Bruch Revisited: The Role of Interpretation of Transference and Resistance in the Psychotherapy of Eating Disorders

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BRUCH'S CONTRIBUTIONS

I believe that most authorities would agree that Hilde Bruch (1970, 1973, 1979, 1984) has had a larger impact on the way that modern psychotherapy is practiced with eating-disordered patients than any other writer. Not only did she influence treatment approaches profoundly, as I shortly describe, but she also gave us a new theoretical understanding of anorexia nervosa, the prototype of all psychologically determined eating disorders. Before Bruch, anorexia nervosa was generally understood to be some form of conversion hysteria in which the refusal to eat symbolically expressed a repudiation of sexuality, especially fantasies and wishes surrounding oral impregnation (e.g., Lorand, 1943/1964; Masserman, 1941/1964; Moulton, 1942/1964; Thoma, 1967; Waller, Kaufman, & Deutsch, 1940/1964). In contrast to this drive-defense model entailing repressed oedipal wishes, Bruch emphasized oedipal development, observing that anorexic patients display major deficits in the sense of self-identity and autonomy. In her view, anorexic symptomatology represents a defensive reparative maneuver against the underlying sense of powerlessness and ineffectiveness associated with major deficits in the personality de-
development of the individual. She further traced these deficits to the failure of the mother to respond appropriately (in a reasonable and consistent fashion) and affirmingly to child-initiated behaviors, which results in gross deficiencies in the individual's sense of initiative and active self-experience (Bruch, 1973). In other words, while earlier writers emphasized triangular, oedipal conflicts between drive and defense at the core of anorexia nervosa, Bruch focused upon psychological deficits in ego- and self-development based on early distortions in the dyadic, mother-child relationship, in which the mother is experienced as controlling and intrusive by the young child.

With respect to psychotherapy, Bruch (1973) eschewed interpretation in favor of what she called a "fact finding, noninterpretive approach" (p. 336). She coined the phase "constructive use of ignorance" to describe her therapeutic approach to anorexic patients (1970, p. 56); by this Bruch meant that the therapist should listen closely to discern the patient's story, should treat the patient as a true collaborator, and should not act in such a way as to mislead the patient into thinking that he or she has a secret store of knowledge that is being purposely withheld. Bruch (1970, 1973, 1978) advised the strict avoidance of theory-based interpretation of unconscious wishes in the drive-defense configuration. Rather, she counseled a "naive" stance, which emphasizes listening to the patient and helping him or her (most often her) define her internal experiences as they unfold in treatment. The goal, of course, is to help the anorexic recognize what she really thinks and feels, an opportunity that she has lacked in earlier development. In short, Bruch recommended what I would consider a "clarifying" approach to the anorexic, in which primary emphasis is placed on assisting the patient to articulate what she experiences at a preconscious level. In contrast, she shunned an interpretive approach in which the primary aim is to uncover mental contents residing at an unconscious level. She felt that interpretation is often experienced by the anorexic as a recapitulation of early trauma in which she was told what she thought and felt by a superior other. She believed that interpretive interventions only confirm the anorexic patient's sense of inadequacy, and interfere with the development of trust in her own self-awareness and self-expression (Bruch, 1970, 1973).

BEYOND BRUCH: INTERPRETATION, TRANSFERENCE, RESISTANCE

My thesis is that while Bruch's noninterpretive, clarifying approach did undoubtedly represent a major step forward in the treatment of anorexic patients, her excessively narrow prescriptions regarding technique have unfortunately caused contemporary therapists to greatly underestimate the importance of interpretive work, especially interpretation of transference and resistance phenomena, in the psychotherapy of anorexics and bulimics. Her writings represented an important advance because they served as a necessary correction to the excessive preoccupation with instinctive aims that characterized psychoanalysis in its formative years. She was patently correct in asserting that early and direct interpretation of unconscious wishes (e.g., the wish to be impregnated by the father) is experienced by the patient as an intrusive assault that damages the working alliance and the spontaneously developing positive transference. On the other hand, I think that the very cogency and brilliance of her arguments have unfortunately engendered a damaging overcorrection in which the "baby" of empathic, tactful, well-timed interpretation of transference and resistance has been thrown out with the "bath water" of unempathic, tactless, and ill-timed interpretation of id-driven wishes. My views about the importance of interpretive work in psychotherapy, especially the interpretation of transference, have been greatly influenced by the writings of Merton Gill (1979, 1982, 1988).

In essence, Bruch recommended clarification instead of interpretation. I believe that she would have been correct if she had stressed clarification before interpretation. Basically, what Bruch did was to abandon the "topographical" approach in which the therapist begins at the surface and moves slowly to the depths (Fenichel, 1941). In this method, the conscious and preconscious are addressed before the unconscious, resistance before content, and ego before id. Instead, Bruch recommended that interpretations be discarded wholesale while confrontation and clarification be preserved. Boris (1984) contends that Bruch did not really object to interpretive work per se, but rather objected to poor interpretive work. However, my reading of Bruch does not support his assessment.

In describing her treatment approach, Bruch declared that "interpretations are strictly avoided" (1970, p. 51). However, a close examination of her work reveals that this was not in fact so. Her last major report on psychotherapy (1979) contained several interpretations of content and defense in the case material, though they are not identified as such. At a critical juncture in her work with Annette, an adolescent anorexic, she made the following interpretation:

"Yesterday you said not once but twice that one cannot squash a sister, indicating a double blind dilemma. When you experienced her rejection you must have felt extremely angry at her; but you lived also with the rule that one must love a sister. Therefore you were unable to protest or make your own demands." (1979, p. 31)
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This was clearly an interpretation of content, or, more precisely, an interpretation of intrapsychic conflict between an angry wish and an equally powerful moral injunction to "love thy sister," leading finally to a state of paralysis. Later in the therapy Bruch offered an interpretation of defense, telling Annette that her self-punishing attitude was related to her angry feelings at her sister (1979, p. 32).

In Eating Disorders (1973) Bruch made an indisputable interpretation of transference, though a displaced, not a direct one. She pointed out to Felice, an anorexic in treatment with another therapist but being interviewed by Bruch in consultation, "that an increase of symptoms during the past few months could be understood as a vengeful message to her therapist that he, too, had failed her" (p. 354).

Along with explicitly discarding interpretation, I believe that Bruch also mistakenly underemphasized the roles of resistance and transference in treatment. There is little mention of resistance in her work, and, to my knowledge, no explicit reference to transference phenomena. For example, she wrote, "Much of what is termed 'resistance' may be the result of discrepancies in meaning and verbal usage, even though it may sound like ordinary words being exchanged. This makes a demand on the therapist that his communication be simple and unambiguous, free of professional jargon" (1973, pp. 337-338). In other words, she suggested that resistance may be largely artifactual, arising from a discrepancy between what the therapist says and the patient hears. The antidote to this is "simple and unambiguous" speech on the part of the therapist. Although it is undoubtedly true that poor technique greatly heightens resistance, it is equally true that resistance is inherent in any therapy. After all, resistance is only the part of the patient that resists change—that opposes the work of therapy and, in doing so, defends the status quo. Although Bruch was a psychoanalyst and a psychodynamic therapist, she appeared not to accept a precept absolutely crucial to her school: namely, that there are forces for and against change residing within the patient, and that these forces are in constant conflict throughout much of therapy.

Actually, I do not believe that Bruch's view of resistance phenomena was simple. Although she explicitly minimized it, several passages in her work implicitly suggest that she thought it important. As was apparently true of her outlook on interpretation, she appeared to be of two minds about resistance. For instance, Bruch asserted, "Patients will cling to their distorted concepts and let go of them only slowly and reluctantly" (1979, p. 27); and "patients will adhere to their distorted concepts, the false reality with which they have lived, since it represents their only way of having experiences . . . " (1978, p. 136). Bruch also noted that "They [patients] also deny that there has been anything troublesome in their relationship to their parents. Everything is perfect . . . " (1984, p. 15).

Furthermore, she (1978) warned therapists of the danger of "pseudo-agreement" on the part of anorexics. That is, the patient will seem to accept interpretation, and even elaborate upon it, but in actuality it means nothing to her on an affective level; in other words, it is just a "phony intellectualization" (p. 13). Although she did not use the term "resistance" to describe these striking clinical observations, they certainly sound like clear-cut manifestations of resistance.

I have much the same criticism of Bruch's neglect of another important technical consideration, transference. In her writings, she did not pay heed to it. Bruch apparently felt that if the therapist employs the proper stance vis-à-vis the patient—a nonintrusive, noninterpretative, fact-finding approach—a milieu is created in which the anorexic patient flourishes and the curative process unfolds sui generis, without transference issues being an important concern. To put it slightly differently, my reading of Bruch leads me to conclude that she believed that if the therapist helps the patient accurately clarify what she really thinks and feels, the stalled process of separation-individuation will be reinitiated, and sufficient growth will occur within the patient to allow her to abandon her symptomatology. This viewpoint runs strikingly counter to the contemporary belief that psychotherapy is always, to one degree or another, an emotional struggle between the patient and the therapist (Blos, 1984), in which transference wishes, attitudes, and enactments play a pivotal role. My experience is that transference phenomena are ubiquitous in treatment, no matter how empathic the approach. This is compatible with the outlook of a number of recent observers (Boris, 1984; Fischer, 1989; Rizzuto, 1988) who have noted that resistance to involvement in the transference is one of the principal problems in treating anorexics. That is, anorexic patients tend to remain aloof from the therapist and not to invest themselves in treatment for long periods of time.

Later in this chapter, I describe the 2-year psychodynamic psychotherapy of a bulimarexic college student (which is still in process) that highlights such interpretive interventions. My approach has not been singularly or relentlessly interpretive. Other forms of intervention, such as clarification, confrontation, and education, have all had consistently large roles to play. Above all, throughout the therapy I have striven to create a "holding environment" (Winnicott, 1965) in which this late adolescent could feel secure and free to share all parts of herself, including those that she experienced as ridiculous, self-destructive, perverse, deeply embarrassing, and the like (Sandler & Sandler, 1983).

Besides the interpretation of resistance and transference, I also want to emphasize another theme: the multilayering of psychopathology, in which issues related to both preoedipal and oedipal development (i.e., deficit and conflict) are intricately intertwined. While I agree with Bruch
thoughts, feelings, and attitudes. Befitting the youth of the population I see, my style is rather active. I place special emphasis on understanding and explaining, in collaboration with the patient, the salient aspects of her intrapsychic and interpersonal worlds as they emerge in the “here and now” of the treatment encounter. For example, in relationship to transference, I emphasize (as does Gill, 1979, 1982, 1985) the relatively early interpretation of transference as it develops in the immediate “here and now” of therapy, while minimizing the “there and then” aspect of transference phenomena, which links current treatment experience with archaic childhood figures (“reliving of the past in the present”). I typically choose the former, more contemporaneous route because it is more immediate and real—and thus more meaningful—to the patient. I would not object if someone described me as an interpersonalist with a strong commitment to psychodynamics.

Early Treatment; Background Information

In retrospect, I considered the first 4 months of Jessica’s treatment to represent an initial “symptomatic phase,” in the sense that concerns about her restrictive dieting, weight loss, and precarious health status overshadowed all others. At a surface level, Jessica was initially delighted by the materialization of her anorexia nervosa. She remarked, “I have been dieting my entire life; this is the first time I have been successful!” As Boris (1984) has so aptly stated, for the anorexic patient the anorexia is the solution, not the problem! My problem was to successfully redefine anorexia as a problem for her; in the beginning it seemed to be more my problem than hers.

Although she came to therapy regularly during the first 6 weeks, her resistance to treatment was obvious, as she quickly lost 13 pounds. This ballistic rate of weight loss culminated in a brief hospitalization at my insistence, during which Jessica managed to gain enough weight to restore her health. Future hospitalizations proved not to be required, as she has managed to maintain a medically stable but below-average body weight throughout psychotherapy. During this early phase, Jessica showed intense resistance to involvement in treatment and equally intense commitment to anorexia nervosa.

My reaction was to internally debate how intrusive I should be about her weight and eating habits before finally deciding upon the course just outlined. I would practice a sort of “benign neglect” for the time being if she managed to avoid health complications. To be “too forward” in this domain, I believe, would have been experienced as intrusive by Jessica; on the other hand, being “too permissive” might have been experienced as an abandonment by me to her own self-destructive tendencies. Large-
ly, I attempted to act as an ancillary ego for Jessica during this difficult period.

To briefly review her symptomatic history, Jessica began bingeing and purging at age 15 following a cross-country move. As is true of the great majority of bulimic patients, she had made multiple unsuccessful attempts at dieting. Jessica was an attractive, tall young woman with a graceful, athletic physique. For years she had longed to look like a fashion magazine model, but had never been able to sufficiently reduce her caloric consumption to approach this ideal until shortly before she entered therapy. It appeared that her success in dieting was triggered by her return to school and what she experienced as a momentous decision, the choice of a major. I speculated to myself at the time that this must indeed be a difficult decision if an individual has little confidence in her capacity to choose wisely on the one hand, and on the other must be perfect in whatever she does. Her anorexic stance was founded on the following logic: “If I am unable to feel in control of my life, I will compensate by exerting total control over my diet in pursuit of perfect thinness!”

The Unfolding of Resistance and Transference

At the start of each session, Jessica always chose the chair most physically distant from me. Her eyes were constantly averted, as if eye-to-eye contact was excruciatingly painful. As the therapy unfolded, it became clear that her eye aversion had multiple meanings. Initially, it appeared to be simply an identification with other family members, particularly her father, who habitually avoided or minimized eye contact. Further inquiry revealed that it was reflective of her profound sense of shame: Jessica experienced herself as so wanting in so many domains that she literally preferred not to be seen. At a deeper level, reconstruction suggested that the eye aversion was an attempt to avoid a traumatic recapitulation of her early relationship with her mother. This was disclosed in the context of the transference relationship, when she told me that to make eye contact was to become imprisoned by me. By this she meant that she would be compelled to “cue off” me; to read my facial expressions for signs of, say, approval or disapproval; to assess my body postures to see whether I was interested or uninterested— in short, to compulsively react to me. By avoiding eye contact, Jessica believed that at least she had the hope of being free, of being herself, of acting instead of reacting for the first time in her life. This transference attitude was eventually linked to early failures in the process of separation-individuation from her mother through the mode of repeated interpretation and working through. From transference material we were able to reconstruct together her earliest perceptions of her hyperemotional mother as an intrusive, dominating, and needy caretaker. In order to insure the survival of the relationship, she had to march to her mother’s beat. Too much independence ran the risk of maternal withdrawal and abandonment (Masterson, 1977).

Silence was the major manifestation of resistance in the first part of psychotherapy. Jessica had great difficulty with the idea and practice of free association. In a flash of insight she stated, “I am used to saying what I should say, but I have no idea of what I want to say.” Nonetheless, silence pervaded many of the early sessions. Beneath her silence raged an internal struggle between holding back and keeping secret versus letting go and sharing, reminiscent of a toddler struggling fiercely with anal issues. To Jessica’s categorical way of thinking, to share just a little was equivalent to “total vulnerability,” and the terrifying self-perception that she was becoming a “giant liquefying Jell-O,” without boundaries or definition. In contrast, keeping secret and silent meant security, but at the exorbitant cost of utter emotional isolation.

With further work it also became evident that her silence had enormous transference implications. We were able to clarify that Jessica feared that if she shared deeper parts of herself, I would be silently contemptuous and disapproving. This was linked to present and past perceptions of her aloof, methodical father. What really galled Jessica was her belief that the contempt was silent and secretive—poisonous, as it were. She said it would be so much better if the contempt was in the open; then she could at least deal with it. Her father and I were both too much gentlemen, too “professional” to openly express our arrogant depreciation of her, but she knew what we really felt. I responded to this accusation on two levels. First, I admitted that I did not know the reality of her father’s feelings toward her, so her judgment of him might well be accurate as far as I knew. Second, I made a defense interpretation: Perhaps because it was too painful an awareness, she was attributing to me her own destructive tendency to be excessively self-critical.

This interactional set heralded the development of a full-blown, very complex negative father transference, which I believe had both oedipal and preoedipal components. Her silences now had a new meaning: They were a way of controlling her “blind rage” at me for failing to respond to her in a warm, human, truly caring way. In reality, her father’s personality and profession played a large part in sowing the seeds of this transference reaction. He was a research scientist at a major university, and when I interviewed him I found him to be much as Jessica described—hyperrational, methodical, and emotionally unexpressive—though I did not feel that he was without care or concern for his daughter. To Jessica, however, he was a compulsive scientist both in his laboratory and at home. It was as if he could never let go and be a real father. When problems arose at home, he responded like the scientist he was: He calmly gathered data, he generated hypotheses that he shared with his
wife and children, he suggested new methods of approach, and so on. However, this only infuriated Jessica because there was no fire; he seemed to give nothing of his personal self to her or the rest of the family.

Jessica interpreted my therapeutic stance of an interested, sympathetic observer to indicate that I was a hardheaded scientist—"You don't really care, it's just a job to you." While she agreed that I might be more attuned to her inner needs than her father, the real difference was so negligible to be insignificant. The overriding facts to her mind were that we were both middle-aged males who heartlessly pursued our work. Her father had failed her, and I was in the process of failing her once again.

This negative transference reaction appeared to be determined by unresolved oedipal issues. (Shortly, I describe another segment of the transference in which preoedipal themes predominated.) I surmised that Jessica had unsuccessfully negotiated the oedipal phase primarily because her father had failed to lovingly affirm both her personhood and her femininity. He had never had a noncoercive phase-appropriate "love affair" with his daughter, which would have drawn Jessica away from her mother's orbit and confirmed her identity as a valued, adviseable young woman. Her hostile, provocative attitude that I had no personal feeling or concern for her seemed to be constructed to elicit two countertransference reactions typical of the oedipus: a provoked enemy retaliating in kind, or a solicitous lover full of good intentions. To my modest credit, I managed to avoid both reactions in favor of empathically interpreting her wish that I would be the loving father that she never had. I also made it clear that while I could not give her now what she had needed then, I could help her come to terms with her father's emotional noninvolvement. I held that if she experienced, understood, and mastered this disappointment, she would be strengthened and better prepared to move on with her life.

This transference "reliving of the past in the present" had to be worked through many times before the strength of the underlying forces was reduced. Not only was there a strong wish to receive what she never got (her father's emotional involvement), but there was an equally strong desire to punish him for his failure. The strength of her rage at times terrified Jessica. She was worried that during one of her self-described "witchy" moods something "vile and destructive" within would be released, and that I and the therapy would be immediately destroyed.

Pre-Oedipal Components of Transference

I would like to shift gears here and describe a preoedipal aspect of Jessica's transference, which was ultimately linked to her mother rather than her father. In a fascinating account, Fischer (1989) has described a "pull-push" dance in the transference-countertransference engagement with a young anorexic patient, which he related to preoedipal development. I saw much the same transactional pattern with Jessica. By "pull-push" Fischer refers to an intense, frantic, circular interaction pattern in which the patient gives conflicting signals in rapid succession. In his case the patient conveyed the following contradictory messages: "I feel helpless and alone; you must help; if you do, I will feel even more helpless and overwhelmed; you must help." This sort of erratic "to-and-fro" activity Fischer attributes to a poorly negotiated rapprochement phase of the separation-individuation process as described by Mahler, Pine, and Bergman (1975).

To briefly review, the rapprochement phase refers to a period in the second year of life (approximately 16–24 months of age) during which rapid maturational development along a number of lines results in the youngster's for the first time having a keen cognitive awareness of both her separateness from the mother and her exquisite vulnerability and smallness when alone. She is caught on the horns of a mighty dilemma: On the one hand, she wants to exercise her newfound independence in the volitional and motoric spheres, but, on the other hand, when she does so she acutely feels the loss of the mother's protective wing. The behavioral manifestation of this internal conflict is "pull-push" or "to-and-fro" activity—for instance, "clarting" away from the mother at one moment in joyful self-assertion, yet in the next instant clinging, literally "shadowing" her mother in an attempt to reassure herself that she is still protected by parental omnipotence.

At the end of the first year of treatment, there was a set of pull-push transactions that illustrated the preoedipal component of Jessica's ambivalent, often negative, paternal transference. (Or perhaps it would be more accurate to say that there was a switch from a paternal to a maternal transference.) Jessica abruptly announced that she was going to spend the next quarter in Japan studying in her recently chosen major. This announcement was sprung within a matter of weeks of her scheduled departure date. She had finalized plans to study abroad some time ago, but had purposely kept me in the dark. She very boldly said, "You can't butt into my trip to Japan if you don't know anything about it." She told me that she hated her dependency on me and her mother, that she would have to stand on her own two feet overseas, and that she wouldn't have our shoulders to "cry on." In the next few days she suffered a period of truly harrowing panic attacks that required the brief prescription of alprazolam. Her declaration of independence had caused an upsurge of unconscious abandonment anxiety, which was experienced as blinding, incapacitating panic states. Eventually we were able to clarify what she
did experience internally and to link it interpretively to her enmeshed relationship with her mother. Interestingly, this theme re-emerged in the session just before she left for Japan. She wanted to know my feelings about the trip. I sensed that she wanted a “vote of confidence” in what she was doing; there was a need to utilize me as a supportive, affirming parental object. I told her that my primary job was to help her understand the psychological meanings of the trip to her, but, yes, I would have objected if I thought the trip was self-destructive or unwise. I thought she was ready to handle the 10 weeks abroad and that it seemed like a great opportunity. We would have much to talk about when she returned. She was clearly relieved by my words. She smiled and said, “I guess I’m ready to set out and conquer the world.” Just in case her confidence flagged, however, she requested a small prescription of alprazolam to take with her. I think this was an instance in which medication was more valued for its properties as a transitional object than for its attributes as a potent neurochemical agent. As it turned out, she never needed the alprazolam, but its presence in her travel bag was greatly reassuring to her.

Current Status

With the continued working through of the transference as it unfolded in the “here and now” of our sessions, there has been a softening in Jessica’s attitude toward both her father and me. This has taken the form of a perceivable shift from ambivalence with a withholding, hostile tone to a mildly idealizing stance. I construe this as a very good sign. Numerous authors (e.g., Adatto, 1966; Blos, 1980; Chused, 1987; Ritvo, 1971) have commented on the importance of idealization, including idealization in the transference, in late adolescent development. The idealization of adults is seen as an important step in the process of internalizing identifications and building psychological structures: The adolescent literally takes in the admired qualities of a special adult and makes them “her own.” In fact, this is believed to be so crucial in adolescence that Chused (1987) contends that the use of the therapist as an idealized mentor is a highly salutary development, and that transference reactions interfering with this idealization should be interpreted, not the idealization itself. This was well illustrated when Jessica learned that I would be speaking on a local radio show about adolescent depression. She nervously vowed to listen, but her greatest fear was that I would make a complete fool of myself. When I managed to sound reasonably competent over the airwaves, she was greatly relieved. Maybe I did really know what I was talking about, and maybe I did really have the skills and energy to help her. She also began to experience loving feelings toward her father for the first time in memory. She began to recognize his transparent vulnerabilities, and her accompanying wish to care for and protect him.

Bruch Revisited

After 2 years of treatment, her eating disorder symptomatology has decreased sharply. Within the first 6 months of treatment, in fact, her anorexia nervosa remitted and has not reappeared. Jessica remains bulimic, however, though the frequency of bingeing and purging has been reduced by roughly three-quarters since admission. The meanings, origins, and purposes of her bingeing–purging cycle need to be more fully explored. This has been an area in which she is fiercely protective about revealing herself. There is much shame and guilt surrounding the whole sequence; her associations suggest that it has been eroticized to a large degree. To her mind, it is the one wild, crazy, excessive, free part of herself, and she wonders out loud whether she will ever be able to completely give it up. For now, it is her “black-hearted friend”—a behavioral sequence that is alternately calming and deliciously relieving, but that extracts a mighty price in shame, suffering, and guilt.

She has begun to date, a large step forward, but intimacy with males remains conflicted and problematic. She will soon be making applications to graduate school, and her professional prospects are excellent. We both understand that the treatment is not yet complete, though good progress has been made. Jessica, an amateur sailor, used the following metaphor to describe her perception of the treatment experience: Before treatment she had a “boat” and a “sail,” but no “keel” and “rudder” to steady her in the constantly shifting winds and currents of life. Treatment has given her the missing psychological keel and rudder, and though she might not always be adroit in how she handles her craft, she nonetheless manages now to remain upright and secure in heavy waters.

CONCLUSION

In my view, Hilde Bruch remains the seminal contributor to the practice of psychotherapy with anorexic and bulimic patients. Although I disagree with her on several major points, I find much more in her work to praise and emulate. For instance, she wrote, "The therapeutic task is to help an anorexic patient in her search for autonomy and self-directed identity by evoking awareness of impulses, feelings, and needs that originate within her" (1979, p. 27). I could not agree more fully. Interspersed throughout her psychotherapy writings are a number of suggestions related to what Stone (1981) has called the “attitude and setting” of psychodynamic treatment that are extraordinarily valuable:

1. Interventions should be based on the clinical encounter, not theory.
2. The therapist should make the patient an active participant in the process, a true collaborator.
3. The therapist should display genuine warmth and honesty in his or her dealings with the patient.
4. The patient should be "educated" about the goals, purposes, and methods of psychotherapy.
5. The tone of the sessions should not be somber. There is room for lightness in a "friendly, well-meaning way" (1970, p. 142).
6. Patience is important. It requires time to repair the developmental deficits that the eating-disordered patient brings to treatment.

In fact, one could make the case that Bruch's greatest contribution has been in transforming the attitudes of therapists toward anorexic patients. By stressing such treatment principles as empathic listening, collaboration, supportive helpfulness, nonintrusive concern, and the need to confirm the inner reality of the patient, she was, in effect, creating the sort of therapeutic setting that Winnicott (1965) called a "holding environment"—a safe, secure place, free from threat, wherein habitual, maladaptive ways of coping could be held in abeyance and new methods tried out. Most therapists would agree that the creation of a "holding environment" constitutes the _sine qua non_ of any successful therapy: Without it, there is simply nothing! Bruch was clearly rebelling against classical psychoanalysis as practiced in her era—the austere, remote analyst, acting as a "blank screen," making interpretive statements from "on high," about profoundly embarrassing instinctual wishes (Stone, 1984). Moreover, these interpretations in her view were predominantly founded on theory and only weakly corroborated by clinical material, if at all.

Nonetheless, I do have some significant disagreements with Bruch. Although she did greatly improve the tone of the attitude and setting of psychotherapy, she unfortunately minimized or neglected crucial technical skills and considerations, such as interpretive interventions and adequate attention to resistance and transference phenomena. To recapitulate, I believe that Bruch failed to distinguish between interpretation of id impulses and interpretation of resistance, defense, transference, and content (e.g., identifications and intrapsychic conflict). While I agree with her that interpretation of id wishes is a hazardous proposition that often has very negative ramifications for the treatment relationship, I believe that she erred by proscribing interpretation entirely. In doing so, she discarded a powerful tool for dealing with the ubiquitous treatment phenomena of resistance and transference, among others. In contrast to her, I also contend that resistance is inherent in treatment, and not largely an artifact of poor technique. I have likewise described my view that Bruch neglected the importance of transference phenomena in the treatment of eating-disordered individuals. I believe that many contemporary psychotherapies of adolescents and young adults, including eating-disordered patients, could be enriched by greater attention to resistance and transference phenomena as well as their interpretive reduction (Swift & Wonderlich, in press).

As we enter the last decade of the 20th century, the world seems to be changing in rapid and marvelous ways. Many new developments in the recent past have improved our ability to treat the heterogeneous pathologies included under the rubric of the eating disorders. I count among these pharmacotherapy, cognitive and behavioral therapies, group approaches, family therapy, and the interpersonal Sullivanian approach exemplified by the work of Hilde Bruch. My concern is that in our headlong rush toward modernity, we will give short shrift to the eternal verities of intrapsychic life (unconscious motivations, conflict, defense, etc.) and the doctor–patient relationship (resistance, transference, and countertransference) described by Freud and his disciples earlier in this century. It is our duty to meld the best of the old and the new as we lay the groundwork for clinical and research efforts in the 21st century. Do our current and future patients deserve anything less?

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**NOTES**

1. To briefly review, preoedipal themes are generally manifested by _deficits_ in such important areas of the personality as self-concepts, object constancy, signal anxiety, body image, affect modulation, and impulse control (Pine, 1988). All of these vulnerabilities can ultimately be related to the faculty structuralization of the ego system and self-system. In contrast, _oedipal_ themes are primarily marked by _conflict_ among the different agencies of the mind (e.g., the clash between superego standards and powerful sexual and aggressive wishes). Typical clinical presentations include success anxiety, excessive guilt and inhibition, and triangular enactments—in the case of a woman, exaggerated rivalry with other females and libidinal wishes repeatedly directed toward " unavailable" or "forbidden" men. Of course, oedipal and preoedipal issues are often intermixed in clinical reality.

2. I think that there is much to be said for Wilson's (1988) suggestion that bulimics be asked to "interrupt" or suspend their habit for a discrete, mutually agreed-upon period of time, so that they can begin to experience fantasies, feelings, and conflicts habitually warded off by the frenetic activity of bingeing and self-purgation.
REFERENCES


