A HISTORICAL OVERVIEW OF THE PSYCHODYNAMIC CONTRIBUTIONS TO THE UNDERSTANDING OF EATING DISORDERS

Luigi Caparrotta and Kamran Ghaffari

The objective of this paper is to give an historical overview of the development of psychodynamic theories and to acknowledge their contribution to the understanding of the aetiology of these complex disorders. Relevant psychodynamic and psychoanalytic papers on the historical development of eating disorders were identified through a search of (1) Medline and PsycholInfo, (2) the library of the London Institute of Psychoanalysis, (3) Psychoanalytic Electronic Publishing (PEP), and (4) a number of textbooks on eating disorders.

The search revealed a dearth of psychoanalytic historical perspectives about the aetiology of eating disorders in general. Overall most psychoanalytic publications were based on single case studies and concerned primarily with anorexia nervosa. No single model was identified, but a number of psychoanalytic ideas remain consistent throughout. Several psychoanalysts and contemporary psychodynamically-informed authors refer to, apply and have further developed a number of these original ideas. This overview highlights the unique contributions of psychodynamic concepts towards a better understanding of the aetiology of eating disorders and how much they have influenced and informed modern thinking on the meaning of these complex conditions. A range of psychodynamic views has emerged and gradually evolved from concentrating solely on intra-psychic factors to a more comprehensive multi-modal model. This tendency has become a fertile ground for cross-fertilization which, along with the bio-social counterparts, remains the fundamental pillars on which modern understanding of eating disorders still rests.
The recognition, description and significance given to abnormal eating patterns and associated severe weight loss have varied in different cultures and have changed over the centuries. For example, the meaning of severe weight loss gradually changed from representing a ritual with religious connotation to being considered a medical disorder.

Early accounts of these disorders centred on the visible signs of severe weight loss. The following evocative description of nearly a century ago gives a taste of the mesmerizing and puzzling effect of severe weight loss on the observing physician.

A Young Woman thus affected, her clothes scarcely hanging together on her anatomy, her pulse slow and slack, her temperature two degrees below the normal mean, her bowel closed, her hair like that of a corpse – dry and lustreless – her face and limbs ashy and cold, her hollow eyes the only vivid thing about her – this wan creature whose daily food may lay on a crownpiece, will be busy – yet on what funds God only knows (Allbutt and Rolleston 1908: 398).

Eating disturbances were initially regarded as sign and/or symptom of underlying medical conditions and only more recently as a separate psychiatric entity. Following the recognition of eating disorders as distinct illnesses various professionals from different specialities (endocrinologists, general physicians, psychiatrists and psychoanalysts) have made various attempts to understand its physical and psychological aetiology and treatment.

Since the acceptance of eating disorders as separate medical conditions, clinicians have strived to find a common pathway for their aetiology. Studies have ranged from genetic studies to neurotransmitters, hormonal variations and psychosocial influences. Similarly psychoanalysts from the outset have endeavoured to identify the psychological influences and in particular what specifically characterized the unconscious conflicts and motivation of an eating disorder. However, it soon became apparent that from the psychoanalytic perspective there was no single model or unified psychoanalytic theory on eating disorders.

The original contribution from psychoanalytic authors has focused on different ways of understanding the unconscious and symbolic meaning of these disorders and anorexia nervosa in particular. The emphasis on the meaning seems to have shifted from a focus on internal conflicts to object-relations and to family dynamics depending on the prevailing theories and concepts at the time.

Furthermore, in the last few decades socio-cultural influences have been increasingly acknowledged (Bemporad 1997). A number of surveys, particularly in western societies, have found that cultural pressures and concerns about body shape, dieting and the cult of thinness have all contributed to the increased incidence of and interest in these disorders.
After a concise historical perspective on the origins of eating disorders, this paper will concentrate on tracing the development of various psychoanalytic models and describe their cross-fertilization and influence over the years to the present time. It is recognized that this paper can neither be an exhaustive review nor an attempt to entertain a discussion of the merits of psychoanalytic treatment, but it is rather an attempt to bring under one umbrella substantial contributions from within the psychodynamic field.

The religious influence on self-starvation has long been recognized. Purification of the body, mortification of the flesh and renunciation of gluttony were considered to be important conduits to higher spiritual life. Within this religious context self-starvation (fasting) became a well-established and acceptable ritual, whose extreme proponents, however, were glorified, treated as freaks or perceived as possessed by demonic forces. In the fourth century St. Jerome, the scholar who first translated the Bible into Latin advocated fasting and incessant praying as a means of dealing with temptations. He indoctrinated a number of religious Roman women, one of whom eventually died from self-starvation. By contrast pleasure-driven behaviour, resembling bulimia, was reported in countries such as Egypt, Arabia, Rome and Greece (Nasser 1993). In the second century the Greek physician Galen described bulimia (Gr. ‘bous’ = ox+‘limos’ = hunger, i.e. abnormal increase in the sensation of hunger). At the time it was thought that acidic humour in the stomach triggered intense and false signals of hunger (Stein and Laakso 1988).

A scholarly review paper on self-starvation through the ages (Bemporad 1996) discusses in greater detail ‘the pre-history of anorexia nervosa’ and highlights how disturbances in eating behaviour have been observed for thousands of years. Early descriptions of disordered eating emphasize the spiritual and hedonistic needs as motivational forces. However, even then, a number of extreme cases were reported and regarded as ill. For example, Ibn Sina, a Persian physician, made an allusion to a form of anorexia in the eleventh century (Porter 1997).

However, the first full medical description of self-induced starvation leading to severe weight loss is attributed to Richard Morton (1694) who described this condition as ‘nervous consumption’. He distinguished this disorder from other wasting maladies and believed it to be amongst others the product of ‘violent passions of the mind’. Moreover, after observing that the psychopathological process lay between the patient and the family, he advocated the removal of the patient from the family. It is noteworthy how this ‘modern’ therapeutic advice was also recommended two centuries later by French and British clinicians (Lasègue 1873, Gull 1874).

Lasègue (1873) coined the term ‘anorexie hysterique’ referring to it as ‘one of the forms of hysteria of the gastric centre’, and believing it to be caused by ‘the mental disposition of the patient’. He underlined the patient’s pathological conviction that food damages the body and thus must be avoided. He also noted
other features such as the need for approval and self-doubt as well as the patient's lack of concern. Almost simultaneously Gull (1874, 1888) named this condition as ‘anorexia nervosa … due to a morbid mental state’ and made reference to how ‘the perversion of the ego of the patient is fostered by domestic surroundings’.

Gilles de la Tourette (1895) described two subtypes of anorexia nervosa according to whether there was voluntary food refusal or gastric pathology. Janet (1911) also distinguished two groups. In the first type refusal to eat was due to an obsession or phobic anxiety about food and eating. The second type was of a hysterical nature, which in his view was less common.

In 1914 Simmonds discovered the role of anterior pituitary insufficiency as a major cause of severe weight loss and wasting (cachexia). He came to the conclusion that loss of appetite (anorexia) and weight loss was the result of pituitary insufficiency and this unfortunate assumption led to a major shift towards a physical view of the causation of anorexia nervosa. Such belief was held for a number of years by the medical profession and several patients diagnosed with anorexia nervosa were in fact treated with pituitary extracts.

There seems to have been some confusion in distinguishing between cases of anorexia and severe weight loss due to different pathologies and anorexia nervosa. Many of the detailed and vivid clinical descriptions of cases with anorexia and severe weight loss due to hypopituitarism in retrospect seem to have been cases of anorexia nervosa and vice versa. Indeed Sheehan and Summers (1948) eventually clarified that weight loss and anorexia were not typical features of pituitary insufficiency.

In addition, weight loss and anorexia can be manifestations of a variety of physical conditions such as gastrointestinal, liver and cardiovascular disease, and cancer, and mental disorders such as depression, anxiety and psychosis.

From the 1930s a number of researchers began to challenge the notion that anorexia nervosa was primarily due to an organic cause. Over the ensuing years attempts were made to identify the causes of anorexia nervosa, the major emphasis being of a psychogenic nature or containing psychosomatic elements (Parry-Jones 1991). Amongst those was Ryle (1936) with his finding that psychosexual traumas could be a cause of anorexia nervosa.

Behavioural psychologists, basing their theory on learned behaviour and positive reinforcement, conceptualized dieting in anorexia nervosa as avoidance behaviour in response to anxiety evoked by eating and consequent weight gain (Leitenberg et al. 1968), whereas cognitive theorists believe that dysfunctional cognition underlie and determine the eating disorder behaviour (Fairburn 1981).

Meanwhile, a number of psychoanalytic pioneers had been exploring the psychodynamic aspects of eating disorders, with particular reference to the specific role of unconscious conflicts and motivation underlying their psychopathology.
PSYCHOANALYTIC HISTORICAL OVERVIEW OF EATING DISORDERS

It is well-known that many psychoanalysts and psychoanalytically informed clinicians have postulated a number of aetiological theories based on their clinical treatment of patients suffering from eating disorders. Although the majority of their publications hinged on single case studies, there is no doubt that their efforts initiated the psychological understanding of and paved the way to the psychodynamic views in the multifaceted aetiology of eating disorders. While it is not possible to do justice to all the authors in this paper, what follows is an attempt to extract from the historical psychoanalytical maze some of their major contributions.

For the sake of simplicity, the sequence of psychodynamic contributions has been sorted from early to more contemporary contributors. However, some of the psychoanalytic ideas put forward inevitably overlap and/or may take into account psychodynamic hypotheses suggested or elaborated by their predecessors.

Early contributions

In Freud's monumental work there is no indication that he specifically treated patients suffering from eating disorders. However, there are numerous references to eating disturbances in his writings. Freud was foremost a clinician and it is worth pointing out that throughout his psychoanalytic practice he continued to revise and supersede some of his earlier explanations depending on new clinical material arising from his observations. Through his clinical observations he gradually attempted to link some clinical manifestations with a number of possible unconscious (and infantile) fantasies. Some of these pertained to eating disturbances that he encountered in his clinical practice.

As early as 1893 he writes about an interesting case of 'mental anorexia' along with 'a brilliant instance of abulia' in a young hysterical mother: Frau Emmy Von W (Freud 1893). In this extensive clinical account Freud clearly mentions that his patient ate very little and had the habit of hiding and throwing food away. Under hypnosis, it became clear that her refusal to eat was linked to early memories of being forced to eat food that had become cold and congealed, under threat of punishment. She was also obliged to eat with sick members of the family, who had disgusting habits and was forbidden to express any affect connected with her repulsion. In this fascinating paper Freud also pointed out that her symptoms were the result of unresolved expression of distressing affects caused by traumatic events (Freud 1893). In the same volume

1. For the purpose of this paper the term anorexia is synonymous with anorexia nervosa unless it is specifically stated otherwise.

2. Inhibition of will, inability to act.

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his colleague Josef Breuer (Breuer and Freud 1893) equally emphasized the role of a traumatic experience in the development of anorexia and disgust in a young boy. Freud also commented that ‘Every neurosis in an adult is built upon a neurosis which has occurred in childhood but has not invariably been severe enough to strike the eye and be recognized as such’. More specifically, he later surmised that a disturbance of appetite, which may have gone unnoticed in childhood, ‘laid down the predisposition’ to anorectic behaviour in later life (Freud 1918: 98).

In draft G (1895: 200) written to Fliess, Freud offered an understanding of eating disturbances by linking them to melancholia. He thus writes:

a. The affect corresponding to melancholia is that of mourning – that is, longing for something lost. Thus in melancholia it must be a question of loss – a loss in instinctual life.

b. The nutritional neurosis parallel to melancholia is anorexia. The famous anorexia nervosa of young girls seems to me (on careful observation) to be a melancholia where sexuality is underdeveloped. The patient asserted she has not eaten, simply because she has no appetite, and for no other reason. Loss of appetite – in sexual terms, loss of libido. It would not be far wrong, therefore, to start from the idea that melancholia consists in mourning over the loss of libido. It would remain to be seen whether this formula explains the occurrence and characteristics of melancholic patients.

Freud reached similar conclusions a few years later in his study of Dora, an adolescent who lost her appetite after encountering Herr K (Freud 1905[1901]).

In a later letter to Fliess (1899: 278) Freud linked psychogenic vomiting to the unconscious fantasy of oral pregnancy. He writes:

Do you know, for instance, why XY suffers from hysterical vomiting? Because in fantasy she is pregnant, because she is so insatiable she cannot put up with not having a baby by her last fantasy-lover as well. But she must vomit too, because in that case she will be starved and emaciated, and will lose her beauty and no longer be attractive to anyone. Thus the sense of the symptom is a contradictory pair of wish-fulfilments.

In this example, Freud views the symptom of vomiting not only as an expression of an unconscious fantasy but as a defence compromise formation.

Freud extended further his field of enquiry and in his seminal essays on theories of sexuality (1905a), on sexual theories of children (1908) and on the history of infantile neurosis (1918) he wondered whether the development of anorexia in girls at the time of puberty or soon afterwards might be an

3. Freud's italics.
expression of an aversion to sexuality and suggested that eating disorders were hysterical symptoms and tied them to Oedipal issues.

Freud's original and interesting speculations on the origins of eating disorders did not detract him, however, from remaining anchored to the reality of the limits of the medical knowledge of the time. It is worth remembering that Freud was only too aware of the gravity of physical symptoms in anorexia and strongly advocated caution about using indiscriminately the psychoanalytic method in the treatment of such conditions. Indeed, in his paper ‘On psychotherapy’ (Freud 1905b), in discussing indications and contraindications of psychoanalytic methods, he warns that ‘psychoanalysis should not be attempted when the speedy removal of dangerous symptoms is required as for example, in a case of hysterical anorexia’.

Abraham (1973 [1920]), following Freud's suggestions, in his writings on woman's sexuality, linked the process of feeding inhibitions with the unconscious infantile meaning of getting pregnant through the mouth. In 1924 Abraham (1973 [1924]) added further to the psychoanalytic understanding of early stages of development. His main contribution was the subdivision, in infantile development, of the oral stage into (1) sucking stage (libidinal), and (2) biting stage (oral-sadistic), the latter corresponding to the teething period. According to him the libidinal sucking and oral-sadistic biting and devouring stages were pivotal to the development of ambivalence, i.e. the conflictual presence of libidinal pleasure and aggression towards a single object.

The understanding of this conflict became central and for some psychoanalysts remained one of the major unconscious factors in the aetiology of eating disorders. Anna Freud (1946), for example, in her paper on infantile feeding disturbances views the fluctuations between overeating and food refusal as a clear manifestation of the ambivalence of the child towards the mother. The notion of ambivalence was emphasized later by other authors (Thomä 1967, Ritvo 1984) who believed that incorporation and expulsion, frustration and gratification, love and hate were all expressions of the oral ambivalence (including its extreme form in oral sadism) colouring the clinical picture of anorexia nervosa.

Waller et al. (1940: 5), following Abraham's ideas on the link between the fantasy of oral impregnation with the act of eating, suggested that in the aetiology of anorexia nervosa syndrome ‘Psychological factors have a certain specific constellation centring on the symbolisation of pregnancy fantasies involving the gastrointestinal tract’. Moreover the authors described the specific and significant role of the mother-patient relationship and mother's own relationship with food in the development of anorexia nervosa. From the cases reported the authors conclude:

The illness allowed the patient to obtain affection, to be the centre of the family, to work out hostilities, and to provoke the environment
to certain acts of punishment which alleviated the guilt (Waller et al. 1940: 14).

Rose (1943), on the other hand, considered anorexia nervosa as a separate entity from other forms of anorexia, where there are specific fears of oral impregnation. He strongly believed the role of resistance to growth to be central in anorexia nervosa. He underlined the universal significance of eating ‘as the equivalent of growth and change’, which is a risk to be opposed at any significant stage of individual development.

In discussing psychopathology in adolescence, Anna Freud (1958: 141) drew attention to the conflict between pre-genital and genital urges and fantasies stirred up during this important developmental phase. In her opinion a typical clinical example of the extreme manifestation of these conflicts can be encountered in the adolescent suffering from anorexia. She writes:

Here the infantile fantasies of oral impregnation receive added impetus from the real possibilities of motherhood opened up by the genital development. Consequently, the phobic measures adopted against the intake of food on one hand are overemphasised to a degree which may lead to starvation.

Later on Sandler (1989: 305) equally emphasizes the phobic defensive nature of anorexia and states that anorexia expresses, ‘the fight against edipal feminine wishes (represented by the idea of remaining a pre-pubertal non-menstruating little girl)’.

Fenichel (1946) noted that children who have difficulties in tolerating ambivalence might express their negative feelings towards the caregiver by refusing to eat. According to him, if the protest is concentrated on eating alone it may develop as an oral conflict where the sadistic component becomes dominant. Subsequent frustration may then be displaced on the oral fixation leading to eating disturbances in later life. However, besides the oral conflicts, Fenichel considers a number of different developmental origins not necessarily mutually exclusive, which in his view may lead to eating inhibitions. He wondered whether they might be due to a hysterical conversion or an expression of underlying fears of oral pregnancy or an expression of unconscious sadistic wishes or an ascetic reaction to a compulsion neurosis or lastly as an early sign of depression or a refusal of any contact with the world, such as in the case of schizophrenic illness. Struck by the compulsive nature of eating disorders Fenichel (1946) was most probably the first author who defined them as ‘addictions without drugs’. He also considered that hormonal changes in anorexia could be primary in some severe cases, whereas in other cases the primary disturbance in ego development fixated at an oral phase could lead to secondary hormonal changes.

In her extensive work with anorexic patients Helen Deutsch (1947, 1981) not only emphasized the role of the fantasy of oral impregnation but combined it
with the role of unconscious aggression against the mother's womb. According to her these two elements were crucial to the development of the delusional idea of a poisonous destructive pregnancy. In her view the anorexic patient acts as if food would be poisonous; hence she has no option but to avoid it or to eliminate it through vomiting.

In conclusion, early psychoanalytic authors linked anorexia nervosa to melancholia, as a manifestation of a fixation to an oral-sadistic stage as well as resistance to growth. The defensive avoidance of genital sexuality as an unconscious solution to conflicts deriving from fantasies of oral and poisonous impregnation was also suggested as a possible underlying factor in the development of eating disturbances. The notion of ambivalence became central in the thinking of many analysts when they considered the psychopathology of eating disorders. Nevertheless the psychoanalytic attempts to understand the origins of eating difficulties were not necessarily exclusive and not set in stone. Some authors began to explore a spectrum of aetiological factors, although by and large the emphasis of the early psychoanalytic writings was on instincts and the Drive-Conflict-Defence model.

Contributions from the British school including the object-relations theory

A more systematic and careful observation of the mother-infant relationship and further understanding of organization of the self, led to the development of object-relation theories and self-psychology. These later theories added another dimension, complementing and shaping the earlier ideas on eating disorders.

Like Freud, Klein believed that human development and behaviour were primarily understood as a function of instinctual drives. However, she later assigned greater emphasis to the drives being inherently attached to part-objects and later to whole objects and their equivalent unconscious fantasies of self and object (part or whole) representations. Klein (1930, 1932) through her clinical work and infant observations highlighted the role of aggression in infantile development. Following on from Abraham's theories, she came to the conclusion that the infant's relation to the mother's breast is sadistic and devouring from the outset.

Klein also did not specifically write about the psychodynamic nature of eating disorders. However, her interesting observations on the early mother-infant relationship and infant feeding difficulties led to important speculations. One such, emanating from her analytic work with young children with feeding difficulties, was the close connection between these difficulties and the child's earliest anxiety situation which, according to her, is invariably of persecutory origins. Furthermore, she noted that children with eating difficulties, through the unconscious repression of cannibalistic impulses as previously suggested by Freud and Abraham, attempt to deny their destructive aggression against their primary object (mother). Her description of innate envy, as the first
manifestation of oral aggression in reaction to the withholding breast, led a number of psychoanalysts to speculate that patients with an eating disorder have major difficulties in separating from their mothers because their unconscious envy of the breast is overwhelming. In order to defend themselves against their destructive envious attacks they need, in fantasy, to possess, control or become mothers themselves (Farrell 1995).

The work of Winnicott and followers added to the theoretical movement from the drive model to an object-relationship model based on the interaction between ego, objects and external environment and the fundamental idea of the mother-baby unit.

The major contribution of Winnicott was his idea that the baby cannot exist on its own but it can only survive and develop as part of a relationship with the mother (caregiver). He thus conceptualized this notion as the mother-baby unit. Through the primary maternal preoccupation (Winnicott 1958) the mother is able to hold and facilitate the development of the baby both emotionally and physically and at the same time to give coherence and meaning to the sensory-motor world of the infant. Through this holding environment the child is able to develop a sense of self and feel secure. A number of studies of families of patients with an eating disorder have concluded that such families fail to provide a ‘holding environment’ (Gedo and Goldberg 1973, Humphrey and Stern 1988).

Winnicott (1965: 182) makes only scanty reference to what he defined as the ‘truly formidable problem for the therapist of [patients suffering from] anorexia nervosa’. He took the view that the anorexia represented the extreme form of ‘an intermediate stage of development in which the patient’s most important experience in relation to the good or potentially satisfying object is the refusal of it. The refusal of it is part of the process of creating it’. Earlier (1989 [1964]) Winnicott gave an interesting account of the dynamics involving the treatment of a young girl suffering from anorexia, including her tendency to split the treatment team. He also stressed that it may take a long time before the anorexic patient is able to acknowledge the psychic component of her eating difficulties.

To conclude, the contributions of the above authors have not been specifically on eating disorders per se. However, by expanding the psychoanalytic theory on the role of objects and their relationship to the internal representation and external ‘facilitating’ environment, these psychoanalysts have paved the way to further work on the importance of mother-infant interaction in eating disorders.

**Contributions from clinicians who developed specific psychoanalytic ideas on eating disorders**

In her seminal work Selvini Palazzoli (1974 [1963]) followed the British object relation school. In her view the role of the mother-daughter interaction is
paramount in understanding the dynamic process of eating disorders. She
came to the conclusion that the anorexic patient experiences her body as
threatening in nature. This is because the anorexic patient perceives the body
as (orally) incorporating a powerful (bad) maternal object disparaging her
and dictating passivity. In this way her ego (self) becomes helpless while
incorporating and controlling the bad object within the body self.
Consequently the anorectic equates her body to a partial (bad) aspect of her
mother.

According to Selvini the mother, with her overprotection and inability to
differentiate the child as a separate entity, fosters compliance and surrender,
thus rendering the child ineffectual. During puberty a splitting between the
incorporating ego and the identifying ego occurs with consequent repression
of the bad maternal object. The anorexic behaviour is thus the result of
distorted mental representations of body, self and object. Self-starvation, with
the ensuing attack on female sexuality, is then seen as an attempt to resolve
and reduce this confusing identification with the mother.

Bruch's (1966, 1973) formulation is not dissimilar from Selvini's in that
they both emphasize the importance of the mother-child interaction and focus
on pre-Oedipal issues unlike earlier psychoanalysts. Bruch however
considers fundamental the distortions of body image, perception and sense of
ineffectiveness (including impaired sense of autonomy) as the three main ego
developmental disturbances.

Failure of the mother to respond by confirming and validating child-
initiated cues confounds and deprives the child. For example, the mother
needs to distinguish a crying baby who is cold, wet or hungry and respond
appropriately. Inappropriate reactions mainly based on the mother's needs
rather than the child result in deficits in the child's self-concept. An erosion of
the sense of autonomy in the child ensues, who accordingly is unable to
perceive herself/himself as a separate entity from the mother. Body image
disturbance including fear of fatness is equated with the bad object and a
failure to recognize body needs and signals.

In adolescence, the early dependence on the mother impedes pubertal girls
from identifying inner needs and making appropriate decisions. This inability
renders them ineffective and markedly impairs their sense of autonomy. The
ensuing defiant denial of their illness can be understood as a defensive
mechanism against this pervasive sense of ineffectiveness. Rather than being
without appetite, these girls tend to be obsessed with food and eating, but
because they are unable to locate hunger in their needs repertoire they use
eating as a form of pseudo-solution to their multifaceted personality
disturbances. Furthermore, by exerting control over their body the anorexic
solution represents a way to gain the very autonomy and sense of
effectiveness that they lack.

In summary, the body image distortion, denial of thinness and fear of
becoming fat became the hallmarks of primary anorexia nervosa. In Bruch's
view they were also indicative of a delusional disorder and in this sense she agrees with Selvini who equally considered anorexia nervosa as a form of ‘special psychosis’.

It may be worthwhile pointing out that earlier on, Binswanger (1944), a Swiss existential phenomenologist, had also come to the conclusion that anorexia nervosa was a form of schizophrenia. Through the famous Ellen West’s *Being in the World* he considered two salient features of West’s psychopathology namely the patient’s gluttony and the dread of becoming fat. He described gluttony as ‘an existential craving, a need to fill up an existential vacuum’ and the dread of becoming fat as a concretization of ‘a severe existential dread – the dread of withering whereby the world of the self becomes a tomb, a hole’. According to him the temporal and subjective experience of existence of the anorexic patient was aimed at fighting a world of existential impoverishment, emptiness, despair and abandonment.

More recently British psychoanalysts Birksted-Breen and Lawrence drew from and expanded on earlier mother-infant developmental theories. Birksted-Breen (1989) along with other authors (Boris 1984, Sprince 1984) argues that the anorexic girl wishes for and fears the fusion with the maternal object. According to her one of the consequences of this fusion is the lack of a ‘transitional space’. Furthermore, she underlines the inherent disturbance in symbolization in these patients as well as their attempt to annihilate the very nature of human existence.

Lawrence (2001) took forward this failure in symbolization by arguing that symbolic aspects of the maternal function are concretely equated with food and consequently renounced. Following on from the controversial research into the identification of an actual trauma and/or abuse in the aetiology of eating disorders Lawrence placed further emphasis on the notion that many anorexic women struggle with the unconscious presence of ‘an intrusive object in their minds’. Therefore any transference relationship with patients suffering from anorexia will inevitably be coloured by this fear of intrusion, which at times could be so pervasive as to make the patient unable to think. Sohn (1985: 55) points to the interchangeability of bulimic and anorexic states of mind as manifested in the relationship with the analyst. He argues that there is: ‘A retrospective belittling of the breast and/or the good object … which is treated as if it had no other function, as if it had no role in mental and emotional life’. Consequently, the analyst is made to feel useless and to give unwanted interpretations.

To conclude, the last three authors identify fusion with and intrusion by the maternal object, accompanied by lack of transitional space and failure to

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4. Boris (1984) conceptualized anorexia as lack of capacity to accept ‘good things’ due to a desire to possess. As envy and greed are unconsciously linked, any act of acceptance of desired ‘things’ that mother possesses increases their sense of envy. The anorexic solution is not to accept anything. Boris also discusses the issue of boundaries and fusion with the maternal object.
symbolize, as the principle obstacles in the psychoanalytic treatment of patients suffering from eating disorders. Perhaps it is not so surprising when authors point out that their interpretative work alone has so little impact.

**North American contributions including the self-psychology school**

North American authors based most of their understanding of eating disorders on object-relations and in particular Mahler's developmental phases. Some examples are the contributions from Blatt (1974), Masterson (1978), Sours (1980), Sugarman (1991) and Patton (1992).

In their observation of normal and abnormal mother-baby interaction, Mahler et al. (1975) identified the following three basic stages of development of attachment in the infant:

1. Autistic phase (first 2 months of life).
2. Symbiotic phase (2–6 months).
3. Separation-individuation with its four sub-phases:
   - a Differentiation (6–10 months)
   - b Practising (10–16 months)
   - c Rapprochement (16–24 months)
   - d Individuality and object constancy (2–3 years).

According to Blatt (1974), object representations develop along a path where initially the infant does not recognize the difference between the need that is satisfied and the object that provides that satisfaction. Self-object differentiation occurs along different phases. He states that the phase of separation-individuation is not complete until the infant has reached the last phase of self-object representation. He thus concludes that patients suffering from eating disorders have failed to reach a mature object-representation.

Using Mahler's theory as a departure, Masterson (1978) postulates that the anorexic patient has two distorted self and object representations deriving from a developmental arrest at the symbiotic and separation-individuation stage. One consists of hostile, rejecting and withholding maternal introjects in response to separation. The other is characterized by rewarding and responsive maternal introjects consequent to compliance and clinginess. Hence the duality of self-representation consists of the guilty and bad on the one hand and the compliant and good on the other.

Sours (1980), while emphasizing distortion of self and object representations, elaborated on a number of difficulties that these patients have in accessing memories, affects and fantasies. According to him ego defects, poor sense of self, and a failure to develop self and object constancy are often present in the developmental histories of eating-disordered patients. He described two groups of anorexic patients. In the first group, who are less disturbed, the
resurgence of the Oedipal wishes in adolescence leads to regressive behaviour. The second group of patients, older and more disturbed, suffer from structural ego defects deriving from the failure of the rapprochement sub-phase of separation-individuation. According to him this failure is due to the mother's inability to tolerate the toddler's ambivalence, assertiveness and curiosity. He also warned about the difficulties encountered in developing therapeutic alliance with eating-disordered patients and advocated the use of confrontation and interpretation in their treatment.

Sugarman and Kurash (1982) and Sugarman (1991) in their study of bulimic patients view them as unable to express needs and affects in a verbal symbolic form and, according to Patton (1992), the experience of abandonment is symbolically replaced with food. Sugarman believed that, in the practicing sub-phase of separation-individuation, a core developmental deficit hinders the capacity of bulimic patients to evoke self and object representations. The maternal object is then accessed through the bingeing thus replicating the symbiotic feeding experience with the mother.

Self-psychology scholars such as Kohut and Goodsitt elaborated further the role of deficits and/or immature psychic structures in the psychodynamic understanding of eating disorders (Garner and Garfinkel 1997). The self-psychology school (Kohut 1971, Goodsitt 1969, 1977, 1983) regards the developmental deficit of empathic mirroring and idealization in the maternal response during childhood as the main stumbling blocks to successful separation. According to these authors, this failure leads to deficits in being able to regulate and to maintain cohesion in the self and self-esteem including control of the body. Consequently, lack of integrity of the self, bodily helplessness and out-of-control experiences ensue, while any external force or supply becomes overwhelming. During adolescence, bodily and emotional changes experienced by eating-disordered patients are regarded as threats because they signify becoming a separate and self-sufficient adult woman. The anorexic patients attempt to arrest this separation process by maintaining a pre-pubertal body and the eating disorder solution thus becomes a form of compensatory identity of the self.

Other authors (Barth 1988, Geist 1989) also believe that patients suffering from an eating disorder are fundamentally suffering from a disorder of the self. The symptoms could then be viewed as the patient's attempt to maintain a sense of self. These patients, due to earlier traumas in the empathic connectedness between parent and child and in particular ‘repeated parental misunderstanding of [their] need to be perceived as a whole person’, are vulnerable to decompensation (Geist 1989).

The concept of concretization has been applied to the understanding and treatment of eating disorders (Atwood and Stolorow 1984, Miller 1991). According to this concept, people with a vulnerable self-organization, when threatened by the loss of
integrity of the self, try to reduce this possible loss of integrity by expressing their inner perceptions through their body. More specifically, the anorexic patient experiences her sense of self so concretely that being out of control, lacking self-cohesion and feeling empty coupled with a deep sense of isolation are expressed through her body. The anorexic patient paradoxically manifests these inner experiences, as Geist accurately summarizes, by symbolically recreating within the symptoms ‘both the danger to the self and the efforts at self-restoration’. A similar point, although not directly linked to concretization, was made by the French psychosomatic analyst McDougall (1989) who understood the life-threatening nature of anorexia nervosa as a way of expressing ‘unrecognised emotional conflicts … and paradoxically used in the service of psychic survival’. Given the high level of concretization in anorexic patients, Miller therefore argues that interpretation of the symbolic meaning of the symptoms is inappropriate – a conclusion that is not dissimilar to some aforementioned British authors.

To summarize, Mahler's work has informed a number of North American authors. Early failure in object representation, separation-individuation issues along with parental misunderstandings, deficits in empathic maternal mirroring leading to poor cohesion of the self and severe deficit in the symbolic function in patients suffering from eating disorders have been highlighted by various clinicians.

**Contemporary multi-modal contributions**

Contemporary psychodynamic practice attempts to bring together the understanding of the aetiology of eating disorders by applying the knowledge gained from some of the early drive theories, recent attachment theories and bio-social influences into a more modern multi-modal model. However, as Zerbe (2001) pointed out, these schools of thoughts need to be adapted and placed within the unique developmental history of each patient suffering from an eating disorder. To paraphrase Jeammet and Chabert (1996: 29): ‘Eating disordered patients are like frozen food, they look all the same when frozen, but they look all different and unique when they are thawed’.

Modern comprehensive understanding of eating disorders have to take into account various interrelating predisposing, precipitating and perpetuating factors and some clinicians have made greater efforts to integrate these perspectives (Yates 1989). It seems fairly clear that patients suffering from an eating disorder do not necessarily follow the same difficulties in their development. Gradually the search for a specific single common developmental pathway has been abandoned to give way to a number of different developmental difficulties. This impetus has led many modern clinicians to integrate and formulate more comprehensive treatment strategies by bringing together psychoanalytic, biological, cognitive and family findings (Tobin and Johnson 1991).
Dare and Crowther (1995) for example, along with other psychoanalytically informed clinicians (Bemporad and Herzog 1989, Jeammet and Chabert 1996, Zerbe 2001), favour a multi-modal ‘integrated model’ where individual and family dynamics are seen in constant interaction with the external environment. This integrated model places the individual and family attitudes (including the attitudes to food) within the context of biological determinants, society demands on body shape, cultural and gender expectations. Family and interactional therapists (Selvini Palazzoli 1974, Minuchin et al. 1978) have discussed at length how the eating disordered patient is unconsciously exploited by the surrounding family in order to maintain the ‘family homeostasis’. Undesired qualities of the parents are projected onto the child who becomes the container of all the bad and unwanted. The balance is maintained by having a sick child. Behind a façade of apparent functioning and family loyalty, there is often poor trust and difficulty in intimacy.

Dare and Crowther (1995) also regard the degree of maternal concern (or controlling intrusiveness), the developmental struggle for autonomy and differentiation to be fundamental factors affecting the self-organization of the eating-disordered patient-to-be. They agree with Freud that eating habits are associated with greed and disgust and argue that eating has to be resisted because it is perceived as a bad intrusive object. Food and sexuality, though highly desirable, can get confused as they both represent threatening and intrusive objects leading to passive surrender and loss of control. They comment: ‘food has to be seen as an alien in order to bolster the resistance to its intrusive potency’.

Gabbard (2000: 344) gives an interesting comprehensive summary of the multi-determined psychoanalytic understanding of eating disorders. This includes:

1. a desperate attempt to be special,
2. an attack on the false sense of self fostered by parental expectations,
3. an assertion of a nascent true self,
4. an attack on a hostile maternal introjects viewed as equivalent to the body,
5. a defense against greed and desire,
6. an effort to make others – rather than the patient – feel greedy and helpless,
7. a defensive attempt to prevent unmetabolized projections from the parents from entering the patient,
8. an escalating cry for help to shake the parents out of their self-absorption and make them aware of the child's suffering.

Moreover he suggests that cognitive features such as body image distortions, magical and obsessive thinking should also be considered.

The French clinicians Jeammet and Chabert (1996) view eating disorders as a conflict linked to dependence along a continuum between narcissistic and masochistic suffering. While underlining the influence on the family unit by the evolution of societal demands based on increased narcissistic gratifications, they
questioned whether there has been a real structural change in the personality characteristics of eating-disordered patients.

They prefer to think that what has changed is how present society favours the manifestation of dependence conflict in a particular way of which the eating disorders are but one of its cogwheels.

**Concluding remarks**

Eating disorders occupy an interesting place at the interface between body and mind, emotions and cognition, childhood and adulthood and most of all between the individual, the family and society at large.

Over the last 30 years a great deal of progress has been made in understanding the genesis, natural history and treatment of eating disorders. Their classification as separate disorders has been helpful and fostered increasing interest in these conditions. However, a number of recent studies have identified an overlap between subgroups. Furthermore, these disorders have been found increasingly co-morbid with other psychiatric disturbances such as depressive and anxiety disorders, obsessive-compulsive disorders and perhaps not surprisingly – in view of their developmental roots – also with personality disorders (Roth and Fonagy 1996).

The psychoanalytic conceptualization of the genesis of eating disorders has focused mainly on intra-psychic factors. More recently, however, consideration has been given to cognitive, family and environmental factors thus further enriching the psychodynamic understanding of eating disorders. Freud's original ideas have been integrated and enlarged by object-relations and the self-psychology theories. Anorexia nervosa was originally linked to melancholia and seen as an unconscious solution to the fears of pregnancy and maturation. Bruch's (1973) monumental work defined the pathognomonic features of anorexia nervosa and highlighted the defensive nature of the illness against the feelings of ineffectiveness and powerlessness. The notions of the fear of intrusion and failure of symbolization have been important additions to the psychodynamic understanding of eating disorders. The advent of attachment theories and the self-psychology school have provided another perspective on the mother-infant relationship. The stages of development of attachment in the infant have led to increasing understanding of the arrest at different developmental levels of the self. Hence the anorexic solution – by maintaining a pre-pubertal body – thwarts any attempt at separating. In addition, the role of dysfunctional families in scapegoating a sick member as a way of maintaining the family equilibrium and the attitude to food which society demands have been increasingly scrutinized and incorporated into the intrapsychic factors. This more holistic psychodynamic approach to eating disorders has invariably influenced several clinicians in their understanding of patients suffering from eating disorders.
To conclude we believe that eating disorders represent various forms of self-imposed starvation and/or bingeing conveying vividly the struggle to thwart any attempts at separating and individuating from the intrusive and controlling mother. Food is thus perceived as bad and intrusive leading to passive surrender and loss of control. In fact, as Davies (2005) suggests, most clinicians have become aware of how patients suffering from eating disorders tend to fear, reject and destroy the therapeutic relationship which is unconsciously perceived as the controlling mother. The unconscious solution found by eating-disordered patients has to be understood within the complex interaction between early emotional and nourishing experiences, family dynamics and societal pressures.

Finally, it is hoped that this overview has succeeded in bringing together some of the painstaking clinical and developmental work of many psychoanalysts and psychoanalytically informed clinicians with interest in these disorders. While most of them concentrated on various important specific intra-psychic and interpersonal aspects of eating disturbances, some of them were also genuinely puzzled by their multifaceted aetiology from the outset. Even in some of the earlier writings the importance of biological, familial and social determinants were often mentioned. Their unique contributions to the understanding of psychodynamic factors in the aetiology of eating disorders, along with informing and shaping the meaning and treatment of these complex conditions, should be more widely acknowledged.

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