Self Psychology and the Treatment of Anorexia Nervosa

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THEORY

Anorexia nervosa is a baffling, disturbing, and intriguing syndrome. Comprehending its meaning requires knowledge of biology, sociology, and psychology. Each of these frames of reference contributes different and at times conflicting perspectives. Psychoanalysis alone offers three divergent theories: the drive-conflict, object relations, and self-psychological points of view.

Which theory is applied in the treatment of a specific patient is not an academic issue. Theory influences what the therapist perceives and ultimately what he does. Gedo and Goldberg (1973) have written cogently on the importance of a correct fit among a specific clinical phenomenon, a psychological model, and a treatment modality.

In this chapter, I examine anorexia nervosa from a self-psychological perspective. I propose that anorexia nervosa is a disorder in the organization of the self. The symptoms of anorexia nervosa represent both a disruption of the self and the defensive adaptive measures against further disruption. I review what I consider to be the limitations of the drive-conflict and object relations models in explicating anorexia nervosa. Specifically, neither of these adequately lends itself to or facilitates the comprehension of the deficits in the self that are characteristic of anorexic patients.

A full description of the syndrome is not needed here. It suffices to state that the particular manifestations of anorexia nervosa state something about the times we live in. Garner, Garfinkel, Schwartz, and Thompson (1980), Garner and Garfinkel (1980), and Schwartz, Thompson, and Johnson (1982) have demonstrated the sociocultural pressures that lead increasing numbers of vulnerable young girls into the pursuit of thinness.

It is unfortunate that this era is also noteworthy for increasing numbers of individuals who suffer from a sense of emptiness, depletion, and aimlessness. These individuals complain of not feeling alive, of a sense of deadness, or of life seeming boring, routine, and mechanical. They cannot fully enjoy themselves, muster enthusiasm, or feel a sense of purpose and direction. They are passive creatures who

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react and respond, but rarely initiate. They rely on external influences to tell themselves what to do and how to feel. Their fragile self-regard needs repeated booster shots from sources outside of themselves. Without external support and structure, they are liable to feel in pieces or incomplete. They have been described as suffering from identity confusion and diffusion (Erikson, 1959). They seem to be out of touch with or alienated from themselves and their core feelings and values. Instead, they tune in to others and devote themselves to taking care of others. Some of these individuals develop anorexia nervosa.

Most anorexics or future anorexics fit this description. It is these kinds of symptoms and behavior that the drive-conflict model and the object relations theory fail to comprehend as well as self psychology does. The symptoms of alienation from the self, depletion, and disruption are signs of our times. These manifestations are quite different from what Freud observed in the well-defined and well-structured, but sexually oppressive, society of late 19th- and early 20th-century Vienna. His patients were conflicted about sexuality, and his drive-conflict theory accurately explained the data. For the most part, our anorexic patients could not care less about sexuality. Their drives seem diminished, not conflicted. A theory of deficit phenomena is more applicable.

Self theory, as systematized by Kohut (1971), provides a better framework for understanding deficit phenomena. Once the therapist accepts he is dealing with a deficit in the self, he is encouraged to go beyond confrontive and interpretive interventions. Long ago, Hilde Bruch (1962) realized the futility of interpretation in working with anorexics. I propose that what is effective is the therapist's actively filling in the deficits in the patient's self. The main thrust of therapeutic activity is to manage the transference rather than to interpret it. The therapist allows himself to be utilized as a "transitional object," in Winnicott's (1953) terms, or a "selfobject," in Kohut's (1971) language.

Later in this chapter, I address in detail the implications of the self-psychological viewpoint for the psychotherapy of anorexic patients and the management of specific symptoms. In a final section, I explore psychological dynamics in depth. Before proceeding with a comparison of the three analytic theories here, I offer some definitions.

When I speak of the "self," or "self organization," I am referring to three things. First there is the person's hierarchy of unconscious and conscious goals, aims, values, and priorities (Gedo, 1979). The self contains affects and cognitions. It includes biological needs and acquired wishes. It replaces the structural model of id drives, ego interests, and superego values.

Second, there is an experiencing aspect of the self organization. When Kohut refers to the "fragmentation of the self" or the "loss of cohesiveness," he is referring to the experiencing self, which feels disrupted or disorganized. This disruption may also be experienced as a depletion, an emptiness, an enfeeblement, and a loss of self-esteem.

Third, there is the self-regulatory structure. The psyche's capacity to maintain self-esteem, cohesiveness, and vitalization, and to regulate tensions and moods, are functions of the self-regulatory apparatus.

By "anorexia nervosa," I refer to a symptom complex or syndrome that may occur within a variety of ego or self pathologies. I am discussing here that core group of anorexics that is most typical and that Bruch (1973) calls "primary anorectics." Besides the drive for thinness, these anorexics manifest a severe disturbance both in
their sense of effectiveness, and in their awareness of inner feelings, experiences, and sensations. They also manifest body image distortions or delusions. These disturbances in interoceptive experience and body image reflect defects in the ego or self organization. It is the explication and treatment of these defects that self psychology facilitates.

Drive-Conflict Model

Freud's (1923/1961) final model of the mind consisted of three agencies: the id, the ego, and the superego. Symptom formation was said to occur as a result of conflict between these agencies.

This model of the mind works best for the neurotic patient whose psyche is well structured. To be more specific, when an individual has a strong sense of morality (a well-developed superego), he or she is more prone to be in conflict with his or her drive impulses.

The early theories about anorexia nervosa were of the drive-conflict type. Moulton (1942), Rowland (1970), and Waller, Kaufman, and Deutsch (1940) all postulated that self-starvation was a defense against sexual fantasies of oral impregation. Berlin, Boatman, Scheimo, and Szurek (1951) and Masserman (1941) thought that the refusal of food was a defense against ambivalent oral sadistic and cannibalistic fantasies. Blitzer, Rollins, and Blackwell (1961), Grimshaw (1959), Maragol and Jernberg (1960), Masserman (1941), and Tustin (1958) all emphasized either ambivalent oral impregnation or oral sadistic fantasies.

These types of conflicts are confined to the focal area of drive impulses and fantasies and are typically dealt with by neurotic symptom formation, social inhibition, and/or sexual inhibition. They do not require the formation of body image distortions and delusions that are characteristic of anorexic sufferers. Considerable anorexic symptomology is left unexplained by this drive-conflict model. Disavowal of dismemberment, delusions of fatness, misperception, and alienation from inner feelings and sensations all reflect more profound and pervasive disturbances in the mental structure of the anorexic patient. Frequently what seems to be a simple sexual conflict will, upon careful exploration, prove to be more complex. The following case report illustrates this.

Mary was 13 years old when hospitalized for anorexia nervosa. She presented during sessions as a passive, empty shell. She said little unless asked. When I would open the door to the interview room, the door would hit the doorstop and invariably bounce back and hit her unless I stopped it. In her transference to me, I was expected to protect her and magically cure her without her exerting any effort to participate in the treatment. In fact, I was to understand her magically, without her having to communicate verbally to me. She related to me as if I were an omnipotent, omniscient symbiotic object. When I pressed for her feelings, she would sometimes refer me to her parents — thus placing the ownership of her attitudes outside herself.

She responded well to benign, supportive, and exploratory therapy, and to the implicit hope that she would eat and gain weight. Early in treatment I took a week's vacation, which coincided with the wedding of her brother. It was at this point that she resumed menstruation. On the wedding night, she psychologically fragmented and delusionally proclaimed that her father was dead. Associative material revealed a pregnancy fantasy and a feeling of being too close to her father. She believed her father would die if he knew how wild (in her own fantasy) she was.

1. For the full case report, see Goodsit (1969).
We were then able to reconstruct what initiated her self-starvation in the first place. Her father had previously had a heart attack. It was her fantasy that her developing sexuality had so disturbed him that it brought on the heart attack. We learned that she had an idealized symbiotic relationship with her father (as opposed to her mother), which is the usual case. She had experienced symbiotic merger with him, just as she did now with me in the transference. As one cuts off a gangrenous arm to save the body, she sacrificed her sexuality to save her father and their symbiosis.

Sexuality was feared not because it was taboo or a transgression against superego precepts, as in a typical neurosis, but rather because it disrupted the symbiotic bond that she felt was vital for both herself and her father. We learned that she was a symbiotic character whose central anxieties were those of fragmentation, annihilation, separation anxiety, and loss of object and self, and not guilt related to superego transgression. Seemingly, sexual anxiety and conflict was secondary to and functioned to deal with these more primary pre-Oedipal issues. A simple drive-conflict theory fails to explain the data in this case adequately.

Object Relations Theories

The object relations theorists attempt to fill in the holes in the drive-conflict model by grafting onto it yet another developmental theory. Mahler's (1968) theory, derived from infant observation, postulates several stages of object relations. The child moves from infantile autism to symbiosis to separation-individuation, and then on to object constancy.

Selvini-Palazzoli (1978) adds the language of Mahler to the language of drive-conflict theory. The future anorexic has unresolved problems in the oral incorporative stage which impede separation-individuation. The anorexic fantasizes an oral incorporation of a maternal, bad, and overcontrolling object. This maternal introject is then equated with the anorexic's body; the anorexic experiences an identity of her body as her mother. Self-starvation is thus the adolescent's attempt to end the feminization of her body and thus to minimize the confused ambivalent identification with mother. Selvini-Palazzoli explains anorexic behavior as resulting from these distorted mental representations of body, self, and object.

The problem I find with Selvini-Palazzoli's theory is that although it makes theoretical sense, there are few clinical data to support it. Anorexic patients do not reveal confusion of their bodies with their mothers, based upon oral incorporative fantasies. Anorexics to a certain degree starve themselves to prevent feminization of their bodies and to minimize identification with their mothers, but I do not find oral incorporative fantasies as the basis for this. Furthermore, this explanation is much too limited.

Anorexics actually view their bodies in multiple ways. Many see their bodies as the battleground of the separation-individuation war. Who owns her body is a matter of contention (Goedsit, 1977), but this is different from saying that the anorexic equates her body with the maternal bad object via an incorporative fantasy.

Adolescent anorexics perceive their bodies to be the last vestige of their infantile, archaic grandiosity. Grandiose individuals need to be the center of all things around which the word revolves, to feel they are in total control of everything, and to experience themselves as perfect. They focus all of these needs on their bodies. Now their bodies must be perfect and unchanging, and they must be in total and absolute control of them. The changes of puberty in a child, then, threaten this grandiosity and thereby threaten the adolescent's fragile psychic equilibrium. None of this has anything to do with oral incorporative fantasies.
Furthermore, the problem with the body seems to be its lack of integration into the self organization. Anorexics are often strangely indifferent to their bodily needs. They fail to take adequate care of their bodies. They ignore nutritional needs. They are strangely unconcerned about dangerous changes in the heart and other organs. They are out of touch with their inner bodily experiences and feelings. They seem not to call upon or to invest in their bodies in a wholesome manner.

In this regard, it should be noted that the self is at core a body-self. The nucleus of the self is bodily sensations. Freud (1923/1961) stated, "The ego is first and foremost a bodily ego" (p. 26). This applies to the self, which is first and foremost a body-self. As Kohut (1971) has pointed out, when the cohesive self becomes unstable, bodily symptoms (hypochondriasis) result. The anorexic's failure to invest appropriately in the body, and the resulting bodily distortions and delusions, are all symptomatic of a lack of cohesiveness of the self organization. The body is poorly integrated into the self organization.

When the integrity or cohesion of the self is threatened, anorexics experience this threat concretely in terms of loss of control of the body. In an attempt to stave off further disruption of the self, the anorexic typically hyperreacts, stimulates, and obsessively focuses on the body (Goodstein, 1983). The anorexic's constant activity and exercise are her attempts to feel herself within her body. They are attempts at feeling whole and cohesive (Goodstein, 1977).

The therapeutic implications for this different perspective are profound. Rather than interpret to the anorexic that she equates her body with her mother, or interpret the oral incorporative fantasy, the therapist should attempt to heal the disintegrated body-self. How this is done is taken up later.

Masterson (1978) is another object relations theorist who adds Mahlerian thinking to the libido theory of the drive-conflict model. For Masterson, the anorexic is plagued by an array of introjects. There is a hostile, rejecting, withdrawing, maternal introject in response to the anorexic's attempt at separation. There is a supportive, rewarding, maternal introject in response to the anorexic's regressive, clinging behavior. There are thus two corresponding self representations that are inadequate, bad, guilty, and empty, and passive, compliant, and good, respectively. Although Masterson speaks of arrested development at symbiosis and separation-individuation, with corresponding ego defects, the main thrust of his theory is to point to the distorted self and object representations as the cause of anorexic behavior. Masterson, like Sours (see below), is burdened in his theoretical writing by abstruse and unwieldy object relations language, with its multiple self and object representations.

Sours (1980) takes the object relations theory a step further in stressing defects in the ego and the self, as well as symbolic, dynamic conflicts and distortions. He refers to defects in the ego, sense of self, poor self-object differentiation, and the failure to develop self and object constancy. Yet his theory of his treatment for these patients hardly differs from that for an analyzable neurotic who does not have structural defects.

Sours notes that the starving anorexic, prior to the restoration of nutrition, is not inclined to report affects, memories, or fantasies, and is, furthermore, not inclined to participate in a therapeutic alliance. For Sours, the therapeutic thrust is toward developing a therapeutic alliance by understanding the nature of the fixated, devotional, and atypical development of ego functions, self representations, and object representations. The main barrier to the development of the alliance—primitive
defenses of denial, negation, disavowal, splitting, and omnipotence—must be dealt with, apparently by confrontation and interpretation.

In contrast to Sours's experience, I have found that primitive defenses in these severely disturbed, starving patients are better managed than interpreted (Goodsitt, 1982). These patients are not ready or equipped for analytic work. Neither the analysis of defenses nor the restoration of normal nutrition becomes the pivotal point that turns a frightened, negativistic patient into one who participates cooperatively. Rather, for the out-of-control, starving anorexic, the turning point is the therapist's taking over (i.e., stepping in and taking whatever measures are necessary to prevent the destructive starvation from continuing). The therapist takes over responsibility for feeding the patient. The patient protests, but is relieved, and then engages in the treatment process.

How is this to be understood? The patient is unable to manage her eating behavior. The therapist recognizes this and takes over. He thereby fills in for the deficits in the self and the ego. It is not simply distortions and defenses that are analyzed, but deficits in the ego and the self, which are filled by the therapist acting as external ego, "selfobject," or transitional object. Filling the defects unburdens and frees the patient's ego and/or self, and an alliance is forged. The alliance is the result of therapeutic action, and not a prerequisite for it. The alliance takes shape when the therapist decides to take over, take a firm stand, and restore nutrition, and long before nutrition is actually restored. Levenkron (1983) provides an excellent example of a therapist effectively utilizing these principles.

Reliance on a theory that emphasizes early structuralization, conflict, and devational self and object representations limits the object relations theorists from acknowledging the importance of deficit phenomena. If the problem is devational self and object representations, then interpretations of these distortions should suffice. In my experience, much more is required.

Sours accurately notes that the difficulty these patients have in discussing their own affects, memories, and fantasies is, in part, secondary to starvation and lack of a therapeutic alliance. This explanation does not go far enough, however. For some time anorexics have been observed to be alexithymic and described as nonverbal (Eissler, 1943; Goodsitt, 1969; Jessner & Abse, 1960; Scott, 1948; Wall, 1959). I believe that their difficulty in relating inner experiences is yet another manifestation of defects in the self organization. These patients fail to relate inner experiences because they have an impaired capacity to live within the body-self. They are out of touch with their core experiences. There is a failure to integrate bodily, cognitive, and affective experiences into an organized core self.

Therapists like Garner, Garfinkel, and Bemis (Garfinkel & Garner, 1982; Garner & Bemis, 1982; Garner, Garfinkel, & Bemis, 1982) have called our attention to the cognitive defects that are one aspect of this phenomenon. Bruch (1962) has long emphasized the need to help these patients get in touch with their feelings. Levenkron (1983) points out that these patients do not have a language for talking about themselves. As therapist, he takes an active role in providing and teaching them a vocabulary for the self. To my mind, all of these therapists recognize the deficits in the self and the ego. They have all devised treatment techniques to deal with these defects. In contrast, the object relations theorists emphasize confrontation and interpretation, which are more effective for conflict resolution.

Selvini-Palazzoli (1978), Masterson (1978), and Sours (1980) emphasize distor-
tions in body, self, or object representations. Sugarman and Kurash (1982) are object relations theorists who propose an ego defect as a central causative factor. Restricting themselves to a consideration of bulimic patients, Sugarman and Kurash assert that these patients lack the ego function of object constancy. Thus, when separated from the symbiotic mother, they are unable automatically to evoke a mental representation of the mother and become soothed. Since eating is a sensorimotor activity associated with the childhood feeding experience with the mother, bingeing becomes a means of evoking the sensorimotor object representation of the symbiosis.

Some years ago, working within an object relations framework, I proposed that anorexics manifest ego defects in synthetic and integrative functions (Goodsitt, 1969). Anorexics reveal impaired self–object differentiation, and they lack object constancy. I asserted that they have a symbiotic character disorder and are arrested at the developmental levels of symbiosis and separation–individuation. They require a symbiotic relationship to remain whole and to defend themselves against psychosis, annihilation, and separation anxiety.

At that time, I did not specifically address what the symbiotic partner provides that is so vital for ego integration and cohesion of the self. What is it that allows the individual to remain intact in the absence of the symbiotic object? Is it the capacity to evoke a mental representation of the symbiotic object, or is it the internalization of the functions of the object?

Theories of Deficits in the Self

For the self psychologist, the capacity to tolerate separation without some form of psychic decompensation depends upon the internalization of certain mental functions and structure. Important functions include the capacity to provide one’s own cohesiveness, soothing, vitalization, narcissistic equilibrium (sense of well-being and security), tension regulation, and self-esteem regulation. These are regulatory functions that are initially provided by an external source, such as the mother. It is the mother who initially provides soothing, doses out stimuli, and protects the infant from stimulus overload. Later these functions are transferred to a transitional object, such as a blanket (Tolpin, 1971). It is then the transitional object, which the child totally controls, that provides a sense of well-being and security. The transitional object is cognitively perceived as external but is experienced as a part of the self (Goodsitt, 1983). If adequate mothering (Winnicott, 1965) occurs, these functions go inside (Tolpin, 1971) and become part of the child’s mental structure. Thus the transitional object is a way station between external structure and internal structure (Tolpin, 1971). If the internalization process goes awry, the individual cannot separate successfully, because he or she cannot provide for his or her own sense of well-being, security, soothing, vitalization, cohesion, tension regulation, and self-esteem regulation. Without these functions, initiative is seriously impaired.

Kohut (1971) emphasizes the importance of empathic “selfobject” parenting that provides mirroring or confirming of the child’s grandiosity and allows idealizing of the parental selfobject figures. By a “selfobject,” Kohut is referring to an object, like a “transitional object” in Winnicott’s words or a “symbiotic object” in Mahler’s language, that is cognitively perceived as external to the self, but is experienced as a part of the self. One relates to a selfobject as one does to a part of oneself, such as one's
arm. A person functioning as a selfobject for another is not perceived as having his or her own qualities, characteristics, needs, and wishes, and is not allowed to be a person in his or her own right.

Given appropriate selfobject responsiveness, the child’s archaic grandiosity and idealization are converted into a cohesive self with good self-esteem and healthy goals and ideals. A disorder of the self or narcissistic personality disorder may result if the internalization process is aborted. Without available external selfobject support, this individual is liable to feel helpless, ineffective, overwhelmed, unworthy, unreal, incomplete, or empty. Activities are perceived as boring, mechanical, and routine. Life is passively experienced.

Some years ago, Bruch (1962) described anorexics in very much the same fashion. She asserted that helplessness, passivity, and ineffectiveness are cardinal features of anorexia nervosa. Many of the features of the disorder are illuminated by self-psychological understandings. Anorexics feel excessively influenced and exploited precisely because they are deficient in self-regulatory structure and are therefore dependent upon external contingencies (selfobjects) for their well-being (Goodsitt, 1977, 1983). It is a well-integrated self that enables one to feel in control, and not just an empty receptacle easily distorted (fattened) or invaded by external forces — whether that external force is food or people. The absence of reliable internal self-regulation results in the anorexic’s feeling inadequate, ineffective, and out of control (fat) — one bite leads to a thousand; one pound leads to a hundred. Lacking reliable self-soothing, tension, and mood regulation, and feeling restlessly bored, empty, and aimless, the anorexic is driven to constant activity and strenuous physical exertion to drown out these painful internal conditions. She finds in being something special (i.e., anorexic) some compensation and some contrived meaning to her existence. By focusing on food and weight, by turning off her need of others and turning inward to herself, by filling up her life with rituals that help her feel a sense of predictability and control, she narrows down her world to something she feels she can manage. She attempts to negate her reliance on the needed selfobjects that she unconsciously perceives have failed her. By devoting herself to the care, feeding, and well-being of others, she becomes a selfobject for them and thereby attempts to negate her own selfobject needs. By starving herself, she feels strengthened and temporarily superior to others. This is the antidote to her feelings of weakness and inadequacy related to her true need of selfobjects.

Anorexia nervosa is a disorder of the self. It is also very much a disorder of separation—individuation (selfhood). Anorexics are deficient in self-regulatory structure and are thus ill equipped to separate. The therapy of this disorder must address itself to the psychological deficit as well as the dynamic conflicts. The therapist, by functioning as a selfobject or transitional object, fills the deficit and enables an aborted maturational process to resume (Goodsitt, 1982, 1983).

THERAPY

In this section, I discuss the process of dynamic individual psychotherapy with anorexics. The treatment style and stages, as well as the therapist’s role, are considered. I examine the importance of the therapist’s flexibility and activity. I discuss how, func-
tioning as a self-object, the therapist provides and teaches tension regulation and integration. He utilizes the leverage of idealization. He explores, values, and confirms the patient's true self, thus facilitating the self's growth and maturation. He teaches the patient what her symbiotic needs are. He attempts to establish a narcissistic equilibrium.

Role of the Therapist

I first address the importance of the therapist's flexibility and activity. Since the syndrome of anorexia nervosa occurs along with all levels of object relationship and the whole range of ego and self strength and organization, the therapist must be flexible (Garner et al., 1982). Any individual patient may be organized at more or less mature levels at any given point in time. The therapist needs to change his mode of therapy, depending upon the type of psychic organization presented (Gedo & Goldberg, 1973). For example, when the anorexic patient presents in a conflctual mode, utilizing repression as a major defense, then confrontation and interpretation are appropriate. When the patient is more disturbed or is arrested in psychic functioning, the therapist must be more active in helping the patient.

A general principle of therapy is that the therapist should allow the patient to do whatever the patient can reasonably accomplish without external assistance. The therapist will support the patient's independent functioning, but he must be ready to step in and actively take over at a moment's notice. This requires therapeutic judgment and flexibility.

Patients who are so out of control as to require hospitalization need the therapist to be more active in structuring than do office patients who are making progress. Gedo and Goldberg (1973) state that when the patient is in an overstimulated state, the patient needs soothing. If the patient is fragmented, the patient needs assistance with reintegration. The primary anorexic, with bodily delusions, interoceptive disturbances, and inadequate self-regulatory structure, generally requires these modes of active therapeutic intervention. When the therapist provides these functions, he is acting as external auxiliary ego and self-object (i.e., as a part of the patient's mental structure).

As such, the therapist's role is conceptualized as being a transitional object or self-object (Goodsitt, 1983).

It is my impression, noted elsewhere (Goodsitt, 1982), that therapists tend to overestimate the capacities of anorexic patients. The typical therapist is not active enough. Taking half measures when full measures are required is both dangerous and disruptive to the therapeutic process. A common fault is the therapist's being fooled by the patient's apparent self-sufficiency (Modell, 1975). The patient often disavows the seriousness of her illness. The therapist may go along with the patient's pleas to "let me do it on my own" when she simply cannot do it.

The anorexic frequently needs the therapist to be her tension regulator. Patients with eating disorders, and in particular primary anorexics, suffer from intense chronic or recurrent tension states (Goodsitt, 1977, 1983). Bereft of internalized psychic mechanisms to soothe or regulate tensions, they are driven to drown out their tensions by intense external self-stimulatory activity. Thus these patients are driven to starve, binge, vomit, and engage in strenuous and constant physical exertion.
Swift and Letven (1984), discussing bulimics, state that the “conveying of insight may be therapeutically less important than the intuiting of unmet developmental needs and emphatically responding to them” (Marohn, 1982). They continue,

[It is] most important for the therapist to be attuned to the impairment in tension regulation and to emphatically respond to mirroring and idealizing needs (Kohut, 1971); for example, by confirming the patient’s nascent, often halting attempts to develop self soothing capacities, to erect a protective stimulus barrier, and to discover new outlets. (p. 496)

I fully agree; furthermore, I submit that all of this quotation applies to anorexic patients. Anorexics require the therapist, acting as a selfobject, to provide internal tension regulation.

The therapist actively reassures or calms the patient. If the patient is panicked about her stomach ballooning up when she eats or drinks, the therapist provides reassuring knowledge about the digestive process (Levenkron, 1983). The therapist should not wait until the patient is panicked. He should empathically anticipate the panic and dose out the preventive medicine of reassuring information. If the patient is hospitalized, he must be sure to provide for supportive reassurance just before, during, and after meals, when the patient is most anxious.

As a tension regulator, the therapist not only soothes the patient, but anticipates her distress and teaches her how to manage it herself. When asking a patient to eat more, he explains that he knows he is asking her to do something that is most difficult. He explains that he is asking her to give up a major adaptive defense that has served important protective functions for her. He expects her to feel anxious. He asks her to sit with her anxiety (while he sits with her). He explains that asking her to give up an adaptive defense is like asking a person who cannot swim to let go of the life preserver and try swimming. The danger is drowning.

The therapist insists on the patient’s sharing her distress with him about eating when she does eat. He wants her to try eating, but he also wants to hear about her distress. She will not be left alone to sink or swim. The therapist may point out that it is really a choice she must make. She may continue to desperately hold on to what seems a life preserver to her (i.e., her illness), and continue to feel some temporary relief in not eating. She can also expect to continue her lonely, miserable, suffering life unchanged. On the other hand, he continues, she can choose to let go and take a chance on eating—and life. Clearly, by doing so, she is entering a forbidding unknown. He knows she has little faith in her capacity to relate to others or to really live an enjoyable or satisfying life of her own. She may indeed have good reason, based on past experience, not to be optimistic about her future. If this is the case, the therapist should acknowledge that. But the therapist tells the patient that he is committed to seeing that she learns the skills (ego and self functions) she needs to make her life better. Until now, she has been trying to learn to swim with one hand tied behind her back. No wonder it is difficult!

This approach is quite different from analyzing the unconscious symbolic meanings of eating and gaining weight. It is not that analysis is not needed: It is needed, but it is not enough.

The anorexic often needs the therapist to provide integration of the disparate parts of her personality. She may act as if the left hand does not know what the right hand
is doing. Desperate for appreciation and longing to be listened to, the anorexic devotes herself to taking care of and listening to others. She ignores, dismisses, and devalues her own inner values and needs. These inner experiences have a low priority.

Garner, Garfinkel, and Bemis (Garfinkel & Garner, 1982; Garner & Bemis, 1982) have emphasized the importance of recognizing and clarifying underlying cognitive assumptions. Some anorexics, for example, assume that if they are thin, life will be perfect. In their hierarchy of values, goals, and ideals, thinness is a higher priority than health. Perfection may be more valued than happiness or well-being.

Certain cognitions are not balanced by the emotional price paid for having them. Wanting cognitively to be perfect, the anorexic wreaks havoc on a perfectly normal body and feels miserable. This failure to integrate various parts of the personality is abetted by the anorexic’s inclination to use the defense mechanisms of splitting or disavowal. Some anorexics may cognitively acknowledge their emaciation, but the significance of this fact is dismissed (disavowal). They act as if the information is irrelevant. One anorexic, when told of dangerous abnormal findings on her cardiogram, asserted, “That is my doctor’s problem,” and continued her strenuous physical activity.

It is the therapist’s job to point out that choices have been made and what the alternatives are. The therapist needs to provide the missing integration and to teach the patient how to integrate reasonably. For the more disturbed starving patient, the therapist must step in and take over this function relatively completely. A decision to restore weight within a controlled hospital environment, despite the patient’s disavowal of nutritional need, is often necessary.

For the somewhat less disturbed patient, integrative work is reduced. Instead, the therapist may use the leverage of an idealizing transference to direct the patient to eat. The patient may not be able to provide self-caring (Khanzian, 1978; Krystal, 1978) and take the responsibility of organizing her caloric intake, but she may follow a prescription from the therapist. This can involve detailed meal planning. The therapist may, still using his authority, delegate this function to a nutritionist. Furthermore, the therapist may utilize behavioral techniques for symptom control or delegate this aspect of the work to a colleague familiar with this technique.

For the patient who is healthier still, the idealizing transference itself will prove sufficient. In certain rare cases, the patient seems to get better before the therapist can do something. In one such instance, the patient was the anorexic daughter of a physician who had read an article I published. This patient came to me expecting magical healing from an “expert.” Almost before I could open my mouth, she had stopped starving herself. In these cases, it is important that the therapist tolerate the idealization and not disabuse the patient of her illusions prematurely (Kohut, 1971). Then the therapist has leverage to accomplish therapeutic ends. When the therapist allows idealization or provides mirroring of the patient’s grandiosity, the well-being of the self organization is enhanced (narcissistic equilibrium). Symptomatic improvement often results from this healing of the self. Furthermore, it creates a more stable balance within the patient, so she is enabled to work better in therapy.

Growth of the self and enhancing the self organization also depend upon knowing oneself. When one is in touch with inner feelings—what feels good and is enjoyable, what feels bad or is boring, what is satisfying, and what is self-destructive—then one is in a good position to make wise life decisions. Anorexics are woefully alienated from core feelings and experiences. Not knowing one’s feelings means that
one can be easily manipulated, which is a typical anorexic phenomenon. It also produces the inner experiences of feeling empty, bored, and aimless. The anorexic has little to say partly because of her alienation from inner experience.

It is the therapist's job to help the patient to direct her attention to inner experience. He values and takes seriously her feelings. Often he knows, by close observation of facial expression and behavior, that the patient is depressed, angry, or disturbed before the patient is aware of it. When the patient denies that anything is wrong, he asks her to look inward to find out what she is feeling. When she explains her binging or vomiting as simply habit, he asks her to examine more carefully what was occurring and how she was feeling immediately prior to the binge–purge. When the patient anxiously and urgently demands a hospital privilege, the therapist asks the patient to examine her feelings. Often, when the privilege is denied and the therapist actively inquires into what has precipitated such desperate pleas, the patient eventually confesses that she was troubled by some disturbing feeling. One such patient, whose demand for immediate discharge from the hospital to go home was denied, broke down and confessed that she had found herself just then deeply hating her parents. To deny this feeling, she wanted to demonstrate that she wanted to be home with them.

Anorexics short-circuit getting in touch with their feelings by instead taking some action. Starving, binging, vomiting, and hyperactivity are measures used to short-circuit recognition of disturbing feelings and cognitions. I have observed that anorexic families as a rule short-circuit feelings by taking actions that cover over and cover up inner experience. The family members of the patient mentioned above who demanded immediate hospital discharge wanted to accommodate her wish, despite their feeling that the patient and they were not ready for her to be home.

Anorexic families do not, as a rule, know how to encourage the exploration and sharing of inner experience. When anxiety or depression occur, it is ignored, minimized, or smothered. The result, for the future anorexic, is a diminished sense of self. When the distress of the child is not ignored, it is frequently dealt with by empathic responses: for example, “You are too sensitive. That is nothing to be upset about,” or “You’re okay. Don’t worry about it.” Such responses dismiss the child’s anxiety. Some parents are so overwrought with the child’s distress that they have to do something urgently to remove the anxiety before they themselves become infected with it. The future anorexic then senses that what counts is not her own experience, but rather not being a burden to others. In these cases, what actually bothers the child in the first place and is causing the stress is never examined. The foundation of the child’s budding self, her inner experience, is not contacted, recognized, confirmed, or taken seriously. Under these circumstances, the self becomes atrophied.

The therapist sees his role as building up and enhancing the self. He does this by truly listening to and taking seriously the patient’s feelings and thoughts. He may disagree openly with the patient, but he is sure to affirm the legitimacy of the patient’s viewpoint. He must be prepared actively to help the patient find her own feelings and to elicit the expression of them.

By helping the patient to get in touch with her inner experience, the therapist is helping her to ground or center herself. He is helping her to integrate external behavior with inner feelings and beliefs. The discrepancy that exists between her “true self” and her “false self” adaptation (Winnicott, 1965) is reduced. This enriches the personality
and solidifies the self organization. When this is accomplished, the patient will no longer experience herself as empty, bored, passive, dead, indecisive, and aimless.

When this is not accomplished, the anorexic combats her sense of inner void by seeking external challenges. To be the thinnest person she knows is one such challenge. It provides the patient with a sense of direction and purpose. One patient reported she could not eat a piece of cake because she would then lose the chance to look forward to and anticipate eating the cake. She would not have a goal. The whole symptom complex of anorexia nervosa, with the goals and values it dictates, thus substitutes for a reasonably organized hierarchy of goals based on true inner needs and desires. The anorexia nervosa provides a substitute self organization. It is also maladaptive, self-defeating, and destructive. Maturation ceases.

Much anorexic behavior is compulsively determined by the urgent need to drown out tensions that exist because the anorexic is not aware of her needs and desires and therefore cannot fulfill them. Actions, then, are simply reactions to a disrupted self, rather than expressions of initiative from the depth of the self—its values and goals. It is the therapist’s job to help the patient find her true self and her values and goals. Only then is fulfillment possible.

If the patient is unable to regulate her own tensions and self-esteem, the therapist must inform the patient of her symbiotic or selfobject requirements. She needs to know that she is easily shattered by slights, criticism, and disapproval, so that she can take preventive measures. She learns, in a nonjudgmental way, that she takes separations from selfobjects very hard. When the patient knows, accepts, and then fulfills her needs, she is no longer driven to disavow her needs through acts of self-denial and abstinence, such as self-starvation. In doing much of what is described above, the therapist is also attempting to establish a narcissistic equilibrium (i.e., a nondisrupted or balanced self organization). If the patient is constantly trying to put out internal emotional fires, she is in no condition to change, learn, or develop.

The therapist is many things. He is a parent, guide, teacher, and coach (Levenson, 1983). He makes himself available as a committed, caring professional. He is involved. He relates. He encourages, cajoles, and exhort. He provides his expert knowledge and experience. He empathically anticipates and cares about the patient’s subjective experience. He patiently explains and clarifies her cognitions and the significant issues. Most important, he is the carrier of hope for a future for his patient, while at the same time truthfully acknowledging her present shortcomings. He does not criticize or belittle her defensive adaptation. There are good reasons for all her behavior, incapacities, and feelings. By doing all of this and more, the therapist is lending her his ego and self organization—his capacity to anticipate, to delay gratification, to use sound judgment, to relate to another, to regulate tension and moods, and to integrate feelings, cognitions, and behavior.

Stages of Therapy

Certain problems are more or less germane to specific stages of therapy. In the first stage of therapy, the main issue is the anorexic patient’s reluctance to be a patient. The disavowal of illness must be addressed during the initial consultation. Frequently the patient appears to have been pushed into the consultation room. She looks as
if the therapist and his office are, respectively, the last face and place on earth she would rather see and be! When a resistance appears, it should be addressed immediately, or the patient will be gone.

The therapist carefully explores the patient's motivation for therapy. If she presents with considerable disavowal of illness or a facade of self-sufficiency, it is important to find and make contact with that part of the patient that hurts or experiences psychic pain. The therapist will actively elicit how miserable, hopeless, and despairing the patient feels. The therapist needs to determine whether the patient believes she is entitled to help and whether it is permissible to seek help for her misery. He must surely advise her that it is precisely because people feel the way she is feeling that they seek and in fact do obtain relief within a psychotherapeutic process. The therapist should explore what myths the patient harbors about the process of therapy.

The therapist keeps in mind that, as a rule, these young women are withdrawn, distrustful, and frequently aloglyphic. He understands that the anorexic is a private person who prides herself upon her independence. She is terrified of intimacy, closeness, and being in an office alone with another person. She is ashamed of her dependent longings. He also understands that she is performance-oriented and therefore panicked about the expectation that she be able to carry the conversation. The therapist must have minimal expectations that these aloglyphic patients can verbalize their inner feelings. The responsibility for establishing meaningful contact and rapport rests with the therapist. He psychologically reaches out to the patient and tries to anticipate and allay her misperceptions and anxieties about therapy. He does not allow silences to continue so that both he and the patient feel terribly uncomfortable. These patients must eventually be taught how to explore their feelings and how to utilize therapy.

During the initial consultation, the therapist verbally anticipates that the patient may not feel comfortable with therapy and may wish to run from it. He tells the patient that when this happens, he wants her to bring this important feeling to him. If the patient is there under duress, he makes it clear that his mission is to help her feel better about herself. He is her agent—not anyone else's. He attempts to establish a verbal contract with the patient to help her with the specific problems that have been identified.

The middle stage of therapy is when the various transferences have been established. The relevant issues repeatedly arise and are worked on. Since I address later what some of the typical issues are, I now proceed to a discussion of the termination phase.

Throughout the middle and especially the later stages of therapy, a particular phenomenon occurs in many patients that is characteristic of anorexics—the negative therapeutic reaction. This refers to an impasse or regression that occurs when least expected. Solid therapeutic work and insight have been achieved, and the patient has made good progress. Then, without warning, the patient acts out self-destructively, falls apart psychologically, or relinquishes hard-earned previous gains. What has happened?

Both pre-Oedipal and Oedipal determinants have been observed to be the root cause of negative therapeutic reactions. Doing well, growing up, and being successful may precipitate guilt because it means surpassing, replacing, or defeating the Oedipal rival. In most anorexics, this is not the issue. Rather, for anorexics, growing up and being successful mean giving up the symbiotic object or self-object that they feel is vital for their existence, cohesion, or well-being (Gooden, 1969, 1977). Growing up
means to the anorexic that, in a very concrete sense, she must be totally self-reliant and never depend or rely on anyone again. It means being sentenced to a life of isolation. This is illustrated in the following case report.

Ann, aged 18, was in the termination phase of a successful 10-month hospitalization. She had been hospitalized the day after her high school graduation, when she weighed 27.273 kg (60 lb) (she was 158.974 cm or 5 ft 2 in tall). With five-times-weekly psychotherapy, she gained to 90% of her ideal weight and made solid psychological progress.

While on a 24-hour pass at home, she was able to eat meals without conscious concern for calories. Feeling proud of her accomplishment, she contemplated discharge from the hospital. That night she dreamed that her parents took in a boarder at home. She consoled herself that since she was younger than the boarder, she might still obtain some small share of parental attention. We understood several things from this dream. Her progress and her growing up in general meant loss—loss of attention and loss of attachment to the pre-Oedipal nurturer and symbiotic object. Furthermore, Ann was also the boarder. She would return home and no longer have the only role she had known—the dependent, symbiotic child. Progress and adulthood meant becoming an isolated boarder or stranger in her own home.

Guilt does play an important role in negative therapeutic reactions in anorexic patients. However, this guilt differs in many ways from the guilt that has been classically described. I call the guilt anorexies manifest "self-guilt," and I will discuss this in detail later. For now, I wish to point out that rather than being guilty for an Oedipal victory, this guilt is more related to becoming a person, developing a selfhood, experiencing pleasure, and separating from parents.

Like Ann, Beth was in the termination phase of a successful hospitalization of 3 months' duration. She too had regained to 90% of her ideal weight after entering the hospital very ill, extremely dehydrated, and 35% under ideal weight. She responded immediately to our taking over the management of her eating and to five-times-weekly psychotherapy. Like Ann, she had an intensely symbiotic relationship with her mother.

Beth was feeling both pleasure and great pride about her recent accomplishments in the hospital. She was boldly and maturely addressing the differences between herself and her mother directly with her mother. After having essentially dropped out of life and living almost totally in her room at home prior to hospitalization, she was now planning to enter college and to live away from home for the first time.

At this point, while on a group excursion from the hospital, she very obviously attempted to steal pills at a drug store and was caught. In explaining her action to me, she stated she had been feeling "too happy" and felt she had to "kill the happiness. It didn't feel natural or right. I shouldn't be happy." She went on to explain that she was undeserving because of "all the bad things I did and the way I was"—referring to how sick and burdensome she had been for her mother. Beth felt guilty for her happiness while she was planning to establish a life of her own apart from her mother. Enjoying life apart from her mother was an act of disloyalty and betrayal. Beth stated that she had been the center of her mother's life and that her mother could never be happy without her.

These termination issues of symbiotic loss, separation anxiety, and self-guilt occur repeatedly and must be worked through by thorough analysis. Each new incident allows the patient and the therapist to view the issue from a slightly different perspective. It is then observed and analyzed in all its ramifications. To get the patient to confront these issues in real life, the therapist encourages, cajoles, prepares, rehearses,
offers suggestions, or takes the patient by the hand and guides her through the task. Fortunately, Beth was able to take what she learned during sessions and immediately put it into action in her life. Patients who do not do this must be confronted with their resistance.

SYMPTOM MANAGEMENT

Food, Weight, and Body Image

In this section, I address the management of food, eating, exercise, weight, body image, family involvement, and hospitalization. As noted earlier, the approach one takes depends upon the psychic state of the patient. The more chronic the symptoms and the more disturbed the patient, the more important direct management of the symptoms becomes. For the less disturbed patient, management of eating and weight may consist of setting appropriate diet and weight goals, examining the psychic issues, encouraging the patient to meet the goals, and providing support for the concomitant anxiety. Some patients need more direction from the therapist, such as being given a prescription to eat. Others benefit from behavioral contingencies.

It should be clear at this point that directly discussing the targeted symptoms is warranted. I used to believe that it would be counterproductive to allow a patient to become or remain obsessed with calories, food, and weight. Since these preoccupations were simply symptoms of underlying psychological conflicts or disruptions of the self organization, then the real work should consist of dealing with these latter problems. Analyze the conflicts, restore the equilibrium of the self organization, and the symptoms will diminish or disappear.

For some patients this is what happens, but for others, more is required. Certain patients will work well psychologically, but they are too ashamed of their eating, bingeing, and vomiting to focus on these in therapy. The place and function of the symptoms in the patient's life never get examined. What, how, when, and where does the patient eat, not eat, binge, or vomit? What precipitates these events? These patients need encouragement to discuss these activities.

On the other hand, certain patients will isolate the symptoms from the context of their lives by discussing only their weight, body, and food preoccupations. These patients need encouragement to look at the context of the symptoms in their lives. How one does this is crucial. The therapist must respect the importance of the symptoms for the patient. The patient's present, albeit misguided, mode of feeling in control, effective, and powerful is tied up in the symptoms. It is useful for the therapist to acknowledge from the start that the symptoms serve an important function and may be the best current solution to the patient's dilemma.

Carol is an 18-year-old girl who was hospitalized when she was 31% under ideal weight. Her parents were divorced. Her home environment was chaotic and destructive. She had nothing in her life to point to with pride and truly nothing to look forward to. She felt weak, ineffective, incapable, unlikable, and defeated. Her delusional obsessions and compulsions made her feel strange and freakish.

Unlike other anorexics, who attempt to burn off calories with exercise, she would rather sit in one place and hold or press her stomach in. She could not tolerate any expansion of her abdomen. She sat because she felt that if she stood up, she would more or less “hang out.”
Any attempt to use reality testing by pointing out her thinness or the flatness of her abdomen resulted in her feeling crushed. Reality testing meant that people were telling her she was crazy, and she would then hold on to her stomach even more intensely. Her therapist reassured her that her symptoms were meaningful. She eventually was able to say that if she did not continue to hold her stomach in, she would be overwhelmed by intense despair and depression. She would feel empty and face the "nothingness" inside. The therapist acknowledged that to remove the symptoms meant, to her, taking away her life preserver and drowning in her depression. She needed to feel she had something else to hold on to, and she needed to learn how to swim. The therapist would let her hold on to him until he could teach her to swim, but she would have to take the risk of letting go of her current life preserver.

The therapist may approach the body image distortion by acknowledging that food and water do in fact expand the abdomen—especially noticeable to the patient, since her abdominal muscles are atrophied and she has no abdominal fat. Rather than argue with Carol that her stomach was not fat, her therapist explored why she could not tolerate any bodily or other imperfection. In patients with tenuous self-cohesion and self-esteem, defensive adaptations are often better managed as above than hammered by confrontive reality testing. When patients are preoccupied with food, weight, and their bodies, it is a mistake to tell them that those issues will not be discussed, since they are not the real problem. Rather, the therapist should acknowledge such patients' concern and listen for the underlying significance of the obsession.

Carol berated herself that all she talked about was food and her body. The therapist told her that when one has a toothache, all one can think about is the ache. The mind addresses itself to problems. They must find the good reason that she is so preoccupied. Carol continued to belabor the point that she was fat, her eating uncontrollable, her body distorted, and that she could not do anything about it. The therapist acknowledged her concerns and said, "I hear from what you say that you also have those feelings about yourself in life. You generally feel you are not in charge, unable to regulate, feel good, or like yourself. You feel weak, ineffective, and helpless." Thus the therapist takes what are tendered—the concrete bodily expressions of a damaged self—and translates them into understandable feelings and cognitions. If the therapist had insisted that Carol not talk about her food and bodily obsessions, she would have felt wrong or strange to be so obsessed, and she would have been hard put to find other words or concepts to convey her inner experience.

Hospitalization

Hospitalization is indicated when office psychotherapy proves insufficient in stopping or reversing an impasse or a deteriorating physical or psychological course. One can and should develop meaningful and specific criteria, but in the end, the therapist must make a sound judgment as to the need for hospitalization. Usually the patient has lost considerable weight and is physically weakened. Office psychotherapy has proved insufficient in mobilizing the patient's inner resources. It has become apparent that it is asking too much of the patient to change or improve without more structural assistance. The patient's deficits in self require active filling by the therapist and the hospital milieu.

Inpatient treatment differs considerably from office therapy. The therapist's activity consists much more of filling deficits by assuming responsibility for the care of the patient. His interventions can be characterized by the acts of stepping in, taking by the hand, and taking over. He establishes a weight restoration program in which the patient is expected to gain at least 454 kg (1 lb) per week, up to a target weight of 90% of ideal weight.

Programs that are strictly behavior modification tend to graft weight onto ano-
rexics while the core pathology, an aborted development of the self organization, is ignored. The potential for self-enhancement and individuation is forced underground, as the anorexic must exclude her inner needs and conform to a totally controlling environment. The patient simply surrenders a part of herself, her body, to the therapist. The result is a “person who suffers as before, but looks normal—an anorectic [sic] clothed in weight” (Goodslitt, 1977, p. 311).

In contrast, hospital programs that do not fill the deficits expect too much of the starving patient, who is already overburdened and out of control. I learned this through experience. Initially, I had some success with patients who were stabilized and were eventually enabled to eat simply by being in a structured, supportive hospital milieu. I interfered as little as possible with the patients’ autonomy. The patients controlled their own eating, with the stipulation that the treatment team would take over if and when their health was endangered. They would not be allowed to die. Weekly tests closely monitored their physical condition.

The problem that occurred with this treatment approach was that most patients were unable to take the responsibility for feeding themselves. Some patients would simply maintain a status quo and never get better. Others would lose weight, but not enough for us to intervene on the basis of keeping them alive. Furthermore, these patients lost confidence in the treatment program.

Debbie was typical of these patients. She was 158.974 (5 ft 2 in) tall and weighed 31.818 kg (70 lbs) when hospitalized. She then lost 5.455 kg (12 lb) slowly, and, amazingly, her lab tests showed no damage to her bodily functions. Nevertheless, she became more and more depressed, sullen, and negativistic. She was correct when she accused us of not helping her by letting her lose the additional 12 lb.

We decided not to wait any longer. We took over the management of her eating. She vehemently protested this abridgment of her freedom, but her affect and her outlook immediately brightened. For the first time, she engaged in the therapy process and worked cooperatively with her therapist.

When we proceeded on the basis that we would respect the patient’s autonomy and not intervene prior to damage to the patient’s body, we were overestimating and expecting too much of the patient. We did not fully understand the depth of the pathology—the structural deficits. Furthermore, we were actually neglecting, rather than respecting, the whole person and her needs—psychological as well as physical.

Thus it is important to find a middle ground between respect for autonomy and total dictatorial control. Psychotherapy combined with weight restoration through direct management of eating has proved successful. Bruch (1977), Casper (1982), Crisp (1980), Garner et al. (1982), and Garfinkel and Garner (1982) all stress the importance of nutritional or weight restoration. Starvation per se produces many reversible anorexic symptoms (Casper & Davis, 1977; Dally, 1969; Garner & Bemis, 1982; Garner et al., 1982; Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950; Russell, 1970). From a psychological viewpoint, Crisp (1980) writes cogently that anorexics are able to avoid heterosexual matutorial issues while maintaining prepubescent bodies. Issues related to separation, individuation, the right to a life of one’s own, being an adult, assuming responsibility, making career and other decisions, competition with peers, and working through the loss of one’s childhood are also avoided.
through anorexia nervosa. Allowing a patient to remain at an anorexic weight is not therapeutic.

It is useful, as Crisp (1980) states, to reach an agreement with the patient and her family prior to hospitalization on the necessity for weight restoration. The rationale for this program is fully explained and must be accepted if the patient is to be treated. A target weight of 90% of ideal weight is appropriate, since it approximates the weight of return of menstruation, thus signifying a normal physiology. The fact that only 90% of ideal weight is requested also assures the patient that the therapist does not need her to be fat—only healthy.

The patient may be allowed to acclimate to the hospital during the first week. The patient manages her own dietary intake, with the knowledge that if she does not gain weight, her treatment team will take over. An extensive laboratory workup is done. The pediatrician or internist closely monitors her physical condition. Weekly examinations and tests keep the internist abreast of the patient's electrolytes, protein, glucose, blood count, and hydration, as well as the condition of the heart, liver, kidneys, and endocrine system.

If after the first week it appears that the patient is continuing an anorexic course, then the treatment team takes over the management of eating and activity. The patient is informed that she will be expected to gain .454 kg (1 lb) a week up to her target weight. The dietician calculates the calories required. The patient is informed that she needs to learn how to eat normally and nutritiously. She will satisfy her caloric needs in three daily supervised, balanced meals. Selecting from a menu, she must satisfy so many exchanges of specific food types to meet the requirements for carbohydrates, fat, and protein. Rarely is it necessary to use nutrient drinks to satisfy caloric needs. Rather, the patient is expected to learn to eat normal foods.

Refeeding is started at a caloric amount calculated only to maintain weight. This is generally much more than what the patient is used to. The patient will gain .908 to 2.170 kg (2 to 5 lb) the first week due to rehydration and retention of fluid alone. The patient is warned of this and is informed that her weight will soon reach a plateau. At that point, she is started on a caloric amount calculated to have her gain .454 kg (1 lb) per week. Usually, this caloric amount also proves inadequate, and the calories are gradually increased to reach the goal. Typically, this takes 2000 to 3000 calories daily.

Eating is supervised by nursing personnel during each meal and for an hour after the meal to prevent purging. If the patient cannot eat as instructed, she is informed that tube feeding or intravenous feeding will be necessary. In almost all cases, this is not needed. It is understood that eating is stressful and that the patient requires extra support at mealtimes. When the supervisory personnel is nurturing, benign, patient, nonpunitive, willing to explain and encourage repeatedly, but able to be absolutely firm in the expectation that the patient will eat, more intrusive medical procedures are not required. Hyperalimentation, with all its medical complications, is unnecessary.

Firm limits combined with sympathetic listening go a long way. This combination of qualities is not easily maintained. It requires devoted and committed nursing personnel. They must be able to listen patiently without letting the patient talk obsessively and endlessly and thus avoid the task at hand. Meals should not last longer than 30 to 40 minutes. I believe that when one sets a limit on some behavior, the limit setter is obligated to listen to the feelings of the patient about the limit. One should not do the former without doing the latter.
Activities may be curtailed, but bed rest is not required. Strenuous physical exertion, exercise, and pacing are prohibited. These activities indicate disruption or disturbance of the self organization. As such, it is a signal to others that the patient needs immediate attention and support.

Given the deficits in self of these patients, it is important for the members of the hospital staff to extend themselves and go more than halfway to meet or connect with the patients. A nurturing, caring approach is indicated. When there is a conflict between a staff member and a patient, the patient cannot be expected to take the initiative to settle the difference. It is preferable for the staff person to take the patient by the hand (metaphorically) and teach the patient, step by step, how to settle differences. Often this will be the first time anyone has taken this approach with the patient.

Anorexic patients who are not comfortable with their enormous needs resort to primitive and maladaptive measures to fill their needs. These patients are known to be provocative, controlling, and manipulative. Those who work with them feel unappreciated, as well as provoked, controlled, and manipulated. It is crucial that the staff members understand these feelings within themselves as communications from a patient of precisely what the patient feels. It is also crucial to take the feeling of being manipulated a step further and to ask, "Manipulated toward what end? What is the patient missing, and what can't she ask for directly?" It is not enough for a staff member to label the patient as difficult, willful, manipulative, and divisive, and then walk away satisfied that the patient has not abused him or her.

Family Involvement

The question of family involvement is intimately related to the issue of separation-individuation. Anorexia nervosa develops within a family setting of arrested symbiosis and separation-individuation (Goodfellow, 1969). For both office and hospitalized patients, the therapist must consider what to do with the family and the symbiosis. Generally the goal is to achieve a disengagement from the entangled family relationship, coupled with individuation of the family members. The modes of achieving this vary from family therapy, separate individual therapy, and couples therapy, to total physical separation of a child from her parents.

Family therapy is most useful with the young high-school-age anorexic who lives at home with her family. Individual therapy may occur simultaneously. For the young adult or older anorexic who lives apart from her parents, individual therapy with a goal toward intrapsychic change is indicated. The same applies if she is hospitalized and plans to live apart. In these instances, supportive counseling for the parents is important. They will need help in allowing their daughter to individuate. They are also vulnerable to depression and psychic decompensation upon "losing" their daughter.

Both the patient and her parents need each other symbiotically. To sever the symbiosis, it may be necessary to bar all visiting and contact between the parents and the hospitalized anorexic. In less extreme cases, individual therapy is directed at the anorexic's gaining a more realistic perspective of her parents and the symbiotic nature of her relationship with them. Does the anorexic feel that it is her birthright to grow up and live her own life? She may clearly describe disturbed, enmeshed family relationships, but she may not have the capacity to formulate them as such. Much of the
separation-individuation work consists of the therapist's helping the patient to gain perspective by formulating what she has already described.

PSYCHOLOGICAL ISSUES

In this section, I discuss some of the major psychodynamic issues underlying the symptom complex of anorexia nervosa. These dynamics involve both structural needs and unconscious fantasies. I discuss the structural deficits in the ego and the self-organization that result in symbiotic, transitional, and self-object needs. Apart from this may be unconscious or conscious desires to regress to an ideal childhood with ideal parents. Related to these regressive needs and fantasies are intense narcissistic needs and fantasies involving archaic grandiosity and idealization. I then discuss the deeply repressed and disavowed hostile, vindictive fantasies of anorexics. Finally, I propose the concept of self-guilt in anorexia nervosa. Successful psychotherapy involves working with and through these dynamic issues.

Regressive Needs and Fantasies

Anorexic patients who are developmentally arrested at the levels of symbiosis and separation-individuation, and have not yet achieved self-cohesion, self constancy, and object constancy, require external objects to supply the missing mental regulatory structure. This is the function of a self-object or transitional object. The anorexic is not consciously aware of this, but she may be quite aware of the manifestations of this missing mental structure. She feels terribly ineffective, incapable, emotionally labile, tension-ridden, desperately needful of external approbation, unable to be alone with herself and her inner feelings, at odds with herself, and lacking togetherness or wholeness. She defends herself against the realization of her symbiotic needs by adopting a facade of pseudo self-sufficiency. Nevertheless, she is aware on some deeper level of her symbiotic needs and is afraid to grow up. Pubertal bodily changes panic her because they mean becoming a self-sufficient adult woman and doing without a symbiotic object. Growing up means loss, loneliness, utter helplessness, and coming apart. The prospect of doing well or gaining weight is dreaded.

Growing up also means giving up the fantasy of being able to return to early childhood and this time having it come out right. In her fantasy, the anorexic can "go home," start over, and this time around be a perfect child to perfect parents. To give up this fantasy is to reconcile herself to the fact that there is no going back and starting over. Any conscious inkling of this fills her with depression. Now she is frightened both of going forward and of the unnerving depression that she has always tried to avoid. The therapist not only deflates her regressive fantasy, but must help her to tolerate the ensuing depression.

The therapist must also address the patient's deficient mental structure. He does this by filling in the deficit by providing the missing mental functions. In addition, the therapist educates the patient about her need for external approbation and assistance so that she can structure her life accordingly. Further down the road, the anorexic will, via internalization, develop her own internal self-regulatory mechanisms.
Narcissistic Issues

There are many narcissistic features in the anorexic syndrome. The patient's incapacity to maintain a reasonable internal level of self-esteem has been highlighted. Here I focus on the anorexic's grandiosity, exhibitionism, and need for external mirroring, responsiveness, power, and control. The deficient self-regulatory capacities leave the anorexic feeling not only inadequate and helpless, but desperately out of control, powerless, and vulnerable to external influence. An example of this is the fear that if she takes one bite of food or gains an ounce, she will not be able to stop eating and will immediately gain a vast amount of weight. To restore her sense of control and self-esteem, she rigidly counts calories and regulates ingestion. Feeling her self-organization to be out of control, she insists on meticulous control of her body-self. She furthermore attempts to take total control of her environment — her peers, family, and therapist, all of whom feel tyrannized.

This tyrannical behavior is often misconstrued as willful and manipulative. If the therapist and treatment team do not comprehend the underlying desperate sense of being out of control, they are liable to react with countertransference reactions. This may vary from withdrawal to a hostile, vindictive exercise of overcontrol of the patient. The overcontrol takes two basic forms. The first is a rigid behavioristic approach, which totally controls the patient's behavior and weight while denying the patient's unique individuality. A more subtle version of this occurs in any hospital program when institutional and staff needs take precedence over patients' needs. The second form of overcontrol is a type of psychological tyranny. The patient is instructed that since eating, food, and body obsessiveness are not the real problems but only the symptoms, the patient will not be allowed to discuss these concerns. The patient's feelings are prohibited rather than worked with.

Psychological tyranny can also express itself through psychologically sophisticated but inappropriate use of transference interpretations. For example, one patient reacted angrily to a questionable limit imposed on her. The therapist deflected the patient's anger directed at him and his real action by interpreting that she was really angry at her controlling mother and transferring her anger at the mother to him. The patient was made to feel that she had no right to be angry at the therapist. She then believed that her feelings were inappropriate and crazy. Transference interpretations should be reserved for situations in which the patient's feelings are truly inappropriate to the current situation, rather than actually provoked by it.

Coexisting with the terrible sense of ineffectiveness of these patients are grandiose fantasies of omnipotence and invulnerability. This is manifest in the failure of the anorexic to be alarmed about her condition when she is close to dying. The need to be perfectly thin, and perfect in everything else too, reflects primitive, unmodified grandiosity. "Life is not worth living unless one is perfect" is the grandiose position taken by anorexics.

The anorexic body and the patient's sickness in general make dramatic exhibitionistic statements to others: "Take notice. Don't ignore me. I'm here. Getting some attention and responsiveness, even if it is negative, is better than none and feeling like nobody." The implication of these demands for self-confirmation is that core needs for confirmation, mirroring, and responsiveness have not been met during early childhood. This may occur when a parent is unable to provide appropriate responsiveness because the parent is anxious, overwhelmed, depressed, or psychotic. Given these
circumstances, the future anorexic frequently commits herself to never being a burden. Her goal is to maintain the parent's well-being or narcissistic balance. She becomes the compliant model child who has turned off her own needs. This is the typical picture of the young girl prior to the onset of the anorexic illness. Theoretically, she can be described as having a “false self” adaptation (Winnicott, 1965). She is devoted to being a selfobject rather than being a self. She cannot allow her wishes and needs to take precedence.

With the onset of the illness, these needs and wishes break through. The illness permits the expression of the wish to be the center of all things and in omnipotent control of at least a narrowly defined world. Nothing else matters except control, and especially control of her body as the concrete representation of her self organization. Her environment is made to dance to her tune. It cannot ignore or be indifferent to her demands.

The therapeutic task here is to make the anorexic aware of and understand the legitimacy of her true feelings, wishes, needs, values, and goals. Once this is accepted, she no longer requires the indirect, maladaptive, pathological means of self-confirmation that she obtains by being ill. Prior to the development of insight, the therapist provides mirroring, responsiveness, and empathy. If this goes well, the patient’s narcissistic equilibrium is enhanced. The resulting stabilization of the self organization both allows the patient to be amenable to insight and may by itself produce symptomatic relief.

Hostile, Vindictive Fantasies

For the most part, anorexics find it difficult or impossible to be angry. Anger is disavowed. Nevertheless, an observer may see it written on the anorexic’s face or expressed in her behavior. For example, an anorexic frequently stops eating when her mother or anyone else is pleased by her eating. In the anorexic's profound stubbornness, negativism, and oppositionalism, anger is apparent.

A central unconscious fantasy at play in the anorexic’s self-starvation is for her to become a concentration camp victim, a vision of (impending) death, a walking cadaver. This can occur in response to a parent's having identified the future anorexic with an ambivalently loved relative who died. In the mind of this parent, the future anorexic is a replacement for the dead relative (Falstein, Feinstein, & Judas, 1956; Goodis, 1969). Fearing the realization of unconscious death wishes now directed at the child, this parent anxiously and phobically overprotects the child and fosters an overly controlling symbiosis. The parent acts as if death is always just around the corner. The anorexic’s appearance is her cruel, vindictive parody of the parent’s worst fears (Goodis, 1969).

A variation on this theme is illustrated by the patient Ann (described earlier). Ann had a fantasy of her parents grieving over her dead body. She could then gloat that her parents finally realized the wrong they had done her, but now it was too late. The patient Beth (also described earlier) went even further: She kept her bedroom darkened except for candlelight, and created an altar in front of which she prayed. She fantasized herself as her parents’ human sacrifice upon the altar. This gloomy, sacrificial room, permeated with the sense of death, was meant to deliver a vindictive accusation to her parents: “You have killed me,” Beth revealed in the knowledge
that when her mother embraced her she would be aghast with horror in feeling only bones. Beth hoped her appearance evoked shock in others as well. She wanted to be sick, ugly, pitiful, and freakish.

This pursuit of ugliness is an often overlooked phenomenon. In contrast, much has been said about sociocultural standards equating thinness with beauty. On a conscious level, anorexics claim they are striving to be perfectly beautiful by becoming thin. On a less than conscious or unconscious level, just the opposite is found, as described above. The goal is rather to achieve a degree of emaciation that is repulsive, ugly, and shocking. This not only fulfills fantasies of revenge, but represents an attempt by the anorexic to awaken her parents to her dreadful plight.

Self-Guilt

The concept of separation anxiety as a significant impediment to separation-individuation has been thoroughly elucidated by Mahler (1968). Individuals who remain symbiotically bound experience annihilation anxiety, psychic disruption, or fragmentation during separation. Those individuals who have progressed to the level of separation-individuation are more able to remain structurally intact or cohesive. These individuals are more aware of their dependency and are thus more vulnerable to experiencing separation anxiety than to experiencing psychic disruption.

In working with anorexic patients, I have found another factor that I believe significantly impedes the separation-individuation process. Anorexics suffer profound guilt for the wish to separate and the act of separation and individuation. This guilt is manifested in different ways from the guilt expressed by neurotics who are conflicted over specific or focal taboo drives or impulses.

Self-guilt, in contrast to neurotic guilt, is experienced by an anorexic as a more ill-defined but pervasive sense of discomfort for simply being or existing. She generally cannot articulate this experience. Nevertheless, she feels guilty for occupying space. She is in constant fear of burdening others. She refrains from making demands and expressing wishes, desires, and needs. She allows others to use and abuse her. She does not confront those who do abuse her. She does not represent herself (her selfhood) well with others. She feels uneasy and guilty when given to. She turns away gifts and compliments. She acts as if she is undeserving. Nevertheless, she considers herself selfish.

The anorexic negates her selfhood. She extols the virtues of self-denial, discipline, and asceticism (Mogul, 1980), while abhorring anything that smacks of indulgence. Unlike the neurotic, who feels guilty for indulging specific taboo desires, the anorexic feels guilty for the act of indulgence itself. Pleasure per se is taboo. The emaciated body shape is an ideal that graphically portrays this moral value of self-negation.

Self-negation is evident in the anorexic's devotion to meeting the expectations of others. Duty, obedience, and obligation occupy high positions in the anorexic's hierarchy of values and ideals. By leading a highly regimented, ritualized life, regulated by rules, taken up by schedules and obligations, the anorexic precludes any chance to look inward and consider her own wishes and needs. She thereby negates her selfhood. Instead, she directs her attention to pleasing, accommodating, and being sensi-
tive to others. The guiding rule for life is to serve others by meeting their needs. She strives to become a self-object and not a self.

It is as if the future anorexic has a hard time justifying her existence. Modell (1965) first described a type of patient who suffers separation guilt. He notes that these patients are arrested in the phase of separation-individuation. They experience a vague yet pervasive and ill-defined type of guilt. He aptly states that these patients do not feel they have a right to a life (of their own). Anorexics are not only afraid to grow up (separation anxiety), but experience guilt for growing up and thereby abandoning the parent(s). Anorexics feel disloyal for having feelings, wishes, needs, interests, values, and goals that are different from those of their parents. They feel guilty for wanting or having a separate identity or selfhood.

Ann reported that she would feel herself “click off” in the presence of her mother and “click on” in the mother’s absence. Debbie told her depressed mother that she would never leave her mother as her older brothers had; they had left home to marry and establish lives of their own. Another anorexic described how she had always felt she owed her mother her life. This patient struggled to feel that her life was her own to live. Beth, as noted earlier, spoke of her being the center of her mother’s life; she felt that her mother could “never be happy without me.” Any time Beth felt happy, she proceeded to “kill the happiness.” She explained, “I am not supposed to be happy. I should give all that to mother.”

These illustrations demonstrate both the anorexic’s self-guilt and the belief that her role in life is to be a selfless self-object. Often she feels she is a special or precious child, born to fill an emptiness or the needs of a parent. She sees herself as compensating her parent for a disappointing spouse or sibling. This goal would then intensify the anorexic’s need to be perfect—to be a model child for the parent.

The need to be a self-object may also be evident in the transference to the therapist. Ann would begin each session by scrutinizing the therapist’s face for any sign of fatigue. She could not begin to talk about herself until she had been reassured that the therapist was okay or in a good mood.

Since it is the anorexic’s obligation to be a self-object, she experiences self-guilt when she does not fulfill this role. She cannot say “no,” refuse to accommodate others’ demands and needs, or obtain gratification for herself unless she does it in a disguised or unacknowledged fashion. The illness of anorexia nervosa serves this purpose well. It provides an excuse for being negativistic and for obtaining exhibitionistic, narcissistic gratification and self-confirming responsiveness.

A conceptualization of self-guilt makes meaningful some aspects of self-starvation. To eat means to give to oneself. It means that one responds to inner sources of need versus outer expectation, duty, or obligation. To eat means one has made a decision that one has a right to consider oneself a priority vis-à-vis others. Self-interest is legitimate. Thinking of oneself and giving to oneself are legitimate; they have their place—and, in fact, their priority—in the scheme of things.

For the anorexic, the act of eating is an unjustifiable self-indulgence. It is a betrayal of the function of being a self-object. Any act that indicates or suggests self—self-indulgence, self-direction, self-caring, self-interest—is pejoratively labeled or experienced as selfish and is therefore considered illegitimate.

When presented with an anorexic’s self-guilt, the therapist takes the position that it is the patient’s birthright to have a life of her own. Self-interest is differentiated from selfishness. Clarification and insight are crucial in working through this issue.
CONCLUSIONS

In 1962, Bruch reported that standard psychoanalytic interpretations did not work for anorexic patients. Bruch found these patients to be out of touch with inner experience (rather than conflicted over drives). She described the anorexic's sense of ineffectiveness, interoceptive disturbance, and body image disturbance. She related these symptoms to early childhood experiences, which resulted in the child's failure to tune in to inner experience and learn about herself. Bruch's therapy aimed at eliciting and respecting her patients' feelings.

Bruch realized that she was dealing with something that had not been described in the psychoanalytic texts. Without theoretical aid from people like Winnicott, Kohut, Tolpin, Gedo, and Goldberg, she described patients whose actions were not centered in inner experience. Their selves failed to thrive and were stunted or atrophied. Bruch devised a therapy perfectly suited for her patients—a therapy aimed at centering, cultivating, and nurturing the self. To my mind, she pointed us in the right direction.

Self psychology has given us a theoretical language to describe what Bruch knew all along. Anorexics are arrested in self-development and deficient or incomplete in self-regulatory structure. I believe that the role of the therapist is to provide an opportunity for growth and healing of the self. The therapist fills in for the missing structure by offering himself as a selfobject or transitional object. Given the deficits in the patient, he actively reaches out, teaches, coaches, encourages, takes by the hand, and takes over if necessary.

Often even this is not enough. The patient cannot let herself grow and be. She acts as if she must be a selfobject and never a self. Self-guilt precludes selfhood. The therapist must help his patient to believe that it is her birthright to be a person. If all then goes well, he will have the distinct pleasure of watching the psychological birth of his patient.

REFERENCES


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