nervous system and thereby help to decrease compulsive and impulsive activity.

**Outcome Literature**

Dally (1969) lists a large number of factors which may influence the outcome of treatment of anorexia nervosa. Among these are the premorbid body weight, amount of weight lost, interval between the weight loss and beginning of treatment, family history of psychiatric disorders, social class, age and personality of parents, death of a family member, parental attitude toward the patients and toward food and eating, premorbid personality structure, and level of intelligence and education.

Crisp, Kalucy, Lacey, and Harding (1977) found that factors
associated with a poor outcome include: being male, being in a lower socioeconomic group, late onset, the presence of concern over weight and body shape within the family, premorbid obesity, marriage, long duration of illness, excessive compliance during childhood, excessive somatic complaints, high levels of depression in parents at the time of presentation, obsessionality in mothers, high level of somatic complaints in fathers, continued misperception of body shape following weight restoration, using binging and vomiting as a means of weight control, and poor motivation for treatment.

Sixteen outcome studies are reported on by Hsu (1980). All were done between 1954 and 1978. All contained clearly stated diagnostic criteria, had at least 15 subjects and a follow-up duration of at least two years. Hsu found that the mortality rate in over half the studies was below 5%. Death was the result of electrolyte disturbance, suicide, or tuberculosis. Nutritional outcome was difficult to determine, but in seven studies, body weight returned to normal in 41% to 81% of subjects. In 15% to 25% of subjects, body weight continued to be below 75% of average. Some 2% to 7% of the subjects had become obese and were at least 15% overweight at follow up.

Twelve studies reported on menstrual functioning at follow up. From one-half to three-quarters of the women subjects had resumed menstruation. However, it was common for menstrual cycles to remain irregular, and some 13% to 50% of subjects had not resumed menstruation even though their weight was within normal limits.

Eating difficulties appeared to continue. One third of subjects in two studies reported that they were eating normally, but half the
subjects reported that they continued to avoid foods high in calories. In two studies bulimia was present in 14% to 50% of subjects.

In terms of psychiatric outcome, four studies discussed the continued concern with weight and body size, even after a return to normal weight. In addition to neurotic preoccupation with weight, psychiatric symptomatology observed at follow-up included depressive reactions, anxiety, obsessive compulsive reactions, drug dependence, and various forms of sociopathic behavior. Schizophrenia appeared only rarely at follow up. An association between abnormal sexual attitudes and behavior and chronic anorexia nervosa was also reported.

It was generally agreed that social adjustment remains poor in a "substantial proportion" of the subjects. Social and family relationships were likely to have remained at a dysfunctional level if the anorexia nervosa had become chronic. Social anxiety appeared even among those patients who had regained weight to normal levels.

Effects of treatment were divided into immediate effects aimed at restoring nutrition and weight, and long term effects which attempted to keep the patient from relapse. Specific type of therapy did not seem to be a significant factor; successful results were obtained with a variety of therapies, including nursing care, behavior therapy, and family therapy.

In two studies, poor prognosis appeared to depend upon the duration of the illness (longer equals bad), age at onset (older equals bad), and the amount of weight lost (more equals bad). Bulimia and vomiting were also identified as poor prognostic indicators by three of the studies in the review.
Rollins and Piazza (1981) studied 56 patients who had been hospitalized for anorexia nervosa. They reported detailed findings on 35 of the 56 patients, and found that 69% were medically much improved or recovered, 79% demonstrated no or minimal psychosocial impairment; 34% were rehospitalized for anorexia nervosa, two of the 35 were rehospitalized for other psychiatric disorders; 64% had resumed menstruation.

In a review of twelve major outcome studies done during the last seventeen years, Schwartz and Thompson (1981) found that 49% had completely recovered from anorexia; 31% had experienced some improvement in weight (although some were obese) and 18% had no significant change in weight. The number of men included in these studies varied from 0% to 25%, which resulted in a total of 8%, which is slightly lower than some past studies. In some studies, men were defined as atypical anorectics; in others, they were excluded. Mortality rates also varied from 0% to 21.5%, with an overall death rate at around 6%. The suicide rate was 1%, a low figure when compared with other psychiatric disorders, unless of course, one considers all mortality that results from anorexia nervosa as suicide.

The percentage of subjects with other psychiatric symptoms was difficult to ascertain, because of rating systems which were difficult to compare. However, Schwartz and Thompson suggest a figure of 46% of patients remain symptomatic in areas of their lives which are not related to food and weight.

Crisp (1980) says that with regard to the recovery rate, about 40% of individuals who were severely anorectic can expect to be free
of the disease five or six years later. However, he notes that although some individuals will recover a normal weight, this may be maintained by dieting in an abnormal way, or they may continue to have concerns about their body image and shape.

Garfinkel, Moldofsky, and Garner (1977) report on the outcome of 42 patients who were treated with a variety of methods. The patient's weight ranged from 45% to 19% of their average weight. One patient was between 90 and 110% of average, three were between 80 and 89%, four patients were 75 to 79%, and thirty-four patients were less than 75% of their average weights. All except one appeared to have some kind of food fad, and in 63% these were considered marked. Nineteen percent of patients (8) vomited occasionally, and six of these patients vomited at least four times a week. Sixty-two percent of the patients (26) had episodes of bulimia and 17% (7) abused laxatives. Only 6 patients had resumed menstruating; the rest continued to be amenorrheic. Only 2% of patients reported that they related well to males, peers and family, while 17% related well in two out of these three areas and 69% related well in just one area of their lives. Twelve percent did poorly in all three areas.

Thirty six of the patients attended school or worked and worked efficiently; 24% worked below potential, 19% were either frequently absent from work or performed poorly, and 21% neither went to work or attended school.

In general, these authors felt that 50% of their patients were doing well. Of those who were not, there were problems with peers and family, psychosexual problems, and recurrent periods of low
weight. Ten patients had required additional hospitalization, one patient died. This is a lower mortality rate (2%) than previously reported, but agrees with the figure presented by Dally (1969) who found a mortality rate of 2.8%.

Pertschuk (1977) followed patients treated behaviorally and with family therapy on an inpatient unit and found that weight gain was correlated with length of hospitalization, but not with weight at admission or duration of illness. As a group the patients continued to improve between discharge and follow up. However, only two out of 27 had recovered normal weight, were functioning well and eating normally. Twelve patients had been rehospitalized, six for weight loss, four after they attempted suicide and two for depression. While none of the patients had been bulimic when admitted to the hospital, ten patients were so on follow-up. This study concludes that improvement in the hospital does not appear to be predictive of long term recovery. They also found that it was possible for the patients to recover weight without recovering normal eating patterns or losing their former preoccupation with food, since at follow-up, most patients continued to express an exaggerated concern with food.

Minuchin, Rosman, and Baker (1978) present data on fifty-three patients treated with family therapy. Their results are extremely optimistic. Eighty six percent of their patients recovered from their anorectic symptoms and recovered in terms of their psychosocial functioning. Only 3 of the patients were medically unimproved at follow-up and there were only two relapses. There were no reported deaths among the patients in this series.
Theander (1983) published a recent follow-up of the 94 women he reported on in 1960. All had been hospitalized in Sweden. A first follow-up came at the end of 1976, after 6 years or more. A second follow-up is now being done, 22 to more than 50 years after initial contact with the subjects. Theander found that in 1966, the mortality rate was 13%. Three subjects had committed suicide and nine had died from the effects of anorexia. At the end of 1982, the mortality rate had risen to 18%. In 1966, seven subjects were still ill with anorexia nervosa. Two of these have since died, and at least two more are still seriously affected. These women are now 47 and 58 years old and have had the disorder for 30 and 42 years. Only one subject has become psychotic. When compared to 1966, more subjects are now completely free from the anorectic symptoms. There are now 100 children born to this group of women.

The difficulties in conducting outcome research are discussed by Hsu (1980), Schwartz and Thompson (1981), and Garfinkel and Garner (1982). In his discussion of studies from 1954 to 1978, Hsu notes the widely discrepant findings among outcome studies. This can be attributed to:

1. the lack of a rigorous definition of anorexia nervosa;
2. failure to use a direct method of follow-up (indirect methods are of little use with these patients who often deny illness or overestimate their weight);
3. failure to trace patients;
4. follow-up done at short duration when relapse may not yet have occurred; and
5. outcome criteria in too few areas and incomplete information.

To these, Schwartz and Thompson (1981) add differences in instrumentation, definition of cure, small samples, different forms of treatment, different theoretical orientations, and clinical investigators who present results in ambiguous or misleading ways. Finally, studies evaluating the outcome of anorexia nervosa are well reviewed by Garfinkel and Garner (1982) who point out one additional criteria which makes outcome study difficult. These authors correctly point out that many of these studies have been done by institutions which specialize in the treatment of anorexia nervosa and may have received only the most difficult cases, referred by other therapists for treatment. Therefore, the data in these studies may be difficult to generalize to the less severe cases.

Swift (1982) reviews seven studies which deal with early-age onset anorexia which has been believed to have a better prognosis (Bruch, 1973; Crisp, 1980; Sours, 1980). Studies included in the review have a mean or median age of less than fifteen years of age. He finds that there is significant evidence to support this contention, although he states that the clinicians who have made statements to this effect may not be incorrect. In the seven studies in his review, results were similar to studies concerned with a later onset.
Anorexia in Males

Compared to the vast literature on anorexia nervosa in women, the literature on males is small. Bliss and Branch (1960) studied the literature and found 51 males in a total of 473 cases, an incidence of 11%. This is higher than other figures and may be explained by the lack of standard diagnostic criteria across studies. In a review of the literature on males, Beumont, Beardwood, and Russell (1972) traced 84 papers from all over the world which reported a total of 250 males with anorexia nervosa. However, in only 25 cases was there sufficient evidence for these authors to confirm the diagnosis. Their own study presented another six cases. Indeed, most of the case studies of males include only a very small number of cases.

Although Dally (1969) made amenorrhea one of the diagnostic criteria for anorexia nervosa, he found that a similar condition could exist in males. He saw only 6 males, compared to 140 women in this study. Dally cites an earlier publication which suggests that the equivalent of anorexia nervosa in males is a rare disorder known as Klein-Levin syndrome which is marked by extremely intense periods of bulimia and hypersomnia, although it is my impression based on some clinical experience of this syndrome that the two are very different disorders.

Dally (1969) states that "homosexual conflicts are prominent in some male patients." Three male patients analyzed by Sperling (1983) were thought to be bisexual, with "feminine wishes and pregnancy fantasies symbolically expressed in pregenital conversion symptoms"
Like Dally, Sperling (1983) does not feel that true anorexia nervosa can occur in a male. She sees the symptoms of anorexia as a desire for independence (from mother) in a woman but says that in males it serves to increase dependence and supplies—i.e., love from mother. Wilson (1982-83) says that male homosexuals and men with latent homosexual conflicts were found to fear being fat, and that this fear is not present in normal males. He also says that this is caused by their feminine identification present in homosexual males.

There seems to be some disagreement about the attachment of males in this population to their mothers. In discussing the gender difference, Bruch (1973) says that the "slave-like" attachment between mother and child is more likely to develop in a girl than a boy, predisposing the girl to anorexia nervosa, and that girls are more likely to solve problems somatically. It is also possible that culturally girls are more likely to identify themselves with their bodies and their attractiveness, while boys are more likely to be judged in more active terms, i.e., by what they do, etc. Bruch adds that a boy is less likely to be caught up in the same kind of developmental impasse as a girl, and that male pubescence will make it possible for a boy to assert himself more forcefully, so that in the event that a dependent attachment was present, it is easier for him to break away. It is interesting to note that Bruch does not limit her diagnosis of true or primary anorexia nervosa to women, but includes males, although she finds that they are truly rare.

In disagreement with Bruch, Sours (1980) cites an earlier study which finds male patients inordinately tied to their mothers,
identified with their mothers, and overfed. He says that "through starvation, the male anorectic attempts to kill the incorporated mother with whom he identified and reduce the fat which he associates with the female form."

Dally (1969) agrees with Bruch (1973) that it is more difficult for a girl to break away from her mother than a boy, and says that eventually, aggression toward the mother manifests itself in the refusal to eat.

Both Bliss and Branch (1960) and Dally (1969) discuss the physical changes of puberty in the context of gender development in anorexia nervosa. They agree that one way for a young woman to deny the changes toward womanhood is to starve herself, so that leanness is equated with immaturity and/or asexuality in certain patients. Since males do not suffer the same developmental problems, starvation might be a less suitable way of expressing conflicted feelings for males in general. Moreover, a young man with uncertain gender identification may be subject to the same conflicts as a young woman (Bliss and Branch, 1960).

Dally notes that the six male patients in his study were all above average intelligence, closely attached to their mothers, and hostile to their fathers. He found homosexual features in two of the six. One was asexual, but this is not unusual in a severely emaciated state.

Beumont, et al. (1972) found that among the 25 male patients who conformed to their diagnostic criteria for anorexia nervosa, there were a number of consistent findings. In each case, the onset of
anorexia nervosa occurred just before or after puberty. Food was refused and certain foods were deliberately excluded because they were too fattening. Patients used vomiting, purgatives, and strenuous exercise to reduce weight. They were afraid of becoming fat and still considered that they were in danger of this even when they were extremely emaciated. In at least three of the six patients, the preoccupation with food was considered to be at the level of "obsessional rumination." The patients lost sexual functioning and interest in sexual activity during the active phase of their illnesses. Testosterone levels were very low, but when normal weight was recovered, these abnormalities were able to be corrected to some extent.

Bliss and Branch (1960) hypothesized that the incidence of anorexia nervosa in males is low because, culturally, males are more sensitive to obesity in women than in themselves. While this may have been more true in 1960, the current interest in running and physical fitness suggests that this sensitivity is now present in both sexes. Still, males tend to be judged more on what they achieve than how they look. Bliss and Branch also suggest that male anorectics are not so rare, but that it is unlikely that a physician will diagnose anorexia nervosa in a male; rather, s/he may pay more attention to issues connected with weight loss such as depression and hyperactivity. In addition, it is possible for men to lose more weight than women without becoming emaciated, so that men with severe weight loss may look thin but not have the emaciated look of anorexia nervosa.

Bruch (1977) studied nine male patients over a 25 year period,
although she reports on ten in an earlier publication (1973). Five of these were considered to be primary anorectics, while four were considered atypical, with weight loss secondary to other psychiatric conditions.

When the two groups were compared, both primary and atypical patients experienced an equivalent weight loss—from 25% to 38% of original body weight. Both groups presented a picture of extreme weight loss after a period of not eating. The illness was considered equally severe in both groups, and there was one death in each. In both groups psychoneurotic diagnoses had been given early on, but certain patients had developed schizophrenia at a later stage. In neither group did the diagnosis seem to have much relationship to the outcome of the disorder.

However, by analyzing the core dynamic issues, the life patterns, the interpersonal experiences, emotional conflicts and ego deficits, Bruch was able to differentiate the patients into two groups. In the primary group, weight, size, and preoccupation with thinness appeared as the primary factors underlying the loss of weight. In the atypical group, the loss appeared to have developed in response to some traumatic life situation such as the birth of a child or the increase in career responsibilities.

Bruch says that the pursuit of thinness is also the pursuit of an independent identity, and that it is this characteristic which clearly differentiates the primary and atypical patients. For the primary group, patients' mere weight loss was not enough. Bruch says of these patients: "when the planned lower weight had been reached,
it proved not enough because much more than weight loss had been expected. Being thin and staying that way had served as a protection against the dreaded fate of being too fat, against the fear of not being in control, but of living as a weak product of 'them.' Since no manipulation of the body and its size can possibly provide the experience of self-directed identity, the pursuit of thinness becomes more frantic, the amount of food small and smaller, and the goal-less activity to 'burn off calories' more hectic" (1971, p. 44).

This description is quoted in full because it describes so very well the young man in the case study to follow. Also present in all the cases of primary anorexia studied in male patients was hyperactivity and the compulsion to achieve. An interest in athletics has been greatly encouraged by the fathers of these boys, factors which are also relevant to the case study.

Age at onset in cases of primary anorexia nervosa is discussed by Hogan, Huerta, and Lucas (1974). Age range among the 18 typical cases reviewed was 11-20. These authors also postulate that the cessation of nocturnal emission and the production of semen may be the analogues of amenorrhea in women with anorexia nervosa.

Anorexia in pre-adolescent boys is discussed by Wiener (1976), Sreenivasan (1978), and Taipale, Larkio-Miettinen, Valanne, Moren, and Augee (1972). In a study of identical twins, one of whom developed anorexia at age 11, Wiener (1976) could find no clear reason why one twin developed the disorder while the other did not. Other twin studies are reviewed by Garfinkel and Garner (1982). In Wiener's study, the anorectic twin was more achievement oriented and
perfectionistic, but the other twin was more phobic and dependent.

Pre-adolescent boys with anorexia nervosa seem to have more severe symptoms and deeper psychological disturbances than girls in general (Taipale, et al., 1972). However, the difficulty with diagnosis may again be at issue here, since the association of anorexia with young women may present the diagnosis in all but the most severe cases in males. Both these authors and Sreenivasan (1978) found disturbances in the father-son relationship of their male patients. Taipale, et al. (1972) found that all the boys in their study seemed to have definite feminine identifications and an unsatisfactory relationship with their fathers, while Sreenivasan (1978) found hostility in the marital relationship of the parents in addition to the father-son difficulties.

Crisp (1980) presents a case of anorexia in a young man and says that while many males are interested in increasing their physical strength and lean appearance, they are less likely to curb their natural appetite than are women. Insecurity in males may be related to a preoccupation with physical fitness and body building, as well as a preoccupation with genital size. Crisp says that large genitalia may be a source of pride, guilt or envy, especially in comparison with father and may be a source of Oedipal rivalry.

Sours (1982) says that fat means different things to males and females. While in a girl it is likely to represent femininity, i.e., the development of breasts and hips, to a boy, it is more apt to be related to thoughts of babyhood and weakness. The presence of gender confusion would help to explain the increased seriousness of anorexia
when it does occur in males, since increased identification with the mother would decrease the ability to differentiate self from mother, and would increase the identification with mother's rounded body shape. This in turn would lead to any hint of fat being rigorously controlled. Sours does not explain how this differs from the dynamics of female anorexia.

Crisp and Burns (1983) review the literature which studies series of male anorectic patients. In general, the numbers of patients reported on have been very small—from three to twelve. Their own study presents data on 36 patients who had been assessed over a period of 20 years. These 36 patients constitute 9% of the 423 patients assessed on this unit. These authors found that age of onset does not appear to be significantly lower in male patients, despite earlier reports to the contrary. Males showed a dietary pattern similar to the female patients, characterized by carbohydrate avoidance; however, the bulimia, laxative abuse, and anxiety about eating with others appeared less frequently in the male patients. Males were found to display more hyperactive behavior and were found to have a higher percentage of normal weight at presentation. It should be noted that 6 of the patients in this study did not meet the DSM-III criteria of a weight loss of 25% or more.

All patients noted a loss of libido in connection with weight loss. This is discussed below in terms of lowered levels of testosterone. Crisp and Burns suggest that the loss of libido allows the adolescent to retreat from maturational conflicts connected to adolescence. Males were ambivalent about the loss, a finding not
reported with females with regard to loss of menstruation, where there is more ambivalence. These patients were either relieved or indifferent to the loss.

A number of articles discuss the variety of endocrine deficiencies in males with anorexia nervosa. Among these are studies by Beumont (1970), Beumont, Beardwood, and Russell (1972), McNab and Hawton (1981), Anderson, Wirth, and Strahlman (1982), Crisp, Hsu, Chen, and Wheeler (1982), and Wessleius and Anderson (1982). It has been suggested that the return of normal levels of testosterone may signal the approach of recovery, analogous to the return of menses in females (Andersen, Wirth, and Strahlman, 1982) and the return of normal hormone levels may be an important development in the context of a psychotherapy, perhaps signalling new issues to be discussed (Crisp, et al., 1982).

A recent study by Lemaire, Ardaens, Lepretre, Racadot, Buvat, and Buvat-Herbaut (1983) studied eight male anorectic patients and found that levels of testosterone were decreased in all eight cases. However, when weight was recovered, it was found that an increase in testosterone did not always correlate positively with weight gain. Therefore, these authors hypothesize that testosterone levels may reflect psychological factors. This finding may be analogous to the hormone imbalances present in female patients, even after weight has been recovered.

The diagnosis of anorexia nervosa in males is one which has already been discussed as problematic and difficult to make, in part because of the lack of expectation of the disorder in males at
all. Kulig and Siqueira (1983) describe a case of diagnosed anorexia nervosa which was found to be mistaken at autopsy. Chipman, Hagan, Edlin, Soll, and Carruth (1983) report a case of weight loss in a 14 year old male runner which presented a difficult diagnostic decision between food aversion in a normal athlete and anorexia nervosa. This was resolved when the patient was found to have a disturbed body image, feelings of inadequacy, and depression. Smith (1980) also discusses the differential diagnosis of excessive weight loss present in normal athletes versus anorexia nervosa. Other discussions of this issue by Yates, Leehy, and Shisslak (1983) and Sours (1980) have already been mentioned.

Swann (1977) described three case histories in males which presented diagnostic problems. One of the three was found to have had cancer, another was found to have cystic fibrosis, and the third was given a presumptive diagnosis of cystic fibrosis. These authors suggest that 10% of male patients have some form of organic disease and not anorexia nervosa. In contrast, Hay and Leonard (1979) describe five cases of anorexia in males aged 13 to 23 and feel that the disorder may be more common in males than has previously been suspected and that the clinical picture in males is similar to what is presented by females.
CHAPTER II

METHOD

The case study method is one which has most often been associated with clinical and personological research, but which has in fact been utilized in every area of psychology. Dukes (1965) offers an excellent review of research using only one subject. He points out that during the period from 1939 to 1963, there were a total of 246 single case research reports which appeared in 10 different psychological journals. Among these were case studies oriented toward advancing the understanding of a particular subject area, as well as studies which applied nomothetic techniques to analyze their data.

The case study method has been deemed particularly appropriate for cases which are rare or unique examples of phenomena, and for research which studies individuals who appear on the margins of the phenomena in question (Dukes, 1965; Selitz, Jahoda, Deutsch, and Cook, 1959). Dukes (1965) says that a single case history may simply reflect a limited opportunity to observe a given phenomenon and that studies of this kind may become part of a larger, more cumulative investigation into a given research area. Selitz, et al. (1959) note that "scientists working in relatively unformulated areas, where there is little experience to serve as a guide, have found the intensive study of selected examples to be a particularly fruitful method for stimulating insights and suggesting hypotheses" (p. 59).

Sherwood (1969) says that the advantages of this method are
that it uses actual incidents from the life of a specific individual, as well as the actual words used by the therapist, so that it does not rely on reports of behavior which are open to interpretation or distortion, or outlines of behavior which may be incomplete. Another advantage is that material may be presented in context and developed as it occurred over a period of time.

While most researchers agree that case studies may be useful in terms of generating hypotheses, there is also the idea that "real" psychological research must be nomothetic and that individual differences are interesting in terms of "error", i.e., something to be considered but without the validity of a controlled variable. It may be felt that a case study is interesting anecdotal material, but more appropriate for a literary biography (the works of Freud and Piaget not withstanding), and that all a case study does is present information on a single individual which may not be generalizable to any other individual. An idiographic purist would point to the limitations inherent in nomothetic research, especially in laboratory research and would discuss the controlled, limited nature of life.

A number of authors (Allport, 1964; Bakan, 1968; Holt, 1978; Raush, 1969) have discussed the split between idiographic and nomothetic methodology and present a variety of objections to the split.

Allport (1964) regrets the lack of development of an idiographic or morphogenic methodology within psychology, saying that subjective validation ought to have a place as well as objective measurement instruments. Psychologists, he says, are too often guilty of
neglecting to use the subject's self knowledge as data. He argues for a place for both quantitative and qualitative methodology.

Holt (1978) was a student of Allport. He locates the development of the nomothetic-idiographic split in the context of a romantic reaction in psychology to scientific positivism at the end of the 19th century. What the romantic movement accomplished was to emphasize that personality, values and motivation, along with the interrelationship of these things with perception and cognition were legitimate things for the psychologist to study. However, even among these psychologists, a new methodology was never developed and the methods used remained tied to nomothetic science.

Holt (1978) discusses some of the "flawed thinking" that has been propounded with regard to the study of persons via idiographic rather than nomothetic methods. To begin, he takes apart a myth that the goal of "personology" is understanding while that of nomothetic science is prediction and control. This he calls a "particularly subtle and mischievous dichotomy" which has all too often been accepted in psychological study. However he does not see these as two separate factors, since most science seeks to both understand and to be able to predict and control via this understanding. There is without doubt an appeal to be found in this "hard" conception of psychology, one which can predict and control without more attention to purely subjective factors, and Holt finds this exemplified in behaviorism. He calls behaviorism a "close analogue of the obsessive-compulsive idea of completely rational thought and action; the behaviorist and the obsessional alike hoped to escape from the frightening enlargements
of emotional subjectivity by banishing it entirely" (p. 17).

Holt also takes issue with a number of the critiques frequently applied to a case study; among these is, first, the idea that intuition and empathy have no place in natural science; and, second, the idea that general laws are not possible because the subject matter is a unique individual and this has no place in natural science. To the first of these Holt replies that the more secure in his/her position that the scientist is, the more respect he/she usually has for intuition and empathy. These factors are used throughout scientific work, in decisions about what to study and how to study it and are not exempt from even the most nomothetic of studies.

To the second criticism, Holt replies that his is the kind of thinking which considers only the norm to be factual and all deviation from the norm error. While it is indeed true that generalities can be hypothesized from a single case, these can only be verified through statistical or experimental studies. However, this does not mean that there can be no scientific study of individual cases. Science is defined by its methods, Holt says, and not by its subject matter. Examples from the physical sciences are given. There is only one sun, one Saturn. In summary, Holt says that there is no need for the dichotomy between an idiographic science and a nomothetic science, nor for a separate methodology. He finds that science, as it is practiced today can be not just one or the other, or even some combination of the two, but rather something which has the potential to be bigger and better than both can be separately.

Bakan (1968), writing about introspection, says that
psychologists have given up introspection in favor of methodology which can be more easily quantified. In his opinion, there is no method which can be free from error. Problems usually associated with the introspective method are those of replication, and, as has been mentioned above, of generality. These can be resolved, Bakan says, by comparing results across studies. If, in reply to this suggestion, there is the criticism that findings from such a comparison may lack consistency, Bakan notes the frequent comparison of laboratory studies done in different settings. He notes that in laboratory research, there is much more likely to be the flawed assumption that results will generalize more easily from one laboratory setting to another.

In addition to generalization, there are difficulties with replication of results, i.e., an investigator who attempts to replicate his own study must be under the influence of his own previous work and, conversely, if the investigator is interested in replicating the work of another, he must take the possibility into account that he is open to suggestion on the basis of the other's work.

The basis of clinical work, according to Bakan, is the assumption that it is possible for one human being to understand the experiences of another. This assumption is at odds with the British empirical school of thought which Bakan feels is responsible for the modern conception of men as isolated and anomic, unknowable to one another. It is this position of the British empiricists which is the basis for the notion of the "privacy of experience." If psychologists are to
accept this notion, then they are limited to research which makes inferences about observable events, and we are back to behaviorism, while it becomes impossible to make inferences about the experience of another human being. However, it is knowledge, according to Bakan, that is usually the result of both observation and inference, rather than one or the other.

Can the clinician be a researcher? The work of the clinical psychologist need not be divorced from that of the researcher (Raush, 1969). Raush sees the clinician as a naturalistic researcher, a participant-observer empowered by the therapeutic relationship to study both the client and the relationship. The client-therapist contract "legitimizes a special class of interventions ... the contract service of the client's aims for change" (p. 125).

According to Raush, there is no way to be certain that results obtained under one set of conditions will transfer to another situation. Very sensibly, he says that results will transfer and should be considered representative to the extent that the situations and characteristics of individuals overlap, but to the extent that there is variation, differences can be expected to occur.

A number of criticisms have been aimed at the clinical or naturalistic method of investigation. These are systematically explored by Raush (1969) and each is in turn rebuffed, since each objection may be applied to other methods of research as well. Objections include first, the idea that clinical data are private rather than public data. Raush says that while this has been true historically, it is now possible to make clinical data known without
breaching confidentiality. The second is that clinical methodology is intuitive rather than objective. One can take issue with this criticism by considering that intuition is not limited to qualitative methods, as indicated by Holt (1978). The third claim is that clinicians consider dissection, reduction and classification as bad. Raush says that the test of whether structuralization is useful is whether it works, and some methods of classification are more useful than others. The fourth criticism is that the clinician searches for causes rather than functional relationships. Raush says that the clinician, with his/her orientation towards process if often forced to choose between data derived from clinical work and statistical inference. It is appropriate for the clinician to consider qualitative studies, rather than to resort to quantitative methods which are inappropriate to the clinical situation.

The grounded theory of Glaser and Strauss (1967) carries the positions of Bakan (1968) and Raush (1969) a step further. Stated briefly, Glaser and Strauss call for theory that is grounded in data, as opposed to theory which precedes data, as it usually does. Grounded theory is less easy to refute, since it has been derived from data, and less easy to manipulate, since the data cannot be molded to support the theory, since the data have come first.

In considering the various theories of anorexia nervosa one is forced to wonder to what extent the various explanations are indeed "grounded" in the data, and to what extent they are products of broader psychiatric theories (especially of separation-individuation) currently in fashion. However, it seems that the relationship must
be a dialectical one. Many of the investigators who have been included in the preceding chapter are specialists in this field and have seen many anorectic patients and, since none (including this author) are unaware of the current theories which emphasize the genesis of more severe disturbances, such as anorexia nervosa, in the pre-genital mother-infant relationship.

The following case study is then an attempt both to analyze and to restructure; and an attempt to add to the analysis so that the restructuring is larger and more inclusive than the original situation. The format is rather standard for a case presentation. Jeff's history is presented, his initial presentation recorded, followed by the initial phase of therapy. This is followed by an explication of the middle phase and, finally, the termination. In Chapter V, Discussion, questions are answered about the etiology of anorexia in a male and issues in the treatment of severe anorexia nervosa are discussed.

This study was officially undertaken about six weeks after the therapy began. All the sessions from that point on were tape recorded, and most of the previous sessions had been recorded and the tapes had been kept. In all, 23 of the 32 sessions were recorded and transcribed. Recording the sessions presented no particular problems since all clients at the clinic where the therapy was carried out sign statements permitting the therapist to tape record sessions. Special permission to include portions of the transcripts in some future writings was requested, and this permission was given by the client, who was assured that his name would not be used.
In addition to the case study, a survey of therapists who work with patients with eating disorders was also undertaken. One purpose of this survey was to gain additional information about males with anorexia nervosa, since there seemed to be such a dearth of information in the literature. Another purpose of the survey was to see whether encountering a male anorectic was really so rare in clinical practice. Yet, another was to gather information about what therapists did with their patients--i.e., how was the issue of food and weight handled, what would the clinician do if the patient's weight dropped too low, etc. A fourth purpose was to find out whether there was some consensus about whether males are true anorectics--i.e., did these clinicians see them as dynamically the same or similar to women with anorexia nervosa, or were they some qualitatively different clinical entity.

As discussions progressed about how to structure this dissertation, it was decided to keep the survey as a separate entity, to be presented and discussed in a chapter separate from the clinical material. Therefore, it has been kept separate and appears in the chapter following the case study. In part the survey began as an attempt to test the hypotheses growing out of the clinical data, namely: 1) that encountering a male anorectic was a rare event--a rare event being approximately 5% or less of the cases reported; and 2) that males with anorexia nervosa were dynamically similar to females with the disorder. In addition, information was gathered relevant to the treatment of anorexia nervosa and is presented with the results of the survey.
CHAPTER III
CASE STUDY

Introduction

As in any case study, the goal of this one is to present as many of the facets of the patient's personality as possible—both separately and in relation to each other, in order to understand as completely as possible this particular young man, who developed a disorder usually found in women. The study proceeds from the assumption that this was a true case of anorexia—not anorexia secondary to a schizophrenic decompensation, or food phobia, or major affective disorder. Inherent in this is the assumption that true or primary anorexia nervosa can occur in males as well as females, and when this occurs, it does so as the exception to the rule—the rare case.

Although this was relatively short-term therapy (it began in January, 1981 and ended in July, 1981—a total of 30 sessions), there is so much material that it has been difficult to know how to organize it most expediently, and it has been necessary to selectively include some excerpts from tapes, while excluding many others. The subjectivity in such a section is clear; however, since much of the material presented comes directly from the tapes, it is hoped that the readers will have enough evidence to come to their own conclusions, and perhaps to formulations other than those which follow.
The theoretical orientation from which the case is analyzed is psychodynamic--influenced by the interpersonal theories of Hilde Bruch, with their emphasis on autonomy, identity, and control as factors relevant in the etiology of eating disorders, and by object relations theory with its emphasis on the structures of the patient's inner world. Given this perspective, the patient's history is considered extremely important. Especially significant for this young man was the early death of this father, and the subsequent abandonment by his mother, as she withdrew into a severe depression shortly thereafter.

Given the short term nature of the work, it was important initially to focus on what was accessible to the patient, and then to strive to broaden the scope of what he could deal with as the therapy developed. The three factors stressed by Bruch--autonomy, identity, and control--were extremely important, especially at the beginning of the therapy, since all three were issues which the patient was aware of and was able to discuss without much difficulty.

Several dilemmas presented themselves early on, and had to be resolved before the therapy could proceed. The first of these was the issue of whether to include Jeff's family in the therapy. A decision was made to have the therapy be strictly individual, with no family participation. The reason for this was Jeff's age, 22, and the fact that he was living at home on a temporary basis. In retrospect, given the importance of Jeff's family relationships in the etiology of his illness, it could be argued that not including the family was a significant error. While family therapy would have
changed the nature of the treatment entirely, it might have indeed been possible to hold a few sessions with Jeff's family sometime during the treatment and preserve the individual treatment while including the family. This would also have given me an opportunity to meet and make my own assessment of Jeff's family, and would have clarified the nature of his illness to the family and involved them in his treatment. At the same time, it would have provided an opportunity for Jeff to share his feelings with his family; initially, feelings of wanting their love and attention and fears that if he were to recover too soon, these would no longer be available to him.

A second issue, even more difficult than the first, was the decision about how carefully to monitor Jeff's weight and whether to include weight gain as a requirement of the therapy. Subsequent reading and discussion with therapists who treat patients with anorexia nervosa has made me aware that there are those who feel that unless weight is recovered, no true progress is made. There are others who feel that if the therapist monitors the patient's weight, or makes weight gain a necessary condition of therapy, she or he risks jeopardizing the therapeutic alliance and recreating the conditions of being compliant, which created the condition in the first place. A pragmatic middle ground is to create the role of behavioral administrator. This person serves to monitor the patient's weight and discuss issues directly related to food, eating, binging, purging, etc., which frees the therapist to deal with the more dynamic issues. Such a method might have been tried in this case.

Instead, a decision was made to keep in close contact with the
patient's physician, and to make it very clear that the treatment could not continue if any more weight was lost. The connection between the starvation related effects of prolonged food restriction was discussed several times with Jeff. When the therapy began, it seemed that to force Jeff to gain a set amount of weight would jeopardize the therapeutic relationship. However, again in retrospect, it might have been possible to see whether there was some amount of weight that could have been gained without being too threatening, and the recovery of even this minimal amount of weight might have acted as a springboard to more weight gain. In fact, this happened spontaneously during the therapy. Jeff could allow himself to gain somewhere between five and seven pounds, but after that weight gain was difficult. This issue is one of the most difficult and complex in the treatment of anorectic patients. Had Jeff's weight at the onset of therapy been any lower, it would not have been a question. Hospitalization would have been necessary and therapy could not have proceeded until weight had been recovered. When cases are less than extreme, the situation is open to more debate. Jeff's 30 pound weight loss represented a weight loss of approximately 22% from his premorbid weight. His lowest reported weight, 94 pounds, represented a weight loss of approximately 33%. I did not begin to see him until after some weight had been regained. At 94 pounds, hospitalization would have been imperative.
Background

Jeff contacted the intake worker at an outpatient clinic in Massachusetts on January 8, 1981. He had been referred to this clinic by a member of a local crisis intervention team, who had seen him several times. Several weeks prior to that, he had returned to his family home from New York, where he had lived for approximately four years. He had been feeling severely depressed and had lost about 35 pounds over a period of six months. He had initially contacted a local psychiatric hospital, seeking admission. Because he did not appear acutely suicidal or psychotic, he was referred to the crisis team, who referred him to the clinic.

On the initial contact sheet prepared by the intake interviewer he was described as "extremely depressed, with anxiety attacks and symptoms of anorexia nervosa ... He has trouble getting up in the morning and being motivated to do anything. He feels that 'if things don't get better soon I might as well die.' He is not presently suicidal, but realized that he has been killing himself slowly with his eating habits." At this time, Jeff listed his weight as 110 pounds and his height as 6 feet 1 inch. He said that a normal weight for him was 140 pounds. He was one week short of his 22nd birthday and was unemployed. He had recently seen a local physician who had prescribed Sinequan, 25 mg, 4 times daily but was taking 200 mg, because he had been given 50 mg by the pharmacist, he said. He had not been honest with the physician about the real reason for the weight loss, only about his depression, nor did he correct the
pharmaceutical error.

My initial impression of Jeff was of a tall, emaciated young man who looked as if he had been let out of a concentration camp. He was an attractive man, with blonde hair, whose skeletal appearance was not masked by his winter clothing. He was casually but neatly dressed. He had a gentle, vulnerable manner, and if anything, seemed rather delicate, as if he might break. When he began to speak, his tone was serious, and it was immediately obvious that he was an extremely articulate young man.

Because it was not clear whether this was a case which was suited to an outpatient clinic with limited medical backup, an initial period of assessment and evaluation was arranged prior to beginning treatment. Jeff agreed to meet in spite of this stipulation and did not appear to be disturbed by the initial forms given to all clinic patients, explaining the nature of a training clinic, and the use of tape recorders, one way mirrors, etc.

History

Jeff was the third child and only boy, in a family of four. His older sister Barbara was 27. She worked at a travel agency and had a long history of emotional problems and problems with alcohol. Another older sister, Deborah, 25, was married and lived in California, where she was an accountant. A younger sister, Ellen, 12, attended a junior high school. Jeff's mother, Leona, 46, worked as a secretary. His stepfather, Fred, 41, worked in security. Fred had two children, ages 19 and 21 who did not live with him, but who visited periodically.
At the time of our initial meeting, Jeff, Ellen, and Barbara all lived at home. (All of the names used are pseudonyms, and other details have been changed.)

Jeff's father, who had been an athletic coach, died unexpectedly when Jeff was eleven. His death had been sudden and unexpected, from a cerebral hemorrhage. According to Jeff, after his father's death, his mother had become extremely depressed and had withdrawn from the family. He presented an image of her going into her bedroom and not coming out for long periods. His two older sisters, teenagers, were able to fend for themselves, but Jeff was left pretty much on his own. He began to act out and eventually was removed to a foster home. He lived in a series of foster homes until his last year of high school. After graduation, he moved to New York.

Early in therapy, Jeff painted an idealized portrait of family life. He described his father's death as the turning point in the family fortunes. As the therapy progressed, he came to see the flaws in this picture. He noted that even before his father died, he had taken to "running away." It was never clear how far he would go, but he recalled that he had begun to do this before his father died. This was the first indication that all had not been well with the family. Subsequent recollections included the memory of fights between his parents; hoping that his mother would leave his father; and recollection of tension between father and son. As a young child, Jeff had not been the kind of athletic child who had fulfilled expectation of an athletic father. Instead of football, he preferred to play with his sister's dolls and tended to stay away from rough
and tumble games.

At first Jeff remembered nothing about the three years after his father's death. His amnesia for this period gradually gave way to a host of unpleasant memories. It was clearly a time of intense anger, a time when Jeff recalled being "filled with hatred." His mother, depressed, began drinking and withdrew. Therefore, in addition to losing his father, he lost his mother as well, perhaps even a more significant loss, since he eventually remembered that he had been particularly close to her as a child, and "spoiled" because he was the only boy. He initially recalled his father as a strict parent, but as one with whom there were "fun times" as well. However, he could also recall a constant tension in his relationship with his father, based on the feeling that he was somehow unacceptable, that he could never really be the kind of person his father wanted him to be.

Jeff began drinking in the seventh grade, after his father's death. When his mother could no longer care for him or control him, he became a ward of the state and lived in 16 or 17 different foster homes. While this number is questionable, it is very likely that he gave everyone a hard time during this period. He did not recall all the foster homes as bad, there were one or two that stood out in his mind because the people were kind and tried to help him, but he would leave, or run away, or get into trouble so that he could go somewhere else. It was as if, having lost his own family, he could not really bear to stay any place else for too long.

His alienation from his mother was complete during this period. He remembers spending one Christmas with her, but that was all. In
fact, his mother had been remarried for two years before he knew that she was married. During the time he lived in New York, a period of four years, he was aware that his mother and stepfather would sometimes visit the city, but would never contact him or come to see him.

In addition to his excessive use of alcohol, Jeff also began to use drugs excessively, and for a brief period was hospitalized while in high school at a facility which specialized in the short term treatment of acting out adolescents. Although he found the experience helpful, it did not deter him. He also got in trouble for stealing cars, and breaking and entering. In short, he was a far cry from the ideal, compliant child usually described in case studies of anorectics.

There were, however, some similarities. While in New York, he attended City College. He described himself as an A student, who studied excessively and compulsively. A biology major, he dropped out of school, after his loss of weight began, when he could no longer sustain the pressure.

Although he had had relationships with women that were sexual, at some point Jeff opted for homosexuality and threw himself into the gay life style. He apparently had numerous casual relationships with men, and on occasion, had used sex when he needed to make money. He was aware that he was an attractive man and knew that he could find someone to be with whenever he wanted. However, he was also aware of the meaninglessness of these relationships and expressed a distain and disparagement of this life style. At the time the therapy began, he reported that he was asexual, a symptom common to anorectic patients, and had been so for over a year. In addition to withdrawing
from sexual contacts, in the months before he began to lose weight, Jeff began to withdraw from other relationships as well, followed by his withdrawal from his studies, and eventually, became isolated and withdrawn and emaciated.

In the year before his illness began, there were two relationships which were extremely important to Jeff. One was with a young woman, Edie, who was heavy and conscious of her weight. This relationship began as a friendship. Jeff was attentive to the young woman's problems, and, as the friendship grew, was introduced to her parents, who became fond of him. At about the same time, he developed a homosexual relationship with a man who became quite important to him. He went to great lengths to keep the two relationships separate, so that neither of his friends knew of the other's existence. His male friend, Bob, was also conscious of his appearance, his weight and what he ate. These relationships appear to have ended at about the same time. Edie apparently wanted more of Jeff than he could give, and as his illness progressed, he could not bring himself to call on her for help, since he had always been the one who had listened to her problems, without ever sharing any of his own. The reasons for his breakup with Bob remain obscure, but with the end of these relationships, Jeff's decline was underway.

Assuming that a change of scene would do him some good, Jeff made an effort to get out of New York, and in the summer of 1981, went up to a resort in Maine and found work in a restaurant. He was again extremely isolated, unwilling to get involved with the
summer gay community there, and withdrew even further into himself. He began losing weight while in Maine. When Edie came to visit him from New York, he could not find ways to tell her what was going on.

When he returned to New York he worked at a bakery and briefly lived with two other women friends, and for a while things were better. This did not last, and his obsession with weight progressed as did his weight loss. From a normal weight of about 145, he reached a low weight of 94 or 98. (He gave different statements at different times.) This is a frequent occurrence in anorectic patients, who perversely desire to be in contact with food but not eat it. Friends who were worried about him sent him to New York Hospital, but he says he was not able to be honest with the physician there and so the visit did him no good. For a brief period of time, he saw a therapist at the Bellevue Hospital, but he was not able to be honest with her about the full extent of his weight loss and his preoccupation with food and eating. Instead, he preferred to concentrate on the depression. He became very active during this time, jogging for miles every day and working out with weights. Eventually, he became debilitated and overcome with depression. At this point, he contacted his mother and asked her to bring him home. This was a drastic step, since it was a great source of shame to Jeff that he could not make it home by himself; and that he had reached a point where he was no longer able to maintain his independence and care for himself.

While he used the word anorectic during the initial intake interview, for much of the time that he was actively losing weight,
Jeff maintained that he had no idea what was happening; he had never heard of anorexia nervosa, and thought that his symptoms were truly unique. He learned about anorexia nervosa from an article in the newspaper and, when therapy started, was able to recognize that it was a psychological process which was the basis of his weight loss. A physical exam in November, 1981, several weeks before the therapy began, listed his weight as 107 pounds.

**Evaluation Phase**

Much of the first session was spent exploring Jeff's symptoms, evaluating his mental status, and getting some sense of his history. He began by saying that he had been depressed for a period of six months and had lost a lot of weight:

I got really down and couldn't do anything at all. I even stopped eating ... I lost a lot of weight, about 30 pounds, maybe even more than that, more like 40 actually. It really bothers me that I let myself get that thin, because it's really killing myself ... I couldn't eat, I would throw it up. It seems like a lot of my anxiety was focused on weight and food and stuff. I still have a lot of problems with it. I don't eat, and when I do, I don't keep it down. I throw it up ... I don't really understand it ... On top of that, I realize I'm still really depressed. I don't want to do anything. I've cut myself off from all my friends. I've just moved back here.

What is striking from his initial description is that Jeff has reached a point where he is disturbed by his thinness. While this was so, it did not mean that Jeff did not have a disturbed body image, or that he had any control over gaining weight. Being able to recognize that he was too thin was indeed a step forward. Earlier
in the illness he had not been able to feel that way. However, in spite of this recognition, and in spite of the fact that he was able to say that he thought he would look better if he were not so thin, Jeff had an extremely difficult time gaining weight. He had allowed himself to raise his weight above the low of 94 pounds or 98 pounds he described, but he could not bring himself to go above 115, a point where he was extremely emaciated.

The other significant point made here is that Jeff was throwing up. He would not keep food down. The extent of this was not clear for some time, although this was an important and potentially critical error on my part. Not only was Jeff throwing up, he was binging periodically, while restricting his diet severely most of the time. Information like this is extremely crucial, and it is necessary that the therapist know exactly what was happening. Especially for the non-medical therapist, close contact with a physician is important in evaluating the extent of the symptoms. Jeff did not mention the binging at this time. When he did, he did not remember that he had told me about throwing up. Binging, which represented a loss of control, was deeply painful to Jeff and made him feel ashamed. He could not tell me about it for some time. However, the fact that I did not press him for details at this point, nor inquire about his use of laxatives or diuretics as well as whether he binged was an error of some magnitude.

Another significant point is that Jeff's therapy did not begin when things were at their worst. He always referred to the period from September to December, 1980 as the worst time, the time when
things were "really bad;" as if, having survived that, he was trying to reassure himself that the worst was really past.

When asked about the history of his illness he replied:

I was going out with someone who was very obsessed with food and losing weight. I think the depression came first and then, for the first time in my life, I became very obsessed with food and I just started not eating and losing a lot of weight. I knew that I wasn't heavy and I didn't need to lose any weight, but that didn't seem to worry me, I can even look in the mirror now and say I wish I weighed 20 pounds more, I would look much better, but still sometimes I eat and then throw up and the depression made it much worse, made it very hard to function ... I don't feel that bad any more, this is going back a couple of months, but it made it really hard to do anything ... I knew that I'd let it go really far, I mean I'm 6'1" and there I was, weighing 90 pounds, but I still couldn't make myself eat like a normal person.

He went on to describe his involvement with sports, jogging and lifting weights and his obsessive and compulsive habits during this time.

Jeff carefully differentiated how much better he felt now that he was home. He created a now-then situation, saying that things were much better compared to the way they had been in September, 1981:

I tried to go back to school in September, I tried to do it. By then I was really sick, and when I tried to go back to school, I got a lot sicker ... I think I used it as an excuse not to go back to school. I couldn't take that pressure again.

and referring to the current status of his eating, he said:

I eat, not always, but sometimes at least.

In his description of his home and family situation, Jeff provides yet another example of the denial and minimization of problems common to anorectic patients. When asked what his home
life was like, he responded positively, saying things were good:

The only real tension in the house is my older sister Barbara ... Barbara has a lot of problems. She's an alcoholic, but even that, she's much better than she ever has been. It feels very good to be there right now. I thought it would be much harder to go and live there.

When asked how long his mother had been remarried, he replied about six years. Jeff described his stepfather in the same kind of pleasant, no problem terms:

I respect him very much. I think he's a really nice guy. He's put up with a lot of stuff, but he's not home very often.

(His stepfather worked a night shift, and Jeff essentially saw him one day a week, on Sundays.)

Towards the end of his first session, I asked Jeff what made him decide to seek help at that time. He replied that he had reached a point where he felt "particularly crazy"; he would eat, but not keep it down and had done this several times. He had contacted a large urban hospital with an eating disorders unit, but had not been accepted as a patient. He then contacted a local hospital which had referred him to the local crisis service, who referred him to the clinic. His meetings with the crisis worker had been helpful. It was as a result of talking with her that he was able to see that food was something he focused his anxieties on, and this began to explain the obsession to him. His early awareness of food as a metaphor came directly as a result of this crisis work; and although, at this early point was something which was assimilated only on an intellectual level, it gave him a point of departure for much work
later in therapy.

Two additional sessions were part of the evaluation period. During this time, most of the major themes of the therapy emerged, as well as a detailed account of Jeff's symptoms, his family history, and the history of his interpersonal relationships. Much of the second session was spent discussing his depression, his self-destructive tendencies and his obsession with food. His sense was that he was "living in a fog." He was unable to keep food down, and would throw up what he ate. Perhaps due to his depleted body resources as much as the psychological state, his depression had intensified and his self-esteem was extremely low:

... I can't maintain, I can't keep it together ... It's really going to fall apart. It's a real effort to try to keep everything together, to try and make it through the day. I keep saying to myself that I want to feel good again, that I'm worthwhile, that I'm worth something, that life can be good again ... I don't want to lose it. I don't want to get to the point again where I'm feeling so bad, where I can't function any more.

When asked to describe his depression, he replied:

It gets really bad. It's not just sitting there thinking about everything that's wrong ... it's just a feeling of spaciness, not wanting to do anything, not really being able to function ... it makes me feel worse about myself. I call myself an asshole or whatever.

Jeff's feelings of worthlessness were connected to self-destructive impulses. Although he denied being overtly suicidal, he was able to recognize that he was indeed, "doing it slowly":

T. By not eating?

J. By not eating, or by eating and then throwing it up. Before this it was drinking, and
before that it was drugs. I can see now that for the past eight or nine years, there's always been something there that one way or another was doing a lot of harm to me, and that goes back a long way.

Particularly when he would eat and throw up, Jeff recognized that the anorectic behavior had gotten out of control:

The thing that upsets me about it is that I've always been able to control everything in my life, and that includes people and everything. I've always been that way; a very contained person, and I like it. I strive very hard for it.

However, in spite of Jeff's depression, he had been able to find a job and was looking forward to starting to work again. The idea of doing something gave him some hope that he could improve and that he would eventually get better. He was able to say that there were "some good things" happening to him, and he was afraid that he would lose those things, i.e., his job, if he was not able to get control over his obsession. The fact that Jeff had been motivated enough to go out and find a job, in a tight job market, and the fact that he was able to recognize that there were some things he could strive for were probably the critical factors for continuing the case in an outpatient setting. Had he been totally depressed, with no recognition of the extent of his illness, it would have been inappropriate to treat Jeff in such a clinic setting. Another all important factor was his willingness to keep in close contact with a local physician, who would monitor both his medication and his weight.

If there were hopeful signs which made the case seem possible, it was difficult for this inexperienced therapist to estimate the strength of the conflicts that Jeff presented. There was very
little grey area at this early point in therapy; only forces in
opposition, life and death, good and bad.

Coming home to live with his family was an extremely significant
event in Jeff's life, one which was greatly desired, and at the same
time, feared. From the period after his father's death on, he had
prided himself on being able to survive on his own, without any
connection to his family. The fact that he had reached a point where
he could no longer survive on his own distressed him greatly. Yet,
it was precisely the incapacitating nature of his illness that enabled
Jeff to return home. It was obviously something that he greatly
desired as well as feared:

If I had been smart, I would have moved home
months ago, and a lot of this could have been
avoided ... The funny thing is that I thought
it was going to be so hard, and it turned out
to be the easiest thing I've ever done in my
life. You see, for years, I really wanted to
be close to them.

It is important to note the idealized terms that Jeff uses to
describe his family now, and contrast them with the more realistic
image that developed as the therapy progressed:

I realize that not only do I love my mother, my
stepfather and my little sister, I like them a
lot too. I enjoy their company, I really do.
As people I enjoy them.

Yet, his relationships with his mother and older sister Barbara
were not easy ones. His anger at his mother begins to appear when
he says:

I think it took this for my mother to see that she
had to put some effort into caring for me. I lived
in New York for four years, on and off ... and my
mother didn't come down and visit me once in
four years. They even came down and went to baseball games, went out to dinner, and she didn't even call me, didn't come down and visit me ... So it took this to make my mother see that she had to show me she cared for me, and to give me a lot of attention.

Initially, Jeff professed to be very pleased with his mother's attentions to him, even acknowledging that there was a part of him which feared getting better, because once over the illness, things would return to their previous state of alienation:

It's like I lived without it for so long, I never had it while I was growing up--I never had a family, I never had that affection since I was 10 years old. I really do want it and I have it and I'm afraid of losing it. I think maybe there's a part of me that doesn't really trust my mother and her affection, because she turned it off and on so often when I was younger.

It is hoped that by now, the reader, like the writer, has become aware of Jeff's unusual sensitivity and his ability to articulate information which is not often so accessible early on in a therapy. As early as the second session, even as he was discussing his desire to be close to his family, his conflicted feelings about closeness became apparent. Jeff had chosen to protect himself from the pain of his father's death and his mother's abandonment of him by becoming "Mr. Aloof," a role which he clung to, even as he acknowledged that he needed his family and wanted to be with them.

During the second session, he described an incident which had occurred only that morning, involving his older sister Barbara. Barbara, with a long history of alcoholism and emotional instability, had been drinking and, upset over a relationship, had slashed her face with a razor blade. Jeff's tone was calm as he related this event.
She slit her face with a razor blade?

... (trails off) I've been trying to get her to start coming here and seeing someone, because she's really pretty bad.

Were you there when it happened?

Well, I'd been the only one home with her today and I went out. When I came back she had started drinking again, it wasn't that bad.

What did you do?

Well, I didn't flip out over it. I didn't get all neurotic over it. I asked her if I could help her and she said no, so we just talked a little bit. She's not going to ruin her looks ... but I know Barbara, Barbara does her suicide attempt about once every two months.

In spite of his cool reaction to the situation, his true feelings for his sister emerged in the next (third) session:

It's really hard to be optimistic, she's been doing it for four years now. It bothers me, I identify with my sister in a lot of ways. Barbara is the one I've always been closest to. She thinks she's the only person that this has happened to. She's the only person who's done all these things and been ashamed of them ... Actually, she's really a pretty classic example of a girl who lost her father at 15, and everything that has happened since then. I think that if she could see that, it would be easier for her.

His identification with Barbara was clear:

We've both done a lot of the same things. I can understand her guilt feelings about her past because we've done the same things ... We knew a lot of the same people. We were really close at one point, but I haven't been close to Barbara in about two years ... because there was a time when we all thought Barbara was going to die and that's all there was to it. In fact, there was a time when we thought she might be dead, and I
think because of that I wanted to put a little
distance between us. I didn't want to get really
close to her, because until I know she's going to
make it, I'm not going to set myself up to get
really hurt. If she died, or killed herself now,
it wouldn't really hurt any more, but if I was as
close to her as I used to be ...

In addition to the identification with his sister, this passage
and the ones just above, begin to reflect Jeff's difficulties with
closeness in relationships. He had adopted a distant stance vis a
vis most of the relationships in his life. He would be the listener,
the distant one, Mr. Aloof, and would be able to protect himself
from rejection, since no one could ever know what he was really like.
Being close to other people was also extremely dangerous, since as
his father had done, and his sister had threatened to do, people
could die; or, do as his mother had done, abandon him emotionally.

Jeff initially presented his family as just a typical family,
with problems but not big ones. His father was strict, he noted;
and he was very close to his mother. Close enough, so that his father
perhaps resented his closeness to her. He remembered stealing money
from his father's bureau and "running away," i.e., going into town
to spend it, but he attached no real significance to this.

When his father died, things changed. His mother, depressed,
literally withdrew to her bedroom and did not want much to do with
her children:

Basically, until my father died, I had a nice home
life. Then everything fell apart. When he died,
it was like my mother died too. She really fell
apart, to the point where she would say things
like "I wish you had died instead of your father."
She won't admit now that she ever said those
things ... I think she honestly doesn't remember
that she ever said things like that ... I was mad, I think. I had to have felt a lot of anger, and a lot of frustration. It made me feel very lost, too. I was close to my father, but I was really close to my mother. He died, and then it was like she died, or she just wasn't there any more. She just wasn't the same person.

Jeff reacted by taking drugs, drinking and getting into trouble. The details of the three years after his father's death appeared somewhat vague. When asked about this, Jeff replied that for a period of time, he had been totally amnesic about this period in his life, and that his memory of this period had only returned within the last year or so. In retrospect, his sense of himself during this time was a lost soul:

I don't think in a lot of ways I've ever gotten rid of the hate I felt, and the feeling of being lost, just lost within my self. I don't think I've ever really felt since then that I had an identity, or belonged to anything. I've never belonged to a certain group of friends, because I've always let myself get just so close to people. I never belonged to a certain club. Even when I was in college, I was involved with all sorts of things, but I was involved in each one only a little bit, instead of one, wholeheartedly ... and all the foster homes I lived in, I would stay in each for a little while, until I felt I might be part of them.

The fact that Jeff could not afford to let himself be part of any close relationship was to be an extremely significant factor in the therapy; one which eventually led to a premature termination. It also facilitated his involvement in the life of the gay community, where he sought casual encounters, without commitment or involvement. Although at times Jeff protested the emptiness of these relationships, there was a part of him that was attracted by the feeling of
empowerment that came with these encounters. It was Jeff who connected his loss of weight with the issue of sexuality, and with his current asexual status:

J. I've always been a very vain person, and when I weigh 140 pounds, I look a lot better than I look now, I know that. I think that's one reason I lost all the weight.

T. To not look good?

J. Yeah, because there's a side of me that doesn't want that to be important any more and there's a part of me that that's still really important to ... I think that I'm afraid to look really good any more, because then I'm going to have to deal with a lot of things that I'm not ready to deal with.

T. Such as?

J. A relationship, my sexuality, how I feel about it ... At this point in my life, I'm nothing. I'm not straight. I'm not gay. I'm not anything. But if I started looking really good again, to the point where I was attractive to other people, I would have to deal with that, and I don't feel ready to deal with that ... I kept saying to myself all week, this is life, you've got to get used to it, you're probably going to end up living alone and working in a job like this and that's it. There's a side of me that's ready to say f--- it ...

It was at this point that our third session was about to end, and it was necessary to make some decision as to whether to continue the therapy. Although the outpatient setting with limited medical back-up and the once a week nature of the therapy were not considered optimum, it was decided that I would go ahead. Jeff and I discussed parameters at the end of this session. There was agreement that if his weight dropped below its level at the time, he would have to
be hospitalized and it would no longer be possible for me to see him. His agreement to maintain contact with his physician, and to allow me access to his medical records and to discussions with this physician also became part of our contract. On a very pragmatic basis, consideration was also given to the fact that there was no facility in the area where Jeff could receive treatment from someone who had a special expertise in the treatment of anorexia nervosa. Because he had no medical insurance and not much income, opportunities for therapy were extremely limited.

The Engagement Phase

It would be incorrect to say that the decision to continue was made solely on the basis of these reasons. In large part, the rapid engagement of both client and therapist was a critical factor. For me, the decision to take the case was accompanied by a considerable amount of anxiety, followed by an immediate emersion in all the available literature on the subject of anorexia nervosa.

It has also become clear that Jeff had sought help at a point where the disorder was no longer quite so ego-syntonic. The numerous conflicts which were manifested in these early sessions functioned as motivating factors which enabled him to confront the problem with an honesty which he had not been able to do when the illness was at its peak. In spite of his description of himself as aloof, he was not restrained during these first sessions. Instead, there was a great deal that he needed to say, and the act of telling his story to someone was in itself therapeutic for him. At the end of
the third session, he admitted that he had been looking forward to
the session for three days; hardly the type of statement made by
someone trying to remain uninvolved.

In spite of Jeff's feelings of intense depression, the tone was
not what one feels in sessions with a severely depressed patient.
This was probably due to the presence of intense conflicts
about being ill versus the prospect of regaining health. The
conflicts were serious, however, and the prospect of fatality had to
be considered, since the nature of the illness was, as Jeff said, a
slow form of suicide. For the moment, he had allowed himself to
live, although barely; and while there were indications that he had
reached a point where he had made the decision to live and try to
recover, there were also indications that his frustration level was
low, and that his impulse control was poor. Jeff was asked to undergo
psychological testing, in the hope that the data from these procedures
would reveal additional information important to the successful
outcome of the therapy. The report from this psychological evaluation
has been included (see Appendix A), as have as much of the data as it
was possible to include without violating confidentiality.

Jeff was shown a version of the report, and was impressed with
what he felt to be an accurate description of his personality. He was
particularly interested in the presentation of his strengths and
weaknesses, especially with the idea that it was his high expectations
of himself which kept him from being satisfied with whatever he did.
He tended to discount the recommendation for further neurological
testing; but noted that he and his sisters had always had a great
deal of difficulty whenever they had to do any serious writing and spelling.

Psychological Evaluation

In terms of the diagnosis in the report (see Appendix A), it is believed that Jeff represents a case of true or primary anorexia nervosa (DSM III, 307.10) with bulimic episodes, and accompanied by a dysthymic disorder (300.40). The examiner asks that a differential diagnosis between dysthymic disorder and major affective disorder be made. Although this differential diagnosis was difficult to arrive at, it became my opinion that the affective component was secondary to the eating disorder. According to the DSM III (1980, p. 222), dysthymic disorder is frequently found in individuals who have borderline, histrionic and dependent personality disorders. The Axis II diagnosis (301.89) categorizes Jeff as a mixed personality disorder, with histrionic, narcissistic and borderline features; Jeff displayed all the criteria for borderline personality but, dynamically, appeared more narcissistic. He was impulsive, and had had intense periods of substance abuse, frequent and casual sexual encounters, overeating (during his binges) and engaging in physically self damaging acts; he displayed unstable interpersonal relationships and tended to both idealize and devaluate his relationships with others; while he was never inappropriately angry during our sessions, his anger was very much there, a constant factor. Once he began to acknowledge it and direct it outwards; he showed the identity disturbance which characterizes borderline personalities; and was
prone to marked shifts of affect. He initially had a great deal of difficulty being alone, was engaging in physically self damaging acts; and had feelings of boredom and emptiness.

In terms of the narcissistic features, Jeff displayed a grandiose sense of self and a quest for the ideal love characteristics of pathological narcissism. He could also manipulate and exploit relationships and was extremely sensitive to criticism. As discussed in Chapter 5, Jeff was a narcissistic personality functioning at a borderline level. Histrionic features of his personality included dependence and egocentricity, as well as his craving for excitement and vanity.

It is interesting to note that with the exception of scale 6 (Paranoia) and 0 (Introversion) on the MMPI, all scales are considerably above the normal range. Scores range from 75 (Ma) to 104 (Sc.). Jeff's profile code is an 84, a code which has been associated with delinquent adolescents, and rebellious acting out as a means of self protection. In this group, family problems, problems with sexual identity and difficulty with authority are also characteristic. Educational histories tend to show marginal adjustment, underachievement and uneven performance as was the case with Jeff. Persons with this profile are also characterized by nomadism and isolation from peers. This profile is common to persons with personality disorders and/or pre-psychotic or early psychotic reactions. It may be hypothesized that Jeff's severe anorexia nervosa prevented a more complete decompensation into psychosis. Jeff's high F scale (70) and his lower K scale (50) indicate some tendency to be
critical of himself and perhaps to make himself look more disturbed than he actually was, i.e., he needed to call attention to how sick he was in order to insure that he would receive help.

Concern about the possibility of a schizophrenic state prompted a review of the Rorschach protocol according to the method described by Exner (1974) show F+ % and X+ scores to be within normal limits (75% and 77%), decreasing the likelihood of a severe thought disorder. However, a low number of popular responses (3), indicates an idiosyncratic way of perceiving the world, or possibly, a lack of attention to convention. Cognitively, Jeff reflected a tendency to be overwhelmed by stimuli, which in extreme situations, would cause him to be overwhelmed when he could not sufficiently organize his world. The data reflect his discomfort with ambiguous situations, and his striving for control in an attempt to organize and incorporate the ambiguity so that the circumstances did not become overwhelming to him. Jeff showed a predominance of unorganized resources, indicating a faltering or strained coping style; stressed by his less than successful attempts to keep the world controlled and organized. It was also noted that Jeff's aspirations exceeded the level at which he was currently functioning, reflecting his dissatisfaction with anything he was presently doing.

In the affective sphere, the test data reflect Jeff's affective lability and his tendency to seek gratification of needs in the world outside himself, rather than turning inward. However, his ability to tolerate affective stimuli was limited, and there were indications of his withdrawal when affective stimuli became overwhelming to him.
Jeff's concern with himself was strongly reflected in the Rorschach data, as was his narcissistic tendency to place excessive value on his own state of being, at the expense of others, or the values of the external world. A tendency to avoid others in his thoughts and actions was also noted. All of these data, as well as the complete report in Appendix A proved to be extremely accurate in describing Jeff's psychodynamic makeup and the cognitive and affective components of his personality structure. Many of these indications from test data were repeatedly manifested in the course of therapy, which I will now begin to describe.

Therapy Part I - February to April, 1981

Preface

In the course of deciding how to structure the large amount of data relevant to this study, a decision was made to present the case both chronologically and psychodynamically. To do so, it was decided to divide the presentation into two parts. It is acknowledged that any such division is quite arbitrary and subjective. However, by creating such a division I hoped it would be easier to recognize the shift and progression of issues as the therapy developed.

In Part I, the emphasis is on Jeff's depression, his anorectic symptomatology and his return to his family. The question which is most relevant to these months was "Would he stay alive?" Part II (April to July, 1981) begins when this question is largely answered. Once the worst of the depression and the anorectic symptomatology began to abate, another question became important: what had brought
him to that point—what configuration of dynamic and genetic factors had combined to cause this kind of pathology in this individual? In the second part, the emphasis shifts to Jeff's history and his interpersonal relationships. In the final segment, the termination, I have tried to sum up what was resolved during the course of therapy and what had to be left undone.

Within the context of two questions (Would he stay alive and what historical and interpersonal events had occurred to cause such severe pathology?), I have tried to present the issues as they occurred within the therapy. The shifts were often subtle ones, so I have written the case study without many major demarcations, adding commentary and additional historical information wherever relevant.

Part I: February to April, 1981

Jeff began therapy depressed about his depression. He felt generally discouraged; he was going to work but not enjoying it and felt tired and run down. His job demanded physical labor and his low caloric intake contributed to his feelings of lethargy and depression. Jeff felt things were hopeless; they would never change and he feared that he would stay anorectic, depressed, and obsessed with food forever. He acknowledged that he felt physically debilitated; with low blood pressure and episodic dizziness. He felt that he really had no life at all. He was reclusive, he stayed home and refused invitations out.

His depression kept him living at home, but home was not an easy place to be. He wanted to be loved, but he also wanted to
remain distant. He felt that he had done many things in his life in order to be loved and felt that for the most part, his efforts had not gotten the desired effect:

I always wanted the world to love me, and before, a lot of time in my life, I really played the role that people expected me to play, or I played the role that I thought would make people like me the best ... never really thinking if that was myself. I've had a lot of people say things to me about myself that I go "Wow, that's not really true"; but I can see the reason that they thought that is what I was when I was with them. I played the role.

He largely denied that this need to be cared about was still important to him:

I don't really care if someone likes me. It makes no difference to me. That sounds awful, but I'm really pretty indifferent towards it. There's no great need for me to love anyone right now ... I don't need to get involved with anyone, so I really don't need anyone to like me.

Jeff acknowledged that the return home had been necessary, but was deeply conflicted about the loss of independence that it meant for him. Although he was not yet aware of it, he had returned home in order to try and recapture feelings and relationships that had long been absent from his life, and to reestablish relationships with his family, especially his mother. This attempt to recapture what may never have existed was doomed, and from the beginning, Jeff had ambivalent feelings; he wanted to be there but did not want to be tied to and involved with his family. The depression that he felt had enabled him to take time out from his adult life and come home again. It also enabled him to ease his high expectations of himself. In addition, since he was depressed, members
of his family could not ask too much of him, so the depression was
of some interpersonal benefit. He could live at home as long as he
was depressed, he knew. If he got better, he would expect himself
to live independently again.

Another contributory factor was his low self esteem and his
negative sense of himself. Despite his protests to the contrary,
what he really wanted was for people to love him. Yet he felt
that if anyone really knew him, they wouldn't like him, since he
didn't like himself. He had no close friends, but had had many
casual, shallow relationships. There is a narcissistic, manipulative
side of his personality which became evident here, as does the
connection between his appetite for affection and his eating disorder:

...instead of getting into relationships with
anyone, serious ones, I just had little ones with
everyone. That applies especially physically,
ever sleeping with anyone for more than a week,
seeing anyone for more than a week; but seeing
everyone I could get my hands on. It was like if
there was someone that I thought was attractive,
I had to have them. If I wanted them, I usually
could get them. Then it turned into wanting
everything.

He clearly was afraid that if left uncontrolled, his appetites
would be insatiable. Rigid control was a reactive measure to prevent
such a thing from happening. Along with his loss of weight, his
world began to narrow, as he withdrew from social relationships. He
became uncomfortable on his own and uncomfortable with unstructured
time. It was as if he wanted to return to an earlier, simpler time
in his life--before bad things had happened to him and before he
developed a negative sense of himself. In therapy, he expressed
a wish that someone would run his life for him, so that he would have no decisions to make on his own. His request for hospitalization at an unattractive state facility attests to his desire to have controls imposed externally and signifies the failure of his own internal controls.

Although it was the depression which caused Jeff to seek help, it was not the depression, as severe as it was, that was most worrisome. Something else was underlying the depression, something which Jeff was scarcely aware of. This other factor did not become clear until the depression had improved, making way for a harsh, angry sense of self to emerge. At this early point, the depression was actually helpful, since it tormented him to the point where he was motivated to get rid of it, and he had sufficient ego strength so that he was not content to passively limit his efforts to taking the anti-depressant medication which had been prescribed for him.

At this time, many of the causes of the depression were already obvious. Physically, the depletion of bodily resources accounted for some part. Emotionally, there was the failure of self-esteem that resulted from the superficial relationships and the failure of his false self; his attempts to be compliant so that people would like him; and the casual sex, drugs and alcohol which had been part of Jeff's life for so long. In addition, the loss of two important relationships several months prior had been another blow to Jeff's self esteem. Finally, relinquishing his independence and feeling that he could not care for himself on his own were important factors. However, the depression was always a secondary symptom, one which is
common to many anorectic patients. The depression functioned as a defense. As long as Jeff felt severely depressed, he did not have to deal with the aspects of his personality which had generated the depression. As he began to understand the feelings about himself which were causing the depression, and understand how these were related to his eating disorder, Jeff became less depressed and was better able to deal with the underlying problems.

One of the first steps in this process was the recognition that he felt very guilty. He felt he had acted badly at the time of his father's death. At that time, his mother had become withdrawn and depressed (perhaps in a depression similar to Jeff's own). Jeff felt that he had wronged her and that the penalty for this was that she had given him up to live in foster homes. When he discussed his father's death and his feelings about that period in his life, he said:

I blamed a lot of people for it ... but at the same time, I'm sure that I can't blame anyone for it. I can resent it, but there's no one to blame for it. I can't blame my mother for it, it really wasn't her fault. I can't blame my father for dying. I'm not going to blame myself, I was only a kid. ... there's a sense that I missed a whole lot. There's a part of me that would like to have a family on my own to kind of make up some of that, to kind of feel some of that. And there's a part of me that never wants to have a family on my own.

Although he was able to say that he acted badly, he still denied that he blamed himself. However, it began to be clear that he was very angry, both at himself and others. Shortly thereafter, he began to express this anger:
I'm angry that this has happened to me, that this is going on in my life. It seems very unfair to me. I have only myself to blame. I'm angry, and at the same time, I find myself saying I can't overcome this, it's just too much; but I have to because the only alternative is to die, and I think this will kill me. I'm sure that it will. You can't do that to your body ... I'm not sure I can overcome this, and its very scary because I don't want to die ... I mean I can say that I'm angry at so many things, but I don't feel. I mean I try sometimes and it just doesn't come ... but sometimes it does come. I'll be in bed at night and cry. The thing that I'm angriest about is this though (the anorexia). I'm angry that this is happening to me. I'm angry that I can't get control over it. I want to cry about it. I want to scream about it, but most of all, I want to make it stop, because if I could make it stop I could enjoy my life so much more. I could do the things I wanna do.

Feelings of depression and anger intensified when his mother and stepfather decided to go away for a weekend, leaving him home alone with his younger sister. Since this weekend followed the above expression of feelings, it appeared that the vacation recapitulated his prior experience of feeling abandoned by his mother, when she became depressed after his father died. He was anxious about his parents' departure, not only because he was dependent on them, as he says in the following paragraph, but because they represented a form of external control which would now be gone, if only temporarily:

I don't know what will happen (over the weekend). In a lot of ways, I have begun to let people take care of me. I'm very dependent on them. My mother's an example of that. I have really let my mother more and more take care of me, and I've become really dependent on her, and here comes this weekend when that person's not going to be around and I'm with myself.
He managed to make it through the weekend, in part because he was ill with the flu, and because of his illness, he did not become preoccupied with food or as depressed as he had feared.

In the following session, he pulled himself together and announced that in addition to severely restricting what he ate, he was also bulimic and had been binging and purging regularly. This came as a frightening revelation, since it made his situation that much more precarious and serious. The anxiety he had felt about the weekend vacation was now clearer. He had been afraid that with no one there to contain him, he would binge uncontrollably. He was both relieved and exhilarated that this had not happened, and the exhilaration over not binging for four or five days allowed him to talk more openly about his situation.

The flu, with its concomitant loss of appetite supported his anorectic habits, and he had not felt the desire to binge. When he had gone for several days without binging, he felt much more normal than he had for a long time. Binging was something he was deeply ashamed of, because it represented a loss of control. He felt that he should be able to control his urges to binge and felt deeply chagrined and depressed when he could not.

The life and death nature of Jeff's disorder was now fully evident. At the end of March, 1981 he was still afraid that he would not survive his anorexia, but he had begun to be less overwhelmed by it:

I was gonna say that I'd rather die than vomit but that's not true. I could say that I'd rather die than live like this forever, but I don't wanna die. I really don't. If I could just get to the base of this and work that out. If I
could just overcome this just a little bit, then
I could start working on other things. I could
feel better (physically).

For the first time, he began to feel that there were things to
do; things he wanted to accomplish and was upset because he felt
limited in what he was able to do:

... probably the first thing I would do is quit
my job, take off and travel. (I mean not quit
my job, just take a month off and go to California
and see my sister. Or even if I could stop it on
a weekend, I could go away, but as it is now, I
can't seem to do any of those things, and I'm
angry about it, I'm upset about it.

He began to see how self-destructive and self-punitive he was
and how he felt that he was unacceptable to himself. As he expressed
these feelings, he became less depressed but increasingly angry and
guilty:

J. I think that I probably deserve to die, but
then if I'm gonna live (I) can't enjoy it;
kinds of self punishment, self destructiveness
... I've virtually been an alcoholic before,
and I've been involved with drugs I couldn't
handle, and I know that this is worse than
those. This is the worst thing, maybe
that's why it started.

T. Why is that?

J. It must be that I feel rotten about myself.
I feel like I've done a lot of real shitty
things to people. I've used a lot of people.
I've hurt a lot of people, walked all over a
lot of people, done it to to myself even.
Everyone who's ever cared for me I've ended up
hurting very badly, letting people really care
about me and using them only because it's a
place to live, using them for their money,
(or) what they can get me.

The depth of Jeff's anger, or properly, his rage, suggests that
it comes from a developmentally early period when things were all
good or all bad and when the intensity of feelings called for nothing short of life or death. Although he had acted out his rage through self destructive acts with alcohol, drugs, and sex, on another level, the rage had remained largely dissociated. When all of his earlier attempts to escape from his internal predicament failed, Jeff found a perfect solution in anorexia nervosa. He allowed himself to live, but only by the slimmest possible margin and in a way that was limited and unsatisfactory. In his statement: "This is the worst thing, maybe that's why it started" is an important key to his feelings. He would live, unless the anorexia killed him, and he knew that that was possible. It was as if he had tried to plea bargain with his rage. He had tried to control his rage by focusing all his attention on food and weight. His attempt at control was flawed in that his preoccupation with eating and control was as self destructive as his rage. In a convoluted way, the two became synonymous.

Once he confessed to binging, sharing something about himself he found unattractive and about which he was ashamed, Jeff became more open about his eating habits and his preoccupation with food. He spoke more freely about food and eating. At the end of March, 1981 Jeff began to indicate that he realized food and weight were metaphorical issues, representative of other things, not ends in themselves. This was a significant shift in his perspective. Likewise, he understood that the issue of weight was something other than what it had seemed initially:
I realize that I'm very unhappy with my life right now. I'm not doing what I want to do, I'm not where I wanna be. So what I've been saying to myself, is that if I gained a ton of weight, how could it make any difference in my life. My life is so bad now. If I gained alot of weight it really wouldn't make any difference. It wouldn't change anything. It couldn't make my life any worse, because my life is terrible.

He understood that he had a tendency to go to extremes and recognized that in the past, attempts to stop binging had failed because he had resorted to a period of rigid control followed by a period of excess when he could no longer sustain the control. Yet, he did not quite see any other way to handle the situation, although he began to search for an alternative:

The funny thing about it is as much as I hate living this way and as much as I wanna change it, I feel an anxiety about not being able to do that (binge) anymore, to live like that anymore! It's incredible, the motivation when I binge is not so much that I want to eat cause I'm hungry, or that it tastes good. I realized that when I was eating an incredible amount (i.e., binging) the other day. I thought, I'm not even tasting this. So the motive can't be that I'm hungry, or that it tastes good, so why ...?

Although he did not understand the cause of the binging, he did understand that the binging made him feel badly about himself, and that this drop in self esteem was related to his depression. He noticed that the depression was worse when he binged, and better when he went through a period of several days without it:

My life is set up in such a way that it causes me to have a very low opinion of myself. I have set it up that way. I didn't realize it 'til this week, but I've done it, and in setting it up that way, I feel trapped. I don't think I could get out of it if I wanted to. This (the binging) holds me to it. This keeps me trapped
in it. It somehow had to tie into my low self worth, keeping me tied to it ... during the weekend I was alone I did really well. I know part of it was because I was really sick and I didn't want to eat, but that wasn't all of it because I was sick before and still (did) that. Maybe the difference was that they were gone. There was no one to take care of me. I had to take care of myself and Ellen and I had this whole house that was mine and it worked.

Jeff was atypical in that from the beginning, he could say that he understood that he was too thin and that he would look better if he could allow himself to gain weight. However, this realization had nothing to do with putting on weight, which was something he just could not let himself do. He had thought of the vomiting as a way of insuring his thinness and in the period before the therapy began, as his weight had dropped dramatically, he rationalized the loss by saying that he would allow himself to gain more and more weight in the future. According to Jeff, his low weight was either 94 or 98 (it varied in different accounts). At the beginning of April, 1981, he weighed approximately 110 pounds. He was aware that his frequent feelings of weakness came from his restricted diet, and knew that he would feel better if he weighed even 20 pounds more. He simply could not bring himself to gain the additional weight:

Now that I'm being more honest about what's wrong with me, I'm depressed. I feel very depressed and I never have the energy to do anything or the desire, but I'm depressed because of the anorexia ... I'm at a point where I know I have to eat a certain amount of food each day and keep it down. I always eat breakfast. I always eat something before I go to bed because I know how rotten I'll feel the next day. I know I won't gain weight and I won't lose any ... I feel very safe at 110 and (will) maintain that for a while while I feel safe. I don't want to lose any more weight.
Although Jeff was correct, and did not lose any more weight, gaining weight proved to be a more difficult matter. Even Jeff's rigid control and vigilance over what he ate constituted an improvement since he no longer went for long periods of time without eating, as he had done previously. Nor did he try to deny his hunger, as he had often done before:

I don't go for periods without eating. I mean that's one of the things I don't do any more. I can remember this summer, last summer, really being hungry and denying the hunger totally. One day sticks out. I was laying on the beach and I was starving. I said f--- this, I'm starving, why am I doing this to myself. I went in and ate something and I was fine. I don't do that any more. Even one day this week I was at work, and I had lunch and then I had to go to [name of town] after work and I felt sick to my stomach after I'd eaten. I got sick and I didn't even mean to, so I stopped and got a yogurt. If I went a day without eating and then tried to go to bed, I'd wake up in the middle of the night. So that part of denying hunger I don't do any more.

In the middle of April, 1981, Jeff reconstructed the history of his weight loss and discussed the period just before he had returned home, when the anorexia was at its worst. This time, the weight loss was connected to the loss of two important relationships. Jeff observed that he had begun losing weight when the first of these relationships, with a man named Bob, was terminated. Over a period of four months (April-August, 1981) his weight dropped from 145 pounds to 132 pounds. In September, 1980, when he returned from the resort town where he had spent the summer, his weight was down to 110 pounds, followed by the low weight of 94-98 pounds:

J. There was that whole thing with Bob ... (who) was so obsessive about weight. I guess he
had a very slow metabolism, could eat barely nothing and not lose weight. He used to beat his brains out every day and take 100 to 200 mg. of amphetamines a day.

T. Who was Bob?

J. He was the guy I sort of had a relationship with. We got to be very close. We spent a lot of time together. It's funny now, when I think about it, because I was never conscious of my weight or what I ate until that relationship, him being so conscious of it and me being around him all the time. When our friendship ended, and at the same time my friendship with Edie ended, I became even more conscious of it.

T. Was Edie also concerned with her weight?

J. She was overweight and always trying to lose weight, not doing a very good job of it. Bob wasn't really overweight. I can look back now and I can see how it built up very strongly, and after I started seeing both of them, I was kind of being careful about what I ate. I was also taking a nutrition course that semester. I became more conscious of what's good for you to eat and what's not.

When he had reached his low weight in the fall of 1980, he moved in with two women friends, as he could no longer stand living alone. The contact with these two women must have been a supportive one, because of a period of two-three months, he was able to stop binging. At this time, he was working in a bakery, and also held a job in a supermarket. Jeff described his work in the bakery:

I was gonna say that I liked it when I worked in the bakery, but I don't think I really liked it. I killed myself, I worked so hard but that's when I was feeling more anorectic. I liked it then because it was hard and it took a lot of energy...I like to have lots of responsibility, which I did have at the bakery and which I don't have at my job now. Now I sometimes think that they
must think I'm a total idiot. At the bakery even though I worked four times as hard as I do now, I opened on weekends. When I was there, I was in charge. That part of it I enjoyed. Lots of things were depending on me to get done and that made me feel good.

Jeff was clearly feeling frustrated at his job and at the same time, allowed himself to voice his frustration with being thin and not being able to gain weight. He said that he would like to weigh 125 and was tired of looking so thin and drawn. He felt that nothing was changing, that he was still following the same old patterns. In addition to the frustration he felt when he went to work, Jeff was becoming increasingly open about the frustration he felt living at home, and about his difficult relationships with his family. When he was able to say that he wanted so much for things in his life to change, I was able to respond that I felt that food was not really the problem, but that it had come to symbolize his problems. Jeff replied:

Neither do I. I think it goes much deeper than that, because even if I eat well for a few days, I still don't feel better. It seems like there should be some way of changing my life a little, doing something different a little to see if I would feel better. It almost seems that to continue doing what I'm doing doesn't make sense, because it's not working. It scares me because I don't know what else to do. I'm afraid to make a lot of changes right now.

If at this point, Jeff was alluding to his dissatisfaction with the therapy and the feeling that the therapy was not doing enough for him, it was not discussed further. Perhaps this was a serious error, since ultimately Jeff was able to feel that the only way of changing his life was to go 3000 miles away and see whether he could
rid himself of his old habits and life style. At this same time, Jeff's increasing frustration seemed to indicate progress. His self concept had begun to change, and he was increasingly able to see himself as a person with legitimate needs, something he had never accepted before. The realization that these needs existed was frightening, since there was always the possibility that the needs could not be satisfied. The connection between this neediness and his eating habits began to appear:

I've always felt that I've never really known what my needs were. If someone sat down and said what are your needs, what makes you feel good, what do you want, I couldn't have told you. All of the close relationships I've had in the past five years has been them telling me their problems and I haven't told mine ... I'm afraid that at this point I have so many problems and no way to fulfill them and I'll be dissatisfied, because I think they built up so fast and there are so many that they're just gonna overpower me, and I'm also afraid that there's no way to satisfy them.

Jeff still maintained the rigid control over what he ate. His initial struggle to allow himself to live was being superceded by the need to live under the most rigidly controlled circumstances. Since this did not allow him to get better, his frustration increasingly forced out factors underlying the control mechanism.

The analogy to both hunger and sexuality is clear in the above passage. This connection became increasingly clear in the session which followed (4/24/81), where Jeff continued to talk about experiencing his own needs and needing to control his eating:

...last week was real important, I was starting to talk about how I'm afraid to find out what my emotions are because I wouldn't be able to fulfill
them; because I haven't ever been able to fulfill my need for people caring about me, I never thought my sexual needs were satisfied. A lot of things I didn't think could ever be satisfied, and I just started burying them in a way that might have a lot to do with eating because in a way I'm afraid that I'll never have enough to eat; even when I'm full, I'll always want more.

By the next session, Jeff said that his binging had stopped. The amelioration of this important symptom was of extreme importance in the therapy. From this point on, the focus was less symptomatic and decidedly more interpersonal--Jeff's feelings towards his family, his feelings about his father's death and his feelings about the relationships, sexual and nonsexual, that he had had until that time.

At this time, Jeff began to regain some of his sexual urges and no longer felt content to live in the reclusive manner he had established. Whereas only a few weeks before he had been content to resign himself to a boring job and living alone, he now began to be seriously concerned with this sexual orientation--a sign that he was moving toward recovery.

Jeff could now connect sexuality with his fears about intimacy and being close to someone. He was frustrated because he felt that he could not have a sexual relationship with a man or a woman, and felt uncomfortable defining himself as either homosexual or heterosexual. The asexuality which accompanied the anorexia had for some time relieved him of this conflict. As he improved, the conflict came to be quite active, but Jeff was now depressed about having no definite sexual preferences. The future without sex began to look bleak, an optimistic sign. As he began to face the question
of sexuality, his sexual feelings began to return.

In addition, Jeff began to see how his eating habits kept him apart from relationships with his family and with potential friends. He rarely ate dinner with his family and used his idiosyncrasies around food as a way of maintaining interpersonal distance. He was ambivalent about his family. As much as he wanted to feel connected to them, he was not sure he could tolerate being part of them. He recognized how not eating with them kept him apart:

I think at home it (eating) keeps me apart from them, which is funny, because I think that's what I still want. I'm not ready to totally be a part of their lives. I think I feel too much anger at them. I always will... I leave and go out around the time when everyone would be up and together...

Jeff needed to keep his distance because of a strong identification with his mother, an identification with his mother that was ambivalent at best. He saw his own depression as similar to his mother's:

I think I'm really afraid of being like them, especially of being like my mother. It seems my mother has been depressed for years. Her life is so empty, and yet she refuses to do anything about it. I can see myself being that way. Being depressed like that and not doing anything. I'm not afraid of becoming like that, I'm afraid I'm already like that. I think I'm different enough not to have it go on for years and years, because I know where she went wrong, it's because she never tried to do anything about it.

He had moved in after so many years with high hopes of recapturing an ideal relationship. These were quickly disappointed:
Now I’m disappointed in her again, after moving away and getting over all that the first time, I moved back home and now I’m disappointed all over again ... years ago I was disappointed in my mother because my father died and she fell apart. I thought she was a stronger person than that. Because she had no personality of her own, she built herself up all around my father. I hate clinging women who are so dependent on their husbands ... I was really disappointed in my mother because the sun rose and set around my father and he died and she fell apart.

Now Jeff continued, his mother had transferred her attachment to her second husband. While it is possible to interpret the Oedipal issues present in this passage, there appears to be a stronger pre-Oedipal content. Jeff wanted his mother to recognize his importance to her, to reclaim the unique mother-child dyadic relationship. His disappointment came from her inability to do this, especially in the light of his dramatic illness. He had recreated an opportunity for restoration of a relationship which could not be restored. His depression was the anaclitic depression of the child experiencing the loss of his mother. Along with the disappointment and depression his anger at his mother and sisters returned; and to add insult to injury, Jeff felt trapped in their house, unable to live on his own because of his anorexia:

I don't know what I'm doing there. I wish I understood. I mean, I know why I live there, because I say that I'm afraid to live on my own. As long as I'm anorectic and do all this stuff I just can't. But at the same time, I can't stand to be around them and I thought that would have changed after all these years ... I find myself saying, well, I love them because they're my family. I'm not sure how much I love them. To me that sounds really awful because that's not the way you're supposed to feel, but maybe I'm kidding myself by saying I don't love
them. I don't know the answer to that. I look at my mother and I think that I love her, she's my mother but I wouldn't want to have to say "hi" to her on the street because there's really nothing about her that I like. She's weak, she's clingy, she's never satisfied, she's moody, she's unable to change her life, she's self centered. My older sister I can't stand. I can say I don't love her and I don't think that's a lie. I dislike her very much. Lately all I see in myself are the qualities I don't like, and don't like seeing them in myself. It's funny, 'cause I thought I'd left all this behind years ago.

Jeff had not been able to leave it behind, although he physically had removed himself from his family and was to do so again. He did indeed identify his mother and older sister Barbara with all the parts of himself that he did not like. Another sister, Deborah, was not subject to these projections. She was the successful one who had married and moved to California. While his physical absence had been a way for him to cope with his angry feelings about his family for a good many years, since his return the situation had become much more complex. Ambivalence predominanted and Jeff was forced to recognize that he had feelings of love as well as hate:

What makes it different this time is that before when I felt that way, that was it. I can cut myself off from them. It was a simple solution. I really felt that way (angry) so I just cut myself off. Then when I started to accept them and want them to be a part of my life, but not really be with them, it was still easy too. I could visit them once a month. I could call once a week and that was easy, but now it's all mixed up and I feel like sitting down on the curb and crying about it. There's no answer, it's all mixed up. It's a hundred different feelings going on at once. It's not clean cut this time. This time it's all crazy. I don't want to totally leave them and I don't want to totally join them and be a part of the family, because I don't feel that good about them. I
I don't want to be distant and I don't want to be close to her. I don't want to live with her and I don't want to live without her.

He might have been speaking about a lover, rather than his mother.

It did not take Jeff long to realize that the desire to re-establish a relationship with his mother had been a fundamental part in his returning home. He eventually expressed his anger at her for leaving him; ostensibly for a weekend vacation, but also for abandoning him after his father died. His initial efforts to idealize his family had become feelings of love, hate and anger.

Jeff initially blamed himself for his mother's behavior toward him. Rather than his mother's leaving him emotionally, he focused on the fact that it was he who left her, physically. He spoke of not leaving his mother alone--meaning that he had continued to demand her attention:

I didn't leave her alone, but I think in some ways I thought I would leave her alone and the only way to do that was to leave. Speaking about my mother, I think I left her alone because I felt she couldn't deal with my life, couldn't handle my problems on top of all the ones she had. I think I was also away from them because I felt she really didn't want me to be close to her with all my problems. So I kind of had to leave them alone because they wouldn't have been able to handle my lifestyle. I would have just ended up causing problems for her. Problems she didn't need.

In mid April, Jeff began to see how he had more or less always felt his needs were not being met, that he had not felt a secure "home base," even as a child. He began to see how this feeling of never being cared about connected to his relationships with other people. The realization represents a shift from the attitude Jeff
first presented in his idealized descriptions of family life. With surprising clarity, Jeff was able to see that it was not all his family's fault:

I think I've always been afraid to get close to people because of my own inadequacy. I wouldn't be able to truly care about them or truly love them. I don't think I've ever been in love outside of mother-son, father-son (relationships). I've often found myself thinking that I'm just not capable of giving that much warmth and affection. It's not in me to give, that's something I can't do. Maybe I keep a distance because I can't love these people, I'm not able to, I'm not capable.

Jeff made the connection between these feelings and his pattern of casual relationships with both men and women. He had fears about being involved with women, fears that he would be inadequate in the relationship. He had rarely found any of the relationships satisfactory, and he continued to protest that he did not really enjoy sex and that his sex drive was low. But, in spite of his need to keep his distance, his need for attachment was very strong. It was the very strength of this need to be attached to someone that caused him to react by distancing himself. Thus, as much as he desired attachment, it was the thing he most feared. It was hypothesized that his sense of inadequacy was a reflection of his interaction with his mother. As hard as he tried, he could never do anything that would be satisfactory for very long. In turn, he had developed his own system of narcissistic defenses, which were strong enough to have him favor relationships in which he could clearly be in control, but which were not sufficient to prevent him from feeling guilt about his own inability to feel for other people. This
hypothesis was substantiated shortly thereafter.

His need to be liked was clearly manifested in his work relationships. Almost from the very beginning, Jeff did not like his job. He felt ill used at work, where he was given little responsibility and asked to do the most menial tasks. By the end of April, 1981, he began to see how he kept silent because he needed to feel that he was liked by his co-workers and that the price of his compliance was a decrease in self esteem, because he could not deal with the situation. Having realized this, Jeff set out to change and deliberately went about asserting himself at work. Although the work situation never drastically improved, his self esteem did, because he was able to assert himself more. The experience at work acted as a kind of catalyst. Shortly thereafter, Jeff began to be more assertive within the context of his family as well.

Jeff's difficulties with closeness and distance had by this time become manifest in the therapeutic relationship. Initially, my impression was that he was only willing to discuss certain topics, those which he considered safe. He later confirmed that in these early sessions he had regularly pre-selected the things he wanted to discuss each time. As his need for so much control diminished, he was able to let himself associate more freely and the sessions lost this pre-structured quality.

What Jeff managed to re-create was his desire for an intimate relationship as well as his fear of such intimacy. It was clear that he looked forward to sessions; he was always glad to see me, and
rarely missed an appointment. He seemed both to need me, yet needed
to keep some distance between us. Although it was never discussed,
at this point I believe I represented a "good mother" to Jeff--the
mother who would perhaps save him, who would somehow solve his
problems with food and eating. I have no recorded record of making
such an interpretation, but in retrospect, I believe this to be the
case. This inference is made on the basis of the disappointment with
the therapy that was to occur later on, and on the basis of Jeff's
tendency to idealize what he wanted very much to have. It is also
made on the basis of my feeling that I never was quite a real person
to Jeff, in the way that an ideal object can never become real.

In spite of this, Jeff's involvement in the therapy was quite real. Although he had said many times that he felt he could not be
involved with anyone, he also needed the intensity of a relationship
that offered more than superficial contact. What he feared was
becoming too involved, so that the relationship became threatening.
This would occur later on, but was not obvious at this point in time.
Just as he allowed himself to become dependent on his mother, he
began to allow himself some feelings of attachment and dependence in
the therapy as well, feelings he wanted to have but found difficult
to tolerate.

Part II: May - June, 1981

Once Jeff was able to stop binging for a short period of time,
in a figurative sense, he got his appetite back. Although he was
still plagued by the fear that he would not be able to overcome the
anorexia nervosa, he began to think that if he could stop binging, he would soon be able to make other changes in his life as well. He began to want more than having a job and living at home. He spoke about his month of summer vacation that was fast approaching and how he felt that there were things for him to do. He began to have some perspective on how draining a disorder anorexia was. But he was by no means sure that he was cured:

I want my life back. Now I feel like doing things again. Actually, it drains everything out of you. It drains all your energy. You have no time or interest for anything else. For me, it's a matter that the alternative is that it simply will kill me. I don't do anything in moderation. I tend to go to extremes in everything in my life. I'm not one of those people who binge once a week. I don't do that. For me it's an everyday thing and it will eventually kill me ... I can't say that it's stopped or that it's over. It's been four days and I feel real good ... I'm just thankful I've had the last four days.

Because he was afraid that he would return to binging, Jeff adopted the attitude of taking each day as it came. It is obvious that he still felt that the disorder was in control of him, but the more he was able to acknowledge his fears, the more optimistic he became about changing:

I don't know why it stops. I think Sunday what started me thinking was that I felt a lot of things ... I got disgusted with it taking up so much of my life, everything about it. Throwing up, I really got disgusted with it. I hate to throw up. It's gross. I'm tired of that ... I realized that it has nothing to do with being hungry ... I'm mixing that emotion with something else I'm feeling. I guess I felt that none of it was worth it. It wasn't worth the money it takes, the time it takes, the energy. What will make a big difference to make it stop this week is, I
think it has something to do with controlling my life. That I can. I say it like it's another person, and this week I feel that I'm not happy with things the way they are and I feel that I can change it if I try to stop or try to work it out and that will put a lot of good changes in my life.

The idea that he could have some control over the events in his life, as well as the connection between binging and feeling states were both extremely important to Jeff. They gave him renewed energy to struggle through the disorder. In therapy, he continued to become increasingly open and the emphasis in our discussions shifted from his feelings about his mother to his feelings about his father's death and his memories of the events surrounding this period in his life. It should be remembered that initially, Jeff had said that he had had to live separately from his family in order to sustain these compartmentalized and dissociated feelings; and to sustain the image of himself as a free, independent person, attached to no one and in control of his life. A piece of further data emerged—shortly before his father dead, he had had an argument with Jeff which remained unresolved. Jeff's feelings of inadequacy and his sense of guilt are quite clear:

I think after my father died, I felt very guilty, because after he died I got very hard and very cold and very distant and very hateful. I've often felt that if I had acted differently, even though I was 11 years old, if I had maintained a little better, I would have been able to help, cause other kids help when that happens. But I was a drain. An additional problem at a time when we didn't need it. I guess I've never talked about my father before. I always felt that the things I was good at were never the things my father wanted me to be good at. When I tried to do the things he wanted me to do, I just wasn't
good enough. I just couldn't do it. My father was very into sports and my parents pushed me to play sports and I was rotten at it. To this day if I play softball, I'm the one who strikes out. But they really pushed me. I remember in the Little League, I would try but I wasn't good. Playing football with the other kids, I was the worst, and although it was my mother who pushed more than my father, I think he was more disappointed. I know he would never admit it, but I felt like I always disappointed him. So I think when I was a kid I decided not to be that close to my father and I wasn't. I really wanted to keep my distance. I can remember a few arguments when my mother was gonna leave my father and I wanted her to, because then maybe I wouldn't feel such pressure to be good in things I wasn't good in ... I think a lot of things go back to before my father died. I wasn't really happy. I remember feeling like I just didn't fit in anywhere, in the sense that I couldn't be what my parents wanted me to be ... I felt a lot of resentment towards my father, I didn't want to be close to him. I was really close to my mother. The night before he died, I had a huge argument with him. I was in the fifth grade and I told him I hated him...

Although here again it is possible to interpret the material Oedipally, it is my feeling that what is more significant in this passage is that it so clearly expresses the etiology of Jeff's narcissistic disturbance--he could not be what his parents wanted him to be. It helps to explain Jeff's desire to please others, to be what others wanted him to be, in the way that he was unable to please his parents. It also helps explain why these attempts to please were doomed to failure: they were really nothing more than the repetition of attempts to please and which had failed long ago. Jeff's anger at himself and the self destructive acts and his self derogation can also be seen in the light of his inability to do what he most wanted to do--please his parents and be loved by them in
return. In all of his relationships, as soon as he felt that there were demands and expectations which he could not meet, he became very distant, very cold; and it was virtually assured that his feelings of inadequacy were always present.

Thus, underlying the anorexia at its most fundamental level was a deep narcissistic injury and a failure of the narcissistic defenses which had developed following the injury. From what it is possible to reconstruct of Jeff's history, it seems probable that Jeff was cathected by his mother as a kind of self-object who received strong affection but who was never accepted for himself.

When these repeated attempts to please his parents failed to provide the constancy and security Jeff needed, he developed a defense based on his ability to distance himself, a way for him to seemingly take control in a situation where he really had none. It seems very likely that Jeff did indeed have a strong relationship with his mother, and that the impact of the intensity in this relationship remained with Jeff throughout subsequent relationships, when he displayed a desire for intensity and closeness but could not tolerate the very same things that he desired. For years, Jeff's narcissistic defenses had provided him a measure of safety. He could "get" whomever he wanted to be in a relationship with him. He had gone from one relationship to the next, in what sounds like a like of frantic effort to stave off his "hunger". Exactly when this defense began to break is not certain. What can be known is that two important relationships he had broke down, and at the same time, Jeff began to regain memories of the events following the death of
his father. It is my impression that once this happened, he was less and less able to sustain the defensive posture that he had held for so long. He then became more and more obsessed with food. It is interesting to note that both Edie and Bob had been preoccupied with food and weight. Jeff's choice of this particular symptom may have come as a way of trying to incorporate some vestige of these two important relationships, even as he was losing them.

Once his defenses began to dissolve, it was difficult for Jeff to be in relationships at all. He progressively withdrew into his obsession with food. Until this point (5/1/81) in the therapy, he had been unable to talk about how easily he was hurt and how much he feared rejection. It was for this reason that he could never afford to let anyone really get to know him—he was basically sure they would not like him if they did, and he wanted to be liked, to be cared for. Initially, he felt guilty about all the things he had done to hurt other people. Later in the therapy, he was able to admit how painful relationships had been for him, and in all probability he had both hurt and been hurt.

He had isolated himself from relationships because he could not afford to let anyone find out what was happening to him. For the five or six months after he returned home, he continued to feel that he could not be close to anyone. He began to be dissatisfied with this distance, and relationships, although still dangerous, began to be desirable again. He allowed himself to go out after work, to buy himself a new pair of pants, and felt good that he could do these things.
There were some setbacks. In May, 1981 he announced that he had relapsed into binging, but felt that the relapse was not indicative of a return to the old pattern. He was able to take the episode in stride and able to connect it to the circumstances which had preceded it, and to the emotions produced by those circumstances. He had been invited out to dinner by some people from work and had refused the invitation, feeling that he could not face a situation which necessitated eating with other people. He subsequently felt sorry and angry that he hadn't gone and the binge had followed. Purified of the troublesome emotions, he allowed himself to go to the movies the next day, something he hadn't been able to do for some time.

The connection between binging and his emotional states was firmly established:

It's been a real bad week at work ... I want to change that. Wednesday, I felt I was really being taken advantage of. At one point I felt the urge to just really go out and binge and go crazy. I said "wait a minute, that's not what you're really feeling." It was the first time all week that I really had the urge like that. It was really hard to control. What I was really feeling was that I was frustrated with my job ... I was being taken advantage of. I didn't really want to go out and eat, but that would have blocked me from having to think about what was really wrong. It would stop me from having to deal with getting frustrated, getting mad. If I had just gone out and binged, I would have been able to avoid feeling all that ... It's a way of avoiding what I'm really feeling. Once I realized what I was feeling, it went away.

Following this, Jeff brought up an argument that he had had with his mother over the weekend. It was, he said, the first time that he had allowed himself to get angry with her about something. During
another incident at work, he stood up for himself, and felt good about being able to do so. Jeff came to realize something important about having emotions and needing to control them:

... Something that's important to me that I've realized; I don't think I've really controlled a lot of my life. I think my emotions have run my life and I think in some ways losing all this weight was a way of saying I can control this. I have total control over this. Now I'm feeling that yes I do really want to go back to school or get some kind of training ... I know I'm not gonna die now. I know that if I can get it together as far as eating and my emotional state, I can handle things ... That way (binging) of controlling my life was wrong. It was actually a way of losing control, because if I do that, I won't find another job, I won't be able to move away from home, besides the fact that I'll eventually drop dead. So before I thought I could control my life that way (but) what that means is that I can't control my life and in time, other people will totally have to take control over my life and I think that's a good thing to see. All those things are just becoming very important to me and even in the past two weeks I look that much better and feel that much better. That's made a difference.

For Jeff, the rigid imposition of control over some fundamental aspect of his life had been a way of imposing some order, although artificial, over what had become an existence with few controls, internal or external. Through his use of drugs, sex and alcohol, Jeff had broken most of the conventional limits imposed by society. Yet within this acting out, there appeared to be the desire for safety of a situation where such things were not necessary. Jeff's control of his diet was an attempt to institute some kind of control where none had existed. When he began to feel that the anorectic behavior was in control of him, he looked for some way to have control
imposed externally--his request for hospitalization at a state facility where all aspects of his life would have been rigidly controlled. As the therapy progressed, he began to feel that it was possible for him to make changes in his life which would offer him some feeling that he was more in control, and he began to develop an internal sense of control which was more flexible and not dependent on an obsessive-compulsive defense.

As this happened, new material emerged rapidly. There was the recognition of the guilt and anger he felt because he could not be what his parents wanted him to be:

I grew up feeling a lot of guilt over a lot of things; feeling very guilty. I always felt like my parents really pushed me to play sports and I wasn't any good at it and I didn't enjoy it. I would have rather been playing dolls with my sisters and I felt real guilty. I can say that now and not feel guilty because there's nothing wrong with boys playing with dolls and I grew up with two sisters who were my only playmates. But I remember playing with them and feeling very guilty because I knew in my mother and father's eyes they were disappointed because I wasn't any good (in sports) but I enjoyed playing with my sisters and I didn't enjoy playing baseball ... 

Jeff could not relate to the "macho" image he carried of his father, and professed to feel guilt about the effeminate side of his personality, "the part of my personality that other people would say was not being a man". In part, this was the side that he identified with the soft, sensitive part of him, the way he had felt when playing with his sisters as a child. It was also the part that wanted to be close to other people, as well as the part that was self-indulgent or, as he put it, "the part that would like satin sheets". Although
he had been told that his father had been a warm, sensitive man, his image of him was of a man who was "stubborn, strong and macho". Jeff saw himself as a mixture, neither really effeminate, nor macho, but somewhere in between. His negative traits he identified with his mother—the passivity, dependence and the depression, these were the things he feared to find in himself.

As his angry feelings toward his mother continued to emerge, his perspective on the events after his father's death began to shift. He no longer felt that the fault was exclusively his. He began to recognize that his mother had not always been able to mother her children. He remembered her saying, after his father died, that she wished it had been one of the children instead. It is possible, that since he had had an argument with his father the night before, that Jeff assumed that he had somehow caused his father's death and assumed, on the basis of hearing his mother say this, that he should have been the one to die.

He also recognized how he had repeatedly tried to call attention to himself, how he repeatedly had tried to maneuver his mother into loving him. Even the anorexia now was seen in this light:

I think a big part of my life I've done a lot of things trying to get my mother's attention. I think I felt really left out, after my father died. I can see everything in my life then as ways to get an invitation to get her caring. As far as doing everything wrong, I thought that might get me her attention. Then I went to the other extreme. In school, I studied really hard trying to do everything the right way and it didn't work. So maybe in some ways I let myself get this sick to get her attention too and I've realized this past week that that really didn't work either. What it did was get her attention
for a while and then she resigned herself to it and thought well, he's either going to make it or die, there's nothing I can do about it.

His disappointment and frustration that such a drastic attempt had failed was obvious, but he appeared to begin to resign himself to the situation. Here again, there is a connection between affection, nurturance and loving behavior and eating:

She really hasn't given me the attention that I've wanted except for maybe the first two or three weeks that I was at home. As far as that goes, this isn't going to work. I think I have to accept that I'm never going to get what I want from her ... I would like to feel that my mother thought her children were the most important thing to her, or were at one time, but that's not true. It's always been my father who was always more important to her, Fred's (his stepfather) kids are more important to her ... part of me can see from my standpoint that if I had a choice right now I would rather be involved with someone, be important to them, (rather) than have my children be the most important thing; as an adult I can see that. But it's hard to realize with Fred and my father that they were both so much more important than the kids, and because of that the question still exists that no matter what I do, I'm still not going to be able to get what I want from her, the love or attention that I want.

What he was saying, with a great depth of feeling, was that his mother would never be able to feed him, and because she would never be able to satisfy his hunger, he had doubts about what would happen to him if he gave up the control he was still imposing and tried to satisfy himself.

Jeff still worried a great deal about his eating. He could not be relaxed about what he ate and worried that he would either eat too much or too little. He was afraid that if he gave up control, he would be overly indulgent. His thoughts on this matter were in terms
of one extreme or the other, he was not sure that he could deal with food appropriately. In metaphorical terms, he seemed to be saying that he wanted the total affection and attention that a parent would give to a child, or nothing at all. He worried that he would not be able to accept what could really be possible for him, that an ordinary, imperfect relationship would not satisfy him or fulfill his needs. He expressed this in terms of food:

I'm afraid that if I had ice cream one day, and then the next day I had an apple, it wouldn't be enough.

If he experienced love, then he would not be able to tolerate life without it. The alternative was to try and live without it at all.

Jeff recognized that his mother's life had not been one which led her to develop the skills of "good enough" mothering. He related that his grandmother had been only fourteen when she had had his mother. She had married a man of 35, an alcoholic who beat her. Jeff's grandfather died when his mother was 8, and his mother had been passed around to various relatives, much in the way Jeff had lived in various foster homes. According to Jeff, his mother felt that she was always "second best", that she never really had a place of her own, much in the way that he too felt second best and never really at home anywhere. Physically, Jeff felt that he resembled his mother, and noted that it was only in the past few years that his mother had begun to put on weight.

One of the things that began to change (5/22/81) was that Jeff now was less demanding and less harsh with himself. As this
happened he could sometimes ease his strict control over his eating. He loosened up in little ways and much to his surprise, did not return to binging, as he had feared. He allowed himself to eat different things. Previously, he had forced himself to follow the same diet every day, in order to make sure that he ate neither too much or too little. He associated his regimentation, his rigidity and his need for control to his father, whose philosophy had been never to take the easy way out. Inherent in this internalized sense of his father was the sense of the "bad me"; i.e., he had to be harsh with himself and things had to be hard for him because that's all he deserved: He related these feelings to his father's death, although in all probability they began much earlier.

I've always regretted that I wasn't able to handle my father's death a little better, but I suffered from that more than anyone else in the family. My life got totally thrown out of whack ... I went from feeling that I deserve this and that, it's fair, to really thinking I don't deserve it and it's not fair.

Jeff seemed to be saying that since he felt that he deserved punishment no matter what, he might as well act badly and so deserve what was already happening to him. He rarely felt that anyone approved of him but was hypersensitive to rejection. Once he felt rejected, he rejected everyone in turn. In his past, he knew there were people who had tried to reach him and be kind to him. "It wasn't like the world deserted me", after his father died, he said. He had rejected the efforts of kindness, the attempts to help, probably feeling that if his mother had withdrawn from him, no help was really possible. He felt that all his life he'd lacked a sense
of belonging and that this alienation had been intensified by his father's death and his subsequent removal to a series of foster homes. Later on, his sexuality made him feel different as well. He expressed this sense of estrangement:

... that feeling fell apart when I was still really young, that the world was safe and I was loved. I don't know what it is. There are two sides to coming back here. I've had a feeling of not belonging, not having a groove. Even when I visited, I didn't realize there's also a part of me that doesn't want to belong. It's like I wanted it and didn't want it at the same time. I was afraid maybe. I don't know. I want to fit in and be comfortable. I don't feel like my home's my home. I don't have any friends and my family drives me crazy.

Jeff's turn toward homosexuality may have been a rejection of his father's machismo. His sexual preference was still conflicted. He leaned toward homosexuality, but expressed ambivalence about being gay:

... there's a part of me that would feel very good being heterosexual, totally sure of my masculinity. I have to admit I would really like that. Then there's a part of me that says well, you could be gay you know, and I've grown so accustomed to the idea that I say to myself that it's okay and I can say that and mean it, but on the other hand, deep down inside I feel I've lived that life and the people are awful and they made me do awful things and then there's the guilt too, I just can't give into it. It's not totally okay if I'm gay. I have a lot of bad memories of it. The gay life is basically ruthless. When you're young and you're handsome people will get you anything you want, but as soon as you turn 25 you're gonna be very lonely. It's impersonal, it's not filled with a lot of close relationships. It's filled with a lot of surfacey relationships. It's very plastic and I don't like it. It's almost like I'm damned if I am and damned if I'm not, I'm always going to be wondering if I am. It's the same thing (as) feeling guilt over that
effeminate side. It's feeling guilty over the part of my personality that other people would say was not being a man.

Given these sentiments, it is possible to postulate a connection between Jeff's anorexia nervosa and his conflicted feelings about sexual preference and gender identity. While these may have been a significant factor in the "choice" of this particular disorder, it is my feeling that the desire to return to his mother and the desire to return to a time when he felt safe and cared for were at least as significant in the etiology of the anorectic symptoms. Although it is true that dieting, being thin and attractive can be important in the world of the gay bars, these seem to be secondary considerations.

Jeff himself provided important data towards these conclusions:

I don't think that's (the gay world) a major reason for what happened to me, because I wasn't involved with that aspect. I wasn't going out to bars every night, I was really more out of it. But it was still on my mind, that whole part of it, the only thing I could come up losing all that weight so I wouldn't get older. It didn't work and if it was the reason, in the gay world all it ever got me was feeling hurt and alone. It never got me a relationship with anyone who really loved me or who I really loved ... but if I went back into that lifestyle, being older is better. What I mean is now if I got into it, it wouldn't be with people who cared about me because I was young, so if that was a reason, which I don't think it was, it didn't work ... the best sense I can make out of it now is that it had to do with my family ... maybe I thought if I got really sick, it would stop the world for a while and show everyone how sick and unhappy I was, and they would come and love me again, or prove to me that they loved me ... I called when I was really thin and sick (called his mother). I think I said to myself, I'm 22 years old and I can't go backwards. I can't go home to anyone. The only way I can have people in my life is to go out and make it and I don't have the energy to do that. I'm 22 and alone, maybe losing all the
weight was a way of stopping time and going back
in a way to being childlike in a way that I
couldn't take care of myself; my mother had to
come take care of me.

What Jeff hoped for was a reunion, both literally and
figuratively, with his mother, a chance to go back and rectify what
had gone wrong developmentally. He both wanted to give his mother
a chance to make up what she had not been able to do for him, and to
expiate his own sense of guilt by hoping things would go better this
time around. The severity of the disorder had necessitated that he
overcome his ambivalence about his family and had allowed him to
relinquish his independence and come home. Possibly, the anorexia
represented a creative solution to a situation which would otherwise
have resulted in a more total decompensation or a suicidal gesture.

Towards the end of May, 1981 Jeff turned his attention to a trip
to California. The limiting aspects of the disorder now became
increasingly important. He felt frustrated with all the things he
still could not do. However, he was also frustrated with living at
home and always being with his family and wanted very much to visit
his sister in California. This sister represented success to him.
She was the one who had lived through the same vicissitudes in the
family fortunes and had come through less painfully than Jeff or his
sister Barbara. She was married, had a house and a professional
position, as well as a master's degree.

Before he went on vacation, Jeff watched a television movie
about a young woman with severe anorexia nervosa. In the film, one
young woman died from the disorder. Jeff identified with this young
woman and was frightened by the realization of fatality. Yet he also identified with the protagonist who recovered. He found that seeing someone who was as thin as himself was unattractive to him. The film reminded him how difficult recovery was to be. He had watched the movie with his stepfather, but had not made any reference to his own condition.

Jeff continued to maintain the strictest control over what he ate. He did not binge, but used control as a way of insuring that he would not begin again. Binging was what he feared most. A return to binging now would have represented a severe setback for him and would have taken a giant step away from recovery. He was aware that at times, especially when he was bored or depressed, he still felt like binging. He described the urge to binge in sexual terms—"like a tension", from which the act of binging would bring release. He recognized the urge as something which occurred especially when there were other things on his mind, things which he found unpleasant or which he did not want to deal with. He understand that he had been letting himself satisfy his urges and indulge himself with food binges, but had never enjoyed them. He would then pay for the indulgence by not allowing the food to stay down. He could now recognize differences with regard to eating, satiety, and binging:

I want to be able to enjoy eating; it's a pleasure and I have realized how that there's no enjoyment when you know you're going to throw it up, but I can sit and eat dinner now and really enjoy it. I'm gonna be full afterwards and I know I'm not going to throw it up. Maybe what I have to realize is that to indulge myself or satisfy my urges, I don't always have to make myself pay for it by throwing up. I think that I don't really
deserve to do that ... I say okay, if I don't binge then I can take the money and use it to buy myself some new clothes. I've been doing that. It's an incentive and its a reward and I don't know if that's good or bad. I guess my attitude is that I never used to buy myself clothes, but I think "well, I would have spent it on this (binging) anyway".

Jeff feared that if he were not ascetic, he would be indulgent and there was no position between the two. The asceticism reflected the harsh super-ego which related to his identification with his paternal introject. There seemed to be a perpetual pattern of reaction formation to this structure, which dictated that everything had to be hard and that if he were to be in control, he had to prove that he could do without. When Jeff felt that the demands being placed on him (or which he placed on himself), were too severe, he would react against this sense and be self indulgent. Whether it was with food, alcohol, sex or drugs did not seem to matter. It was the rebellion against the sense of being harsh that was important. An important part of the therapy was to moderate this harsh sense of self and to substitute a more gentle introject in its place.

The sense of the conflict is evident in the next passage in which Jeff describes how he felt when he had reached his low weight. Although this has been discussed before, there is an increased openness and perspective on the sensitive subject:

J. I was obsessed with weighing myself. I would binge and vomit and then go weigh myself. It went on for a long time.

T. Did you have any idea that you were in serious trouble?
I think I felt two ways about it. I knew I could be in serious trouble, but I was also fighting with myself. I was scared but I still couldn't let myself gain weight. I thought I was the only person in the world this thing had ever happened to. I had never heard of anorexia or borexia (bulimarexia), it seemed to be awful and bizarre. I didn't think it would even happen to anyone, but I can remember binging and thinking, this is crazy. I should eat. I would go and really try to keep it down, but I couldn't do it. There were a lot of fears then. I'd eat and think about what if I felt hungry the rest of the day. I'd throw it up in case I got hungry later. I was afraid if I started to gain weight I'd never be able to stop it.

Looking to the present and into the future, Jeff wanted to be able to relax about food:

I want to get to the point in my life, and I am getting to that point again, where I don't want to be afraid of food. It's nothing to be afraid of ... I don't want to feel the anxiety I've felt this past year. Not just anxiety about food, but anxiety about everything; so wound up inside. I don't wanna feel that way. I want to keep getting better and I now realize that getting older is getting better. I can see that getting older is not anything to get bothered by. I have something to look forward to in a lot of ways, and besides, there's no way of stopping it even if I wanted to, and I don't want to. But being anorexic won't stop it. Being anorexic won't stop time or being sick. If that was a cry for help and a cry for love that's not the kind of love I wanna get. It's not the kind of help I want to get. I don't wanna be 94 pounds and have everyone hovering over me showing me all their love which is really their worry and their guilt. I don't want that kind of love. I want to be healthy and to be an adult. If people love me and give me a lot of attention, then I want them to do it for the person I am, not because I'm sick.

In short term therapy such as this, questions can be asked about symptom relief versus deeper structural changes. Jeff had experienced
partial symptom relief. He was no longer binging, and although he continued to strictly control his diet, he found it increasingly frustrating to have to do so. What seemed remarkable was the amount of change that took place in his attitude. The above passage clearly reflects this shift. Inherent in the last sentence is the idea that there is a person who is worthy of being loved and cared for. This is a far cry from the angry young man of a few months earlier, who didn't even know he was angry but who had acted out or was in the process of acting out his feelings of low self worth with every form of self-destructive behavior. Jeff recognized these changes in himself, saying that he felt less "closed up" than he had for a long time, less trapped within himself.

The issue of food and eating was now of paramount importance. Jeff was basically able to manage by sticking to a routine way of eating. He would eat the same thing at the same time each day:

I want to get to a point where I don't think about it, though in that routine and that pattern there's also a sense of safety. I know that if I stick to the routine and the pattern I can make it through the day, no matter what. I know in my mind that if I stick to that pattern I won't be hungry ...

He worried about having to eat in restaurants and in the company of other people while he was on vacation. Yet, there were indications that he was not being as strict or as harsh with himself as he had been previously. He was able to say that if he didn't feel ready to go out to eat, he could accept that, since he knew there would come a time when he would be able to go out. This was the first concrete indication that he was developing a more gentle attitude towards
himself, one which implied a greater trust in his own internal capacities than he had ever shown.

He now juxtaposed dealing with eating and dealing with his emotions:

There's the fear that I might not be able to deal with things like having to eat in restaurants. I guess I know in the back of my head that I will be able to deal with it. One thing that's been good is that food and eating haven't been very important to me lately. I mean I'm hungry and I'm eating. I think I'll be able to deal with it. I'm not really that afraid of gaining weight, because I've gained weight. I've gained about five pounds. I guess I'm just not so afraid of it. I know that now. It's the same thing with my emotions. I know that I can deal with certain things now. I don't let them overtake me and it would be the same thing with eating. I really feel that I wouldn't be carried away with it ... I'm going to make myself go out to eat. I'd be really nervous ... real conscious of my order. I wouldn't order the most fattening thing on the menu. I couldn't do it and I probably wouldn't enjoy the meal, but I think I'd go through it and I'd be nervous, but I'd get through it and find that it was all okay and the next time it would be better. I think part of it is that I wouldn't know what to order. I'd be afraid I'd eat too little because then I'd be hungry later. The fear is that I don't have complete control over it, that's the nervousness. I guess what I'm really afraid of is that it's a new situation, which is why I should make an effort to do it (go out to eat) before I go, so it won't be a new situation. It means breaking my normal pattern. What I'm afraid of is anything new, it's not just eating, I'm afraid that it won't work out and for some reason I'll go back to binging.

Jeff had become afraid that anything which upset him very much would lead back to binging. Each new event--a period of depression, an argument with his sister--threatened to trigger a binge. Each time this did not occur, Jeff was more readily able to identify the
feelings in the situation which were troublesome. The fear began to abate.

Weight recovery was another matter. Although Jeff professed to have gained five pounds, he did not appear to have gained anything. While he said that he was not afraid of gaining weight, he did not recover any appreciable amount of weight at the time the therapy ended. One year later, on follow up, he was considerably heavier and said that he had gained over thirty pounds. At this weight he was far from fat, but had lost his skeletal appearance and looked much better. If the therapy had continued, a more active approach to weight gain might have been possible.

His fears about the vacation persisted until he actually went. Jeff felt that:

... I would rather try it and go back to binging than not try it (the vacation) and not take the chance. There are times (now) when food becomes not important to me. Sometimes I'm afraid to not let food be important to me because then I don't know what will be important to me. I don't want it to be important, but it is. Sometimes I think if it's not important to me then nothing will be. I want something to be important to me. I want something to focus my energy on. I'm really energetic and I can't sit still ...

T. Before it seemed that you wanted food to fill you up, but at the same time you couldn't let it because you had to be so careful.

J. In a way, I wanted it to be the most important thing in my life ... Before, there was just nothing else important to me, but now there is. Relationships are getting more important to me. It is going to get easier (to relinquish his preoccupation with food) if I let other things become more important to me ... (Before) the whole time, even
when I wasn't binging, I think my head was just in a fog. Maybe it wasn't in a fog, but I was always thinking about food, whereas now, more and more I feel like myself. I feel like I did two or three years ago. I'm getting excited about things, wanting to do things and before, I wasn't thinking clearly for a long time. Even when I wasn't binging I was very depressed. I think it's really important, the part about food being so important to me and not being able to think about anything else. There are two things for me to keep in mind on my vacation. One is that I know now there are certain things I do; when I don't wanna do something I put all my energy into thinking about food. If I start really dwelling on food when I'm not hungry, I can say to myself, look, what's really wrong. I know that now I'm not gonna focus all my energy into it. I've seen that I can face up to a lot of those things and they don't overtake me. Now I really do have the attitude that it's worth taking a chance. It's all worth taking the chance and going to California and taking that vacation. Other things are going to be very important to me. It's worth taking the chance and getting away and hanging out and going out and having some fun and letting the people I care about become more important to me than having to stick to that routine. I decided the day I stopped binging that if I do start again, then I guess it's okay, and I'll be thankful for the time I've stopped because my life has been so much better.

With this, Jeff left on vacation. We would not meet for three weeks.

As the focus of the therapy became more interpersonal and historical, the issues of intimacy and trust manifested themselves clearly within the therapeutic relationship. The more Jeff was able to tell about himself, the more he felt that there was someone who could accept him for the way he really was, rather than the persona he projected. The greater the trust in the relationship, the less
he needed to structure and control the sessions and the more he was able to share openly. There was a feeling of shared intimacy within the sessions, yet there was still a certain guarded quality, as if the intimacy could become too great at any moment.

From a regressed state of depression, Jeff made many steps towards regaining his independence and individuation. He had found a job, was able to stop binging, was able to enjoy going out and was now able to tolerate being on his own. He confronted feelings which for many years he had repressed and denied. Each of these steps took him further towards recovery. He seemed to want to prove that his new found gains were real. The vacation in California was an important test of how far he had come in the months we had been working together.

As far as he had come, there was still much to accomplish, particularly with regard to his many unresolved feelings about his mother. Although he had felt cared for when he first returned home, as time went on he was increasingly dissatisfied with her. It is possible that he was similarly dissatisfied with the therapy at this point, although he gave no indication that this was so. It is also probable that I had assumed the role of his mother in the transference, although this was never fully explicated. In this sense I too could not fulfill his expectations and become the perfect mother. The intimacy that developed in the therapy was cause for conflicted feelings, and in his reaction to these ambivalent feelings, Jeff followed an old pattern. He left when he was afraid of losing control or being overwhelmed.
Termination

Jeff returned from vacation very tanned and blonde, looking much like a southern California surfer. He said that he had gained a full six pounds while away, but did not appear any heavier. He was very cheerful. He reported that he had felt like his "old self" once again. There had been some problems and anxieties about food, but he had been able to overcome them better than he expected by being in situations which forced him to act appropriately. He had eaten out, had eaten conventional amounts of food and had enjoyed himself.

He also returned feeling very strongly that he no longer wanted to live at home and work at a job he didn't like. He wanted to go back to California to live and had made up his mind that that was what he would do. He had essentially returned home to quit his job and to say goodbye to his family and to me.

While in California, he had had at least one sexual relationship; something he had not had for a year and a half. He had decided that like it or not, for the moment he was gay, and that California was the place to be. He no longer felt that he had to be alone and, for the moment, felt that he could accept his sexuality; felt that staying at home, he would slip back into being reclusive, never going out and having no friends. He was pleased that he had been able to overcome the sense of isolation which he had imposed on himself for so long. He intended to leave, he said, in a little over two weeks.

Much of his desire to leave had to do with his feelings about
his family. While in California, he had spent a great deal of time thinking about them. He felt:

... I don't want them to be an important part of my life. I love them. I need them. But I don't want them to be an important part of my life. I can't overcome that. My avoiding eating with them was a way of keeping distance. I don't think even with years of therapy, I could work out all my feelings about my family. I just have to accept that. I love them and I do need them, to really be close to them ... and that's not really that bad. I don't think that that's bad. In some ways I felt I had to stick it out and stay with my family until I really loved them and could let them be part of my life. I don't think that necessarily true. I think maybe being better is being able to realize what the situation can be and what it can't be. The other thing that brought me to it is that I don't want to live with a group of people or make them the biggest thing in my life, when I can't share my life with them, like having to avoid eating dinner with them. I really enjoyed eating dinner with my sister and her husband, and I don't want the biggest thing in my life to be my family if I can't let them be part of me. I do want to be part of something. I do want to be close. I do want to have that kind of relationships, and I don't think they could give it to me and I don't think I could accept it even if they could. I think getting better is realizing what you're capable of, and maybe, what you're not.

T. Or what they are and what they're not?

J. And I love them, but I just can't make them the most important thing in my life. I can't let that happen. As long as I'm in that situation, I'm going to keep building those walls there. It keeps me feeling kind of empty and kind of lonely, because I'm part of something yet I'm not.

Jeff felt that he had to act immediately, that he had lost over a year of his life to this illness and he did not want to waste any
more time. He felt strongly that he needed people in his life and that they had to be relationships which felt important to him, i.e., ones in which he could share himself. He wanted friends and he wanted to be able to go out and enjoy himself.

He had many anxieties about the move, but an important part of it seemed setting a challenge for himself and being able to take the risk. In this case, the risk was considerable, because Jeff felt strongly that he could not again end up in a situation where he had to come home to his mother.

Jeff was leaving with a considerable feeling of anger. He was angry at his job, and felt that his employer had treated him badly, and he was angry at his mother, for much the same reason. His anger was now quite open:

(I'm) angry at my mother. I think mainly angry because I've realized a lot of things. I realize I think her priorities in life are really screwy. I realize that I don't like her values. I realize that I've been angry at her for along time. She's a funny person. She chose time and time again other things over her children and then she thinks that whenever she wants her children she can just go like that (snaps his fingers). Well, you make your bed and you have to lie in it. I wouldn't say these things to her. There's no sense in it. There's no point in it. I love her, but I think the woman's a mess. She always placed my father before her children. Well, that was one thing, and she placed Bill before her children. Then she placed her living room furniture before her children.

But Jeff was also angry at himself. Angry because of what had happened to him. Angry because he felt he had been wasting his life for the past year by being so very preoccupied with himself and with food. Although the therapy came to an end before he could work
through his anger at his mother, Jeff was able to begin to come to terms with the anger that he felt towards himself before therapy ended. He began to have the sense that he had been punishing himself, and when asked to think about what had happened to him, he gave the following description of his experience:

Well, I think maybe part of it comes from punishing myself. I think maybe that was where some of it came from. I didn't have that outlook on it before. I think that a lot of this year was punishing myself for things that I thought I did; that I was and for the person that I wasn't but should have been. I think the most important thing for me to remember is that I can change some things, and do have the ability to change things. At the same time, I have to accept who I am and make the best of it. There's nothing wrong with that. That's okay. That if I choose to be, whatever I choose to be and wherever I choose to go with my life, it's okay. I don't have to be punished with my life, it's okay. I don't have to be punished for the bad decisions I've made, and the things in me or my personality, because they're normal, they're there. I can work on them, but I have to accept myself for who I am.

When asked why he might have been so punishing to himself, Jeff attributed it to the failure of his relationships with Bob and Edie and to his guilt about the end of these relationships. He felt that he had disappointed Edie because he did not want to sleep with her, or have a permanent relationship with her. He felt like he had played a dirty trick on her and felt that he had to punish himself for what he had not been able to do for her:

I couldn't fall in love with her and get married and have a bunch of kids. I couldn't even sleep with her. And I think I started punishing myself for that. Another thing that has helped was that I did need to come back. I did need to do what I've done. But I also see now that some things you can't really work out.
These last words were said very sadly, very softly. In the session which followed, Jeff's attitude reflected the complexity of the ambivalence he felt about leaving his mother. He was aware that he loved her in his own way but he found her hard to be around and hard to deal with. Jeff recognized that in the past, when things had not worked out to his satisfaction he had had a tendency to bolt, and he recognized that some of this was present in his wanting to leave so quickly for California:

I get very frustrated because I don't want to run away from them ... but I realize that I'm still partly running away from them. I just wonder if its different in the sense that I accept them, and I do love them. It is a love and I do need them in my life. But I also see now that no matter how many years I'm in therapy, I don't think I'm ever going to really accept them, or really feel a lot of warmth to them. I love them, I need them, but the feeling of warmth toward them is missing. I don't know if that will ever change. I don't want to run away from them all my life and I don't want to run away from them now. I'm leaving them because they're not enough for me.

The thing he most feared was that he would have to come home yet another time because he could not make it on his own. He wanted very much to return to being on his own as a way of reassuring himself that the worst of the disorder was over. Being independent was synonymous with recovery. Now, however, Jeff realized something which he had not previously been aware of—that safeguarding his independence had been a full time job, one which had kept him away from other people.

Independence had been equated with being alone, and had required him to maintain a vigilant attitude over his relationships with other people. Anyone who threatened to come too close threatened his sense
of independence.

In a sense, the worst had happened and he had survived it.

Leaving home this time was an important step:

... to me what would be a big step backwards would be to go out there and have everything fall apart. I don't think I could handle failing and falling on my ass again. You know the hardest thing about this past six months, year, is that I've always been able to take care of myself. Maybe not always very well, but I always managed to take care of myself. That's why I've never really gotten involved with anyone, 'cause I can take care of myself; not someone else. I feel like I failed so miserably. I lost all my self respect because I failed so badly, because I had to come home to my mother, because I couldn't take care of myself any more, physically, mentally, anything. I feel like I lost my sense of dignity and my sense of pride because that's where I always got it from. I realize now that you do need other people to help and that's another side of it.

Jeff was leaving without being cured, but he now knew what the trouble signs were and how to seek help. Although he was less strict with himself, he still could not bring himself to eat foods he knew to be fattening. Certain foods reminded him of binging and he would avoid eating some kinds of ice cream for this reason. We agreed that it would be an improvement for him to weigh 130 pounds, although at 130 he would still be far from heavy. Another goal was to be able to be more relaxed about a meal, to be able to let down the vigilance around food and eating that he still maintained.

When he left he was no longer depressed. He had things to do with his life, things to look forward to. Although he had not worked things out with his family the way he had hoped to, he left with a sense that his family was important to him, although he could not be
part of their day to day lives. He understood that there was a place for him there, but that it was not an easy one, since it meant that he had to work out his differences with them. He understood that he could be different from them, and that in some ways, he was like them too, but that the similarities were not as terrible as he had feared. In short, his attitude toward them was more realistic. More important, he left with a more consolidated sense of self; and a sense that he was not as bad or need be as guilty as he had felt before. He was less harsh and able to accept himself much more.

In leaving, he talked about the therapy and what it had meant to him, saying that it had been the only consistently good thing in his life over the past months. However, much a with his family, the work of the therapy was not enough to keep him from leaving the area, and in spite of the fact that he knew there was more for him to do, he was anxious to be on his own again. He felt that we would be able to come back to therapy if he returned to the area, and he knew how to contact me. In the event that he wanted to pursue therapy while in California, I would be able to give him some referrals. He was very grateful for the relationship and grateful for what he had been able to learn about himself. The therapy ended on this note of gratitude.

In a therapy which ends prematurely, the therapist has a great deal of sorting out to do; sorting out issues which may have played a part in the termination, sorting out what was accomplished and what was left undone. I found too that there was a need to determine what part my own actions had played in the termination, and wondered what,
if anything, I could have done to prevent it. At the time, I believed that Jeff's angry feelings towards his mother, and his disappointment in her attitude towards him were the most significant factors in his departure for California. Not only was he running away, I thought, but he was recreating his departure of eleven years previously. His attitude, once again, seemed to be that if he could not be properly cared for, that he would have to go off and make it on his own.

While I think now that this is true, I think it is only a part of the picture. Jeff had a strong need to regain his independence. He needed to regain his sense of pride at being able to be on his own and he needed to feel that he was healthy enough to be able to live this way again. He had a strong need to feel that he was in control of the anorexia, and since he equated the disorder with having to come home, being cured meant being able to be on his own once again. This was also a significant factor in his leaving for California.

Looking back, I think that a great deal was really accomplished in this short term therapy. If the issue of his anger at his mother could not be dealt with, if it was left unresolved, Jeff left with the awareness that these uncomfortable feelings existed and were an important part of the way he felt about his family. He no longer had the need to keep them separate. He was able to acknowledge his anger, even if he could not deal with it. He was able to be sad as well as angry about the role of his family in his life.

He had been able to integrate a great deal. His feelings about his father as well as his identification with the harsh side of his father were more available to him; and his feelings about himself were
less harsh and more understanding. He had begun to trust himself to a considerable extent and as he did this, he had begun to relinquish pieces of the control that he had used in such a defensive way for so long. He had made a connection between his feelings and his eating; especially between feeling needy and the feeling that he would never be satisfied. He understood that for him, food had become a metaphor and that if he could deal with his feelings head on, he would not need to be so preoccupied and obsessed with food and eating.

It is not clear whether Jeff will have satisfactory relationships, or whether the element of never being satisfied will always be present. Certainly, this attitude, left uninterpreted, played a part in his premature termination of therapy. With hindsight, I would go back and interpret this aspect of the therapy more vigorously than I did at the time. Even so, it is not possible to say whether the therapy would have continued, or whether Jeff needed more time to develop and mature in order to be able to deal with these issues.

Countertransference

The term countertransference is used here in the broadest sense possible; to encompass the total range of the therapist's reactions. Therapy with Jeff elicited strong feelings from the very beginning. It is only in retrospect that I have been able to see how anxious I felt with him initially, both because of his skeletal appearance and because of the severity of the disorder and the possibility that it would be fatal. I responded to this anxiety by reading everything on
anorexia nervosa that I possibly could. My supervisor's suggestion of a trial period to see whether it was a case that could be treated in an outpatient setting such as the one I was in enabled me to regain a sense of my own control of the situation. For a brief period I understood all too well the feeling of lacking control in a situation where one was supposed to be in control, and this recognition provided a way to empathize with Jeff.

It was not difficult to establish a relationship with Jeff. He was an extremely pleasant young man and it was easy to see how he had been able to form so many relationships, even if they were casual ones. It was obvious that he wanted to form a relationship with me, and gave every indication that it was important to him to do so and that he was willing to comply with the terms on which I said the relationship had to be established, i.e., that he not lose any more weight and that he keep regular contact with a physician and enable me to have regular contact with the physician as well.

Once the relationship was established, however, I began to feel that there was something superficial about the compliance, and began to feel that this was a way for Jeff to maintain control over the relationship. Jeff's ambivalent feelings about closeness and distance were quickly recreated in the therapy and were perplexing and frustrating to me for quite some time. On one hand, he was clearly asking for help. On the other hand, he was extremely self protective and would withdraw from areas of discussion in which he felt threatened. He was difficult to pin down. There were discrepancies in his stories, about his weight at its low point, about when the
various points in his illness had been reached. At times I found him evasive, "stand-offish"; at other times, he seemed to be saying "do something". I began to feel that I had become a mother to him in the transference, although this was not explicitly stated. He did elicit maternal feelings from me, and at times I understood very well how he made his foster parents feel when they tried to help him and repeatedly failed.

Yet I did not feel that I failed, because Jeff made steady progress throughout the therapy. Jeff was never demanding in the manner of borderline patients I had treated; his demands by contrast were much more gentle, less strident. Although I felt frustrated by his evasiveness, I felt satisfied by the overall progress that was made. As the therapy progressed and Jeff became more open and less guarded, I was encouraged by his progress and was able to encourage him in turn. As time went on, I began to feel a considerable sense of admiration about his feelings and his life. I think the fact that I genuinely cared about him and liked him was an extremely important factor in the therapy, since I believe it was this sense that Jeff internalized. The fact that I could be gentle with him when he was harsh with himself enabled him to internalize my sense of him, and eventually, he began to use this internalized image to modify his own harshness about himself. In respecting him, no matter what he told me about himself, I believe that I was able to facilitate the growth of his own respect for himself. Since it was obvious that Jeff needed to be able to control the closeness and distance in the relationship, I was careful not to overstep boundaries. In this one,
it was important to demonstrate that a relationship could be close and still maintain boundaries, something which Jeff had never before experienced. It was, therefore, important to me that he perceived me as genuinely interested in him but not as overwhelmingly so.

I became upset when Jeff told me, after the fact, that he had been binging to the extent that he had, since I felt that he had put both of us in a position where his life might be jeopardized because of metabolic imbalance. I felt as if I had been helpless, because he not only told me about it while it was happening, but only when he had been able to stop.

Even now, it is difficult to say how undertaking this project affected my feelings toward Jeff. I prefer to think that this project was undertaken precisely because of the feelings I already had for him. In undertaking to write about Jeff, very little changed, except that I began to record every session and to keep the tapes, instead of destroying them as I had done with some of the earlier ones. I did feel that Jeff was special, in part because he was the exception to the rule, a male with anorexia nervosa; but also because of his pathos and because the issues that he was dealing with were so very fundamental. I have seen a considerable number of patients with eating disorders since Jeff, but with only one of them (a young woman from an upper middle class family, who was much closer to the traditional image of the anorectic patient) did I feel the way I did about Jeff. He had an extraordinary capacity for insight and he used the therapy well. There was scarcely a session where he did not refer to something that had been said previously. It was clear that our
work together made an impact on him and that in between meetings, he would continue the work of the therapy.

This is not to say that working with Jeff was easy. His difficulties with closeness and distance, his desire for intimacy and his fear of it created a feeling that there was an edge to the therapy, a kind of fine line which had to be walked, such that intimacy would develop but in such a way that Jeff could tolerate it. Because I felt this edge, I think I was more hesitant to make transference or even relational interpretations than I might otherwise have been. I took seriously, perhaps too seriously, Jeff's statements about being the one to run away once he felt that any demands were being placed on him. Hearing this as a caveat, I may not have challenged him enough; instead, I aimed my interpretations at what I was sure he could tolerate.

Jeff's return from California and his announcement of an imminent departure were initially quite shocking, although there had been indications on numerous occasions that such a "bolt" was possible, so that although I may have been shocked, I was not altogether unprepared. I felt, as Freud did when Dora announced her departure precipitously, that I had failed to interpret these stirrings sufficiently and that there was some vengeance toward me in the act of departure. Just as with his mother, I felt that Jeff was telling me that I too had failed to keep him in therapy and for a long time afterward, I wondered whether there were not things I should have done, or could have done that would have altered the course of events. At the time, there was a feeling of disappointment, but also a sense that it was important
that Jeff feel that his decision to leave was acceptable to me and that I respected it. I felt that it was important that Jeff be as aware as possible of the various feelings that had contributed to his making the decision and was gratified when he could see that he was in some ways running away. I had many feelings about the fact that Jeff was leaving before the work of therapy was done. Although I knew that we had explored many important issues, I felt that there had only been partial symptom relief, i.e., Jeff had been able to stop binging, but had not been able to recover weight. However, I had made a decision at the beginning of the therapy not to insist on a specific amount of weight to be gained, as long as no weight was lost, feeling that as long as Jeff was in no physical danger, weight would be recovered when certain dynamic issues were resolved. Of course, I did not know at the time that Jeff actually was in danger, because I did not know about his frequent binges and subsequent purges.

It has now been three years since the therapy with Jeff began and in listening to the tapes and transcribing the session, I have become aware that if I were to undertake such a therapy at this time, I would do some things differently. I would definitely increase the frequency of the sessions. Once a week was too little, I think, and may have contributed to Jeff's feeling that there was "not enough" therapy for him to remain longer. I feel too that I would now be more interpretive and more confrontative, challenging him when there were discrepancies, etc.

On the issue of weight gain, I remain undecided. With a less severe anorectic I do not think I would make an issue of it at the
onset of therapy. If the therapy was to continue for a longer period of time and I felt that there had been sufficient work so that the individual would not be too threatened and if sufficient collaboration had been established, I might suggest a program of weight recovery. This is an area in which there are few guidelines. With a patient as severely disordered as Jeff, a period of hospitalization might be in order, so that he could recover weight before outpatient therapy began; or, if that was not possible, perhaps the physician involved in the case might function as a behavioral administrator and monitor weight, blood pressure, etc. on a weekly basis, and discuss matters related specifically to food and eating, caloric intake, nutrition, etc.

Follow-up

It was extremely important to see Jeff in person for a follow-up interview, to know what he actually looked like. Almost one year after the therapy ended, I found an occasion to visit friends in California, quite near to where Jeff was living. I wrote to him, telling him about my visit and asking him if he would like to meet. He responded enthusiastically.

The follow-up interview took place on June 15, 1982. Jeff was working as a clerk and we met at lunch time, near his place of work. He decided not to eat, however, but we got some coffee and went to a beach nearby to talk. The first thing that I noticed about Jeff was that he had gained weight and looked much healthier than he had previously. He said that he now weighed about 140 pounds. He had
allowed himself to gain weight only after he had been in California for about six months. He had wanted to look better and felt that he did at his new weight. More important, he had begun to realize that he was on his own in California, and that there was no one to fall back on if he should get sick, the way there had been when he lived in New York. In California, he felt more in control of his own life, but recalled that he had had many "delusions" about being in control during the active period of his anorexia. Jeff could not allow himself to reach his pre-morbid weight of 150 pounds. When he first discussed this in therapy, he said his pre-morbid weight was approximately 140 pounds. Although he was able to eat with people in restaurants (he didn't demonstrate it), he said he did not feel the anorexia had left him completely. He still watched which foods he ate and would choose fish rather than a steak if offered a choice between the two.

Jeff reported that he had had periods of binging and purging since his arrival in California, but felt that these had occurred primarily when he wanted to push other disturbing things out of his mind. There had been three or four times in a ten month period and Jeff was able to accept that this was not an indication that he was reverting to his anorectic behavior. On the other hand, it suggested the possibility of a chronic form of anorexia with bulimia which would recur at intervals over a long period of time. In Jeff's own opinion, there was one level of health which he had not been able to reach; this was the point at which he could give up his preoccupation with food, dieting and with weight. He attributed some
of the reason for this to his being gay, as there was much emphasis in
the gay community on "looking good" and being thin.

Jeff had had some trouble accepting himself as gay but said
there was no doubt in his mind about his sexual preference. He was
currently involved in a relationship and was trying to decide whether
he wanted to live with his friend but felt that he still had problems
with close relationships and was not sure.

He had had several periods of severe depression since he had
been in California, which he felt were caused largely by feelings of
loneliness and the lack of relationships. He had problems being
intimate, he said and recalled that intimacy was one of the
outstanding factors in the therapy. When he asked me what I
remembered about it, I corroborated his sense that intimacy had been
an important factor by saying that for me it was the experience of
watching him become increasingly able to have an intimate
relationship, watching "layers peel away". Jeff confessed to having
been frightened at what was happening in the therapy, as much as he
wanted the relationship. Clearly, he continued to have problems with
intimacy and his ambivalence about being close to someone had not
been resolved. His impression was that at the point the therapy
terminated, we needed to talk less about his anorexia and more about
other life problems such as intimacy and this had frightened him.
His sense was that he had become anorectic because of the two
relationships which had been important to him and which had not
worked out and because both of his friends had been concerned with
their weight.
Jeff also said that although he knew he was much heavier than he had been, he could not see any difference between the way he looked at 140 and the way he looked at 115 pounds. This distortion of body image was extremely interesting, since Jeff had been atypical in maintaining that he was too thin throughout the therapy.

When I asked Jeff whether he saw his sister who lived nearby, he shook his head and said that things between them had not worked out. His sister and her husband were afraid he would "get sick" and become dependent on them. He remarked that his family members were all so distant from each other that sometimes months would go by without any contact; then at times, he would call every week. Yet, when I had telephoned his mother to get his address, she said they were in contact by phone about every two weeks.

Our meeting lasted about 90 minutes, and ended with an open invitation to stay in touch. I have not heard from him since and at this time, have not initiated any further attempts at follow-up.
CHAPTER IV
SURVEY OF THERAPISTS

Introduction

The following survey was undertaken in order to learn more about anorexia nervosa in males—how clinicians view this disorder and how they treat it. Some of the information is about the treatment of anorexia and bulimia in general; some of it is specific to these conditions in males—the rare case. A survey seemed a way to get the broadest perspective possible. Letters were sent out to therapists throughout the United States, Canada, England, Sweden and Australia.

Many of the questions included in the survey evolved directly from the case study presented above and represent issues in that particular case. When these questions were considered, a survey appeared to be the best way to find out what other clinicians were doing. With this in mind, I decided to send letters to those clinicians who had some demonstrated expertise in this area—therapists who had published articles on the subject of anorexia and bulimia, therapists who either worked or trained at a facility with a special eating disorders unit, or therapists who, within their particular institutions, had achieved a measure of recognition for their work with these patients. An interesting by-product of the survey is information about who these people are, what their training has been, where they work, and what kind of treatment approaches
they favor.

It should be stressed that the survey was designed to put the case presentation in perspective, and therefore does not represent the major focus of this dissertation. It is hoped that the information presented here will serve to strengthen the conclusions that can be drawn about anorexia nervosa in males and about the treatment of eating disorders in general.

Method

Respondents

Participants were selected on the basis of published journal articles, work or training experiences on a unit which specialized in the treatment of eating disorders, or work in an agency where they were likely to be the person who would have contact with such patients (e.g., a college mental health service). In all, 102 survey questionnaires were sent out. Four were returned when the addressee could not be located; thirty-five were returned completed; and five were returned without being completed. One person wrote that he could not answer because most of his work involved evaluation rather than treatment of anorectics; another wrote that the data requested was in his computer but he had not yet processed it; another returned a personal letter describing the two males that he had seen with eating disorders during the ten years of work he had done with college students, but said that he did not feel that either of these students could be called anorectic or bulimic; finally, two other participants did not complete the survey but included their own publications on
the subject. One female analyst who did so included a note saying that she had never seen an anorectic or bulimic male in the thirty-seven years she had been in practice, and felt that the development of such a condition in a male had "different implications" from these symptoms in a female. She did not specify further, unfortunately. Based on the ninety-eight people who received questionnaires, the total of 40 people who responded represented a return rate of approximately 41%. When only the thirty-five completed questionnaires are considered, the return rate is approximately 36%. In the analysis of the data which follows, only these thirty-five respondents are considered.

A copy of the survey is included in Appendix C. In Part I, respondents were asked to specify gender, the type of setting in which they practice, their major therapeutic orientation, mental health discipline, highest degree earned, and number of years they have worked at their present level of training.

In Part II, respondents were queried about the number of anorectic patients they had worked with, the number of patients who were both anorectic and bulimic, and the number of bulimic patients they have had. They were asked how many (if any) in each of these categories were male. They were then asked to give an opinion about whether anorexia and bulimia are clinically different when they occur in males and females, and to explain why this might be so. Finally, they were asked how they work with this patient population—e.g., individually, in groups, families, etc.

In Part III, specific questions were asked about the techniques
these clinicians use when working with anorectic and bulimic patients. Do they discuss nutritional issues, monitor weight, offer consultations to parents, etc.? The results of this section are summarized in Table 2. Respondents are also asked what they do when a patient's weight drops below a certain point.

Part IV attempts to gather more detailed information about males with anorexia nervosa. Respondents were asked to describe the age at onset, the age at inception of therapy, the percent of total body weight lost, the amount of weight gained during the treatment, the duration of treatment and whether the patient was also bulimic for each male with anorexia nervosa that they have treated.

Procedure

Questionnaires were mailed to participants with a letter explaining the nature of the project and enclosing a stamped, self-addressed return envelope. In those instances where the participants were outside the United States no return postage could be included. A copy of the letter which accompanied the survey is included in Appendix C. Respondents were asked to return a slip with their name and address if they wished to receive a copy of the results of the survey.

When addresses were not available, phone calls were made to the institutions at which the prospective participants worked and a request was made for the correct mailing address for the specific individual. This information was obtained from the department secretary. In no instance was the participant telephoned directly.
Results

Results of the survey have been divided into three areas: demographics, treatment practices, and information about males with anorexia nervosa. The presentation of the results has been structured according to these topics rather than following the strict format of the survey in order to avoid repetition and to present the results in the most informative way possible, and so as to focus on the two main research questions: what do other clinicians do when faced with the complex and difficult issues involved in the therapy of patients with severe eating disorders; what information could be gathered about males who are included in this predominantly female population; and have other clinicians had cases and treatment experiences similar to the case presented in this dissertation?

Demographic information

Of the thirty-five clinicians who responded to the survey, twenty-five (71%) worked in inpatient hospital settings, while ten (29%) treated patients on an outpatient basis. Fourteen (40%) regarded their major theoretical orientation as psychoanalytic or psychodynamic; twelve (34%) regarded themselves as eclectic; five (14%) saw themselves as cognitive and/or behavioral therapists; three (9%) said their primary orientation was family systems; and one (3%) woman said she was a phenomenologist.

Fourteen participants were psychiatrists (40%); sixteen were Ph.D. level psychologists (46%); and five held other degrees: Psy.D., Ed.D., M.S.W., and M.Ed. Ten of the respondents were female
(29%) and twenty-five were male (71%). They had been practicing at their present level of training from between one to thirty years, with a median of 7.8 years.

The number of anorectic patients (both sexes) seen by the thirty-five clinicians in this sample was approximately two thousand one hundred and ninety (2190). However, even among this group selected for their apparent expertise and interest in this particular problem, fourteen therapists (40%) had treated eight or fewer patients. Another eleven therapists (31%) had seen between ten and forty anorectics, while ten clinicians (29%) had evaluated and/or treated over one hundred anorectic patients. In all, the range of experience among these clinicians was from zero to five hundred patients. The median number of anorectic patients treated by the therapists in this sample was twenty. The results of this question are summarized in Table 1.

When asked about the bulimic patients they had treated, results were similar. The thirty-five respondents had treated a total of one thousand four hundred and forty bulimic patients (approximately) with a range from zero to four hundred cases. Again, in this group, twelve clinicians (34%) had seen under ten bulimic patients; thirteen (37%) had seen from ten to forty such patients; two (6%) had seen between forty and one hundred bulimics; and eight (23%) had seen over 100 bulimic patients. The total range of experience with bulimic patients was from zero to more than four hundred patients. The median number of bulimic patients treated by the therapists in this sample was fourteen. These results are also summarized in Table 1.
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Numbers and Percentages of Anorectic, Bulimic and Bulimarexic Patients Treated by Clinicians for the Sample.
Anorectics who were also bulimic (bulimarexics) were found in approximately 32% of the anorectic patients. The total number of bulimarexics estimated by the clinicians in this sample was approximately seven hundred, although this number may not be exact, since several respondents \((N = 3)\) failed to answer this question. Twenty-one clinicians (60%) had treated less than ten bulimarexics; eight (23%) had treated between ten and forty patients; another three (8.5%) had treated between forty and one hundred; while another three (8.5%) had treated over one hundred anorectic patients who were also bulimic. Thus, in this sample, clinicians treated anorectic patients more often than bulimics and bulimics more often than bulimarexics. These results appear in Table 1.

**Treatment**

The majority of respondents utilized individual therapy as their primary mode of treatment. Thirteen clinicians (37%) indicated that they preferred to work individually; another five (14%) said that they utilized primarily individual and family treatment combined; four (11%) used group therapy as a primary treatment modality; while the remaining thirteen clinicians (37%) said they used a variety of treatments: individual, family, group and drug.

Responses to questions about what actually goes on in the treatment of anorectic and bulimic patients appear in Table 2. When the data of this table were related to other variables (by way of the chi-square analyses), some interesting and significant results emerged. For example, the issue of discussing diet, appears to be more
TABLE 2

Aspects of Treatment With Anorectic and Bulimic Patients

<table>
<thead>
<tr>
<th></th>
<th>Regularly</th>
<th></th>
<th>Sometimes</th>
<th></th>
<th>Never</th>
<th></th>
<th>No Reply</th>
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<td>%</td>
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<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1. Discuss diet; nutrition; caloric intake</td>
<td>16</td>
<td>46</td>
<td>16</td>
<td>46</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Discuss weight</td>
<td>22</td>
<td>63</td>
<td>13</td>
<td>37</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Monitor weight</td>
<td>14</td>
<td>40</td>
<td>12</td>
<td>34</td>
<td>9</td>
<td>26</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Prefer to work with a physician who monitors weight, nutrition, caloric intake</td>
<td>13</td>
<td>37</td>
<td>11</td>
<td>31</td>
<td>8</td>
<td>23</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>5. Refuse to work with a patient whose weight drops below a certain point</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>26</td>
<td>20</td>
<td>57</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>6. Discuss self imposed dietary restrictions; binging and purging; use of laxatives, etc.</td>
<td>23</td>
<td>66</td>
<td>12</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Encourage not to keep track of circumstances surrounding food restriction, binging-purging</td>
<td>20</td>
<td>57</td>
<td>13</td>
<td>37</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. Discuss psychological effects of starvation</td>
<td>23</td>
<td>66</td>
<td>9</td>
<td>25</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Regularly</td>
<td>Sometimes</td>
<td>Never</td>
<td>No Reply</td>
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<tr>
<td>9. Discuss medical consequences</td>
<td>26 75%</td>
<td>9 25%</td>
<td>0 0%</td>
<td>0 0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Prefer not to discuss issues pertaining to food and weight</td>
<td>0 0%</td>
<td>8 23%</td>
<td>24 69%</td>
<td>3 8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Consult with parents about the patient's diet, weight, eating habits</td>
<td>13 37%</td>
<td>20 57%</td>
<td>2 6%</td>
<td>0 0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Feel that matters related to food are best left out of therapy or discussed only briefly to allow for focus of therapy to be on the more dynamic issues related to eating disorders</td>
<td>1 3%</td>
<td>11 39%</td>
<td>23 66%</td>
<td>0 0%</td>
<td></td>
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</table>
frequently done during inpatient treatment ($p = .02$), while therapists appear to be more likely to actively monitor weight if they work in a hospital setting ($p = .01$). Approximately 60% of the outpatient therapists in this sample reported that they never monitored a patient's weight, while only 12% of inpatients therapists never did. Therapists working in hospitals were also more likely to discuss the psychological effects of starvation with their patients ($p = .03$) while both inpatient and outpatient clinicians discussed the medical consequences of anorexia and bulimia with their patients at least some of the time. Inpatient therapists appeared to consult with therapists parents more regularly than outpatient therapists, but this difference was not significant ($p = .10$).

Sixteen respondents (46%) did not think that anorexia and bulimia in males were different clinical entities than when these disorders occurred in females, while ten respondents (29%) thought they were clinically different, and nine (25%) were not sure. When asked to explain their responses, three of those who indicated negatively pointed out that eating disorders were multi-determined and complex in their etiology and that neither anorectics nor bulimics should be considered homogeneous groups, but rather heterogeneous clinical populations with common symptom configurations. Those who said that there was a significant difference between males and females stated that anorexia and bulimia in males appeared to them as clinically more serious than in females, since both were more deviant in males, who did not have the strong cultural component of preoccupation with body image and thinness which facilitated the
development of eating disorders. Males with eating disorders were also considered more regressed and clinically more disturbed.

Therapists whose orientation was psychoanalytic were more likely than others to believe that significant clinical differences exist between males and females with eating disorders \((p = .03)\). Twenty-one percent of psychoanalytically oriented therapists never discussed dietary matters with their patients. Conversely, therapists who were not analytically oriented were more likely to discuss matters of diet and nutrition with their patients \((p < .01)\). Therapists with a psychoanalytic orientation were less likely to monitor patient's weight \((p < .01)\), preferring instead to work with a physician who would monitor weight as an adjunct to the therapy \((p < .01)\). These therapists were also less inclined to keep track of the manifestations of anorexia and bulimia with their patients, less inclined to discuss the specific dietary restrictions, circumstances surrounding a specific binge, etc. \((p = .01)\). They are less likely than other therapists to discuss the psychological effects of starvation with their patients \((p = .01)\) but would discuss medical effects as much as therapists who worked behaviorally, cognitively, etc.

When psychologists were compared with psychiatrists, psychiatrists were more likely to consult with families than were psychologists \((p < .02)\), but otherwise there were few differences between the disciplines on the variables listed in Table 2. However, therapists who had been in practice for ten years or less (and who were therefore presumed to be "younger") were less likely to offer consultations to parents \((p < .05)\) than therapists who had been in
practice longer.

Anorexia in males

Specific questions about males with eating disorders were asked in parts II and IV. While in part II twenty-two of the thirty-five respondents indicated that they had had experience with males, only eighteen completed the specific questions about males in treatment in part IV.

Initially (Part II) fourteen therapists (40%) reported that they had never seen a male anorectic. The total number of male anorectics treated by these respondents was ninety-seven, a very small number in contrast to the two thousand one hundred and ninety anorectic patients reported on earlier. Using these statistics, males constituted approximately four percent (4%) of the total number of anorectic patients treated by the thirty-five clinicians in the sample. Male bulimarexics were an even smaller minority. Twenty-seven therapists (77%) had never treated a patient in this category. Six more (17%) had seen one or two such patients, and only two (6%) had treated ten or more, indicating that seeing this kind of patient was a truly rare event. Likewise, the number of male bulimic patients reported on was very small. Twenty-one therapists (60%) had never seen a male bulimic. Of the fourteen therapists who had, only three (8%) had seen six or more such patients.

Of the respondents who completed the specific questions on males in part IV, nine (26%) had each treated only one male anorectic patient. Five therapists (14%) had treated two patients who were male and four
had treated three, five, eleven and twenty patients, respectively.

In general, the male patients had been quite young, but were older than the average male anorectic reported on in the literature. The median age of male patients was 15.2 years with a range of 8 to 40 years (\( \bar{X} = 16.4 \)), Most patients appeared to have begun treatment relatively soon after the onset of symptoms: median age for the beginning of therapy was 15.9 years (\( \bar{X} = 17.3 \)).

The median amount of weight lost by these male patients was reported to be 25% (\( \bar{X} = 26\% \)) with a range from 10% to 65% of normal body weight. The median length of treatment was 9.5 months (\( \bar{X} = 16.1 \)), with a range of duration from 2 to 50 months. The median amount of weight gained by male patients over the course of treatment was 25 pounds (\( \bar{X} = 24 \)) with a range from 0 to 45 pounds.

**Discussion**

The responses received from this sample of clinicians indicate that seeing a male anorectic is indeed a rare event, and a male anorectic who is also bulimic is even less common. Along with the rarity of the disorder was the perception on the part of some clinicians that anorexia nervosa in a man was a more pathological condition than anorexia in a woman. Since culturally men lack the tradition of being preoccupied with their body image, the appearance of the disorder in a man would seem to lack the culture-related component which accompanies anorexia in women. While this may be so, the argument is flawed in that it overlooks the exceptions to the rule--i.e., men who, as in the case presented above, have a gender
identification which is mixed or confused. It also overlooks men who, because of their devotion to a variety of sports, become preoccupied with control of their weight and control of their bodies. Moreover, with a range of weight loss from 10% to 65% and a median weight loss of 25%, it seems that anorexia in males has a range in the severity of the symptoms which may be compared to the range of the disorder in women.

The depth of emotional disorder, represented by some as more pathological in men than women, is more difficult to comment on, and more research needs to be done in this area. Even such research would be difficult, I suspect, because anorexia in males may be more readily diagnosed as weight loss secondary to other kinds of pathology, such as depression. Severe cases are outstanding, and the severity of the physical symptoms may be some indication of severely psychopathological states as well. However, I tend to agree with those who feel that there is no homogeneous psychopathology underlying the development of the symptoms of anorexia nervosa or bulimia. Given heterogeneity, it seems logical that there is a range of psychopathology in males similar to that which accompanies the disorder in women.

While it is possible that the cultural component has thus far protected all but the most vulnerable males from the development of anorexia, it is also possible that the increased awareness and publicity accorded the disorder will generate a "spread" to men as well. While culturally men may be less subject to those factors which move women in the direction of an eating disorder, they are no longer
immune from being preoccupied with their appearance, being thin, dieting, etc. Women may be more sensitized to these factors, but the emphasis on fitness for both sexes may suggest that the disorder will have more of an effect on males in the near future. Finally, both males and females are subject to the kind of underlying psychopathology which provides the template on which the symptoms of anorexia develop. This is discussed in the following chapter, which focuses on the factors underlying the development of the disorder in a male, and examines the configuration of factors which caused anorexia to develop in the subject of the case study.

The limitations involved in this survey come primarily from the small number of respondents in the sample. Nevertheless, the results of this survey are in accord with the literature regarding the small number of men in this population. These data also provide an opportunity to see how other clinicians handle various aspects of the treatment of eating disorders. It is obvious that the easiest place to be involved with the treatment of anorectic patients is in a hospital setting with a unit which specializes in eating disorders. There, the clinician functions as part of a therapeutic team and does not have to concern him/herself with matters of weight recovery and behavioral management if s/he is not inclined to do so.

For the outpatient clinician, the situation is more complex and difficult. Therapists with a cognitive or behavioral orientation have the least difficult time incorporating active monitoring techniques into their treatment of anorectic or bulimic patients. Psychoanalytically oriented therapists are least likely to do so.
Yet, psychoanalytically oriented therapists must find a way to deal with these issues although they may not want to incorporate them into the therapy. Among this group difficult decisions must be made as to how this should be accomplished. Possible solutions include finding a physician who will regularly follow the patient and monitor weight, nutrition and general physical health. These may also be followed by a non-medical behavioral therapist who can discuss such specific aspects as eating behavior, social skills, relaxation around eating. This situation may, however, be more complicated in terms of transference developments, especially if the patient has a tendency to split therapists into good and bad transference figures. Therapists who work in such self contained units as college or university health services or health maintenance organizations also take advantage of cross disciplinary referrals to insure monitoring of patients with severe eating disorders.
CHAPTER V
DISCUSSION

Introduction

When considering the myriad of issues related to anorexia nervosa that might be included in this chapter, two broad issues stood out. First is the issue of etiology--i.e., the question of why Jeff developed anorexia nervosa and why he became the exception to the rule and developed a disorder which almost always occurs in women. There are questions about what configuration of events (dynamic, genetic and even cultural) conspired to cause this condition to occur. Second are issues related to the treatment of anorexia nervosa and the question of whether the sex of the patient made the treatment different in some significant way.

The discussion in this chapter begins with a review of Jeff's developmental history and addresses the issue of what happened in his intra-psychic development. The theoretical problems which I found most useful in understanding Jeff (those of Hilde Bruch, Alice Miller and Otto Kernberg) have been integrated along with case material. There is also a brief section on the role which cultural factors played in the etiology of this particular disorder. In the section which discusses treatment, the focus is on issues in the treatment of both narcissistic personality disorders and anorexia nervosa.
Developmental Perspective

Hilde Bruch (1973) addresses the developmental aspects of anorexia nervosa (i.e., how the anorectic individual lacks a sense of identity, autonomy and control, and has a distorted body image and sense of self). In reconstructing Jeff's history from this perspective, it was clear that a large number of events played their part, beginning with Jeff's position in the family.

Jeff was the third of four children. For eleven years, until the birth of his younger sister, he was the youngest child and only boy. His younger sister was born shortly before his father's death. After being the youngest for so long, it is reasonable to assume that being displaced by his sister stirred up some feelings in Jeff and that he may have experienced some sibling rivalry. As the youngest, it is likely that he was given special attention. As the only son of an athletically inclined father, there must have been hopes that he would follow in his father's footsteps.

Jeff's primary attachment, however, was to his mother. He recalls that they were always close. He had more ambivalent feelings about his father and felt that he could never be the son his father wanted because he was not "macho" and did not enjoy sports. Instead, he preferred to play with his sisters and their dolls.

Nothing is known about his father's early history. His mother's early life was filled with trauma. Her parents had an unhappy marriage, and her father, an alcoholic, died when she was only eight. After his death, she lived with relatives and felt that she was a
"second class" member of the family, much as Jeff did when he lived in foster homes during his adolescence.

Although initially Jeff tried to depict his family life as problem-free before the death of his father, there are many indications that are contradictory. Jeff reported at least one discussion of marital separation, and remembered hoping that his mother would leave his father and take him away with her, so that they would be together on their own.

The Oedipal implications of this are rather striking. Jeff wanted to live with his mother, free from competition with his father. While it is possible that Oedipal conflicts played their part in the pathogenesis of Jeff's anorexia nervosa, there is also a pre-Oedipal dimension present in this early wish. Jeff had been hurt by the fact that he could never be what his father wanted him to be. His mother colluded with his father, wanting what he wanted. By separating his mother from his father, Jeff had a better chance of making her accept him as he was, not as his father wanted him to be. It is also possible that Jeff could not acknowledge the anger that he felt at his mother and displaced this anger onto his father. In this way, he could preserve the image of his mother as a good and loving parent and protect her from his angry feelings, as well as protecting himself from a persecutory maternal introject.

Jeff's argument with his father shortly before his father's death was another critical event. His father died the next day, before the argument had been resolved. Jeff's ambivalent feelings about his father led to feelings of guilt after his death. His
mother's remark that she wished that one of her children had died in place of her husband may have been interpreted by Jeff as her wish that he had died instead of his father.

His father's death led to changes within the family. Financially their situation changed and money was lacking. The emotional climate within the family was one of depression and alienation. Jeff had lost both parents at once. Jeff began to act out, turning to alcohol, sex, drugs and stealing to release his feelings of anger. He did not feel them as such. In retrospect, he observed how much hate he had felt, but the actual feelings remained repressed for many years.

All of Jeff's efforts to attract his mother's attention failed, and this failure served to strengthen his feelings of unacceptability. When not acting out, Jeff did what he could to be compliant and make people like him. He tried hard to obtain the acceptance he could not get from his mother and would never get from his father. He became independent and prided himself for being independent, alone, away from his family. In reality, he remained very much attached to them, never genuinely separating, never really establishing a separate identity. He believed that because he lived apart from them, he was free of them. He was to learn that this was not so.

He could not stay in relationships very long. He went from foster home to foster home, never wanting to become too attached. Although he recognized that there were people who tried to help him, he felt that he could not accept help, it was too risky, it would make him too vulnerable.

Sexually, he had relationships with both men and women, but for
the most part, he remained uninvolved. His relationships were for
the most part casual and superficial encounters. He could function
easily in the atmosphere of gay bars. His relationships seemed to be
motivated by his need to be filled by the other person. He recalled
that his lovers had often told him they loved him, but he never
returned the feeling. He maintained that his sex drive was low and
that he did not enjoy sex. It is possible that his promiscuity had
little to do with sex but with the search for an ideal object so that
he could maintain the narcissistic sense of himself (Horner, 1979).

Increasingly, Jeff found that he would not be vulnerable in
relationships if he remained aloof and uninvolved. In this way, he
could control the relationship and not risk being hurt. Only a small
part of himself was ever really involved in any of these relationships.
During the therapy, Jeff was to observe how people's impressions of
him would vary and how he would always feel like a sham, thinking
that they never really knew him. His emotional distance allowed him
to depreciate individuals who were involved with him, who, he felt,
were trying to make him into something he was not. He had developed
a false self, adopting a friendly, socially acceptable facade, and
keeping much of his personality hidden away from intercourse with the
external world. Unfortunately, this meant he could never really
become engaged in a relationship and meant that he remained very much
alone, even while surrounded by people. At one point, Jeff wondered
whether he had the capacity to love.

He tried to gain approval by studying hard and doing well in
school, hoping to become a doctor. He was disappointed when he found
that he could not do the work and dropped out of school. Leaving school at the onset of his anorexia contributed to his sense of failure and low self esteem.

In spite of his need for distance, Jeff had a strong need to be in relationships. When his relationships with Bob and Edie failed, Jeff felt abandoned and alone. The fact that both his friends were preoccupied with food, dieting, and weight may be of significance as the factor which triggered the onset of Jeff's anorexia nervosa. In his identification with his friends, he may have adopted some of their habits with food and dieting.

The loss of Bob and Edie recapitulated the loss of his mother and father ten years before. This time Jeff did not turn to substance abuse and sexual acting out but became depressed, as his mother had done. It was also at about this time that Jeff began to recover memories of the period after his father died, memories which had been blocked out for years. The more these repressed memories returned to consciousness, the more Jeff needed to have something which would serve as a defense against the feelings of rage and guilt that were associated with the return of the memories. Jeff then began to restrict his diet. As he withdrew from relationships, his preoccupation with food and dieting became all consuming. When even the most severe restricting of his diet failed to relieve his internal situation, Jeff became increasingly depressed. Eventually, he felt that the situation was desperate.

The harshness of Jeff's superego was evident during the treatment, and physically and emotionally Jeff's struggle took on
life and death proportions. I believe that if Jeff had wanted to
die he would have. If he had wanted to commit suicide he would
never have returned home. When he called his mother and asked her
to take him home, he unconsciously chose to live. He had hoped
for an intense emotional reunion, perhaps a refusion with his
mother and a chance to start again. This never took place. When
he abandoned his independent posture, allowing himself to depend on
his mother for support, Jeff made his first compromise. This
compromise allowed him to live, but only at the most marginal level.

This choice of life was not unconflicted. Jeff was aware that
he could die as a result of his restrictive habits and his frequent
binging and vomiting. In a kind of grandiose way, he left it up to
fate. Because of his narcissistic pathology, Jeff may have thought
himself invulnerable. He voiced the opinion that he was special,
because he had come through so much, and thought he would be able to
get through this too. He had abused his body in so many different
ways for such a long time that he may have believed that nothing
would really happen to him.

To summarize the significant factors in Jeff's history: being
born into a family of women; his conflicts with his father; he
experienced multiple traumas; his father's death; his mother's
emotional withdrawal and his life on his own, with concomitant
feelings of abandonment, all at an early age. Even before his
father's death there were indications that, although he was a special
child, with an intense attachment to his mother, he was not accepted
for himself, but rather narcissistically cathectored by one or both
parents. Jeff prided himself on being independent, but in reality never attained a sense of autonomy, identity or control in his life. He was strongly attached to his mother and remained so even though he saw her very little. He could not develop an independent identity because of this attachment and because of the perpetuation of a false self, which meant that only certain aspects of his personality could be exposed to the world. The rest were kept hidden away, so that they formed a kind of psychotic core. Although Jeff tried to create a sense of control in his life, he was often out of control, prey to feelings that he could not recognize and which had been repressed and dissociated. He used alcohol and drugs as a means of expressing these feelings. He used sex as a way of being involved in relationships, but had a need for relationships which went beyond the casual sexual encounters of the gay bars. This very strong need was one of the factors which eventually precipitated his return home, in an effort to work things through with his mother one final time. However, before he could allow himself to return, the conditions had to be extreme. A severe case of anorexia nervosa enabled him to overcome the last vestige of his false sense of independence and ask for help.

**Intrapsychic Perspective**

Palazzoli (1978) and Rizzuto, et al. (1981) have offered object relations perspectives on the development of anorectic psychopathology. In Palazzoli's schema, the evil maternal introject is identified with the body, which in turn, is divorced from the self. If the self is
to survive, then the body must be controlled so that the self is not overcome by the maternal introject. Rizzuto, et al. (1981) also postulate a split between the psyche and soma in anorexia nervosa, but suggest that the pathology originates when the mother fails to provide her child with the mirroring she/he needs to develop normally. The mother recognizes only the child's body, she cannot see her child as she/he really is. Even the body is perceived in accordance with the projected needs of the mother, i.e., in accordance with the image of the child which the mother has constructed in her own mind. Rizzuto, et al. (1981) do not see the anorectic as a narcissistic or borderline personality, but as evidence of a schizoid disturbance.

Although these authors differ, they agree, as does Bruch (1973) that the pathogenesis of anorexia nervosa lies in the early mother-child relationship and is due to a disturbance of separation-individuation where the mother fails to recognize her child's own needs, fails to perceive him/her as a separate person so that development cannot progress normally. Basic needs cannot be recognized as such, only certain feelings are responded to so that others, unacceptable, must be repressed or dissociated. The pathology occurs originally at a period before there is clear separation of the child's psyche and soma, so that feelings of frustration in response to bodily needs lead to psychic frustrations as well.

In thinking about Jeff, I find it difficult to agree with the position taken by Rizzuto, et al. (1981) that anorectics are neither borderline nor narcissistic personalities. Evidence presented by Masterson (1977) supports the idea that anorexia may occur in a
borderline personality, and more recent evidence (Garfinkel and Garner, 1982) supports the idea that anorexia nervosa may be less homogeneous than previously supposed, so that the anorectic symptomatology may occur in a variety of underlying personality disorders. Indeed, it would seem logical that the significance of the anorectic symptomatology may have different meanings for different individuals and that, even within a single individual, the meaning of the symptoms may change over time.

Conceptually, Jeff's case is complicated by the fact that anorexia nervosa was not the first manifestation of serious psychopathology. Jeff was atypical in this regard, since anorexia nervosa is usually the first indication that something is wrong intrapsychically. This makes understanding the etiology more difficult in Jeff's case. His prolonged periods of substance abuse were in some ways comparable to his eating disorder, since in all of them some substance, food, drugs or alcohol was used in an indulgent way and was used to divert Jeff's attention from the underlying intrapsychic conflicts. Taken in the context of these earlier episodes in his life, Jeff's eating disorder appears as one further diversion from a more basic form of decompensation.

I believe that Palazzoli (1978) is correct in maintaining that anorexia nervosa involves a schizoid split which does not involve the external world, as it would in the case of the schizophrenic, but which limits the boundaries of the conflict to the borders of the individual. I have already stated my disagreement with Rizutto, et al. (1981), who feel that anorectics are neither borderline nor
narcissistic personalities. I propose that Jeff was a narcissistic personality functioning at a borderline level (Kernberg, 1975). This means that he had the configuration of pathological object relationships of the narcissistic personality described by Kernberg (1975) as well as the lack of anxiety tolerance, a tendency toward primary process thinking as manifested on psychological testing, and rage and lack of impulse control which characterizes the borderline personality. It also means that I have located anorexia within the realm of the narcissistic disorders, i.e., developmentally earlier than the neurotic types of disorders on the psychopathological continuum.

In understanding pathological narcissism, I have found works by Miller (1981) and Kernberg (1975) very helpful and the following discussion draws heavily on their works. Miller's work is in turn based on the theoretical positions of Winnicott, Mahler and Kohut. She offers the following succinct explanation of the origins of pathological narcissism:

- The child has a primary need to be regarded and respected as the person he really is ... and as the center--the central actor--in his own activity. In contradistinction to drive wishes, we are speaking here of a need that is narcissistic, but nevertheless legitimate, and whose fulfillment is essential for the development of healthy self-esteem.

- When we speak here of the "person he really is at any given time", we mean emotions, sensations, and their expression from the first day onward.
In an atmosphere of respect and tolerance for his feelings, the child, in the phase of separation, will be able to give up symbiosis with the mother and accomplish the steps toward individuation and autonomy.

If they are to furnish these prerequisites for a healthy narcissism, the parents themselves ought to have grown up in such an atmosphere.

Parents who did not experience this climate as children are themselves narcissistically deprived; throughout their lives they are looking for what their own parents could not give them at the correct time—the presence of a person who is completely aware of them and takes them seriously, who admires and follow them.

This search, of course, can never succeed fully since it relates to a situation that belongs irrevocably to the past, namely to the time when the self was first being formed.

Nevertheless, a person with this unsatisfied and unconscious (because repressed) need is compelled to attempt its gratification through substitute means.

The most appropriate objects for gratification are a parent's own children. A newborn baby is completely dependent on his parents, and since their caring is essential for his existence, he does all he can to avoid losing them from the first day onward, he will muster all his resources to this end, like a small plant turns toward the sun in order to survive.

There was a mother who at the core was emotionally insecure, and who depended for her narcissistic equilibrium on the child behaving, or acting, in a particular way. This mother was able to hide her insecurity from the child and from everyone else behind a hard, authoritarian and even totalitarian facade.

This child had an amazing ability to perceive and respond intuitively, that is, unconsciously, to this need of the mother, or of both parents, for him to take on the role that had unconsciously been assigned to him.
This role secured "love" for the child--that is, his parents' narcissistic cathexis. He could sense that he was needed and this, he felt, guaranteed him a measure of existential security.

(Miller, 1981, pp. 7-8)

Miller continues to say that by adapting his or her own needs to the needs of the mother, the child grows up without being able to experience certain feelings of his own. This is in accord with Bruch's thesis that the anorectic is an individual who has not been allowed to develop an awareness of her/his own needs. For the child who is narcissistically cathected, certain kinds of inner promptings cannot be answered, since to do so would be at odds with what is demanded of the child and to pay attention to these needs would be to risk a loss of love. Most often, according to Miller, these original needs are repressed and do not resurface easily, often not until the patient has had many years of analysis.

In order to accommodate the needs of the parents, and to maintain the parent's love and security, the child may develop a false self or "as if" personality (Miller, 1981). In this situation, only certain personality characteristics are obvious. This may be the compliant, passive personality type described by Bruch (1973). Miller (1981) says that "the person develops in such a way that he reveals only what is expected of him and fuses so completely with what he reveals that ... one could scarcely have guessed how much more there is to him" (p. 12).

The child with the false self grows up without a sense of identity, since large portions of the self are kept hidden, even
from the individual. Like Bruch, Miller (1981) describes the child who is not aware of his/her own basic needs: "The child, who has been unable to build up his own structures, is first consciously then unconsciously (through the introject) dependent on his parents. He cannot rely on his own emotions, has not come to experience them through trial and error and has no sense of his own real needs, and is alienated from himself to the highest degree" (p. 14).

The false self keeps the child attached to the mother, and real individuation cannot take place, because the continued existence of the false self means that the child is still prey to the emotional circumstances which caused the false self to be created in the first place (Horner, 1979). This appears to have been the case with Jeff, and helps explain his strong need to return home and to re-attach, in a sense, to his mother. Miller (1981) also notes how the attachment between such children and their mothers may be extremely intense, as was also the case with Jeff. This is in accordance with the descriptions of the anorectic as the child who has been singled out in some way, who is cathected in a way that is different from other children in the family.

Miller's (1981) discussion of the false self also helps explain why Jeff was initially so unable to recognize his own needs and why he was so frightened when he came to realize that he had very strong needs for love and affection. These were the needs that he had kept isolated for so long, hidden in a kind of psychotic isolation. Because they had been kept in this way, they had not matured as Jeff did, so that this fragment of his personality resembled that of a
younger child. Jeff was afraid that if unleashed, these needs would become overwhelming, which suggested that this "true self" had been kept in isolation for a very long time and was developmentally at an extremely early age.

Jeff did not become psychotic, although psychotic regression was always a possibility, Kernberg (1975) says that pathological narcissism is the result of a pathological fusion of the ideal self, ideal object and real self images at a point in development where stable ego boundaries have been formed, separating the self from the object. The result is a grandiose self image, an inflated self concept. This idea differs from the alternative explanation of pathological narcissism proposed by Kohut (1971) who considers pathological narcissism as the result of a developmental arrest.

Once this triad of images has re-fused, Kernberg (1975) says that the "normal tension between (the) actual self on the one hand, and (the) ideal self and ideal object on the other, is eliminated by the building up of an inflated self concept within which the actual self and the ideal self and ideal object are confused. At the same time, the remnants of the unacceptable self images are repressed and projected onto external objects, which are devalued" (pp. 321-322).

While in the normal case, the superego is able to integrate ideal self and object images, it is the tension between these ideal images and the actual images which becomes the tension between the
ego and superego (Kernberg, 1975). In the case of pathological narcissism, this cannot occur, because there has been a fusion between the ideal and the actual self images. In addition to the development of the grandiose self which is at the core of the narcissistic condition, there is a merger of the usual boundaries between the ego and superego. Aspects which would ordinarily belong to the superego are integrated into the grandiose self and the unacceptable parts of the self are dissociated or repressed.

When the grandiose self is not fulfilled, depression may result (Miller, 1981). According to Miller, depression is the other side of grandiosity, which occurs when narcissistic supplies are not forthcoming or when, like Jeff, the narcissistic individual confronts the loss of an object which has been narcissistically cathected.

Kernberg (1975) differentiates three forms of narcissism which occur during adolescence, when narcissism is prone to increase. In the first form, there is an increase of libidinal investment in the self which is manifested in increased self-absorption and concern for the self. This is the most normal type of increased narcissism. In the second type, there is a "pathological identification of the self with infantile objects, and the search for objects that represent the infantile self" (p. 327). In the third type, the most pathological, the grandiose self is projected onto an object, "while the patient still maintains this grandiose self, that is, the 'self to self relation'" (p. 28). This third form differs from the second in that while the second is object related, the third is not. Instead, the object has been replaced by a projected representation of the self.
Kernberg also applies this typology to various kinds of male homosexual relationships. Again, he differentiates three kinds of relationships with a narcissistic component. In the first, there is a "predominance of genital, oedipal factors, in which the homosexual relation reflects a sexual submission to the parent of the same sex as a defense against oedipal rivalry ... In these cases, the infantile submissive oedipal self relates to the domineering, prohibitive oedipal father" (pp. 328-329). In the second type, the male has a conflicted identification with the internalized maternal image and "treats homosexual objects as a representation of his own infantile self" (p. 329). Although this form of homosexuality is considered more narcissistic than the first, Kernberg stresses that there is still an object relation present, even if it is between mother and child. In the third case, the partner is treated as "an extension of the patient's own pathological grandiose self, and ... we find the relation, not from self to object, nor from object to self, but from (pathological grandiose) self to self" (p. 329). This type of relationship which characterizes the narcissistic personality, may appear in individuals who are superficially well. However, the interpersonal involvement is "transitory and superficial" and there is a lack of "depth" or "empathy" for the other individual involved.

In addition to this inability to have relationships characterized by depth and empathy which Kernberg has described, another characteristic of pathological narcissism is the inability to depend on another person. Kernberg contrasts this absence of dependence with the clinging of the borderline patient as one way of making a
differential diagnosis between the narcissistic and borderline personality disorders. However, Kernberg also designates a group of patients who present with some combination of narcissistic and borderline features. These are patients with a narcissistic personality structure who also lack the ability to tolerate anxiety, lack impulse control, manifest primary process thinking and possess a relentless and depreciatory rage.

Although such a short synopsis can do little justice to the depth of Kernberg's work on pathological narcissism, I hope to have included a sufficient amount to draw a parallel with Jeff's personality. As I came to understand him, Jeff was a narcissistic personality functioning at a borderline level. Although he was superficially well organized (i.e., socially appropriate, acceptable, polite), Jeff did devalue and depreciate other people, especially those who showed any sign, real or imagined of rejecting him, or of coming too close to him. He could, as he said, be manipulative and cold with other people, and had many relationships without caring for the other person involved. His difficulties with dependency have been well established. His rage was either dissociated or acted out unconsciously until the anorexia nervosa forced him to confront it. He displayed the poor impulse control, lack of anxiety tolerance and a tendency to primary process thinking, which Kernberg mentions as characteristic of this group of people.

Kernberg's explanation also helps elucidate Jeff's homosexuality. I believe that he showed characteristics of both the second and third types, i.e., the homosexual relationship based on the mother-child
dyad, and the homosexual relationship based on the self-to-self relationship which Kernberg describes. In more general terms, Jeff seemed to fall between these two categories, or rather, he encompassed both, sharing some characteristics of each. He possessed the need for affection of the child longing to recapture a lost relationship with his mother, as well as the colder, starker, more manipulative relationships described as the "self to self" or object-less relationships. It is my opinion that Jeff's oedipal resentment toward his father played only a secondary role in his homosexuality. His conflicted identification with his mother, and his longing to recapture and recapitulate the early mother-child relationship are more significant factors. His intense need for love was conflicted by his inability to depend on anyone and his inability to let anyone get too close.

For Jeff, the development of anorexia nervosa came as an alternative to psychosis or suicide. Anorexia nervosa allowed him to remain sane, with delusions limited to food, weight and eating, and at the same time, was a way for him to express the conflicts within himself.

In spite of the emotional vulnerability created by the false self around which his personality organized, Jeff had certain strengths of character which helped him during the course of treatment. He was intelligent and had the capacity to observe himself and his actions. He was extremely sensitive and was someone who would reflect and consider his situation between sessions. He was, in a way, mature for his age. He was determined to work out what was happening to
him, but was hampered by a low frustration tolerance and poor impulse control. In spite of this, he worked through a great deal in a short time. This progress is reviewed shortly, in the section on Treatment. However, before reviewing this aspect of the case, there is another important factor to be considered. This is the role which present day culture played in the genesis of Jeff's eating disorder, and plays in the genesis of eating disorders in general.

**Cultural Contributions**

When Jeff first developed anorexia nervosa, he believed that what was happening to him was unique. He had never heard of a disorder with this strange sounding name, and he had no awareness of having anything in common with many other adolescents and young adults, most of them female. He learned about anorexia and bulimia from the magazine section of a Sunday newspaper and, several months later, wrote for information about anorexia nervosa.

In spite of the fact that Jeff was not aware of the existence of the disorder, the pervasive consciousness of physical fitness, dieting, and the emphasis on the self which exist in present day culture may have been important catalysts. As a member of the gay community, Jeff was well aware of the emphasis on appearance, being attractive, being thin and wearing clothes well. Both Bob and Edie had been conscious of their appearance and were constantly on diets. Their proximity to Jeff only served to increase his awareness of these issues. When Jeff began to restrict his diet after Bob and Edie were both gone from his life, he may have done so in an attempt
to incorporate both these lost relationships. In Jeff's case, and, it is to be presumed, in many other cases of anorexia nervosa, there was something in the configuration of symptoms which was well in accord with Jeff's psychopathology. Two things in particular seemed to make this particular means of expression attractive to him. Both of these factors are very much present in our culture. The first of these is the pervasive emphasis on the self and which is the principal characteristic of anorexia nervosa. The second is the preoccupation with control.

In anorexia nervosa, the cultural preoccupation with the self is focused on the body of the individual. The individual's world shrinks, as Jeff's did, until the body and issues of food and weight are all that really exist. There is a regression to a state which bears some similarity to earliest infancy. The individual is totally preoccupied with bodily functions. Whereas the infant refuses to tolerate hunger and signals hunger immediately, the anorectic refuses to acknowledge it, in a kind of perverse reversal of this original state. There is also a perversity in this total preoccupation with the self which refuses to recognize the fundamental need for sustenance. It is as if, by refusing any kind of sustenance or nurturance, the anorectic believes that she/he can regain control over an existential situation in which control is lacking.

Lack of control with the appearance of control is another feature of modern life in western society. While popular psychology preaches that we must "take control" of our lives, the decrease of small businesses and the increase of multi-corporate conglomerates
makes real control over most aspects of modern life an impossibility. As production of goods is increasingly fragmented, and even as the service sector becomes increasingly so, we are told to "take charge" in an effort to make us feel that taking charge is still possible.

Much of this situation is replicated by the anorectic, who feels increasingly out of control and who tries to implement ever more rigid controls as this occurs. The anorectic prides herself (himself) on being in control. Losing control, which occurs when the anorectic gives in to the urge to binge, is reacted to with feelings of shame. It is as if the anorectic is saying that her body is a tiny island in a giant ocean, and it is the only thing she can have any control over. It is ironic that even this last ditch attempt fails when, what begins as an exercise in control becomes the factor to which all others must be subordinate.

Therefore anorexia nervosa is very much a disease of modern life, though not exclusively so, because its history is so long. Its increased incidence (I believe that the incidence is increasing, not that we hear more about it) seems to be due to the fact that it expresses the dilemmas of modern life so well. There is also evidence that anorexia may have become a "faddish" disease, since awareness of it on the college campus is currently so high, and that many sub-clinical cases of anorexia, i.e., preoccupation with food, dieting and some weight loss, may exist among college age youth (Zuckerman, 1982).

Finally, with regard to the issue of gender and eating disorders, cultural factors appear significant, as are the ways in which these
factors are internalized. The question of why anorexia nervosa and bulimia occur primarily in women is rarely well answered, but always asked. Perhaps there is no one answer, but rather a number of factors which converge to produce this phenomenon. To begin with are the studies cited in the literature review which support the idea that girls are more apt to somaticize their problems while boys tend to act them out. Paralleling this is the idea that more women more readily define themselves through their appearance while men define themselves and are more likely to be defined, through their acts.

Historically, women have been associated with food and nurturance, so that at adolescence when a girl wishes to rebel against her mother, she can do so by making her body different from her mother's, by refusing to let her body become rounded the way her mother's is. For most boys, going through puberty means that their bodies become less like their mothers'--they lose baby fat and gain muscle. The development of secondary sex characteristics further strengthens this differentiation, while in females, it strengthens the identification.

But for Jeff, who rejected identification with his father and preferred to identify with his mother, it made it possible to become the exception to the rule.

### Treatment

According to Hilde Bruch (1973) the "aim of therapy is to assist (anorectics) in developing a more competent, less painful, and less ineffective way of handling their problems. Changing their abnormal
eating patterns becomes possible only when at least some of the underlying problems have been resolved. It is then the visible expression that some improvement has taken place" (p. 336).

In so few words, Bruch sums up such a complex undertaking. Although following her proposal in the above statement meant that the major focus of treatment did not need to be on the pathological eating patterns themselves, it is also true that the psychotherapy of an anorectic must find some way to include issues of food, diet and weight, as well as the underlying dynamic issues. Traditional psychotherapy (i.e., classical psychoanalysis), which interprets the anorectic stance in terms of oral drives or fear of pregnancy does not address these issues adequately (Bruch, 1973). Instead, Bruch advocates a modified form of therapy in which the patient plays an active role and where the focus can be on helping the anorectic more effectively deal with issues of identity, autonomy and control, as well as with self-esteem, self-concept and problems of body image.

From another perspective (Miller, 1981) the goal of treatment with patients such as Jeff, who manifests a narcissistic personality structure, is to move the patient away from the need to maintain a false self system, so that the true self can emerge. To achieve this, the individual must become aware of the array of feelings which have long been repressed and dissociated, and confront the conditions whereby s/he was loved not for her/his intrinsic self, but for some aspect of her/his personality which was narcissistically cathected by one or both parents.

A third perspective (Kernberg, 1975) says that the treatment
of pathological narcissism involves the separation of the self and object images which have refused to form the pathological grandiose self, so that the superego and ego form separate intrapsychic structures and there is no longer a pathological configuration of self and object relationships. Once this pathological configuration no longer exists, the individual will be increasingly able to have "normal" relationships with external objects, instead of the pathological ones described earlier in this chapter. A final perspective (Kohut, 1971) would define the goal of therapy to help the individual so that s/he was no longer fixated at a point of pathological narcissism, but to further development via the aid of transmuting internalizations. Although I have tended to agree with Kernberg rather than Kohut in this matter, I found all of the above helpful in working with Jeff.

However, initially, and throughout the course of therapy, I found Bruch (1973) most helpful in providing a treatment approach which could be followed. Much of Jeff's therapy, directly or indirectly, focused on the issue of identity. A large part of Jeff's initial depression came from his low self esteem, and his sense of not being valued. He felt that he had to hide much of his personality because no one who knew him would like him and to expose himself would make him vulnerable. As a result, he could not be close to anyone, and could only expose what had come to be the false self. Within the therapeutic relationship, which functioned as a kind of microcosm, or an experimental template on which interpersonal relationships could be tested, Jeff became more aware of who he was. He learned that he
had needs, strong ones, which he gradually was able to incorporate into his personality. As the therapy progressed, he began to confront his feelings of anger and disappointment at his mother, his attachment to her and his need to be separate from her.

Jeff wished to be attached, but he wanted to remain autonomous. Earlier, it was explained how Jeff's false self kept him tied to the internalized image of his mother and how real autonomy was prevented as long as this self system was maintained. Over the course of therapy, Jeff allowed himself to experience his rage and disappointment at his mother for the first time. Jeff also realized that he had equated being alone with being autonomous. It was difficult for him to tolerate feelings of closeness to anyone for very long. As Kernberg (1975) describes, he could not afford to depend on anyone.

He reflected this inability in therapy. Although Jeff looked forward to our weekly meetings, it was difficult for him to tolerate feelings of closeness which began to emerge. This difficulty precipitated his abrupt departure. On follow-up, he observed that he still had many problems with being able to have an intimate relationship, and it is probable that difficulties in this area will continue.

A great deal of time in treatment was also spent discussing issues of control. While initially Jeff had requested external control (hospitalization) because of his faltering internal controls, he eventually began to recover a sense of control in his life. This occurred synonymously with his acceptance of the idea that his
preoccupation with food and weight were really not what they seemed, that he had used those issues to cover other conflicted areas in his life. Lapses in control--eating binges--were seen as shameful, and Jeff came to dread even the possibility of a return to binging. The cessation of these binge-purge episodes was the single most significant event during the course of therapy, a turning point which meant to Jeff that he had actually begun to be in control of his anorexia nervosa, rather than being controlled by it.

In the actual treatment, these issues were rarely separate, and discussions tended to integrate at least two, or even all three. They were issues which Jeff could immediately understand, which were obviously relevant and to which he was ready to give a great deal of consideration. Discussion of identity, autonomy and control extended into other areas of Jeff's life--to his anorectic symptoms, and to their relationship to his depression. While at first the therapy tended to focus on recent events in Jeff's life, i.e., what was actually happening to him, or what had happened shortly before, in the pre-morbid period. Once a genuine therapeutic relationship was established the depression abated, and the emphasis in sessions became more historical and interpersonal. Throughout the therapy, the formation of a more cohesive identity was a central theme, with issues of control and separation following close behind in importance.

The problem of dealing with excessive dieting, binging and purging, weight recovery and nutrition in a limited outpatient setting are among the most difficult factors in the treatment of a severe case of anorexia nervosa. Bruch (1973) says that although
psychotherapy with anorectic patients should focus on their personality problems and not on their eating behavior, "the fact that food plays such an active role in their psychic economy is a complicating factor" (p. 347). She also says that a "wait and see attitude, an unrealistic expectation that the weight will correct itself after the psychological problems have been solved, may be harmful, even fatal ... in the treatment of anorexia nervosa" (p. 349). She points out the near impossibility of making progress in psychotherapy with a starving patient, for whom the effects of starvation confound and compound the psychological climate, so that one cannot be distinguished from the other. In such cases, a period of hospitalization may be required in order to restore some weight and nutrition, but consideration must be given to the underlying problems as well as weight recovery (Bruch, 1973).

At the beginning of therapy, the physiological effects of weight loss were explained to Jeff, and this led to the institution of a two point contract. Without such a contract, it would have been unwise to undertake such a therapy in an outpatient setting. If the contract had been broken, it was understood that therapy would have to be discontinued. The first stipulation was that Jeff maintain regular visits to his physician, who would monitor his weight, and who had permission to share information with me if there was any change regarding his weight. The second point that Jeff agreed to was that he would not lose any more weight. It was easier for Jeff to keep up this part of the agreement than it was for him to go one step further, i.e., he could not bring himself to gain more than a few
pounds throughout the entire course of therapy.

Results of the survey indicated that it is easier to treat severe cases of anorexia nervosa in an inpatient setting, where consultations with medical personnel and involvement of family members is facilitated by the multi-disciplinary hospital team.

Regardless of orientation, most of the clinicians (74%) who participated in the survey said that they monitored a patient's weight on a regular or at least a partial basis. While the majority (57%) said they would never refuse to work with a patient whose weight dropped below a certain point, a significant number (39%) said they would do so either regularly, or under certain circumstances. What to do if this occurs is especially difficult for the non-medical clinician working in an outpatient setting without strong medical back-up. In general, as can be seen from the survey results, clinicians who work with anorectic patients usually feel that it is necessary to discuss matters of food and weight in some meaningful way, and to try and integrate these issues into the therapy.

What becomes difficult is to accomplish this without replicating conditions within the anorectic's family, where family members are all too aware and often very anxious about the eating habits of the patient. In Jeff's case, it was important to establish a firm sense that no more weight could be lost and that psychotherapy would be impossible if he could not maintain basic nutritional requirements and regular caloric intake. We did, rarely, discuss what he ate on a daily basis, but these discussions seemed to arise spontaneously; they were never the result of direct inquiry, unless the context for
the question had already been established by Jeff.

What was more important with regard to eating behavior was Jeff's ability to be honest about it, which increased throughout the therapy. Although he did not initially disclose the fact that he was binging, once he did, he could talk about the periodic relapses which occurred, even though these were a source of shame and disappointment to him.

A second significant factor was the association of pathological eating behavior with various emotional states such as boredom, anger and depression. Once he was able to observe a correlation between pathological eating, or extreme preoccupation with food and the existence of some psychological state which made him uncomfortable, it became easier for Jeff to focus on what was troubling him. The more this occurred, the more obvious it was to Jeff that food had become the metaphor, and if what was troubling him was not obvious, he would attempt to determine what was wrong.

Anxiety about the peculiarities of his eating habits increased as Jeff's vacation in California approached. The social ramifications of anorectic eating behavior are often not addressed by clinicians whose orientation is psychodynamic or psychoanalytic. Yet even within these therapeutic approaches, the underlying fears of eating with other people, maintaining appropriate behavior when eating in public and eating appropriate amounts of food can be explored. All of these were problematic for Jeff. For him, eating had become an extremely private matter, it was not a time to be social. This is common among anorectics. Consistent with Bruch's predictions, Jeff was able to try out new approaches to eating and change his behavior.
when sufficient material had been worked through with regard to the underlying dynamic issues.

On follow-up, when asked what he thought was most significant about the therapy, he replied that it was the intimacy of the relationship, because it was precisely the issue of closeness and the concomitant issue of dependence that caused Jeff to end therapy precipitously. While the therapy succeeded in sustaining his life, alleviating depression and furthering the consolidation of a sense of identity, autonomy and control, it did not progress to the point of being entirely able to rectify the narcissistic condition which prevented Jeff from being able to depend on anyone outside himself and enable him to engage in an intimate relationship. Jeff longed desperately for a genuine relationship with an object, but was afraid of actually being involved in such an intimate way. He became less able to accept the fact that his mother would never be able to provide the narcissistic supplies he needed. The therapy provided him an alternative. It provided a framework where new facets of his identity could be tested and where he could control the amount of intimacy by sharing as much information about himself as he wanted. In this way, he was in control. It was also a relationship in which he could allow someone to know him while still maintaining his autonomy. Jeff was indeed correct in remembering the tone of the sessions as intimate. He was also correct in his assessment of the therapy as moving towards a point where the focus was no longer the anorexia nervosa, but a whole new set of issues dealing with closeness and distance, separation-individuation within the framework of a narcissistic
personality. Ostensibly, Jeff chose to recover his independence by leaving for California, by setting up a situation which would test the gains that he had made in the therapy and which would allow him to see whether he could live on his own. On another level, Jeff left because the idea of closeness frightened him. It threatened his ability to be on his own and he risked becoming dependent.

Watching Jeff leave, with the knowledge that there was still much that was unresolved, was extremely difficult. Even as I wondered whether there were things I might have done differently, I knew that this was Jeff's way of handling a painful and conflicted situation and that he was not ready to confront it in a different way. It was important to allow him to leave with a sense that he had accomplished much, and at the same time, alert him to the fact that there was much left undone. Jeff was able to agree that this was so, and able to see what he was running from. Once he was aware of this, it was important that he leave with a sense of being in control, and a sense that he could return to therapy again if he chose to do so.

Finally, Jeff left without regaining the weight he had lost. Over the course of the therapy, he had gained six or seven pounds, but not much more. It was not until follow-up, when the change in his weight could be observed, that I felt truly sure that my assessment of the gains Jeff had made in therapy was truly correct, and that these gains had been consolidated. For this reason alone, an in-person follow-up is extremely important with anorectic patients.
Summary and Conclusions

While the subject of anorexia nervosa has received a great deal of attention in both popular and scholarly literature, males with anorexia nervosa remain a small minority of the population. Experienced clinicians, working with eating disordered patients over a period of years, may encounter only a few male patients, or none at all. For this reason, a male with the features of primary anorexia nervosa was considered very unusual. Beyond that, the young man in question was an extremely articulate and sensitive individual, who managed to convey the pathos of his situation with impressive clarity.

At the onset of therapy, Jeff had lost approximately twenty-five percent of his total body weight and was in a depression so severe that he had wanted to be hospitalized. The severity of the case presented a very considerable challenge to this clinician, who had no prior knowledge of, nor experience with, anorexia nervosa.

Deciding on the best course of treatment was difficult because of the multiplicity of therapeutic approaches described in the literature. The literature on anorexia nervosa, including its etiology, treatment, theoretical approaches, and anorexia in males was reviewed in Chapter 1.

In Chapter 2, the methodology relevant to this study was reviewed:

Chapter 3 presents the case of Jeff, and reviews the intake period, evaluation and assessment, the two major portions of the
treatment, as well as the termination. Before treatment could commence, the question of whether Jeff was a true anorectic had to be settled. There is debate in the literature on this point of diagnosis. It was decided to treat Jeff as a case of primary anorexia nervosa.

Several ground rules had to be established as well. Jeff agreed to maintain contact with a local physician and agreed that he would not lose any more weight. We discussed the impossibility of making progress in psychotherapy while in a starvation state and the interaction of the physiological and psychological effects of starvation.

Once the therapy was established, the works of Hilde Bruch (1973, 1978) served as invaluable guidelines. While in the earlier part of the therapy the emphasis was on the depressive and anorectic symptomatology, as the work progressed the emphasis within the sessions became more historical and interpersonal. Throughout the therapy, the themes of identity, autonomy and control were of paramount importance. Much of the work of the therapy was to help Jeff form a more cohesive self, a true self in which all aspects of his personality could be integrated, both just those few which he felt were acceptable. Separation issues were also important in helping Jeff gain a real sense of autonomy, rather than one that was based on a false sense of independence. The issue of control, so relevant with regard to eating, was one in which a great deal of progress was made. Jeff went from feeling that everything was out of control, to feeling that he could have some control over his life. As this
feeling changed, he stopped his binging and began to have more appropriate eating habits.

As his vacation trip to California approached, Jeff became increasingly concerned about his eating behavior: his ability to eat neither too much nor too little, whether he could eat with other people, whether if something happened on the trip he would begin bing, etc. Although Jeff did have several relapses with the binging at various points, he was able to take each in stride, and see that a relapse did not necessarily mean a return to being out of control. By the time Jeff left for California, he was well aware that his preoccupation with food was really a defense against conflicts and emotions which were more difficult to face, and he had begun to look for the underlying conflict each time he felt himself becoming preoccupied with food and eating.

While in California, Jeff recovered his sexual feelings, had a relationship, and decided that he wanted to go back there to live. He came home briefly and the therapy terminated abruptly. Jeff was aware that ambivalent feelings, both about his family and about issues which had begun to surface in the therapy were factors in his hasty departure. On follow-up, one year later, he was able to articulate that he felt that the therapy was getting into other areas (e.g., intimacy) which had frightened him deeply.

Jeff gained very little weight during the course of the therapy but had, as Bruch (1973) suggests, worked through the underlying dynamic issues sufficiently so that weight recovery could proceed. When seen a year later, he had gained over thirty pounds and although
still thin, looked and felt a great deal better.

Because of the paucity of information about males with eating disorders, and because of the lack of clarity about how clinicians who work with this population actually deal with the difficult management issues presented by these patients, it was decided to do a survey of therapists who worked with eating disordered patients.

Approximately one hundred surveys were sent out to therapists in the United States, Canada, Europe and Australia asking about: their experience with anorectic and bulimic patients; their experiences with males with anorexia and bulimia; and their theoretical orientations and treatment practices. Results of this survey were reported in Chapter 4. According to the results of this survey, males with anorexia nervosa are rarely seen, and although the majority of clinicians felt that males and females were not clinically different entities, a significant number either disagreed or were unsure about this point.

My own conclusion with regard to this last point is that I was not able to observe any significant clinical differences between Jeff and the female patients with eating disorders that I have subsequently treated. In each case, an important aspect of the treatment is to understand the meanings of the anorectic symptomatology in the context of the patient's life. The meaning of these symptoms may change over time, and may even mean different things at different points during the illness. For Jeff, the pathological eating was a defense against long-standing and deeply regressive narcissistic conflicts. When other defenses, such as repression, dissociation and denial began to
fail, Jeff became preoccupied with food and weight as a way to stave off a more total decompensation because of his underlying feelings of rage and guilt. Since Bruch (1973) does not consider anorexia from an object relations perspective, Palazzoli's (1978) writings on anorexia nervosa as well as the works of Kernberg (1975) and Miller (1981) on pathological narcissism were extremely helpful in understanding Jeff from a vantage point which includes structural and object relationships. Their ideas were discussed in Chapter 5, Kernberg's view of pathological narcissism as a pathological configuration of the ideal self, ideal object and real self helps explain the grandiosity of the narcissist and explains the quality of relationships in narcissistic persons. His formulations were extremely helpful in understanding Jeff.

Since treating Jeff I have learned that some therapists do not like to treat patients with severe eating disorders. They do not find them attractive, and they are known to be difficult patients. I believe that anorexia nervosa and bulimia are increasing, and that there is a cultural element which supports the increased incidence of these disorders. Many of these cases are sub-clinical in their intensity and will not reach therapists' consulting rooms, but many will come for treatment.

For me, Jeff was not an easy case. He was difficult and challenging. He was frustrating. What he made me see, in his quiet way, was the pathos of the anorectic predicament, of the narcissistic personality. As the therapy unfolded he made me see the origins of what had happened to him. I have written about him in this way
because of what I did learn from him, and hope that what I have written may be of some use to others in their treatment of anorectic patients as well.
REFERENCES


APPENDIX A

PSYCHOLOGICAL ASSESSMENT REPORT

Psychological Services Center
University of Massachusetts
Amherst, Massachusetts 01003

Client: "Jeff"  
Date of Examination: April, 1981

Examiner: Mary A. Scarcliff, M.S.

Test Instruments:  
WAIS, Rorschach, TAT, Bender Gestalt,  
Draw-A-Person, Adjective Check List, MMPI,  
Life History Questionnaire, Forer Sentence Completion.

Referral Question:  
Evaluate the client's intellectual, affective, behavioral, interpersonal, 
psychostructural, neurological, and object relational functioning. Evaluate his 
areas of strength and weakness. Make a differential diagnosis and discuss the 
possible ontogenesis of his difficulties with specific reference to his anorectic 
symptomatology. Discuss the prognosis for and recommendations for treatment.

Behavioral Observations:

Jeff was cooperative with testing and compliant with all procedures. Nevertheless his reserve appeared to reach the level of guardedness at times. A lack of spontaneity accompanied his responses. His seemingly easy and relaxed manner appeared to be belied by anxiety suggested in frequent half-laughing, qualifying comments, and verbalized self-doubt.

Neurological Findings:

There is substantial evidence of right parietal dysfunction, with acalculia, constructional apraxia, sporadic agraphia, and loss of topographical orientation. The impairment could cause difficulties in visual-motor coordination. The extent of the impairment and its cause could not be evaluated on the basis of the data and would require a full neuropsychological assessment. The impairment revealed is sufficient to cause difficulty in work requiring reproductive manual dexterity, visual or manual computation, accurate writing and spelling, or a reliable sense of direction.
Intellectual Findings:

Jeff is of bright and normal intelligence, with an intellectual potential in the 90th percentile although current functioning is substantially lower (in the 80th percentile). Jeff's intellectual impairment appears to result from a combination of neurological (see above) and emotional factors. The latter include pervasive evidence of high anxiety, tension, and depression. The client shows strong tendencies to use his high intelligence defensively in intellectualization at the expense of his affective experience which tends to be constricted.

There are strong indications that Jeff sets lesser goals than he is capable of achieving, possibly due to negative experiences of failure when he has set his sights higher. Thus the client appears to have very high aspirations and self-expectations which either past experience or a pessimistic and hyper-critical attitude deters him from attempting to attain. The question must be raised whether his neurological impairment is a factor in this; that is, if he is neurologically incapable of doing what he wants to do or feels he should be able to do, he may generalize the resultant task-specific feelings of incompetence, producing pessimism, anxiety, and a lowering in self-esteem.

Affective Findings:

Jeff's affective world appears to be a subjectively painful one. There is evidence of a high level of psychophysiological tension accompanied predominantly by anxiety and depression. The client shows severe defensive constriction of affect apparently in an effort to reduce the subjective experience of pain.

Jeff shows strong passive-dependency needs and primitive needs for affection. The nongratification of those needs produces deep feelings of helplessness, disappointment, frustration, and anger, defended against by distancing cynicism.

Interpersonal Findings:

Although Jeff shows heightened sensitivity to interpersonal cues and social nuance he has not developed the basic social skills to translate that sensitivity into gratifying interpersonal interaction. He appears to be harshly critical and disapproving of his own needs for intimacy and closeness which his high self-expectations cause him to inhibit and to repress. Thus he uses his sensitivity to others to maintain interpersonal distance secondary to his strong expectation of hostility, rejection, and concomitant non-fulfillment.
Jeff defends against his interpersonal insecurity with rebelliousness which allows him the illusion of control. That rebelliousness is not likely to be destructive to society or to others, but will more probably be self-destructive in socially tolerated ways, e.g., substance abuse, particularly alcohol.

The client's awareness and understanding of others within a social context is not usable at present due to his distrust of others and himself. He tends to defend against his hostile and angry impulses by denial, withdrawal, and projection as well as by turning those impulses against himself secondary to fears of loss of control.

Psychostructural Findings:

Jeff shows major ego deficits between his ungratified infantile needs for affection and his rigid, harshly judgmental, and heteronomous superego structure which places on him excessive and unrealistic demands for achievement. The client's use of the mechanisms of projection, projective identification, denial, splitting, omnipotence, and primitive idealization does not appear to be defensive but rather characterological, representing a developmental arrest. He does show some higher level defensive operations consisting of repression, intellectualization, rationalization, displacement, and reaction formation. The pervasive indications of the use of conversion, which is also manifested in the anorectic symptomatology, appears to be used at both levels, as a characterological pattern and as an ego defense.

Object-relational Findings:

Jeff shows primitive object-relational development. He appears not to have yet developed a firm sense of a unified and autonomous mind-body-self capable of gratifying self-fulfillment. Instead he seems to depend on external sources for gratification, for self-definition, and for control. This dependency causes substantial anxiety and pain in that the client also views others as punitive, intrusive, and demanding. Jeff's rebelliousness and flouting of societal norms appears to relate to his lack of firm personal somatopsychic boundaries; by butting against the limits set by others he can achieve the illusion of having intact boundaries around himself. This effort at self-definition also is conflict-ridden since it depends on confrontation and the experience of rejection rather than on cooperation and the experience of rejection rather than on cooperation and the experience of empathic acceptance. A positive aspect is the striving for independence reflected, despite the self-defeating nature of the effort.

The archaic level of somatopsychic organization is specifically reflected in the client's symptomatic efforts to exert control over
his body. The pervasive indications of substance abuse and eating disorders suggest primitive efforts to define and claim his physical body an thus to attain someatic differentiation. There are also suggestions of inadequate development of a strong sexual identification at a pre-Oedipal level. The client seems currently to be functioning asexually and to possess stereotypic, indeed almost caricaturish, and untested schemata for male and female sexuality.

These self and object relational deficiencies seem to have their ontogenesis in faulty relationships with significant others in early childhood. Jeff appears to have experienced his mother as controlling, demanding, and inconsistently nurturant such that he developed an early pattern of superficial and surface behavioral compliance accompanied by affective withdrawal and guardedness. The data depict the client's mother as highly narcissistic, bestowing her approval when her son functioned as a gratifying extension of herself and withholding it when his needs and hers were not congruent. Thus when the client pleased his mother the two coexisted in a state of fusion accompanied by absence of psychological boundaries and individuation. On the other hand, when he displeased his mother he felt fragmented, a part-person with no sense of positive self-definition outside the relationship. The mother's unpredictability heightened the son's vulnerability to and fears of rejection in an intimate relationship.

The data further suggest that Jeff experienced his father as authoritarian and alternately as highly punitive and as disengaged. The client appears to have been unable to use his father as an effective role model and object for identification. The father does not appear to have been available to his son as a source of identity-formation or as a buffer between son and mother. It is conjectured, based on the data, that the mother may have turned to her son for the gratification of needs her husband was unable to fulfill. A question raised by the data is whether the mother presented her own father as an archetypal ideal man, unsuccessfully projected those ideals and the concomitant expectations upon her husband, and set up unattainable standards for her son as a consequence.

The client's highly archaic splitting, in which good and bad cannot coexist even in separate objects, is another indication of primitive object relational development. His splitting, as well as other mechanisms described above, does not appear to be defensive or regressive, but rather reflects a developmental lag and a consequent characterological pattern of dealing with the world.

Areas of Strength and Weakness:

Jeff's major strengths also are his major weakness: 1) His high intelligence is potentially a source of self-gratifying achievement, but he is currently utilizing it primarily in intellectualizing defenses to maintain interpersonal distance, to
control his affective experience, and to curtail his anxiety.
2) Jeff's acute interpersonal sensitivity is similarly used to avoid intimacy and thus to ward off potential rejection rather than to achieve intimacy and the gratification of his interpersonal needs.
3) Jeff's impulsive tendencies toward loss of control and self-destructive acting out have the potential to be channeled toward enhanced spontaneity and more constructive and self-fulfilling freedom of genuinely autonomous action rather than reactively as they are currently used.
4) The client shows a powerful emotional reservoir and a strong capacity to give and receive affection, but his fears of painful affective experience have led him to repress and constrict all feeling. Much of this is related as well to his lack of affective differentiation.
5) Jeff's excessively high expectations of self, if modulated by acceptance of his realistic potential so that they become appropriate aspirations rather than the source of self-deprecation and self-punitiveness, could provide him with fulfillable and ego-building goals.

Diagnosis:

On the basis of the data it is not possible to make specific diagnoses on Axis I, but general categories of dysfunction were indicated:

I. Eating disorder, unspecified
   Substance abuse, probably alcohol; ? other substances
   Rule out Substance dependence
   Depression: Rule out Dysthmic disorder vs. Major depression

II. 301.89 Mixed personality disorder with histrionic, narcissistic, and borderline features (primary diagnosis)

The client's Axis I dysfunctions appear to derive from efforts to cope with the developmental deficits suggested in Axis II rather than to be response to environmental stressors.

Although the client's test data suggest the potential for psychosis--either depression with psychotic features or schizophrenia with mild to moderate paranoid features--his dysfunction, when the total picture is considered, appears to lack either the genetic or the psychosocial environmental stressor components to confirm either diagnosis. Rather his symptomatology appears to reflect the use of subtle strategies to gain affection and to avoid rejection.
Prognosis and Recommendations for Treatment:

The data suggest a very favorable prognosis for intensive, long-term reconstructive treatment focusing on self-differentiation, the development of an executive ego capable of self-gratification, the replacement of the client's harsh and punitive superego with appropriate reality-based aspirations, the improvement of his interpersonal reality-testing and social skills, and the gradual developmental progression in his fundamental coping strategies.

The client does have the potential for severe decompensation with possible threats of suicide, but he should recompensate rapidly with empathic interpretation. Disappointment in the therapist may be expected to elicit intellectualization and withdrawal.

A strong recommendation is made for a full neuropsychological work-up.
APPENDIX B
TAT AND RORSCHACH DATA

1. 15"

The story is about a boy whose parents force him to take violin lessons. They also force him to practice playing his violin for an hour each night. Right now he's sitting in his room, waiting to start playing his violin for that night. And he's thinking about how much he hates it, and how rotten he is at it (laughs). The end—the short end is that he'll practice his violin time and hate it (half-laugh), and as soon as his parents will let him quit playing it, he'll quit playing the violin for good.

2. 10"

Hmm... (15") I'm to make up a short story, o.k. This is about a family who lives in Kansas (half-laugh) on a farm. The girl with the books is the daughter of the father and the mother in the picture here. She's on her way to school in the morning while the parents work in the field. And because she got an education when she was younger, in a couple of years when she grows up she moves to New York City and becomes a famous author. (E: And what are the people feeling?) Girl's thinking about how much she wants to get away from there. The father's not feeling anything, he's just working very hard, and the mother's taking a break, enjoying the sunshine.

3. 10"

Can't really imagine it—o.k. This one's about a son who had moved away and uh, while he was away married a very voluptuous woman (half-laugh) and has come home to tell his mother, and the mother looks out at the car and sees what the woman looks like and is shocked (laughs), and he is concerned about what her reaction will be. (Laughs) That's it, that's quite a story. (E: How will it turn out?) In the end the mother was right in disapproving. The woman spends all his money and leaves him which shows the moral of the story is mothers know best (laughs).

8BM. 6"

I would say this is a story about a boy—day-dreaming about becoming a surgeon when he grows up. And uh at the end of the story when he grows up he does indeed become a surgeon. (E: What is he feeling?) Day-dreaming about how much he would like it, enjoy it, how he would like to be a surgeon to help people.
4. 35" This is a story about a man and a woman who are in love. And he's on his way out the door to do something awful, something he might get in trouble for, and the woman is trying to hold him back. She's thinking she's afraid if he goes he won't come back, and he's thinking it's something he has to do. And in the end after much trouble or whatnot he does in fact come back and everything's okay. Reminds me of some movie, an actor and an actress. I dunno who. Looked like a Clark Gable movie, with him running off to rob a bank to save the family and the woman's pleading with him, "don't go."

12M. 46" Gee this is about (sigh) -- very old man who feels that he is about to die, going to uh, his favorite grandson's bedroom-- one he's very close to-- while he is asleep-- and taking a last look at him and saying goodbye. And the end of the story is that in the morning the grandfather has died. (half-laugh) Pretty morbid.

17BM. 15" I dunno. This is the middle of a story about how this particular athlete works out to stay in shape. Right now he's in the middle of his workout which is climbing rope. And he's thinking about how good the exercise makes him feel (half-laugh). And the end of the story is that he's in great shape and lives to be a very old age because he exercised regularly throughout his life (laughs).

7BM. 9" Okay, let's make up a good story here.

20" This is a story about a very powerful family in the Mafia. This old man is the don and the younger one is his son who his foolish in his judgment and always trying to take control. And in this picture the-- they're talking about a business deal and the father is telling him how ridiculous his idea was (clears throat). The son even though he knows he's right, because he knows he's right, feels resentful, feels stupid because he knows that he was wrong, but resents being wrong, having it pointed out to him ... And the end of the story is that the younger son, not this son, gets control of the family.

(After returning card) Reminds me of Marlon Brandon in the Godfather.

13MF. 30" (Sighs) This is a story about a man who has just strangled -- looks like she's dead the way her arm is-- has just strangled his wife because she was always following around on him and in a fit of rage he strangled her, and now he's feeling great regret and sorrow for having strangled her and in the end he goes to jail for it.
10. 10" This is a story about two people who are very much in love and right now they're embracing each other, both thinking about how much they care for the other person and enjoying the closeness felt between them. I guess the end of the story would be, that they remain in love throughout their lives.

3BM. 0" Oh boy, I see they're getting vaguer and vaguer.
15" I may be wrong about what I see on the floor but this is the story of a girl who is a heroin addict and she's just shot up and she's feeling the rush. Let's give this a happy ending. And the end of the story is that she did too much heroin this time and would have overdosed but some friends find her and bring her to the hospital. And from there when she's better she decides to go to a rehabilitation center--where she works out her problems--and in the end leads a very happy life, and learns to live with herself.

(After returning the card: I just came out of therapy so I'm feeling very optimistic.)

15. 10" Hmn!
45" This is a story about grief. Uhm--this woman is in the cemetery, looking at the graves of everyone in her family--and--feelin overcom with grief--and hate -------------and------the end of the story is that--she leaves--and--eventually makes a new life for herself--but never forgets what happened.
Rorschach Protocol (4/20/81)

I. 4"  
1. That looks like a bat ...  
2. ...an insect. Possibly an insect--some type of an insect would even be better. That's about it (pushes card away; 55").

Inquiry:

E: First you said, "That looks a bat." Tell me more about the bat.  
S: Well I think it looked more like an insect than a bat the longer I looked at it-- The reason I said it looked like a bat was the way it had wings and it looked like it had a type of head--and then the color--black.  
E: Then you said, "An insect, possibly an insect, some type of an insect would even be better." Tell me about the insect.  
S: Yeah--uh--because of the holes in the wings, sort of--and--it looked like it had a head still but also maybe tentacles? Or antennas?

Location inquiry:

E: Now would you look at the card again and circle with your finger around the part that was the bat.  
S: (Starting at top center of blot, outlines whole shape with index fingers of both hands simultaneously.) (Pointing:) There's its body--head--claws--I dunno if bats have claws (half-laugh)--wings (thumps each wing).  
E: Now could you do the same thing for the insect?  
S: (Touching the card with right index finger:) Insect's body--head--tentacles--insect's tail. And it would to be a flying insect because it has these wings.
II. 10" 3. Butterfly--that would definitely be a butterfly and I think that's about all I'll see in it. (Continues to look at card.) (E: Anything else?) (Pushes card away, shaking head; 45")

Inquiry:

E: First you said, "butterfly, that would definitely be a butterfly." Tell me about the butterfly.

S: It had its--It's head was down here, and mostly the color made me think of a butterfly too. The head was red, and there were the wings which was the black part with spots of red on them, and the tips of the wings were red, and the middle part of its body was white. Not only the shape, the color.

Location inquiry:

E: Could you circle with your finger around the butterfly?

S: (Circling with two index fingers simultaneously:) The whole thing. Here's its head down here, the red, with the antenna. The black part is the wings, with splotches of red through here, and the tips of the wings are red. The white part in the center is the body.

Testing the limits:

E: Can you see dogs or bears anywhere in this blot?
S: Oh yeh, right here, heads, paws. Could be dancing bears.
III. 45"  4. What's it look like, huh-- (half-laugh)--uhnn...  
70" It doesn't look like anything to me.  
85" Yeh--except for the red spots (covers them with hands)  
I can see like an aerial view of land masses with  
higher regions, mountain regions, and lower regions...  
or maybe thickly forested areas and fieldlike areas...  
but this--(counting, touching card with index finger)  
Three different land areas--but that still leaves the  
red spots out of the picture ... I would say very  
thickly forested areas and fields rather than higher  
and lower elevations.  

5. Taking the red spots away from the picture, the remind  
me of sea horses. That was my first thought. Though  
that doesn't tie in with the total picture.

Inquiry:

E: First you said (repeats from "except for the red spots ...  
elevations"). Tell me more about that.

S: It looked like an aerial view from very high up. I dunno,  
I saw the white part as being ocean, and the black part as  
being land areas. On each of the land areas the tone of  
the black was darker and lighter. I saw the dark areas as  
heavily forested and the light areas as maybe fields--I  
shouldn't say fields, large grass areas. Even that was  
kind of stretching it. I was trying very hard to see  
something in it.

E: Then you said, "Taking the red spots ... thought." Tell  
me about the sea horses.

S: Not the middle red spot, but the shape of the two red spots.  
What is it the shape of? Two seahorses. Had a head, and  
then it curved around into a body which was a little wider,  
and then they had tails which curled at the end.

Location inquiry:

E: Show me where you saw the aerial view.

S: (Circling with two index fingers around black:) The black  
part. There are three land masses, one, two, three  
(pointing). Here where the ink is darker are the forested  
areas, and these are fields.

E: And the seahorses?
S: Here and here. You see their heads, and they have the little points—I dunno what you call 'em on their heads and then the body, and the tails. The tails don't curl after all.

Testing the limits:

E: Can you see two human figures anywhere in this blot?
S: Hmn ... Maybe heads here, no bodies though.
E: How about using the head and these areas here (pointing).
S: Yeh, but they would be very distorted—grotesque. But yeh, they could be modernistic drawings of people, arms, legs, bodies. Sure.

IV. 10" It's an ugly picture.
35" 6. Maybe (laughs) a beaver, no--
   7. Some type of creature. Looks like it has feet and a tail, arms of some type—Just a real ugly picture. That about all. (Pushes card away; 90")

Inquiry:

E: First you said maybe a beaver?
S: The very front of it. Looked like it had whiskers. That was it.
E: And some type of creature?
S: Yeh, just because it looked like it still had a head and feet of some type. Little arms. Something very ugly about it—the color of it, the shape of it—kind of grotesque.
E: Grotesque?
S: Some kind of deformed grotesque creature. (laughs) Guess I've watched too many horror movies or whatnot.

Location inquiry:

E: Show me the beaver.
S: (Covering lower part with hand) Just the top, could be a beaver or an otter, a sea otter. Whiskers here. This would be the nose.
E: And the creature?
S: The creature's head is small, here. It has little deformed arms, not proportioned, and really big feet. The body is all kind of out of shape and whatnot.

E: And its tail?

S: This here may be, that's a tail--I--stretching it but ...

Testing the limits:

E: Can you see a furry animal skin anywhere in thi blot?

S: Yeh, a beaver or sea otter.

E: How about shoes or boots?

S: Guess what I said were feet could be seen as shoes or boots, misshapen ones.

V. 10" (Clears throat.)
50" (Sighs.)
80" (I don't see anything I can think of that it looks like, reminds me of.

115" 8. A rocket? A missile? (Continues looking at the card; pushes card away; 128")

Inquiry:

E: First you said a rocket or a missile?

S: Yeh. Well it had a front that was kind of coming to a point, and maybe with two, uh--sensors to pick up the direction. In the back it lookied like it had maybe an opening where fuel came out--and maybe propellar with two little wings for balance,-----and then larger wings to help it stay in the air.

E: Could you decide which, a rocket or a missile?

S: A rocket, instead of a missile because it's too big to be a missile.
Location inquiry:

E: Can you outline the rocket with your finger?

S: (Pointing using finger and thumb of both hands, moving hands from middle outward:) The whole thing. This is the front, and here are the sensors. Back here is the part where the fuel comes out, between these two smaller wings for balance. The larger wings are to propel it, keep it in the air.

Testing the limits:

E: Can you see a winged insect in this blot?

S: Oh sure, just that when I got to this one I was all insected out (half-laugh). Head, tail, wings would be an insect.

VI. 33" 9. This s gonna sound really silly (half-laugh): some type Indian--American Indian design? And the part that basically makes me see that is from there up (covers lower portion with hand), some type of carving or painting. (Continues looking at card; pushes it away.) That's it (86")

Inquiry:

E: You saw an American Indian design. Tell me more about it.

S: The top portion of it reminded me of the style that the American Indians used for their paintings or carvings. The color in it, something about how it was darker in the middle. I've looked at American Indian paintings, studied about the American Indian. It struck a familiar note.

Location inquiry:

E: Show me the American Indian design.

S: (Covers lower portion with hand) From here up. The coloring down through the middle. And this (winglike extensions) may be a familiar shape.

Testing the limits:

E: Can you see an animal skin, hide, rug, or pelt in this blot?

S: No.

E: How about if you just look at the lower part?
S: Oh yeh, but you have to leave out the top. There's no whole.

VII. 0" It's pretty.
17" 10. Clouds. That's a common answer I'm sure, but it kind of reminds me of rain clouds. It's very light and kind of fluffy-looking, but then because it's a dark color it would have to be rain clouds.
11. Can sort of see faces in it ... (counts) Four faces.
12. Couple fish ... Two faces, two fish. That's it. (Pushes card away; 135")

Inquiry:

E: First you said rain clouds. Tell me more about them.
S: First I said it was pretty, and clouds to me are pretty. They were just light, fluffy-looking. Then they had to be rain clouds because they were dark and dark clouds to me mean rain.

E: Then you saw four faces, but you changed that to two faces, two fish. Tell me about the faces.
S: Well there were two faces below two fish. I sort of could see noses, eyes, mouth, and they were looking in opposite directions like this.
E: Anything else about the faces?
S: No--they were vague, I mean.
E: And the fish?
S: They were on the upper--well, I guess it would be the top to you. They were facing each other. They each had fins, open mouths. That's it.

Location inquiry:

E: Show me the clouds.
S: (Points) The whole thing.
E: And the faces?
S: Here (circling): eye, nose, mouth (half-laugh), pointed head.
E: And the fish?

S: The top part (circling): Bodies, back fins, open mouths (half-laugh).

VIII. 5" Color!

15" 13. Looks like when you look through a kaleidoscope? Especially right here (lower two portions).

14. I see a flower.

15. (laughs) See two dogs, uhm... The flower's a uh--pansy maybe--something like that, yeh. That's it. I don't see the whole as anything (95")

Inquiry:

E: First you saw a kaleidoscope?

S: The colors, the way they run into each other. And kaleidoscopes always have bright colors.

E: Can you say anything else about the kaleidoscope?

S: Only that I was looking through a kaleidoscope at work today. First time in ten years. I don't think I would have thought of it if I hadn't looked through one today.

E: And the flower?

S: It could have been a pansy or a rose. Decided pansy because of outside shape, and then the colors. Pansy has sections of different colors on one leaf, rose tends to be all one shade. The shape and the color--about it.

E: And the two dogs?

S: They were on the outside. Each had a head. They were facing each other. They each had a body. They each had three legs with the other hind leg behind the hind leg, and then they each had a tail.
Location inquiry:

E: Show me the kaleidoscope.

S: All of it except the grey part up here (covers upper portion with hand). The center colors blend into each other the way they do in the center of a kaleidoscope.

E: And the flower?

S: Just this part down here. Four leafs sticking out, and the colors fading together.

E: And the dogs?

S: On the sides. They're a little distorted, but their heads are here, and there are one, two, three legs so I'm assuming a fourth leg behind the hind leg, that they're not three-legged dogs (half-laugh). The bodies, tail here I guess.

IX. 16" 16. I see an explosion--radiating out different colors, different fields of energy. There's kind of a dome, and a central part of the explosion where it all radiates out from something. Down at the bottom it's very red, very hot, because that's the point the explosion is coming from. (Pushes card away; 85")

Inquiry:

E: Tell me about the explosion.

S: It's very hot--red--bright--down at the bottom, the base of the explosion, the center of it. And then as it rises up in the center, the center's something very hot, very strong, and the other colors radiate out from that as it starts to cool--not as strong energy forces.

E: What particularly made you think of an explosion?

S: The way it was most red--hot--at the bottom, and the way the other colors radiated out. I see an explosion as going up and out as it starts to cool.
Location inquiry:

E: Show me the explosion.

S: Here's the base, and even down here as it radiates out from the center it gets cooler. Then its hot energy force radiates upward through the center where the color is stronger and radiates out. Out here it's not as strong.

X. 15" (Smiling) It's a nice picture. There's a lot happening in it.

33" 17. It looks like one of those fantasy pictures you see with all the little creatures from outer space gathered together—all gathered together for a party, a celebration. Lots of little faces and lots of little animals. Very fantasy-looking. There's 1-2-3-4-5-6—about eight different kinds of bugs—bugs isn't the right word—little things.

18. What it really looks like is an ink blot folded over. That's it.

These don't kind of fit in with the rest of the picture. They're too big. This whole center. Whole thing doesn't fit in to the rest of the picture (Pushes card away; 165")

Inquiry:

E: First you said, "It looks like ... little things."

S: That was because of the color. Little creatures because of the different shapes. Outer space because different little shapes. I would say party or celebration because of the color. It wasn't dark colors, bright colors, cheerful colors. There was two of each kind and that's because it was folded over (half-laugh)—makes two of each kind. Very distinct and different shapes. And each pair was one color. Except the red in the center didn't fit in. It certainly wasn't another thing or anything—thing or anything! (Laughs)

E: And the ink blot folded over?

S: (Laughs) That's what it is, makes two of everything.

Location inquiry:

E: Show me the creatures and the celebration.
S: (Pointing) These two are one, two, three--These are really distinct, I could see eyes and mouth on them. Four, five, six--eyes and nose. This red doesn't fit in. And this green part down here, it doesn't really fit in either.

E: And the inkblot?

S: All of it, just alike on the two sides.

**Testing the limits:**

E: Do you see anything that could be a crab or a spider?

S: Yeh, these right here, with all the legs.
APPENDIX C
SURVEY OF THERAPISTS

June, 1983

I am writing to enlist your help in a research project on males with anorexia nervosa and bulimia. The enclosed survey is being sent to therapists whose published work indicates that they have worked with anorectic and bulimic patients or who have been referred to me on the basis of clinical work with this population. The brief questionnaire enclosed should require no more than fifteen minutes of your time. In responding to the questions on the following pages, please base your answers on clinical experiences you have had with anorectic and bulimic patients or clients. Some of the questions ask about anorexia nervosa and bulimia in males. If you have no experience with men with these eating disorders, please respond to the other survey questions and return the questionnaire anyway. A self-addressed envelope has been included to facilitate return of the survey.

I am doing this project as part of my doctoral dissertation in clinical psychology at the University of Massachusetts Health Services. I am presently an intern at the Harvard University Health Services. This project has been approved by my dissertation committee and by my department.

You need not include your name or the name of your agency anywhere on the following pages. However, if you wish to receive a summary of the findings of the survey, please fill in the section at the bottom of this page and return it with your questionnaire.

I appreciate your help with this project.

Teri Pomerantz Rumpf, M.S.

Please send me the results of this survey:

Name _____________________________________________

Title ______________________________________________

Address ___________________________________________
SURVEY OF ANOREXIA AD BULIMIA

1. Name of the agency you work for (optional) _________________________

1. Type of agency:

   Children's Hospital
   Psychiatric Hospital (inpatient unit) __________
   Psychiatric Hospital (outpatient unit) __________
   University Counseling Center __________
   Private Practice __________
   General Hospital or Medical Center __________
   Community Mental Health Center __________
   High School or Junior High School __________
   Child Guidance Center __________
   Other (please explain) _________________________

2. Is your major therapeutic orientation:

   psychoanalytic __________
   psychodynamic __________
   client centered __________
   behavioral __________
   cognitive __________
   other __________
   (please explain) _________________________

3. Please specify your mental health discipline:

   Social Work _____  Psychiatry _____  Nursing _____
   Psychology _____  Counseling _____  Other _____
   (please explain) _________________________

4. Highest degree you have earned _____

5. Are you: female _____  male _____

6. How many years have you worked in the field of mental health at your present level of training? _____

II.

1. Approximately how many anorectic patients have you worked with? _____
2. Of the anorectic patients you have treated, how many were also bulimic?  
How many (if any) of these patients were males? 

3. Approximately how many bulimic patients have you worked with?  
How many (if any) of these patients were males? 

4. Do you think that anorexia nervosa and bulimia in males are different clinical entities than in females? Yes/No  
If you answered yes, please briefly explain why:

5. In your work with patients or clients with anorexia nervosa and bulimia, do you do primarily:
   individual therapy  
   family therapy  
   group therapy  
   drug therapy  
   combination  
   (please specify) 

III. In your therapeutic work with anorectics and bulimics, do you:

   Regularly  Sometimes  Never

1. Discuss the patient's diet; its nutritional content, caloric intake, etc.? 

2. Incorporate discussions of the patient's weight into the therapy? 

3. Monitor the patient's weight 

4. Prefer to work with a physician who monitors the patient's weight, nutrition, and caloric intake? 

5. Refuse to work with a patient whose weight drops below a certain point. 

6. Discuss the patient's dietary restrictions, binging and purging, etc.?
7. Encourage the patient to keep track of particular times when food restriction takes place, or when binges occur?

8. Discuss the psychological effects of starvation with an anorectic patient?

9. Discuss the possible medical consequences of anorexia nervosa and bulimia with the patient?

10. Prefer not to discuss issues pertaining to food and weight with the patient?

11. Offer consultations to the patient's parents to discuss the patient's weight, food intake, eating habits, etc.

12. Feel that specific matters related to food are best left out of therapy, or discussed only briefly during the course of a therapy to allow for discussions of more dynamic issues related to eating disorders?

13. If the answer to 12 is yes, please describe how you handle issues relating to weight, food intake, binging, purging, etc. (For example, do you discuss these issues briefly at the beginning of therapy, then prefer not to discuss them on a continuing basis ...)

14. If you answered yes to #5, what do you do when a patient's weight drops below a certain point? Please describe.
IV. Specific case material on males with anorexia nervosa and bulimia is somewhat sparse. The following section is an attempt to gain more detailed information on specific cases.

Males With Anorexia Nervosa

1. Number you have treated
2. Approximate ages at onset of weight loss
3. Approximate ages at inception of therapy
4. Percent of original body weight loss at the time treatment began
5. Approximate weight loss (number of pounds or kilos--please indicate which) at the time treatment began
6. Approximate weight gain by the end of treatment
7. Duration of treatment
8. Was the patient (in each case) also bulimic?

Sample answers:
1. 2
2. 13, 19
3. 13, 22

ETC.

Thank you very much for your participation in this project.