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**A psychodynamic view of psychosis within the context of
anorexia nervosa**

Schulwolf, Marthe, Ph.D.

City University of New York, 1991

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**A PSYCHODYNAMIC VIEW OF PSYCHOSIS
WITHIN THE CONTEXT OF ANOREXIA NERVOSA**

by

MARTHE SCHULWOLF

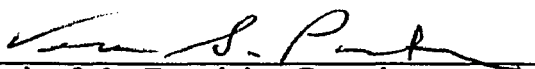
**A dissertation submitted to the Graduate Faculty in
Psychology in partial fulfillment of the requirements for
the degree of Doctor of Philosophy, The City University
of New York.**

1991

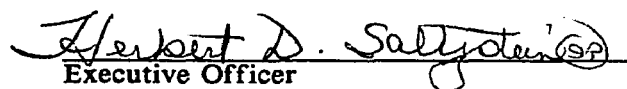
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Abstract**A PSYCHODYNAMIC VIEW OF PSYCHOSIS
WITHIN THE CONTEXT OF ANOREXIA NERVOSA****by****Marthe Schulwolf****Adviser: Professor Vera Paster**

This study addresses the intersection between anorexia nervosa and psychosis, i.e., the circumstances, nature, and content of psychotic phenomena in individuals with anorexia nervosa, in order to illuminate the underlying dynamics of anorexia nervosa. Based on the theoretical literature on anorexia nervosa and on the anaclitic/introjective model of personality and psychopathology developed by Blatt and Shichman (1983), it is proposed that anorexia functions as an exaggerated introjective defense structure against anaclitic needs. It is often precipitated by an intensification of anaclitic needs or by the demand for separation at adolescence, a demand which individuals with a personality strongly skewed towards the anaclitic line can only meet via exaggerated introjective mechanisms. Based on a review of the clinical literature on psychotic phenomena among anorexics, four variables are proposed which can be classified as either anaclitic or introjective: (a) precipitant of psychosis, (b) quality of psychosis, (c) content of psychosis, (d) process of recompensation. It is hypothesized that variables (b) and (c) show a high tendency toward congruence, allowing for an easy differentiation between two types of psychosis--an introjective psychosis, which represents an exacerbation of the introjective defense of anorexia nervosa at a more primitive level, and an anaclitic psychosis, resulting from a disintegration of the defense with the ego becoming flooded by anaclitic needs. The case of "Sylvia" is presented. Sylvia manifested a lengthy depressive psychosis centered on the belief that "God wanted her to fast," in conjunction with a unique "atypical eating disorder" consisting of continuous self-feeding via nasogastric tube, resulting in a 9-year hospitalization. Sylvia's illness is conceptualized

as an introjective "psychotization" of anorexia nervosa. Sylvia's case supports the views of Palazzoli (1978) on anorexia nervosa, of Winnicott (1960/1965a) on the False Self defense, and of Rizzuto (1979) and Jones (1991) on the role of the God representation as a transitional object. It illustrates the progressive function that regression can serve, the importance of the patient remaining in control, the role of processes of internalization, and the necessity for a rebalancing and reintegration of the two developmental lines in order for a true recovery to occur.

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The clinical work that lies at the center of this dissertation took place at a psychiatric facility under the auspices of the New York State Office of Mental Health. This facility offered a truly unique treatment environment, that resulted from the contributions of all those involved, who must remain unnamed. Without the supportive and challenging presence of all these people--supervisors, nurses, therapy aides, a chief resident, psychiatry residents, other therapists who preceded and followed me, and all the support staff involved in running a large psychiatric hospital--none of the extraordinary events related in this work could have taken place.

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CHAPTER I

INTRODUCTION

A. Overview

This study addresses the intersection between anorexia nervosa and psychosis, i.e., individuals who manifest both phenomena, either concurrently or sequentially. Its primary purpose is to explore the circumstances, nature, and content of psychotic phenomena associated with anorexia nervosa in order to illuminate the underlying dynamics of anorexia nervosa. The study focuses on an in-depth case report of one individual who manifested an unusual form of psychotic illness which appeared to be intimately related to an underlying and preceding chronic anorexic adjustment to life. It also explores the theoretical literature on anorexia nervosa and the clinical literature on individuals who manifest anorexia nervosa and either psychotic episodes or ongoing psychotic illnesses. The following questions will inform and organize the review of the clinical literature:

1. (a) With what frequency do anorexics manifest psychotic phenomena or psychotic illness?
(b) What categories of psychotic phenomena are involved, i.e., what is the relative proportion of ongoing psychotic illness vs. transient psychotic episodes?
2. In the case of ongoing psychotic illnesses:
 - (a) Are these illnesses primarily affective, schizophrenic, schizoaffective, or delusional?
 - (b) What kind of temporal relationship can be said to exist between the anorexia nervosa and the psychotic illness?
 - (c) What kind of content relationship can be said to exist between the anorexia nervosa and the psychotic illness?
3. In cases of transient psychotic episodes within the context of ongoing anorexia nervosa:

- (a) What is the relationship between the precipitating factors of the psychosis and those of the anorexia nervosa?
- (b) What is the relationship between the contents of the two illnesses? E.g., can the content of the psychosis be seen as either a psychotic disintegration or a distillation, elaboration or exaggeration of anorexia nervosa--in Escande, Gayral and Girard's (1975) terms, a "transitory psychotization"--and, if so, what light does this analysis shed on the internal dynamics of anorexia nervosa?
- (c) To what degree can anorexia nervosa be viewed as either a "mono-symptomatic psychosis" and/or a defense against psychosis?
- (d) How can the model of psychopathology developed by Blatt and Shichman (1983) (which will be discussed in Chapter II) be applied to illuminate and clarify these phenomena and interrelationships? Can we locate anorexia nervosa within this model and what do we gain by doing so?

My interest in these questions stems from a unique treatment experience that took place during my internship year placement on a locked ward of a long-term psychiatric facility. I was fortunate enough to have the opportunity to treat a very unusual patient, a middle-aged woman who had exhibited chronic anorexic/bulimic behavior, probably at a mild or even sub-clinical level, through most of adulthood. In her early 40s she developed a unique psychotic delusion in conjunction with a major depressive disorder. Her delusion seemed to have a particularly "anorexic" quality--she believed that "God wanted her to fast" to atone for her sins. She experienced 8 brief hospitalizations within one year--ostensibly for anorexia nervosa, although the diagnosis is arguable in light of the delusion--before transfer to a long-term facility, where she remained for approximately 9 years under the diagnostic labels of "major depression" and "atypical eating disorder." In the course of this lengthy hospitalization, she developed a very unique adaptation and way of life: she refused to take any form of nourishment by mouth and sustained herself via self-feeding by naso-gastric tube, maintaining an adequate non-anorexic weight in this fashion. This adaptation was the result of a complex

set of forces and circumstances, with secondary gain playing a crucial role in its maintenance. During this lengthy hospitalization, there were several brief periods of more disorganized psychotic thinking and behavior, accompanied by the expression of more bizarre types of delusions--events which can be viewed as further decompensations into deeper, more disintegrative psychosis. I was fortunate enough to work with this patient during the period when both the symptom picture of food refusal with self-feeding via naso-gastric tube and the delusion, which had originally motivated the food refusal, became accessible to treatment and were largely resolved. While brief (less than one year), our work together was intense and provided me with a rich set of background information on which to base hypotheses regarding the underlying dynamics of symptom/delusion formation and resolution. Although many aspects of this are unique products of a special set of circumstances, psychotic illness during the course of anorexia nervosa or associated with anorexia nervosa, while hardly routine, is not unique. The data available on this case, in conjunction with other cases reported in the literature, impressed me as having the potential to illuminate, on a broader level, the underlying dynamics of anorexia nervosa as a whole and, on a narrower level, those of anorexic patients who are prone to either brief decompensations or flagrantly psychotic outcomes.

The relationship between the disease entity known as "anorexia nervosa" and the broader psychiatric category of psychosis has been problematic almost since the time "anorexia nervosa" was first identified in the medical literature--an event generally attributed to the British physician Richard Morton in 1689 (Bruch, 1973). After many attempts in the past to subsume anorexia nervosa under other disease labels, both psychotic and non-psychotic (to be discussed further in Chapter II below), the illness is now recognized as a separate and unique entity, as demonstrated by its separate status within the American Psychiatric Association's [APA] DSM-III (1980) and DSM-III-R (1987) classification system. This classification system reflects the more modern view, or perhaps the large-scale modern emergence, of a category of "typical" (also termed "classical" or "primary") anorexia nervosa, considered to occur far more often in present times than in the past. This typical anorexia nervosa is largely, although not exclusively, a

disease of female adolescence and young adulthood, and is not considered inherently psychotic, despite limited impairments in reality testing centered on the crucial issues of food and weight. It is a form of self-starvation based on the need to maintain "a pathologically low body weight" (Crisp, 1977, p. 690). It is far more prevalent among females than males, among the middle and upper-middle classes than among the poor (Crisp, 1977) and shows an especially high concentration in certain occupations (e.g., ballet dancers and models) (Szmukler, 1987); both the prevalence of the disease and professional and popular awareness of it appear to have greatly increased in the last few decades (Brumberg, 1988).

There have been reports in the literature of cases where patients diagnosed as suffering from primary anorexia nervosa have also manifested some form of psychotic illness--such developments being the exception rather than the rule. In some cases, these reports involve anorexic patients who suffer transient psychotic breaks; in other cases, the patients may show long-term recurrent or chronic psychosis. The occurrence of transient psychotic episodes in anorexic patients is quite consistent with the view that at least a sizeable portion of anorexics fall in the severely narcissistic/low-level borderline spectrum of personality organization, i.e., that anorexia nervosa occurs, at least with some degree of frequency, among individuals who are, by virtue of their underlying personality organization more than by virtue of their anorexia, subject to transient psychotic episodes (Rothenberg, 1986).

At this point, an examination of the nature and boundaries of the diagnostic categories involved is appropriate. The following two sections address these issues, first for anorexia nervosa and secondly for psychosis.

B. Anorexia Nervosa

A useful way to approach the question of defining anorexia nervosa is to clarify the boundaries between this illness and other forms of self-starvation. A good starting point is the classification schema proposed by Bruch (1973), a pioneer in the study of eating disorders and especially anorexia nervosa. Bruch (1973) divided modern

self-starvation phenomena, with the exclusion of politically-motivated hunger fasts, into three categories: (a) "typical" or "primary" anorexia nervosa, (b) "atypical" anorexia nervosa, and (c) "psychogenic malnutrition."

To proceed in reverse order, i.e., from the category most removed from anorexia nervosa, "psychogenic malnutrition" is the term Bruch (1973) used for cases where self-starvation resulted from some other psychiatric illness and anorexia nervosa was not in the picture. She defined this term as applying to cases where there is "neither the morbid interest in food nor active rejection of it, nor concern with weight or a relentless pursuit of thinness" (p. 229). Thus it is essentially a remainder category, covering all non-somatically caused self-starvation which is not due to anorexia nervosa. Nicolle (1939) mentioned several fairly common possibilities which can easily be distinguished from anorexia nervosa: melancholics whose food refusal is tied to delusions of unworthiness, manic patients who neglect meals when they are carried away by their flight of ideas, and paranoid patients who suffer from delusions that their food is poisoned. To reiterate, the focus for these patients is neither thinness nor eating per se, but rather some other aspect of mental life. These patients fall outside the scope of this study.

The second of Bruch's terms, "atypical anorexia nervosa"-- as distinct from "typical anorexia nervosa"--is one that she grappled with at some length. For Bruch (1973), in the "typical" form the patient is preoccupied with a "relentless pursuit of thinness", a preoccupation stemming from underlying issues of separation, identity and autonomy, whereas in the "atypical" form "the eating function itself is disturbed with various distortions of its symbolic meaning and thinness is only an accidental by-product" (p. 285). This definition is identical to a psychoanalytic definition of hysterical phenomena involving the eating function, and, logically enough in light of this hysterical aspect, Bruch (1973) noted that atypical patients displayed far more concern with sexual issues than typical ones. To further complicate matters, Bruch added that, over time, the two forms tended to resemble each other more and more, making the distinction nearly impossible to establish in more chronic cases.

Bruch's distinction between typical and atypical anorexia nervosa closely echoes an earlier debate among 19th century French observers who attempted to make a distinction between "hysterical anorexia" and "anorexia nervosa," or between "anorexia hystérique" and "anorexie mentale" to use the French terminology (Dubois, 1913; Palazzoli, 1978). In modern times, the term "hysterical anorexia" has fallen into disuse and the term "atypical anorexia nervosa" is now used in a different sense than the one in which Bruch used it--a usage which will be discussed in Chapter IV below. Garfinkel and Garner (1982) suggest that it is more reasonable and appropriate to classify Bruch's atypical patients under other diagnoses, usually within the realm of hysterical or schizophrenic phenomena, and to reserve the term anorexia nervosa for those who show the crucial terror of obesity and obsession with thinness, thus concurring with the modern view of weight "phobia" (Crisp, 1977) and body image disturbance as the motivating force underlying the illness.

In this report, we will adhere to this terminology, using the term "hysterical self-starvation" to refer to patients who might, in the past, have come under the category of "anorexie hystérique" or under Bruch's label of "atypical anorexia nervosa". Yet, while this practice on our part may constitute an improvement in terminology, it hardly addresses the underlying problem, i.e., the difficulty in distinguishing between hysterical phenomena and anorexia nervosa when faced with individual patients whose conformity to theoretically typical forms and lists of diagnostic criteria is at times quite imperfect, and on whom the data available may be sketchy as well. A number of factors have been involved in creating and perpetuating some degree of diagnostic confusion in this area. One is the now well-known propensity of anorexics to give disingenuous answers when asked why they engage in self-starvation or restricted eating. Some of the confusion in the older literature may be due to the fact that earlier authors were less aware of the dynamics of anorexia nervosa and consequently more apt to take anorexics' pseudo-explanations (e.g., stomach pains, lack of appetite, difficulty swallowing) at face value, without probing further; this tendency would, in modern eyes, lend a more hysterical cast to their reports, whatever diagnostic terminology they may have chosen to

use. We are now far more aware of the volitional aspect of the illness and of the intense denial of hunger that often accompanies it, to the point where hunger sensations may not be perceived in a normal fashion (Bruch, 1973). We are also far more attuned to the subtle signs of preoccupation with food and thinness--both of which are generally present. Indeed, the preoccupation with food is particularly diagnostic and may take a variety of forms--food rituals and obsessions, hoarding of food, much involvement in cooking and feeding others, livening up at the mention of food or food-related topics (Palazzoli, 1978). As we now view it, the term "anorexia," which signifies "lack of appetite," is a misnomer in relation to anorexia nervosa and remains in place largely for the sake of tradition and convenience. On the other hand, many authors (e.g., Garfinkel & Garner, 1982) consider the behaviors that reveal a preoccupation with food to be sequelae of the physical state of starvation. They invoke the point that many of the more obsessional behaviors, such as pushing small quantities of food around on a plate, very slow eating, food fads and unusual food combinations, hoarding of food, stealing, and preoccupation with food-related matters, were observed in the celebrated Minnesota studies of starvation (Bruch, 1973; Garfinkel & Garner, 1982). The case to be reported in Chapter III is interesting in this regard, as the patient manifested some of these behaviors (e.g., preoccupation with food and with feeding others) while in a nutritional state far from starvation, but in a psychological state of total deprivation of oral intake.

Another factor tending to confound the distinction between anorexia nervosa and hysterical self-starvation lies in the cultural context within which the patient lived. As we will see in Chapter II below, hysteria, which appears to have been more prevalent in the last century, included among its commonly occurring forms those which affected the eating function and resulted in self-starvation. Many of the explanations that have been advanced to explain the recent increase in anorexia nervosa could just as well explain a decrease in hysterical forms in favor of more typical ones: e.g., the modern obsession with thinness, the pressure on women to excel in the area of appearance, and the conflicts induced by increasing opportunities, demands and expectations that women experience in modern Western society (Chernin, 1985; Palazzoli, 1978); we need also

note the greater psychological sophistication of the post-Freudian era, which is sometimes held responsible for the overall decline in conversion symptomatology, as well as the modern prevalence of "disorders of the self" and addictive illnesses in all their myriad forms. In other words, it is indeed possible that earlier authors tended to come across more hysterical forms of self-starvation, and that typical anorexia nervosa is truly a disease of modern times--as we will see in the historical analysis in Chapter II below.

Nicolle (1939) made two cogent suggestions for making this differentiation between anorexia nervosa and "hysterical abstention from food." The first characteristic she noted was the "mono-symptomatic" nature of anorexia nervosa, where the patient's illness stems from one central dominating factor, the dread of obesity as "an unbearable affront to narcissism", in contrast to the "protean" quality of hysteria (p. 157). The second difference lies in the patient's mental attitude:

The hysteric makes parade of her inability to eat and undoubtedly eats when it suits her; the anorexic tries to dissimulate the fact that she does not eat. The hysteric desires to elicit sympathy: this is far from the anorexic, but she may enjoy in some less direct way her ability to tease and deceive those about her. I should say that the purpose of the anorexic to starve herself is of fundamental importance. This is illustrated by their different reactions to isolation: emotional neutrality in the environment will make the hysteric eat in order to escape to one more congenial to her purposes, and we know she will eat when unobserved. Not so with the anorexic, who will only eat when under strict supervision. The hysteric welcomes attention from her environment directed to her disabilities, while the anorexic is mysterious and tries to evade inquiries; it is as though the hysteric plays a drama to her environment and the anorexic to herself. (Nicolle, 1939, p. 157)

This passage differentiates between the anorexic's denial of illness directed at both herself and the external world and the hysteric's "belle indifférence," which, while superficially similar, are not identical, the first being a more active process and the second a more passive one. In short, the classic hysterical patient will tend to seek treatment for her symptoms, albeit insisting on a somatic cause, whereas the anorexic will deny the existence of any problem whatsoever. This stresses the adaptive functions that anorexia serves from the patient's point of view and its ego-syntonic quality (Crisp, 1977).

This report will adhere to the American Psychiatric Association's definition of anorexia nervosa--a term which will be assumed to mean typical anorexia nervosa--and will use the term hysterical self-starvation to refer to phenomena of self-starvation that

do not fit the picture of anorexia nervosa, that do show characteristics of hysteria, and that are not directly attributable to other mental illness (e.g., affective disorder, schizophrenia, delusional disorder). The APA's DSM-III (1980) and DSM-III-R (1987) diagnostic criteria for anorexia nervosa are listed in Table 1 below. As can be seen, the emphasis is on weight loss, fear of gaining weight or becoming fat, and body image disturbance. To briefly review the change between the earlier and later sets of criteria, we may note that the weight loss requirement has been reduced from 25% to 15%; however, a criterion reflecting the requirement of a "hypothalamic-pituitary axis dysfunction" (Garfinkel & Garner, 1982) has been added, at least for women of menstruating age where this manifests as amenorrhea (be it primary or secondary to the weight loss). This change provides a clinical cut-off point which is more closely related to the individual's body type and metabolism and thus less affected by the arbitrary qualities of weight tables (Drewnowski & Garn, 1987; Knapp, 1983). By and large, we will attempt to rely on the later (APA, 1987) criteria whenever possible, but not rigidly so, since much of the literature presently available bases itself on the earlier set. When a more general rule of thumb is called for, we will refer to Bruch's (1973) criterion of a dual obsession with food and thinness which forms the core of the illness.

Table 1

DSM-III Diagnostic Criteria for Anorexia Nervosa

- A. Intense fear of becoming obese, which does not diminish as weight loss progresses.**
- B. Disturbance of body image, e.g., claiming to "feel fat" even when emaciated.**
- C. Weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.**
- D. Refusal to maintain body weight over a minimal normal weight for age and height.**
- E. No known physical illness that would account for the weight loss.**

(American Psychiatric Association, 1980, p. 69)

DSM-III-R Diagnostic Criteria for Anorexia Nervosa

- A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.**
- B. Intense fear of gaining weight or becoming fat, even though underweight.**
- C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.**
- D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)**

(American Psychiatric Association, 1987, P. 67)

C. Psychosis

English and English (1958) define "psychotic disorder" as "a general term for a disorder characterized by some 'degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres.' Individuals with such disorders fail to relate themselves effectively to other people" (p. 429-430). Laplanche and Pontalis (1973) give a more classically psychoanalytic definition of psychosis as "a primary disturbance of the libidinal relation to reality" with the majority of the symptoms, and particularly delusional ideas, being viewed as "secondary attempts to restore the link with objects" (p. 370). Whether the focus is on the ego's abdication of its function of reality testing or on the libidinal break with reality, reality testing remains the usual demarcator, as specified in a more detailed fashion in the DSM-III-R (APA, 1987) definition of psychosis:

Gross impairment in reality testing and the creation of a new reality. The term may be used to describe a person at a given time, or a mental disorder in which at some time during its course all people with the disorder are psychotic. When a person is psychotic, he or she incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, a depressed person who underestimates his achievements would not be described as psychotic, whereas one who believes he has caused a natural catastrophe would be so described.

Direct evidence of psychotic behavior is the presence of either delusions or hallucinations (without insight into their pathological nature). The term psychotic is sometimes appropriate when a person's behavior is so grossly disorganized that a reasonable inference can be made that reality testing is markedly disturbed. Examples include markedly incoherent speech without apparent awareness by the person that the speech is not understandable, and the agitated, inattentive, and disoriented behavior seen in Alcohol Withdrawal Delirium. (p. 404)

DSM-III-R is somewhat equivocal with regard to the relationship between the Psychotic Disorders and the Organic Mental Disorders, i.e., disorders due to degenerative illness of the central nervous system, to ingestion of psychoactive substances, or to physical disorders affecting brain functioning. It does state that there is overlap between the two categories and lists a number of the same symptoms among illnesses in both groups. But it does not clearly state which organic disorders are "psychotic" and which are not. The role of organic factors will arise in the context of our study with

regard to the effect of starvation and starvation-induced metabolic changes in inducing psychosis, an area that unfortunately is not addressed by either DSM-III or DSM-III-R.

DSM-III-R's list of non-organic Psychotic Disorders consists of the following:

1. Schizophrenia, which is defined as showing "characteristic psychotic symptoms during the active phase of the illness" (i.e., what are commonly termed the positive symptoms) and a low level of functioning in the residual phase (the negative symptoms). The characteristic positive symptoms are listed as follows, with the proviso that none are specifically pathognomonic of schizophrenia: disturbances in the content of thought (delusions), in the form of thought (formal thought disorder), in perception (hallucinations), in affect, in the sense of self, in volition, in interpersonal functioning and relationship to the external world, and in psychomotor behavior. Schizophrenia is always considered a psychotic illness.
2. Delusional (Paranoid) Disorder, characterized by "a persistent nonbizarre delusion" not due to any other mental or organic disorder. This is a psychotic disorder where, on the surface at least, the personality appears not to show disintegration.
3. Brief Reactive Psychosis, the definition of which bears noting:

The essential feature of this disorder is sudden onset of psychotic symptoms of at least a few hours', but no more than one month's, duration, with eventual full return to premorbid level of functioning. The psychotic symptoms appear shortly after one or more events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in that person's culture. The precipitating event(s) may be any major stress, such as the loss of a loved one or the psychological trauma of combat. Invariably there is emotional turmoil, manifested by rapid shifts from one intense affect to another, or overwhelming perplexity or confusion, which the person may acknowledge or which can be judged from the way he or she responds to questions and requests. (p. 205)

As we see from the emphasis on the presence of a serious stressor, the term "reactive" appears to be as important as the term "brief" in the definition of this disorder. Indeed other psychotic disorders, such as Mood Disorders or Schizophreniform Disorder, which can be diagnosed with or without the presence of a major stressor, preempt this diagnosis. The diagnosis is also not made if the prodromal symptoms of Schizophrenia were present before onset of the psychosis or if the person had Schizotypal Personality Disorder (p. 205). On the other hand, the

manual also notes that individuals with a Personality Disorder "may, under stress, develop Brief Reactive Psychosis, in which case both diagnoses should be made," i.e., it suggests that such individuals may be especially vulnerable to this disorder. What is not fully clear is whether the severity of the stressor can be adjusted to the individual's subjective vulnerability. To put it differently, an individual with a severe personality disorder may experience as very stressful something that others would judge to be mildly or moderately stressful, and the manual is somewhat ambiguous in this regard.

4. **Schizophreniform Disorder.** This is defined as an illness showing the same features as Schizophrenia, but with a duration of less than six months.
5. **Schizoaffective Disorder.** This is a category intermediate between Schizophrenia and the Mood Disorders. It is used for patients who "at one time have presented with both a schizophrenic and a mood disturbance and, at another time, with psychotic symptoms but without mood symptoms" (p. 208).
6. **Psychotic Disorder Not Otherwise Specified (Atypical Psychosis),** a residual category for illnesses with psychotic symptoms that do not meet the criteria for any of the other non-organic psychotic disorders. This category may be used for brief psychoses that are not reactive to a major stressor (p. 380-381).
7. **The Mood Disorders.** These come in a variety of forms depending on the combination of depressive or manic features. The primary point, from our perspective, is that the "major" forms are not considered inherently psychotic, but rather can be classified as either showing or not showing "psychotic features," which in turn may be "mood-congruent" or "mood-incongruent." The milder Mood Disorders--Cyclothymia and Dysthymia--are, by definition, not psychotic.

We might note that the above DSM-III-R classification is essentially the same as that found in DSM-III (1980). The only relevant changes are the following:

1. A change in the temporal limits of Brief Reactive Psychosis and Atypical Psychosis (from less than 2 weeks' duration in the earlier version to up to one month) and in the temporal limits of Schizophreniform Disorder (between 2 weeks and 6 months

in the earlier version to simply less than 6 months in the later version). In other words, DSM-III-R allows for overlap between these categories, making the distinction between them contingent on factors other than simple duration, namely the question of the severity of the stressor, as discussed above.

2. Schizoaffective Disorder is given a more general definition in the earlier version and perhaps one that more accurately reflects the actual use of this category in clinical practice:

The term Schizoaffective Disorder has been used in many different ways since it was first introduced, and at the present time there is no consensus on how this category should be defined. . . .

The category is retained in this manual without diagnostic criteria for those instances in which the clinician is unable to make a differential diagnosis with any degree of certainty between Affective Disorder and either Schizophreniform Disorder or Schizophrenia. (APA, 1980, p. 202)

For the purposes of this study, we will adhere to broader categories than either of the two diagnostic manuals. First of all, we will make a broad distinction between brief psychotic episodes and ongoing psychotic illnesses. In the case of brief psychoses, we will not attempt to make the difficult distinction between Brief Reactive Psychosis and Atypical Psychosis (which hinges on the term reactive, i.e., on the relative gravity of the psychosocial stressor); rather we will speak of brief psychotic episodes or decompensations. We will, however, take up the question of the stressor, or to use a different term, the precipitating factors, in some detail. The distinction between Schizophreniform Disorder and Schizophrenia, which hinges on the time boundary of a duration that is either less than or greater than six months, is also one we will generally not have sufficient data to make; thus we will use the broader terms "schizophrenia" or "schizophrenic psychosis." We will attempt to adhere to four broad categories for the ongoing psychoses: schizophrenic psychoses, schizoaffective psychoses, affective psychoses (i.e., Mood Disorders with Psychotic Features, in DSM-III-R terms), and delusional psychoses. We will attempt to use these terms in a manner that is, as much as possible, congruent with the spirit, if not the letter, of the DSM-III-R definitions.

D. Definitions

This section recapitulates the definitions of diagnostic terms discussed above as they will be used in this study. It also introduces the central concepts of psychoanalytic object relations theory which will be used in the chapters that follow.

1. Diagnostic Terms

Anorexia nervosa

This illness (also known as "typical," "primary," or "classical" anorexia nervosa) is defined by the APA (1980, 1987) diagnostic criteria listed in Table 1 above. It is considered to be an illness centered on an obsession with thinness and a terror of obesity; in addition, one can generally find signs of its converse, the obsession with food and eating (Bruch, 1973; Palazzoli, 1978).

Hysterical self-starvation

This term will be used to refer to forms of self-starvation that are due to symbolic distortions of the eating function rather than to an obsession with being thin and a terror of obesity. These can be considered forms of "psychogenic malnutrition" secondary to hysterical illness (see discussion above). Psychogenic malnutrition secondary to other illnesses will fall entirely outside the scope of this study.

Psychosis

Our broad definition of psychosis will be the generally accepted one of a condition characterized by a break with reality and abrogation of the ego's function of reality testing (APA, 1987). Psychotic symptoms may include delusions, hallucinations, incoherence, grossly disorganized behavior, and all of the other symptoms listed above under the discussion of the diagnostic label of Schizophrenia.

Brief psychotic episodes

These are episodes that are generally brief, i.e., less than one month in duration, and are followed by a return to prior level of functioning.

Ongoing or recurrent psychotic illnesses

These are psychoses that show longer duration or recurring episodes, with a more chronic course resulting in decreased overall level of functioning. We will distinguish four broad categories, which will adhere as much as possible to the spirit of the DSM-III-R definitions: schizophrenic psychoses, schizoaffective psychoses, affective psychoses ("Mood Disorders with Psychotic Features" in DSM-III-R terms) and delusional psychoses.

Decompensation

This term refers to the process of becoming psychotic, i.e., the breakdown of the ego's defenses to the point of a serious disruption of reality testing.

Recompensation

This term refers to the process of emerging from psychosis, with the reestablishment of reality testing and adequate ego functioning.

Bulimia nervosa

An eating disorder closely related to anorexia nervosa, characterized primarily by severe eating "binges" and also in many individuals by behaviors designed to avoid weight gain (induced vomiting, laxative or diuretic abuse, compulsive exercise, fasting, etc.) (APA, 1987). This disorder is not limited to anorexics, and can also occur in individuals who are of normal weight or who are overweight. The term "bulimic anorexic" is often used to refer to anorexics who also manifest bulimia and the term "restricting anorexic" or "restrictor" to those who do not.

2. Psychoanalytic Terms

The structural theory - id, ego and superego

According to Freud's structural theory, the psyche is composed of three agencies of the mind. The id is the repository of the drives, which remain in the unconscious, although their derivatives (impulses, wishes, fantasies) do reach consciousness. The id represents the biological substrate of the psyche and is ruled by primary process thinking, which is primitive and irrational, knows no negation or contradiction, and is

governed solely by the pleasure principle, i.e., is not affected by the forces of reason. Freud's conception of the drives varied over time; the most commonly accepted view is that the two primary drives consist of libido (a term meaning sexual energy, love, desire) and aggression. The ego is the agency of reason and adaptation to reality, which in the normal course of events grows steadily stronger as the child matures; its purpose is to tame and modulate the expression of the drives in accordance with the reality principle. It is governed by secondary process thinking which is rational and logical. The superego is the agency of the mind that evolves out of the ego and that represents the individual's conscience--the repository of the prohibitions of society and morality. It is closely related to the ego ideal, which represents the individual's ideal self.

Oedipus conflict

The conflict that arises when libidinal/sexual feelings for the parent of the opposite sex come to the fore and engender fears of castration, mutual destruction or loss of love in relation to the parent of the same sex (Freud, 1917/1966). For Freud, the resolution of the Oedipus complex involves the internalization of the sublimated desexualized parental representation and the formation of the superego, which indeed is based in this identification.

Representations - self and object

The internal representational world is composed of the representations, i.e., affectively-tinged mnemically-based mental images of the self and of other people, who in psychoanalytic parlance are referred to as "objects" since they are the objects of the wishes and impulses derived from the drives.

Jones (1991) discusses the nature of internal object representations in depth, a discussion which goes beyond the scope of the present study. Suffice it to say that Jones' emphasis on the internalization of the affective quality of the relationship with the object seems justified.

Gain from illness - primary and secondary

Primary gain refers to the original force that motivates unconscious symptom formation, e.g., the resolution of an unconscious psychic conflict. Secondary gain refers

to external advantages that the psychic illness entails and that may, in turn, serve to prolong it--e.g., exemption from having to function at a normal level, caretaking on the part of others, avoidance of fearful situations, financial or other benefits.

Defense

The defenses are the ego's strategies for coping with unacceptable impulses and wishes derived from the drives of the id. There are a myriad of defenses. In general terms, they perform an alteration in the impulse by changing its nature or its aim, so that it can be expressed in a fashion that is acceptable to the ego.

Regression

The process of returning to an earlier or more primitive level of psychic functioning.

Transference

The vast body of primitive needs, feelings, fantasies, and object relational patterns that the patient transfers to the therapist in the course of therapy. The "positive transference" embodies the loving aspects of this and the "negative transference" embodies the angry, hateful aspects.

Countertransference

The therapist's feelings towards the patient, which can consist of either or both of the following: (a) the therapist's reactions to the patient's transference; (b) the therapist's projection onto the patient of aspects of his own internal world. This distinction, it should be noted, is a theoretical one. In actuality, the two tend to interact in a cybernetic fashion.

Internalization

As Schafer (1968) suggests, this term is a broad one referring to "all those processes by which the subject transforms real or imagined regulatory interactions with his environment, and real or imagined characteristics of his environment, into inner regulations and characteristics" (p. 9).

Introjection

This is a narrower term, referring to one type of internalization, namely "the setting up of an introject," i.e., an internal object representation (Schafer, 1968).

Identification

Again as per Schafer (1968), "identifying refers to modifying the subjective self or behavior, or both, in order to increase one's resemblance to an object taken as a model" (p. 16). It often follows upon or is interwoven with introjection, but refers to an alteration in the self-representation rather than the establishment of an object representation. This involves the assimilation of aspects of an object representation into the self-representation.

Incorporation

This term refers to a primary process fantasy of taking another person into one's self corporeally, i.e., generally through the mouth, although other forms of entering the body may be involved (Schafer, 1968, p. 20).

Projective identification

The projection (i.e., externalization) of aspects of one's self onto others--almost always defensive in nature and occurring at an unconscious level.

Borderline phenomena/personality organization

These terms are based on the present assumption in psychoanalytic thinking (e.g., Kernberg, 1975) that there exists a realm of personality organization between that of neurotics whose sense of self is fairly cohesive and stable and that of psychotics whose sense of self shows serious disintegration and very poor boundaries. Individuals with a borderline level of personality organization--who often have severe problems in the narcissistic area--are prone to regressive swings and even brief decompensations. This broad use of the term is different from the narrower term "Borderline Personality Disorder" as defined by DSM-III (APA, 1980), which refers to individuals characterized by "affective instability and intense and unstable interpersonal relationships" (Blatt & Shichman, 1983, p. 240).

The paranoid-schizoid and depressive positions (Melanie Klein's object relations theory)

Melanie Klein's object relations theory (as summarized by Segal, 1969) outlines the infant's evolution from the "paranoid-schizoid position" to the "depressive position." The paranoid-schizoid position refers to the period of earliest infancy when the immature ego of the infant is dominated by its own innate aggression and by its strikingly intense good and bad experiences with the external world. The ego is incapable of integrating these contrasting experiences and, in any case, very much needs to maintain a profound separation ("split") between the good and bad part object representations (usually referred to by Klein as "the good breast" and "the bad breast") so as to protect the good internal object from being destroyed by the ego's own aggression. This period is dominated by splitting and by introjective and projective mechanisms. For example, in an effort to be rid of its own aggressive bad parts which it experiences as intolerably destructive, the ego projects them onto the bad object; this in turn intensifies the ego's persecutory anxiety. The aggression is so extreme that the ego often feels that it has fragmented the bad breast into "bits". Splitting at this early stage is necessary both in order to allow the ego to organize its experiences and emerge out of chaos and in order to maintain the good object. However, as the ego matures, its good experiences in the real world promote and strengthen both the good object representations and the good self-representations; persecutory anxiety decreases; the ego becomes more able to contain and experience its own aggression; and integrative capacities increase. All these processes mutually reinforce each other. This paves the way for the transition into the depressive position. The depressive position is "that phase of development in which the infant recognizes a whole object and relates himself to this object" (Segal, 1969, p. 68). The term "whole object" refers both to the infant's new capacity for integrating "previously perceived parts" into a whole person and to his capacity for integrating previously opposed good and bad representations of this person into one ambivalently perceived representation which can be both loved and hated at the same time. The ego also becomes more able to contain its feelings, both good and bad, leading to a decreased reliance on projective defenses. Persecutory anxiety is replaced by guilt, as the infant

no longer fears being destroyed by the object, but rather fears "that his own destructive impulses have destroyed or will destroy the object that he loves and totally depends on" (Segal, 1969, p. 69). This fear of having destroyed the good object leads to internal mourning for the lost object and to depressive feelings. The destructive envy of the paranoid-schizoid position is replaced by reparative wishes and concern for the object. According to Klein, "the fixation point of the psychotic illnesses lies in the paranoid-schizoid position and at the beginning of the depressive position" (Segal, 1969, p. 74)--a point we will return to in the theoretical analysis in Chapter II below.

The separation-individuation process - Margaret Mahler's developmental theory

Mahler's developmental theory (Mahler, Pine, & Bergman, 1971) evolved from direct observation of infants and young children. "Separation-individuation" refers to the process whereby a child comes to experience himself or herself as separate from the mother and as possessing an individual identity. This dyadic process precedes the later triangular oedipal phase. It follows the symbiotic period (age 2-5 months), where the infant's experience is one of merger with the mother. The process is divided into four subphases:

(a) Differentiation and the development of the body image

This subphase begins with the "hatching process," the evolution of the infant's perceptual-conscious system such that he is more alert and more outwardly directed. Consequent to this, at about 6 months, the infant begins to strain and pull his body away from the mother's and is fascinated by her face and belongings, exploring them via both vision and touch. These behaviors are construed to indicate early efforts to delimit self from other. The infant also begins to slide down from mother's lap, but tends to crawl back and play at her feet. At around 7 or 8 months, the visual pattern of "checking back to mother" sets in, as do stranger reactions and stranger anxiety.

(b) Practicing

This phase is made up of two parts. The first is the early practicing period (approximately 7 to 12 months) when the infant begins to move physically away

from mother by crawling and straightening himself while holding on to supports. This period is characterized by the infant's need to return to mother for "emotional refueling." The second is the practicing subphase proper (age 10 or 12 months to 16 or 18 months) when the toddler masters upright locomotion. This leads to a giddy sense of powerfulness and elation ("the world is my oyster"); this period is the peak of the child's narcissistic involvement in his own functions and his body. The toddlers' elation, however, is replaced by "low-keyedness" when the mother is absent from the room. This "low-keyed" mood is construed to indicate the child's effort to image the mother and is "reminiscent of a miniature anaclitic depression" (p. 75).

(c) Rapprochement

This period occurs at approximately 18 to 24 months of age. As a result of free locomotion, the toddler becomes both more separate from mother and more aware of his separateness. This leads to increased fear of object loss, ambivalence, and an increased need to know the mother's whereabouts and have her share in his every experience. The latter development indicates a change in the toddler's way of viewing mother from seeing her as a "home base" to seeing her as a separate person. This period is characterized by an internal conflict between the toddler's fear of loss of love and his fear of having his recently achieved autonomy impinged upon: "Two characteristic patterns of the toddler's behavior--the 'shadowing' of mother and the darting away from her, with the expectation of being chased and swept into her arms--indicate both his wish for reunion with the love object and his fear of reengulfment by it" (p. 77). The toddler also begins to realize that he is small and helpless and that "the world is not his oyster." This painful giving up of his own delusion of grandiosity leads to intensified fear of losing mother's love, increasingly demanding behaviors, and a very ambivalent attitude towards his own developing autonomy, often manifested in the form of mood swings, temper tantrums, and regressive behaviors. The acute "rapprochement crisis" itself is characterized by intense awareness of mother's whereabouts and clinging upon

being left by her, followed by a depressive mood and an inability to become involved in play for some time thereafter. "Transitional activities" (in Winnicott's use of the term--see below) become particularly important at this time. This is also the period of awareness of sexual differences and beginnings of gender identity; according to Mahler et al. (1975), this makes the process of separation more difficult for girls, who upon experiencing penis envy turn back to mother with blame, demand, and disappointment, thus remaining ambivalently attached to her.

However, with the development of language and symbolic functioning and the progression of internalization processes, all of these problems begin to subside, leading into the fourth subphase.

(d) Consolidation of individuality and the beginnings of emotional object constancy

This takes place during the 3rd year of life. The name of this subphase indicates its twofold nature. At the level of the self, the ego becomes more developed and structuralized; specifically "there are definite signs of internalization of parental demands indicating the formation of superego precursors" (p. 109). At the level of object representations, the toddler comes to develop a constant, positive inner image of the mother, which allows him to function adequately in familiar surroundings in her absence, despite some tension and discomfort. This development of "emotional object constancy" is based in the cognitive achievement of the "permanent object"--i.e., in knowing that things continue to exist even when not visibly present--but goes beyond it as well. It implies not only maintenance of the internal representation of the absent love object based in the child's growing symbolic capacity, but also maintenance of its relatively positive emotional investment, which in turn is based on the unification of the good and bad object into one representation (see above section on Melanie Klein). This requires tempering of the aggression directed at the mother and is based in a sufficient sense of "basic trust" going back to the symbiotic period. If, however, the ambivalence towards the mother is pronounced, then the positive image of the mother cannot be sustained and the child will continue to experience difficulty with separation. By the age of 3 years,

libidinal object constancy is generally well established, as "represented socioculturally in the choice of age 3 as a common point of readiness for entry into nursery school" (p. 112).

Kohutian self-psychology--the self and its selfobjects

Kohut (1971) pioneered the psychoanalytic investigation of patients suffering from narcissistic disorders. While traditionally the term "narcissistic" was used to refer to an excessive degree of self-centeredness and in earlier psychoanalytic thinking was thought to indicate "unanalyzability", Kohut viewed these patients as having specific weaknesses or defects in their sense of self which nonetheless did allow them to form "narcissistic transferences" which could in turn be analyzed. One of Kohut's (1966) basic tenets is that self-love and object-love are not inversely related (as had been thought earlier) and that narcissistic libido is not transformed into object libido as the child progresses from early narcissism to object-relatedness, but rather follows an independent course of development. While in the earlier stages of theory development (1971), Kohut attempted to incorporate his theories into the framework of the structural theory (see above) by defining the self as an "experience-near" "content" of the mind rather than an "experience-distant" "agency" such as the ego, he eventually broke away from traditional theory to view the self as the center of the psyche and the core of the personality. An individual with a firm sense of self experiences himself or herself as continuous in time and space, as a mind-body unit, and as an independent recipient of impressions and center of initiative. The various degrees of cohesion or damage of the self define the broad categories of psychopathology. In the structural neuroses or normal personalities, the self is structurally cohesive but can experience secondary disturbances in the form of oscillations in self-esteem related to life events. The primary disturbances of the self include the psychoses, where the damage is serious and protracted and few defensive structures are available, the borderline states where the damage is also severe but complex defenses cover it, and the narcissistic disorders, where the self is cohesive, i.e., not threatened by irreversible disintegration, but made up of archaic self-structures and subject to regressive swings (Kohut & Wolf, 1978).

Kohut defines two lines of development in the narcissistic sphere of the personality. When "the child's original narcissistic balance, the perfection of his primary narcissism, is disturbed by the unavoidable shortcomings of maternal care, . . . the child attempts to save the original experience of perfection by assigning it" to two basic narcissistic configurations (Kohut, 1968, p. 86):

- (a) the grandiose self, which is a grandiose and exhibitionistic image of the self--the central mechanism is "I am perfect" (1971, p. 27);
- (b) the idealized parental imago, to whom the child assigns all power and perfection and with whom it seeks to merge--the central mechanism here is "you are perfect, but I am part of you" (Kohut, 1971, p. 27).

Corresponding to these two narcissistic configurations or lines of development are two types of object representations, known as "selfobjects" because they serve to promote and maintain the cohesiveness and vitality of the self:

- (a) the mirroring selfobject, who, first of all, responds to the child as if he had a cohesive nuclear self, which promotes the development of such a self from the child's original representations of mind-body-self fragments, and, secondly, confirms the child's sense of vigor, greatness and perfection via empathic mirroring, echoing and approval of the child's grandiose self;
- (b) the idealized selfobject, who is seen as an image of calmness, infallibility and omnipotence, with whose soothing power and strength the child seeks to merge.

The two narcissistic configurations coexist from the start and follow largely independent lines of development. Under optimal conditions--meaning both optimal fulfillment of the child's phase-appropriate narcissistic needs and optimal, gradual, phase-appropriate frustrations--the grandiosity and exhibitionism of the grandiose self are tamed and the entire structure is integrated into the adult personality, supplying the instinctual fuel for our ambitions, the enjoyment of our activities and our self-esteem (Kohut, 1968, p. 87). Similarly, the idealized parental imago is also integrated into the adult personality, via phase-appropriate disappointments in the parent and the evolution of a more realistic parental representation. This results in the laying down of internal

structures, via the process of "transmuting internalization." These internal structures provide guiding ideals, raise the self-esteem, regulate and channel the drives, maintain narcissistic homeostasis and carry out self-soothing anxiety-regulating functions. The result of this normal course of development is a firm self, composed of three major constituents: (a) one pole from which emanate the nuclear ambitions, the stirrings for power and success derived from the grandiose self, (b) another pole which harbors the nuclear ideals derived from the idealized parental imago, and (c) a central area consisting of the person's talents and skills (Kohut, 1977; Kohut & Wolf, 1978).

Narcissistic disorders result from severe and chronic narcissistic traumata that cause the narcissistic configurations to remain archaic and split-off or disavowed. If the narcissistic traumata have centered on the relation to the mirroring selfobject, the archaic grandiose self continues to seek constant mirroring and echoing, to pursue grandiose aims, to be subject to states of elation due to sudden flows of unneutralized exhibitionistic libido, and to be extremely prone to narcissistic injury, narcissistic rage, and intense shame. If the narcissistic traumata have centered on the relation to the idealized selfobject, the person continues to require the presence and approval of an idealized figure, and, when this is not available, the person feels empty, depressed, and worthless; or, to put it differently, the individual experiences intense selfobject hunger. Narcissistic traumata are usually not specific, grossly traumatic events but rather derive from the long-term pathogenic relationship between the child and its primary objects who fail to provide appropriate empathic mirroring responses, to allow for appropriate idealization, and/or to provide the necessary empathic failures and frustrations as development proceeds--this, we might note, is often the result of their own narcissistic pathology. Generally speaking, it is only when severe traumas occur along both lines that serious pathology results (Kohut, 1977).

The two lines of development result in two types of transference phenomena. In the "idealizing transference" the patient assigns perfection to the therapist and working through centers on the patient learning to maintain idealizing investment despite occasional absences or failures in empathy on the part of the therapist. Eventually this

results in internalization of the homeostatic functions performed by the therapist as an idealized selfobject. The "mirror transference," which results from the reactivation in the therapeutic situation of the grandiose self, comes in three forms depending on the stage of development of the grandiose self:

- (a) the most archaic form is the merger transference, in which the patient experiences the analyst as part of himself and expects to have the same kind of control over the analyst as he would have over a part of his own body;
- (b) a less archaic form is the alter-ego or twinship transference, in which the patient assumes that the analyst is like him and shares his thoughts and feelings;
- (c) a still less archaic form is the mirror transference in the narrow sense, in which the analyst is experienced as a separate person, but has significance to the patient only within the framework of the narcissistic needs of his grandiose self. This is the reinstatement of the phase in which the "gleam in the mother's eye," mirroring the child's exhibitionistic display, confirms the child's self-esteem and gradually channels it in realistic directions (Kohut, 1968).

Both types of transference evolve naturally in the course of treatment. It is essential that the therapist be able to tolerate their evolution and their presence. Working through centers on the analysis of phase-appropriate frustrations of the narcissistic needs as expressed in the transference, which tend to occur around the therapist's absences or empathic failures. The danger for the analyst lies in either rejecting the patient's idealization in the case of the idealizing transference or feeling reduced to a mirror or an extension of the patient's self in the mirroring transference. The key to coping with this is to realize the nature of the selfobject functions being performed and to act accordingly. Thus the therapeutic process consists of allowing the regressive repressed self-structures to emerge and providing the circumstances that will allow development to proceed. As Jones (1991) emphasizes, for Kohut the central agent in the treatment is not insight but rather the therapeutic relationship, which provides a positive "reparenting" experience.

Transitional objects and phenomena

This term is used by Winnicott (1953/1971) to refer to an object or realm of experience which is experienced as lying in the area between "self" and "non-self" or, from the infant's perspective, between "me" and "not-me." Transitional objects and experiences belong to the period of transition between the state of infant-mother symbiosis and that of awareness of separation and self-boundaries. Winnicott observed that newborns engage in self-soothing oral behaviors--"fist-in-mouth activities" that serve purposes of both oral stimulation and "quiet union"--and that a few months later they often begin to show an attachment to a soft, cuddly toy or a piece of a blanket, which also becomes central to what we might term the child's psychic homeostasis. The transitional object is located "outside, inside, at the border" (p. 2) and is both "created" by the infant and "found"--as indeed is the breast in optimal development (see below). All sorts of self-soothing behaviors fall under the designation of transitional phenomena, e.g., the infant's babbling or repeating a repertory of tunes and phrases while preparing for sleep. These phenomena make up the whole "intermediate area of experiencing . . . the intermediate state between a baby's inability and his growing ability to recognize and accept reality" (p. 3). They form the "substance of illusion"--a term which Winnicott uses in a positive sense to refer to the realms of fantasy, imagination, creativity, and belief. The transitional object and phenomena help the infant to cope with anxiety, e.g., at the time of going to sleep. They particularly serve as a defense against "anxiety of the depressive type" (p. 4)--what we might term a depressive reaction to feelings of aloneness and abandonment.

For Winnicott, the focus is not on the object itself but rather on how it is used and experienced by the infant:

Summary of the Special Qualities in the Relationship

1. The infant assumes rights over the object, and we agree to this assumption. Nevertheless, some abrogation of omnipotence is a feature from the start.
2. The object is affectionately cuddled as well as excitedly loved and mutilated.
3. It must never change, unless changed by the infant.
4. It must survive instinctual loving, and also hating and, if it be a feature, pure aggression.
5. Yet it must seem to the infant to give warmth, or to move, or to have texture, or to do something that seems to show it has vitality or reality of its own.

6. It comes from without from our point of view, but not so from the point of view of the baby. Neither does it come from within; it is not a hallucination.

7. Its fate is to be gradually allowed to be decathected, so that in the course of years it becomes not so much forgotten as relegated to limbo. By this I mean that in health the transitional object does not 'go inside' nor does the feeling about it necessarily undergo repression. It is not forgotten and it is not mourned. It loses meaning, and this is because the transitional phenomena have become diffused, have become spread out over the whole intermediate territory between 'inner psychic reality' and 'the external world as perceived by two persons in common', that is to say, over the whole cultural field. (Winnicott, 1953, p. 5)

In adulthood the areas of symbolization, dreaming, artistic and cultural experience, scientific creativity, and religion all belong to the realm of "illusion" and "transitional experience."

Winnicott also stresses that, while the transitional object is at first "symbolical of some part-object" representing the mother, usually the breast, the fact that it is not the breast or the mother is as important as the fact that it stands for it. A "true" transitional object--which is to be distinguished from simply a "comforter"--becomes more important to the infant than the mother, "an almost inseparable part of the infant."

The transitional object is different from an internal object (which is a mental concept of an external object, a representation of a significant relationship with another person); "it is never under magical control like the internal object, nor is it outside control" like the external object (p. 10). The progress of the infant from the pleasure principle to the reality principle via the realm of transitional phenomena depends on the presence of a "good enough" mother, i.e., one who "starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure" (p. 10). At the start, the mother's adaptation to the baby's needs allows him to feel omnipotent, to "create" the breast over and over again as he needs it--this is what makes it both "created" and "found" and this is the source of the capacity for illusion. Like Kohut, Winnicott views appropriate doses of frustration as equally essential: "the mother's main task (next to providing opportunity for illusion) is disillusionment" (p. 13). This in turn constitutes the "weaning process," a term referring not to the cessation of

breast feeding per se, but rather to a complex internal process culminating in Klein's depressive position.

True and False Self

"False Self" is a term coined by Winnicott (1960/1965a) to refer to an identity created to please others and conform to social demands. It is distinguished from the "True Self," which refers to the individual's deeper feelings and sense of identity. The False Self evolves during the earliest period of infancy, in large part so as to preserve the True Self. Its goal is to eventually allow the True Self to come into its own. Over time, however, the gap between the two can increase. If it becomes clear that conditions will not be found which would allow the True Self to come into its own, the individual may, in despair, resort to suicide, which "in this context is the destruction of the total self in avoidance of the annihilation of the True Self. When suicide is the only defence left against betrayal of the True Self, then it becomes the lot of the False Self to organize the suicide" (p. 143).

The health and vitality of the True Self depends on the presence of "good enough" mothering in early infancy, specifically on an empathic and connected response from the mother to the infant's spontaneous gestures and fantasied omnipotence. On the other hand, when the mother's adaptation to the infant is not good enough, the infant is reduced into compliance and the compliant False Self takes over, in order to hide and protect the True Self. At the most pathological extreme, the True Self is so hidden that it barely exists. At the other end, in healthy development, the False Self provides the necessary "polite and mannered social attitude" (p. 143), but the True Self remains vital and alive and can override the compliant False Self. Thus there are low and high degrees of "the False Self defence, ranging from the healthy polite aspect of the self to the truly split-off compliant False Self which is mistaken for the whole child" (p. 150). The degree of discrepancy between the True and False Selves is partly a function of the degree of attunement of the environment to the child's unique and evolving identity. If this discrepancy is great, it results in an impoverished capacity for transitional experience, i.e., for using symbols and for cultural expression (p. 150).

Winnicott makes an important point with regard to treatment. In the case of a "False Personality," the patient is brought into treatment by the False Self, very much as a nurse would bring a child. But the work only begins when the nurse leaves the child alone with the therapist, i.e., when the False Self begins to abdicate its caretaking functions. "At the point of transition, when the analyst begins to get into contact with the patient's True Self, there must be a period of extreme dependence. . . . The patient has an illness, or in some other way gives the analyst a chance to take over the False Self (nursemaid) function . . . " (p. 151). This is a crucial moment of opportunity; if the analyst fails to understand and allows others to step in and care for the patient, the moment is lost. Thus regression into dependency is crucial to the process of recovery in cases of extreme False Self defense.

The "God representation"--its nature, role and evolution

This area is being addressed due to the specific and crucial functions that the internal God representation played in the genesis and resolution of the psychotic illness reported in Chapter III below. This is an area that has been the focus of several recent psychoanalytic investigations, notably those of Rizzuto (1979) and Jones (1991).

In her pioneering study The Birth of the Living God, Rizzuto (1979) set out to do "a clinical study of the possible origins of the individual's private representation of God and its subsequent elaborations" and "of the relations existing in the secret chambers of the human heart between that God and the person who believes in him during the vicissitudes of the life cycle" (p. 3). Rizzuto stresses that every child evolves such a representation and every adult continues to harbor this representation in the depths of his or her psyche, whether he or she "believes" in God or not. Indeed Jones (1991) notes that, when one asks an unbeliever about the God he or she does not believe in, the individual always "has a very clear idea of who or what God is" (Jones, p. 44), which supports Rizzuto's view. This separates the exploration of the God representation from philosophical issues regarding the existence of God and makes it a valid field of psychoanalytic study.

Rizzuto begins with Freud's thesis that the image of God is based in the internal representation of the father, is consolidated at the time of the resolution of the Oedipal conflict (in the boy, at any rate), and incorporates the "inherited representation of the primal father," blending it with the idealized, sublimated image of the real father. However, Rizzuto goes far beyond Freud. Her clinical observations lead her to the conclusion that the God representation is far more complex than Freud envisioned--it is made up of many components deriving its source from the representations of various primary objects rather than simply that of the father--although in most people one source tends to prevail. The self-representations also contribute to the development of the God representation, which is a complex creation of the psyche and not reducible to its sources. Moreover, the process is not limited to the Oedipal period; rather the components of the God representation are evolved throughout early development and bear the mark of the specific developmental period in which they are formed. The God representation varies in its degree of integration. It can continue to evolve throughout the course of the life cycle and indeed must do so if it is to remain vital and useful within the psychic economy. The corollary is as follows:

If this reasoning is correct, we can no longer talk about God in general when dealing with the concept in psychoanalytic terms. We must specify whose God we are talking about, at what particular moment in that person's life, in what constellation of object, and in what experience of self as context. The God representation changes along with us and our primary objects in the lifelong metamorphosis of becoming ourselves in a context of other relevant beings. Our description of a God representation entitles us to say only that this is the way God is seen at this particular moment of a person's psychic equilibrium. (p. 52)

For Rizzuto, God is a "special type of object representation" which differs from other object representations in that, from the start, it is located in what Winnicott (1953/1971) termed "transitional space" and "the realm of illusion," which lies "outside, inside, at the border". In fact, Rizzuto's analogy between the God representation and concrete transitional objects such as teddy bears tends to be rather concrete. This leads her to point to what she views as a crucial difference--transitional objects in the course of normal development are "relegated to limbo" (Winnicott, 1953/1971), whereas the representation of God is not. Because it is created so directly "from representational

materials whose sources are the representations of primary objects," the God representation "is increasingly cathected during the pregenital years" and during the Oedipal crisis; even if it seems to disappear from view, it remains a very real presence in the psyche:

Sometimes . . . [God] may seem to lose meaning, paradoxically, on account of being rejected, ignored, suppressed, or found temporarily unnecessary. Nonetheless, as is true of all other objects, God cannot be fully repressed. As a transitional object representation he is always potentially available for further acceptance or further rejection. It is this characteristic of being always there for love, cold disdain, mistreatment, fear, hatred, or any other human emotion that lends the object God its psychic usefulness. This psychic usefulness is at the service of protecting the minimum amount of relatedness to primary objects and a baseline of self-respect and obscure hope through common (or, at times, paradoxical or even psychotic) maneuvers. Often, when the human objects of real life acquire profound psychic meaning, God, like a forlorn teddy bear, is left in a corner of the attic, to all appearances forgotten. A death, great pain or intense joy may bring him back for an occasional hug or for further mistreatment and rejection, and then he is forgotten again.

In summary, then, throughout life God remains a transitional object at the service of gaining leverage with oneself, with others, and with life itself. This is so, not because God is God, but because, like the teddy bear, he has obtained a good half of his stuffing from the primary objects the child has "found" in his life. The other half of God's stuffing comes from the child's capacity to "create" a God according to his needs. (Rizzuto, 1979, pp. 178-179)

Rizzuto draws on Kohut's views in her analysis of the role of the God representation in the psyche--if it is to be used, it must perform crucial selfobject functions in maintaining the cohesiveness of the self. Indeed, its earliest origins--as one aspect of the broader capacity for symbolic functioning--lie in the first experience of mirroring, namely the eye contact between infant and mother:

The mother is there to give the child a representation of himself, to tell him what he looks like, call him by name, and tell him the names of the parts of his face and then of his body. As Winnicott (1971) says, the eyes of the mother, and the entire face of the mother, are the child's first mirror. Later on, the experience is to be used directly in the first representation of God, whose mirroring function, interestingly enough, echoes the biblical account of man's creation: "So God created man in his own image, in the image of God created he him," (genesis 1:27). Freud found satisfaction in reversing the process and demonstrating through his lifework that it is man who creates God in his own image. Nevertheless, Freud remained in the area of reflection of images between man and God, thus confirming the paramount importance of the intertwining of faces by mother and child and God and man. (Rizzuto, 1979, pp. 185-186)

A child who has received adequate mirroring can go on to separate and in the process begins to evolve transitional representations in the intermediate space between self and other. However the child who does not receive adequate mirroring "may suffer

partial arrest of his development and remain fixated to a narcissistic need for psychic mirroring Bewilderment, narcissistic rage, vengeful grandiose wishes . . . and identification with God are the common adaptational reactions to make the painful state of not being mirrored as oneself tolerable" (p. 186). Alternately, if the mother exalts the child but in so doing reflects not the true child but rather the image of him that she has developed for her own narcissistic uses, then also the child may identify with God.

While the God representation finds its earliest roots in infant/mother eye contact, it evolves in good part during the toddler years, growing out of the intense imaginative experience of the young child, who creates many fantasy characters--imaginary companions, monsters, heroes, witches, and so on--which draw on self and/or object representations and over whom the child has magical control. The God representation, however, is unique among these in that it receives sociocultural validation from adults in authority, e.g., ministers, priests, rabbis, and the child's parents. Whereas other fantasy characters are treated by adults with condescension, God is taken seriously and the child cannot fail to notice. Furthermore, the child's curiosity, his investigations of causality, and his animistic notions contribute to this. He asks about the causes of natural phenomena and the origins of life; sooner or later, as he continues "pulling the chain of causality with his ceaseless questions," these events are attributed to God. The child, needing to imagine a person formidable enough to do all these things, builds a representation based on the most formidable beings he knows, namely his parents. This is the god of age four, who is very much an anthropomorphic being. Rizzuto agrees with Freud that the Oedipal crisis leads to consolidation of the representation. The resolution of the Oedipal crisis involves a transformation of self and object representations--desexualization of the parental imagos, acceptance of the Oedipal defeat, and development of more realistic self-representations which also draw on the child's widening experience with peers and school. Concomitantly, around age five, the God representation tends to become "more pedestrian" and is often used to comfort the child in his feelings of loneliness and separation and in his disillusionment with his parents; it can also serve as a fantasied ally against his parents. The child is often introduced to

organized religion around this time; however, if he arrives there with either a very negative self-representation or a very negative God representation, "the God offered by official religion" may be more than he can tolerate and may be rebelled against or discarded. Adolescence, when the capacity for abstract thinking appears, lends itself to theorizing, philosophy, theological questioning, and often brings with it a crisis of belief, although "emotionally . . . it adds nothing" (p. 200). The transition into early adulthood is another turning point, as are all later crises and transitions; each time they bring belief into question and offer the opportunity to revise the God representation, which, if it is to remain vital and be used for belief, must keep pace with the rest of the individual's emotional development. Indeed, this is where the interaction between the issue of belief and the nature of the God representation occurs:

Belief in God or absence of belief are no indicators of any type of pathology. They are indicators only of the particular private balance each individual has achieved at a given moment in his relations with primary objects and all other relevant people, whether or not he uses the mediatory services of a transitional object for this process. This transitional object appears in early childhood and must undergo transformations in the course of life if it is to keep up with the transformations of the life cycle. If it loses its meaning, however, it can be set aside without being forgotten. And it can recover its meaning at the time of a life crisis, either by a progressive new elaboration of the God representation or by regressive return to an earlier representation which once more lends itself to belief. It may also become so incompatible with psychic balance that it cannot function naturally as a transitional object; along with aspects of oneself that have become consciously unbearable, it may have to be repressed. If the God representation has been abandoned as a meaningful transitional object, it will retain the characteristics it had when it was returned to the toy box in the transitional space. Then, if the individual suddenly feels a need for it in some regressive moment--a death, a rite of passage--it may be used temporarily and then quietly returned to the box, too anachronistic to meet the daily needs of the evolved and transformed self-representation. (p. 202)

Thus "the central thesis is that God as a transitional representation needs to be recreated in each developmental crisis if it is to be found relevant for lasting belief" (p. 208). As a vital internal representation, it is to be distinguished from the abstract "concept of God" which is a product of secondary process thought:

This is the God of the theologians, the God whose existence or non-existence is debated by metaphysical reasoning. But this God leaves us cold. . . . Even someone who believes intellectually that there must be a God may feel no inclination to accept him unless images of previous interpersonal experience have fleshed out the concept with multiple images that can now coalesce in a representation that he can accept emotionally. (pp. 47-48)

Two relevant corollaries ensue. One is that the God representation, if repressed, can return quite suddenly, which is Rizzuto's explanation for "the surprising phenomenon of conversion." The other is that the nature of the God representation can provide important information about other aspects of the internal world, i.e., can serve as a particularly useful diagnostic tool in light of its intimate connection to other central object representations. Rizzuto suggests that this is especially true in the case of a decompensation, and even more so "when the decompensation occurs after the death of an important object, the birth of a child, or any other critical moment in life, when the relations to primary objects need some transformation" (p. 210).

Finally, Rizzuto, in comparing the God representation at the pre-oedipal stage to imaginary companions, notes that, just as imaginary companions usually play little part in child analyses, the God representation is frequently absent from adult analyses despite its often remarkable importance in the patient's life. In other words, it maintains its subtle, private and transitional nature even in the course of analysis.

Jones (1991) focuses on the transferential aspects of the God representation, i.e., the ways in which "the affective bond with the sacred" (p. 65) mirrors the internal world and the affective bonds with significant others. He takes both a Kohutian and a hermeneutic view of the functions of the God representation. In the Kohutian sense, it is a selfobject, helping to maintain the cohesiveness of the self and providing it with emotional sustenance. From the hermeneutic perspective, it helps the individual to make sense of the world and the universe, forming an integral part of his or her world view. In this manner, Jones addresses the same questions as Rizzuto, namely the ways in which the God representation is "made from" the internalized relationships and the functions that the God representation fulfills in the psyche. In fact, he suggests a number of clinical possibilities:

One might explore what projective identifications are at work in the person's relationship with his God. Does the deity carry an internalized critical parent imago so that coming into the presence of God re-creates that relationship of fear and judgment? Or does God function to sustain self-cohesion as the perfectly mirroring selfobject? Or does that sense of being one of the favored offspring of the supreme being mobilize a broken grandiose self? Is a detached selfobject matrix re-created through investing the self in intellectualizing about an abstract world

spirit or universal system of energy? Is a relationship to a chronically unavailable primary caretaker continued through a perpetually unresolved search for the meaning of life? Is a warm symbiotic bond re-created, or the lack of it compensated for, through the intimacies of a baptism in the Holy Spirit or a merger with the Great Mother or the vast ocean of being? What inner relationship patterns go into our devotional exercises, meditational disciplines, philosophical theologies? (p. 65)

Rizzuto, by her own admission, limited herself largely to a cross-sectional analysis or, perhaps more accurately, a naturalistic one--she explored the nature and role of the God representation in several patients' psyches at a given point in time, occasionally tracing changes that had occurred in the course of their lives. On the other hand, Jones (1991) is especially interested in how changes in the internal world resulting from psychotherapy are mirrored by changes in the God representation--"the connection between the coming of a new sense of self and the development of a new image of God" (p. 66). Indeed, Jones reports four cases in which the reparative experience provided by the therapeutic relationship was internalized, bringing about changes in the self-representation in the form of increased self-acceptance, which in turn led to changes in the patient's conception of God, generally from a judgmental image towards a more nurturing and supportive one.

Jones raises an interesting question when he notes the apparent prevalence of the "judgmental image of God in childhood"--indeed, we might add, in adulthood and in many organized religions as well. He suggests several possible explanations. First, "many parents use God as a means of social control"--i.e., a social learning explanation. Secondly, as Freud suggested, the God representation is in part "the projection of [the] controlling superego" and partakes of the superego's harshness which derives from "the contravailing instinctual power"--i.e., a psychodynamic hydraulic explanation. Thirdly, on a cognitive level, the "god of judgment and sanctions" may be rooted in "our early stages of cognitive moral development" which are "stages of punishment and obedience, focused on sanctions, rule keeping and rule breaking" (p. 81). However, the most powerful explanation--which indeed derives from object relations theory--is that a child subjected to intense psychic or physical pain and left alone to make sense of it can either blame him/herself or blame the environment. Due to the child's dependence on

the environment, the latter feels too dangerous; it is better to blame oneself. "Thus begins the core of a sense of self-condemnation that like a snowball will gather associations and grow larger throughout life" (p. 82). Since every child encounters failure and shame, the judgmental quality of God resonates in everyone's experience; and all the more so for those whose early environment is truly unsafe, emotionally or physically. Fairbairn's theory of the "moral defense" against bad object relations supports this view:

Fairbairn believes that the child internalizes painful and punishing objects in the hope of controlling them. One way in which this works, Fairbairn suggests, is to take the "badness"--the pain and grief associated with those objects--into oneself. This makes it possible for the child to regard the external objects as "good," since the child, not the parents or other external objects, is now felt to be the source of the pain and misery. Thus he sacrifices himself in order to save the system or, at least, to regard it as benign.

This is important since the child is totally dependent on his object world. If he experiences that world as arbitrary or destructive, a feeling of safety and security is impossible for him. The child must do everything he can to make that world seem safe, even if it means blaming himself for all the pain being experienced so that the outside world can remain guiltless and good.

. . . [Fairbairn] concludes, "it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" . . . (Jones, p. 82-83)

On the other hand, "a chronically angry God" which served its purposes in mirroring a fragmented or diminished self is no longer useful or meaningful for someone whose sense of self has become cohesive, autonomous and positive; these changes in the sense of self are "mirrored in a shift from a vengeful to a nurturing deity" (p. 83). Jones's emphasis, as he himself states, is largely on the sense of the sacred as the dependent variable which changes as a consequence of changes in the independent variable, "the inner object-relational constellation." The active agent of change is the therapeutic relationship. Jones raises the theoretical possibility of starting from the other end--for, in analyzing an interactive network, if one exchanges "a model of linear causality for one of reciprocal interaction, an atomistic model for a systemic one", then "the choice of starting place is purely heuristic" (pp. 112-113)--however, this alternate possibility that changes in the sense of the sacred might lead to changes in the inner relational world, i.e., moving the point of the fulcrum away from the human relationship with the therapist towards the internal one with the sacred, remains a theoretical one.

CHAPTER II

REVIEW OF THE LITERATURE

A. Theoretical Literature

This section will explore the theoretical literature pertinent to evolving an understanding of the nature and dynamics of anorexia nervosa. It will begin by reviewing the broad model of personality development and psychopathology formulated by Blatt and Shichman (1983) within which this study will locate both anorexia nervosa and psychotic decompensations in the context of anorexia nervosa. The next subsection will examine the literature on the inherent nature of anorexia nervosa from both a symptomatic taxonomic perspective and a psychodynamic perspective, locating it within the anaclitic/introjective model as an exaggerated introjective response to intensified anaclitic vulnerabilities. The following subsection will place anorexia nervosa in the larger context of female self-starvation in Western civilization, focusing on its evolution as an introjective phenomenon specifically characteristic of twentieth century western culture. Section B of this chapter will deal directly with the clinical literature on the co-occurrence of anorexia and psychosis and will apply the anaclitic/introjective model to these occurrences.

1. The Anaclitic/Introjective Model of Personality Development and Psychopathology

Blatt and Shichman's (1983) model is an elaboration of an earlier distinction by Blatt (1974) between two fundamental types of depression--an anaclitic depression centered on feelings of loss and emptiness and an introjective depression centered on internal self-condemnation by critical introjects. We might note, in passing, that the term "anaclitic" is derived from the Greek word for dependency (English & English, 1958) and the term "introjective" comes from psychoanalytic theory (see Definitions section of Chapter I above). Blatt and Shichman (1983) extend this distinction between two types of depression into a model of personality development based on the concept of two basic

developmental lines --"an anaclitic developmental line leading to the establishment of satisfying, intimate interpersonal relationships, and an introjective developmental line leading to a stable, realistic, and essentially positive identity" (p. 187). They also extend the model into a distinction between two basic categories of psychopathology: (a) psychopathology in the anaclitic configuration which focuses on libidinal issues-- concerns about interpersonal relationships, the need for love and nurturance, the capacity to be close; and (b) psychopathology in the introjective configuration, which focuses primarily on issues of self-definition, self-control, self-worth, and self-reproach, i.e., on issues related to separateness, autonomy and identity. The psychopathological syndromes within the anaclitic configuration consist of anaclitic depression (also termed the infantile personality) at the lower pre-oedipal level and hysteria at the higher oedipal level. The psychopathological syndromes within the introjective configuration consist of paranoia at the lower level, the obsessive-compulsive disorders at the middle level, and introjective guilt-laden depression and phallic narcissism at the higher level. These six syndromes, each of which is fairly well-delimited, all demonstrate a very clear exaggeration and distortion of one developmental line at the expense of the other and are easily classified within one of the two categories.

Blatt and Shichman (1983) further suggest that the two categories of psychopathology can also be applied to the issue of differentiating among borderline and schizophrenic disorders. Specifically, they suggest that a distinction can be made between more anaclitic borderline patients with predominantly infantile hysterical features and more introjective patients with predominantly paranoid-obsessive qualities. They draw a parallel between this distinction and the conceptualization in DSM-III (APA, 1980) of two different types of patients within the borderline range--patients with "Borderline Personality Disorder" who are characterized by "affective instability and intense and unstable interpersonal relationships" (i.e., an anaclitic dimension) and patients with "Schizotypal Personality Disorder" who are characterized by "thought disorder (e.g., magical thinking, ideas of reference, depersonalization, and derealization), social isolation, suspiciousness or paranoid ideation, and a hypersensitivity to criticism" (i.e., an

introjective dimension) (p. 240). They also suggest that, within schizophrenia as well, there is evidence for a distinction between nonparanoid patients who "have the amorphous, diffuse qualities characteristic of anaclitic psychopathology" and paranoid patients who "have rigid, focused, and fragmented functioning typical of introjective psychopathology" (p. 241).

Thus, Blatt and Shichman (1983) begin to outline the possibility that the distinction between anaclitic and introjective psychopathology may be of use in the study of borderline and psychotic disorders. The present study will attempt first to locate anorexia nervosa within the model and secondly to apply the model to the exploration of psychotic decompensations in anorexic patients. It will attempt to highlight both anaclitic and introjective elements and, more specifically, their interplay within the cases to be discussed below. We will define four variables which can be either primarily anaclitic or introjective in nature and we will attempt a broad classification of the case reports at our disposal along the anaclitic/introjective dimension. This, we hope, will both support our theoretical analysis of anorexia nervosa and illuminate the dynamics of anorexic patients who are subject to psychotic decompensations.

Before we can proceed with this analysis, however, the model itself requires clarification and elaboration, from both the perspective of normal development and that of psychopathology--although, for our purposes, the emphasis will be placed on psychopathology. The model itself is based on the assumption that, while the two developmental lines are conceptually separate, in fact they evolve via a complex dialectical process whereby healthy development along either line is contingent upon healthy development along the other; to put it more simply, evolving a healthy self-concept and establishing satisfying interpersonal experiences are mutually interdependent processes. On the other hand, the various forms of psychopathology are viewed as distortions of one or the other of the two developmental lines and are "defined primarily by exaggerations of the tasks" of the given developmental line. More specifically, "anaclitic psychopathologies are distorted and exaggerated attempts to maintain satisfying inter-

personal experiences, introjective psychopathologies are distorted and exaggerated attempts to establish an effective concept of the self" (p. 188).

The psychopathologies of the anaclitic configuration--anaclitic depression (or the infantile personality) and hysteria--are characterized by a predominance of concerns focused on interpersonal relationships, on the capacity to love and be loved. Defenses in this type of psychopathology are primarily avoidant--denial and repression. Cognitive processes are underemphasized in relation to affective ones; the predominant perceptual mode is field dependent. "The development of a sense of self is neglected in exaggerated and distorted struggles to establish satisfying interpersonal relationships" (p. 188).

On the other hand, psychopathology in the introjective configuration--which includes paranoia, obsessive-compulsive disorders, introjective depression and phallic narcissism--focuses on "issues of self-definition, self-control, self-worth, and identity" and "expresses exaggerated attempts to establish self-definition and identity" (p. 189). These efforts are pervasive, characterizing the individual's entire personality style and approach to life:

Defenses in introjective psychopathology are basically counteractive. Projection (splitting, externalization, disavowal, and reversal), doing and undoing, reaction formation, isolation, intellectualization, rationalization, and overcompensation are all attempts to control, modify, and transform impulses. Cognitive processes are literal, focused primarily on things, thoughts, and deeds (actions) rather than on people, feelings and interpersonal ties. Thinking is analytic, critical, precise, linear, and sequential. Concerns are about cause and effect, responsibility and blame. Attention is focused on details and contradictions; differences are exaggerated. There is little spontaneity and feeling; the emphasis is upon power and control. The predominant perceptual mode is field independent. Struggles to achieve separation, definition, and independence from controlling, intrusive, punitive, excessively critical, and judgmental figures are expressed in conflicts around the management and containment of affect, especially aggression directed toward others and the self. The development of satisfying interpersonal relationships is neglected in the exaggerated struggles to establish an acceptable self-definition and identity. (p. 189)

Psychopathology is characterized by a lack of flexibility; when this occurs along either of the two dimensions, it in turn restricts development within the other dimension. When the imbalances that occur are less extreme, the two pathways show up as the two primary configurations of personality; in cases of more extreme imbalance,

they define the two primary configurations of psychopathology. The differences between the two developmental lines can be summarized along four primary dimensions: "[the] relative emphasis on different instinctual preoccupations (aggressive or libidinal), the focus on the representational world (on self-definition or on interpersonal relatedness), the basic emphasis in life events (to work or to love), and the primary utilization of different types of defensive operations (counteractive or avoidant)" (Blatt & Shichman, 1983, pp. 194-195).

While Blatt and Shichman (1983) stress both the fundamental internal coherence of each of the two configurations and the dissimilarities between them, they also point out that distinctions can be made within each configuration along a variety of developmental dimensions, including "etiology, level of ego development, . . . quality of interpersonal relations, . . . nature of self and object representations. . . integration of instinctual strivings, preferred modes of defense and adaptation . . ." (p. 195). They hypothesize that progress to a higher level within one of the two lines is contingent upon having "successfully negotiated earlier developmental tasks" of both developmental lines. In other words, the assumption is that a hysteric, for example, has established at least some degree of self-definition, or that an obsessive-compulsive has at least some capacity for interpersonal relatedness. To put it differently, in both cases, the developmental line that is being neglected has become stunted at a later stage rather than an earlier one (p. 197). Furthermore, the level of development along these dimensions is not fully fixed and there is room for movement, i.e., regressions and progressions to lower or higher levels of organization within the given configuration.

Within the anaclitic configuration, the distinction is between dyadic pre-oedipal pathology as manifested in anaclitic depression (the infantile personality) and triangular oedipal pathology as seen in the hysterical personality. These two forms of psychopathology are characterized by an emphasis on different types of avoidant defenses--at the lower level, denial suppresses infantile oral rage, which threatens the hand that feeds; at the higher level, repression stifles erotic impulses, which are potentially disruptive to interpersonal relationships (pp. 202-203).

The distorted attempts at self-definition that characterize the introjective configuration can also occur at different levels of development. At the lowest level, paranoid pathology shows exaggerated isolation and severe struggles around self-definition; paranoid projection is used to maintain separateness and self-definition. At the intermediate level we see the anal struggles over control in the obsessive-compulsive personality. The obsessive-compulsive is preoccupied with autonomy, with mastering mind and body, with preserving all his thoughts, feelings, and actions as his own productions and prerogatives. The higher phallic-urethral levels represented by introjective depression and phallic narcissism are focused around exaggerated concerns about self-worth. Introjective depression is characterized by "a continuing sense of a punitive, harsh, relentless introject creating feelings of self-doubt, self-criticism, self-loathing, blame, guilt, and depression" (p. 205). This is due to introjection of or identification with a "rigid, overdemanding, judgmental parental figure" (p. 205). These individuals attempt to involve themselves in activities to counteract feelings of worthlessness and guilt and to "modulate and mediate negative hostile, punitive, critical introjects" (p. 205). Alternately, in phallic narcissism, exaggerated estimates of one's body and capacities predominate. Individuals may show considerable variations in their potential for regression along this continuum. For example, an individual patient may alternate between internalizing blame and projecting it, i.e., between depression and paranoia.

Blatt and Shichman (1983) stress a unique quality of the introjective defenses that will be particularly relevant in our analysis of anorexia. They point out that, due to the counteractive nature of the defenses in the introjective configuration, introjective psychopathologies tend to appear "paradoxical"--"there is a simultaneous expression of the basic underlying concern as well as the defensive compensation that creates the opposite of the conflicted wish" (p. 206). While compromise formations are involved in all psychopathology, this aspect is particularly striking in these pathologies. For example, the "vulnerability to boundary dissolution" which is at the root of paranoia "appears along with intense, exaggerated, distorted attempts to preserve the boundary." Obsessive-compulsive syndromes manifest "indecision, ambivalence, and ruminations, as

well as . . . rigidity, focused attention, and obstinacy." In individuals with introjective depression, "profound concerns about self-doubt, self-worth, and intensely painful proclivities toward self-criticism appear along with efforts for overachievement and overcompensation, fantasies of grandiosity, and demands for perfection." Phallic narcissism results from an exaggeration of these latter grandiose mechanisms as a defense against "profound introjective depressive issues and painful feelings of vulnerability and worthlessness" (pp. 206-207).

Which of the two developmental lines becomes the focus of compensatory maneuvers and thus of psychopathology depends on a host of possible factors, including both biological predispositions and experiential factors related to early environment, i.e., the family and cultural matrix. Blatt and Shichman (1983) suggest that there may be specific differences in familial etiology. Within the psychopathology of the anaclitic configuration "the basic issues appear to be the reliability and dependability of care and affection"; thus the etiology probably involves inconsistent, depriving, unpredictable, or overindulgent caretaking (p. 207). On the other hand, "psychopathology within the introjective configuration focuses around conflicts with aggression, as expressed in attempts to achieve a sense of separation and independence from a controlling, intrusive, punitive, excessively critical, and judgmental object," which suggests that the parental figures were intrusive and controlling, and that they interfered with the development of autonomy and the sense of self (p. 208).

We will dwell at greater length on the issue of introjective depression because of its particular relevance to the case to be discussed in Chapter III. Introjective depression is "characterized by feelings of worthlessness, guilt, and a sense of having failed to live up to expectations and standards. There are intense fears of loss of approval, recognition and love from the object" (Blatt, 1974, p. 107). According to Blatt and Shichman (1983), this form of psychopathology evolves during the phallic-urethral phase along with superego formation, sexual identification, and the early phases of the oedipal conflict:

Markedly ambivalent, demanding, depreciatory, and hostile parent-child relationships lead to intense feelings of guilt and worthlessness and to a vulnerability to depression. And this depreciated sense of self seriously interferes with the capacity to establish satisfying interpersonal relations. . . . Exceedingly high ideals . . . , an overly harsh superego, a keen sense of morality and commitment, and a constant self-scrutiny and evaluation are concomitant with preoccupations about feeling unworthy, unlovable, guilty, and having failed to live up to expectations and standards. . . . Insistent demands for perfection and a feeling of being driven to perform and achieve interfere with the capacity for enjoying one's accomplishments and experiencing feelings of satisfaction and success. There is a proclivity to assume blame and responsibility. One feels unable to ever gain approval, acceptance, and recognition. Intense, overstated standards, often attributed to external figures, restrict the degree to which one can accept one's own limitations and shortcomings. One tends to blame oneself rather than to even consider, let alone express, hostility towards others. . . . (pp. 229-230)

The paranoid and the obsessive-compulsive focus on feelings of "danger and anxiety about transgressions," with little sense of guilt. In introjective depression, on the other hand, the harsh parental value system has been internalized, leading to intense feelings of guilt and shame, self-criticism, and self-deprivation of pleasurable experiences. Interpersonal relationships are characterized by severe ambivalence, i.e., an inability to integrate positive and negative feelings.

The major defenses are introjection, overcompensation, and identification with the aggressor, with a proclivity to assume responsibility and blame and to be harsh and critical toward the self. (p. 230)

In introjective depression, the individual views and judges himself in the same harsh judgmental terms by which the paranoid and the obsessive fear that they will be judged by others. . . . (pp. 233-234)

In the earlier introjective pathologies, i.e., paranoia and obsessive-compulsive syndromes, "archaic, punitive forms of the superego are personified, and these excessively harsh and critical standards are experienced as potentially dangerous, controlling external forces or people." Introjective depression is a higher level phenomenon, where the superego is less primitive and has been internalized at least to some degree. However, decompensation can manifest as regression to the earlier forms of introjective pathology. Thus the continuum within the introjective configuration is in large part defined by the degree of internalization and integration--or, to paraphrase Kernberg (1966/1976), the degree of "metabolization"--of the introjects; this will prove to be an important issue in the case to be discussed in Chapter III below. Indeed, Blatt and Shichman (1983) stress the potential for movement along this dimension often found in

all of the psychopathologies of this developmental line. They go even further and state that, for many of these patients, "there is a complex hierarchical relationship and balance between introjective depressive, obsessive-compulsive, and paranoid features." Patients at one level often have features characteristic of one or more of the other levels and these features can become activated during periods of regression or progression. Specifically, "patients at a phallic narcissistic or introjective depressive level often have many paranoid features, and if they decompensate they can become more actively paranoid as the introjective mechanisms become more projective." Similarly, obsessive-compulsives, in periods of decompensation, will manifest a more paranoid type of organization. And, conversely, paranoid patients "often struggle with profound feelings of guilt and depression, frequently intermingled with a predominantly premorbid obsessive character style" (pp. 234-235).

To summarize the model as a whole, psychopathology results from "exaggerated distortion of one developmental line to the neglect of the other" which in turn represents "compensatory or defensive maneuvers in response to developmental disruptions" (p. 245). Within each of the configurations there are different levels of personality organization from the more primitive to the more integrated. Patients show differing potentials for progression and regression along these dimensions within their configuration; often their disorders involve "a complex mixture" of both primitive preoedipal features and more advanced oedipal ones. The model as a whole allows us to view the various forms of psychopathology "no longer as isolated, independent disease entities, but rather as inter-related modes of adaptation, organized at different developmental levels within two basic configurations that focus on either interpersonal relations or self-definition" (p. 246).

We might also note that, while the model is cast in the psychoanalytic language of pathology, it offers a "yin-and-yang" vision of healthy development. Indeed, it is hardly coincidental that the pathologies and concerns of the anaclitic line bear a "feminine" imprint and those of the introjective line a "masculine" one. Nor is it insignificant that full, healthy human development requires, for each individual, an internal balance

between, and integration of, the elements of both lines of development--libidinal connection with others on the one hand, and autonomy, achievement, and self-definition on the other--or, to use a different terminology, the masculine and feminine aspects of the personality. Not only is health defined as in Freud's celebrated aphorism "lieben und arbeiten"--to love and to work--but, to go further yet, neither faculty can be truly whole if the other is stunted. If development is skewed towards one or the other of the two lines, if one is emphasized at the expense of the other, the price will ultimately be paid in both.

2. The Nature of Anorexia Nervosa and Its Relationship to Other Psychiatric Illnesses

This section explores anorexia nervosa from the perspective of modern psychiatry. As Szmukler (1987) points out, despite its relatively high degree of specificity, anorexia nervosa has at one time or another been reduced to a variant of any number of other psychiatric syndromes. These views of the illness consist of attempts to locate it within the psychiatric taxonomy by virtue of its surface symptomatology. They serve to highlight important dynamic aspects and to inform the depth psychology perspectives which will also be reviewed. They furthermore present an apparent set of contradictions, which locating anorexia nervosa within the anaclitic/introjective model will allow us to resolve.

As already noted, earlier authors suggested that anorexia nervosa might be a "pre-psychotic" illness, prodromal of a schizophrenic outcome (Dubois, 1913; Nicolle, 1939). This view has been discarded in modern times, as our experience with the illness has broadened, and this has been found not to be the case, at least for the vast majority of patients. Indeed, the case reported by Dubois (1913) would, in our eyes, more likely be classified as a case of hysterical food refusal, which over time evolved into a schizoaffective illness with a deteriorating course.

More recently, Bemporad, Ratey, O'Driscoll, and Daehler (1988) suggest that anorexia nervosa is, in fact, the modern version of hysteria--a hypothesis that will be supported by the historical analysis reviewed in the following section of this chapter. It

is important to note that these authors do not equate anorexia nervosa with hysteria, nor do they reduce it to hysteria, but rather they draw a historical and sociological parallel between the two illnesses, in terms of their role in the broader cultural contexts out of which they have evolved. Bemporad et al. (1988) suggest that both illnesses represent "the clash between normal female development and the contradictory demands of an unhealthy and pathogenic female social ideal"--in the case of hysteria the soft femininity of the Victorian era and in the case of anorexia the "self-controlled, autonomous super-woman valued by American culture today." The surface presentations are diametrically opposite--the "charming and fragile hysteric" versus the "iron-willed anorexic"--yet both are "exaggerated stereotypes of their times." Bemporad et al. note that many celebrated hysterics of the past, e.g., Anna O., recovered by going to the opposite extreme--"pursuing an ascetic life committed to social reform and exclusive of intimate heterosexual contact"--an interesting point which we will return to in our analysis below. The parallels between the illnesses are clear. Both "strike adolescent females, . . . are characterized by an almost psychotic indifference to gross bodily dysfunction, . . . are used to attract the attention or concern of significant others," and tend on the milder end to merge into the cultural ideal of young womanhood. Patients with both illnesses are quite resistant to treatment. In both cases psychic issues are displaced onto the body and, at a deeper level, both illnesses are attempts "to salvage a sense of self and a degree of self-determination, in an environment that is perceived as offering no possibility for autonomy" (Bemporad et al., 1988, p. 98).

Family backgrounds are similar for both illnesses, being characterized by a conventional surface covering severe enmeshment and very poor boundaries. Each individual in the family feels responsible for the well-being of all the other family members, leading to what Winnicott has characterized as a false self; this "allows for a peaceful and compliant façade and gradually erodes the vitality of the true self that is hidden and, eventually, forgotten" (Bemporad et al., 1988, p. 98). This constellation interferes with the development of autonomy and results in a personality development which we would locate within the broad borderline/narcissistic range of pathology. Bemporad et

al. (1988) describe a more specific family constellation for hysteria, which centers on a seductive and exciting father and a demeaned mother who is described as "cold and ungiving, yet also as submissive, depressed and, in a word, dreary." The future hysteric "conforms to the paternal expectation of a flattering, pretty, and ineffectual individual" and wins the oedipal struggle, but sacrifices her own autonomous development in the process (p. 98).

The modern anorexic family is similar in its enmeshment and poor boundaries, but different in that the mother, rather than being demeaned, tends to be "the mainstay and strength of the family . . . a model of perfection that is difficult to emulate rather than a martyr to be pitied." The pre-anorexic, like the hysteric, is often the father's favorite; however, as she reaches puberty, this becomes frightening and she turns away from him. The anorexia is her solution to the need for establishing some degree of identity. (As we will see in Chapter IV below, this analysis is very pertinent to the case reported in Chapter III). Both hysteria and anorexia provide a solution to an unbearable dilemma, without requiring that the patient challenge the family system itself. The differences are in the emphasis:

Both the anorexic and the hysteric seem to struggle with fear of maturity and sexuality. The hysteric rejects these developments by continuing her Oedipal attachment through flirtatiousness and a surrender to the emotions. The anorexic rebels against any seduction by exerting a stern control over her family, her feelings and her body. She strives to rid herself of any trace of femininity in the traditional sense. . . . Whereas the hysteric succumbed to her body, the anorexic keeps it in tight reign [sic]. (p. 100)

In their early forms, both illnesses tend to be reinforced by social approval as both are consonant with the cultural ideal of their times. Furthermore, both are "exercises in power by the powerless," occurring in those individuals whose sense of self is too fragile to handle the challenges of autonomy and individuation presented by the transition into adolescence and adulthood. We might summarize the thesis presented by Bemporad et al. (1988) as suggesting that anorexia nervosa and hysteria are both based in a fundamental deficiency in self/object differentiation and weakness of identity formation, but that the two illnesses show diametrically opposed surface presentations. Within the anaclitic/introjective model, this would suggest that both are based in a personality that

is focused on anaclitic needs, that is fundamentally anaclitic and that shows deficiencies in the introjective developmental line--something we will return to below.

In contrast to this thesis, Rothenberg (1986) suggests that anorexia nervosa is a modern form of obsessive-compulsive syndrome. Rothenberg bases this argument on the classically obsessional qualities of the illness and on an analysis of the defenses that are responsible for this presentation. The primary symptoms are, on the one hand, the voluntary and intentional food refusal and, on the other, the generally involuntary and incessant mental ruminations regarding calories and food. Rothenberg stresses the value placed on control of all bodily functions--intake, excretion, menstruation--and even, more importantly, of all affective experience, a control which is based in a mind/body split, with the mind exerting sadistic control over the body and the emotions. Furthermore, while the symptom of food refusal is voluntary, the mental ruminations are experienced as involuntary and ego-dystonic, which is explained by viewing them as an obsessional symptom attributable to the obsessional defense of isolation of affect and thought. Another classic obsessional defense, doing and undoing, is illustrated in the pattern of vomiting food after intake, which we might note is present in some anorexics, albeit not all--specifically in the group now classified as bulimic anorexics and generally contrasted with restricting anorexics. Reaction formation is seen in excessive helpfulness towards others; intellectualization in the "espousal of elaborate food crazes and theories" (Rothenberg, 1986, p. 47). Anorexics also show many of the typical character traits of the obsessional individual: "perfectionism, excessive orderliness and cleanliness, . . . meticulous attention to detail, . . . stubbornness and rigidity, . . . scrupulousness, self-righteousness and miserliness." Also prominent are oppositionalism and a drive to excel. The frequent preoccupation with laxative and diuretic use above and beyond their utility for weight control are seen as further highlighting the fixations which stem from "the anal or control phase of childhood." In summary, in anorexia nervosa "concerns about control and modulation of aggression and rage supersede the apparent focus on attachment and nurturance connected with eating and ingestion" (Rothenberg, 1986, p. 48)--a crucial formulation which we will return to below. On the other hand, we will take

issue with Rothenberg's statement that "the data and the foregoing theoretical considerations suggest that obsessive-compulsive patterns are the intrinsic structure upon which the particular content and focus on food and eating is superimposed" (p. 51). Rothenberg adds that the obsessive-compulsive patterns may in turn be superimposed on an even more serious psychopathology, specifically borderline psychotic conditions--"In these cases, the obsessive-compulsive features serve as defenses against psychotic decompensation and they maintain the patient's borderline state" (p. 51). Like Bemporad et al. with regard to hysteria, Rothenberg suggests that modern culture is responsible for evolving this variant form of obsessional illness. He highlights the culture's focus on food and thinness, its classification of food into "good" and "bad" categories and the prevalence of almost magical beliefs about the health giving values of foods.

Three recent experimental studies (Hecht, Fichter, & Postpischil, 1983; Kasvikis, Tsakiris, Marks, Basoglu, & Nashirvani, 1986; Solyom, Freeman, Thomas, & Miles, 1983) have attempted to address the questions raised by these two theories--i.e., is anorexia nervosa fundamentally a hysterical or an obsessional illness--and all three in a broad sense support Rothenberg's viewpoint, in good part because they focus on surface symptomatology. Solyom et al. (1983) make the interesting suggestion that anorexia may begin as a weight phobia, then evolve into obsessional rituals and even into a delusion, with depressive symptoms resulting from the social impairment that the illness tends to cause--an analysis fairly consonant with the model we will be evolving below.

Indeed, this brings us to the issue of depression and its link to anorexia nervosa, a question that has received a great deal of attention in recent years. This issue is particularly germane to the case reported in Chapter III and as such will be discussed in some detail. It can at this point be taken as a given that an important relationship exists between anorexia nervosa and depressive illness, based largely on two types of data: (a) reports of high proportions of patients with anorexia nervosa (from 25% to 80% depending on the study) also fulfilling diagnostic criteria for some form of depression; and (b) a significantly higher probability of affective disorder in the families of anorexics than in those of controls; both these general findings have been replicated in a number of

different studies (Szmukler, 1987). It should be noted that the literature in this area relates to the affective disorders--or, in DSM-III-R terminology, the mood disorders--as a group, without distinction as to whether these are psychotic in nature or not, albeit with the general implication that they are for the most part non-psychotic, and often without distinguishing between the more severe forms of mood disorder--major depression and the bipolar disorders--and the less severe forms such as dysthymia.

A number of hypotheses have been put forward to explain this relationship. The first and most traditional hypothesis is that the mood disturbances in patients with eating disorders are secondary to the eating disorders themselves (Swift, Andrews, & Barklage, 1986). There are several problems in making this assumption. One is that there appears to be an area of overlap between the symptoms of "starvation syndrome," as identified in the Minnesota studies of starvation, and the symptoms of major depression--specifically, "dysphoric mood, irritability, weight loss, sleep disturbance, decreased libido, social withdrawal, and inability to concentrate" (Swift et al., 1986, p. 291). Furthermore, Swift et al. (1986) point out that individuals with anorexia nervosa usually "take great pride in their physical shape and the willpower to which it attests," rarely expressing feelings of worthlessness, ideas of suicide, or thoughts of death. In other words, Swift et al. appear to be suggesting that anorexics manifest some symptoms of depression, which can be attributed to starvation, but not others, which are perhaps more central; the corollary is that, due to diagnostic practices which do not differentiate among these symptoms, anorexics may be prone to misdiagnosis, leading to an inflated estimate of the co-occurrence of true depressive symptomatology. On the other hand, as we will see below, a number of authors would suggest that the absence of some of these depressive symptoms does not allow one to rule out depression, but rather reflects the defensive functions of the anorexia in relation to an underlying depression.

In any case, in recent years, another viewpoint has arisen and has received considerable attention in the literature. This viewpoint suggests that the eating disorders, namely anorexia nervosa and bulimia, are in fact variants of and secondary to an underlying affective disorder. The supporters of this viewpoint emphasize the data

stemming from outcome studies, which have found high levels of depression in anorexics at follow-up. However, many of these studies do not differentiate the quality of the outcome with regard to the eating disorder itself, i.e., they essentially beg the core of the question (Hatsukami, Mitchell, & Eckert, 1984, p. 353). There have been some studies that have attempted to control for this factor and have found that "even anorectics who improve show a significant rate (up to 37 percent) of depressive symptoms"; however, it cannot be determined whether these symptoms result from adjustment problems or from an underlying affective disorder (Hatsukami et al., 1984, p. 354).

The most convincing line of evidence in favor of the hypothesis that anorexia nervosa reflects an underlying affective disorder lies in family studies, which generally indicate an increased frequency of affective disorders, especially depression, in the relatives of anorexics compared with those of normal controls or even psychiatric populations such as borderlines and schizophrenics, and particularly in the families of bulimic anorexics even more so than in those of restrictors; however, again, the effects of genetics as opposed to those of environment cannot be separated (Hatsukami et al., 1984). Biological studies--be they of endocrine abnormalities or of the pharmacological effects of antidepressants--have been on the whole rather inconclusive (Hatsukami et al., 1984).

Strober and Katz (1987) offer a strong challenge to the view that the eating disorders can be reduced to variants of depressive illness. They argue that "only a small percentage of depression-prone individuals develop these syndromes" and that the eating disorders are quite specific and clearly demarcated from the affective disorders in their symptomatology and course of illness. Strober and Katz (1987) recognize that "periods of definite depression antedate the onset of eating disorders and body shape concerns in 10-25% of patients" and that 40-80% also meet criteria for a lifetime history of major depression, but point out that the majority of these depressive episodes are concurrent with or parallel the course of the eating disorder (p. 173). They argue that this in turn puts into question the diagnosis of affective disorder in these patients. Furthermore, they note that the clinical signs of endogenous depression--i.e., "melancholic mood of fixed intensity, early morning awakening, retardation, morbid ideas of guilt, sin, or

punishment"--are found in only a small percentage (approximately 10 to 20%) of the depressions that occur among eating disorder patients (Strober & Katz, 1987, p. 173). Also the clinical course of eating disorders and affective disorders is quite different--affective disorders show a variable pattern of recovery and relapse, often with a cyclical quality, whereas anorexia nervosa tends to have a much more chronic course (p. 175). Finally, adolescents who initially present with major depression do not show an increased rate of anorexia nervosa (p. 175), i.e., cross-over is negligible in this direction. Strober and Katz (1987) also note that, in some family studies, albeit not all, the higher loading for affective disorder in relatives was specific to anorexics who also suffered from concurrent depression.

Szmukler (1987) adds further fuel to this argument. He suggests that viewing anorexia nervosa as a variant of affective disorder is tantamount to suggesting that "all cases of anorexia nervosa are simply those of affective disorder with an atypical presentation" (p. 183), a view that is not supported by the data, specifically by the fact that many anorexics do not show depressive symptoms and by the different "natural histories" of the two conditions. Even before the days of pharmacotherapy, affective disorder tended to show an episodic pattern with episodes lasting 6-12 months, whereas anorexia nervosa is generally chronic and ongoing, lasting at least 2-3 years. Szmukler further stresses the epidemiological data on the distribution of anorexia nervosa with regard to age, sex, social class, and occupation (e.g., ballet dancers, models) and, even more importantly, "the increasing incidence of anorexia nervosa over the past two decades or so . . . in the absence of any evidence of a comparable increase in the incidence of affective disorder"; while this could be attributed to a "pathoplasticity" on the part of depression which would take the form of anorexia nervosa in certain subgroups, the explanation tends to become strained and implausible (Szmukler, 1987).

Strober & Katz (1987) conclude that the overall picture argues against shared common mechanisms of causation between anorexia nervosa and depression; rather it is consistent with the hypothesis that some individuals, by virtue of their affective predisposition or actual affective illness, would be especially vulnerable to the develop-

ment of an eating disorder, although it would also be possible for starvation to precipitate a depressive state. Indeed, Swift et al. (1986) concur with this view, pointing out that the eating disorder can "serve as a defensive reparative maneuver to mitigate dysphoric affect" or alternately the mood disturbance can start out as a secondary symptom but in turn contribute to the eating disorder in a "vicious cycle" (p. 297).

Katz (1987) expresses this view even more forcefully, arguing that the evidence is most consistent with the view that only a specific, albeit substantial (probably around 50%), subgroup of eating disorder patients manifests a depressive disorder as well. He notes that a recent series of studies reported "significant abnormalities" in a number of biological indices considered related to depression in a subgroup of anorexic patients which represented 30-45% of the entire sample and which was "essentially the same subgroup that met Research Diagnostic Criteria for major depression " (Katz, 1987, p. 224). Furthermore, a study of sleep polygraphs found shortened REM latency among a subgroup of eating disorder patients also characterized by depression (p. 224).

Szmukler (1987) agrees with this viewpoint that "anorexia nervosa is a specific process that may develop in a variety of settings of which depressive disorder, or a diathesis for it, is one" (p. 181) and adds yet another possible explanation, namely that the presence of depression "may predispose to the presentation of anorexia nervosa to physicians and, in particular, to psychiatrists" (p. 181). In other words, a referral bias may be giving clinicians a skewed view of the size of the subpopulation that suffers from major affective psychopathology above and beyond the sequelae of the starvation state. He notes that surveys of the general population have revealed that many cases of anorexia nervosa do not come to medical attention and tend to show a "spontaneous" remission, e.g., in ballet schools where anorexia nervosa is quite common.

Szmukler (1987) furthermore stresses that, even if anorexia nervosa evolves out of an affective disorder, it comes to the fore as an independent entity and that indeed "the course of the illness is largely determined by the anorexia nervosa rather than the affective disorder. . . . The anorexia nervosa may thus be conceived as an 'opportunistic' development in someone suffering an affective disorder in an analogous manner to the

development of an infection in a patient suffering from an immune deficiency syndrome" (p. 184). Sz mukler (1987) goes on to explore the specific nature of this opportunistic process that would constitute anorexia nervosa and evolves the view that anorexia nervosa is, in its essence, an addictive disorder, a dependency on "the state of semistarvation" (p. 186), as argued earlier by Sz mukler and Tantam (1984). The arguments in favor of this view are based on a series of specific and powerful parallels between anorexia nervosa and alcohol dependency. Both starvation and alcohol consumption may be unpleasant when first experienced, but for some individuals become pleasurable with repeated exposure (Sz mukler & Tantam, 1984). In both cases, the behavior in question--dieting or drinking--is something that is normally "indulged in moderation and that induces deliberately an abnormal physiological state . . . [which] is experienced as pleasant or calming for some individuals, perhaps particularly for those who are depressed" (Sz mukler, 1987, p. 186). In the case of dieting, some of the pleasure may come from the subjective sense of "being in control"--a phrase often used by anorexics in the early phase of the illness (Sz mukler & Tantam, 1984, p. 303). However, over time, as the dependency takes hold, this search for control leads to a paradoxical result:

At some point the behavior appears to become out of control and carries obvious destructive consequences. However, this is denied by the patient, and offers of help are rejected. The patient's life becomes increasingly organized around the need for a drink in the one instance or the need to avoid the ingestion of food in the other. Tolerance develops, this being suggested in the case of anorexia nervosa by the patient's need to increasingly restrict her intake or to lose a few more pounds. Withdrawal effects are noted in both conditions; when the state of food restriction is interrupted in anorexia nervosa, the patient experiences an intense dysphoria with some physiological accompaniments . . . She consequently seeks to avoid such occurrences in the future just as the alcoholic attempts to secure the availability of alcohol at all times to avoid the emergence of withdrawal symptoms. In time, most patients will come to admit a subjective compulsive quality to their starvation that is difficult to resist even when they wish to gain some weight. Both conditions also show a rapid "reinstatement" of dependence where, after a period of abstinence (from drinking or dieting), the dependence syndrome quickly follows on the heels of attempts to indulge in the addictive behavior in moderation.

Epidemiologically, anorexia nervosa also shows a parallel with substance dependence since its incidence is related to the degree of exposure to the agents; the more subjects exposed to alcohol or dieting in a population, the more cases of alcoholism or anorexia nervosa (for example, in ballet schools). (Sz mukler, 1987, pp. 186-187).

Szmukler and Tantam (1984) note several more points in common between anorexia nervosa and alcohol dependency, specifically the "narrowing of the 'eating repertoire'" with a tendency to rigidity and stereotypy; the almost continuous mental ruminations on the subjects of food and weight; the recourse to "deceit and subterfuge" to avoid eating, with "the avoidance of eating assum[ing] primacy in the patient's life" over and above all other concerns; the patient's unresponsiveness to social pressures, as she easily promises to stop starving but does not follow through (p. 304)--all behaviors which are found among alcoholics in relation to their drinking. Katz (1985) suggests several biological factors that provide what we might term feedback loops which serve to fuel the illness--specifically, as the stomach's capacity shrinks, the patient feels fuller when she eats; as the abdominal muscles weaken due to starvation, her stomach protrudes more, which reinforces the distorted body image; finally two central features of anorexia nervosa--starvation and increased physical activity--both tend to elicit a rise in endorphins, the substances that serve as "the body's own opiates" and many anorexics describe a sense of being "high" early in their illnesses--a drive to recapture this "high" could be one of the primary forces fueling the illness and could also be one of the mechanisms whereby anorexia nervosa can serve as a defense against an underlying or emerging depression (p. 623).

Indeed, recent animal studies (Epling & Pierce, 1988; Epling, Pierce, & Stefan, 1983) suggest that strenuous physical activity and reduction of food intake may operate in a mutually reinforcing and thus synergistic manner at a basic biological level. This could be one explanation for the parallel between and occasional co-occurrence of anorexia nervosa and various forms of intensive physical activity, e.g., long-distance running. The "traditional" view was that increased physical activity was a side effect of anorexia nervosa, stemming from an attempt to lose more weight or to deny physical depletion. However, as early as 1906-1907, Janet in his celebrated Harvard lectures (cited in Bell, 1985) took the view that hyperactivity was a primary and central phenomenon in anorexia nervosa, accounting for the "euphoric" feeling of the anorexic at this stage. Katz (1986) reports two cases of male runners in whom long-distance run-

ning served as the trigger for eliciting anorexia nervosa. Furthermore, when these men were forced to temporarily reduce their level of activity, both manifested depression and bulimia. Thus physical activity certainly can serve as a catalyst in vulnerable individuals.

To return to the question of starvation-dependency, Szmukler (1987) notes that therapists have observed the necessity of withdrawing patients from the addictive intoxicated state, i.e., from the state of self-starvation in the case of anorexics, before therapeutic measures can be effective. He adds that the incidence of affective disorder in the patients themselves and among their relatives is similar for anorexics and for alcoholic females. Thus depression could serve as one of a number of predisposing factors towards the development of addiction, with exposure to the addictive state acting as a necessary catalyst. This exposure, in the case of anorexia nervosa, could come through dieting, depressive weight loss, or physical illness associated with weight loss. Furthermore, some authors have observed that patients with anorexia nervosa may show an increased risk for alcoholism later in life, which "supports the notion that there may be a sustained propensity for addictive behaviors, the nature of which changes through the life cycle" (p. 187).

Szmukler and Tantam (1984) add a very interesting and provocative idea:

When we have asked patients with anorexia nervosa for their reasons for not eating, there have been a variety of responses. The most common is a stated fear of becoming fat. However, other patients will not express concerns about weight but might complain of the absence of hunger, of intense discomfort if they should eat, of a need for the stomach to feel empty, of food 'dulling the mind' or impairing alertness, or not infrequently, of bewilderment--"I feel hungry, I want to eat, I just can't. I don't know why."

A 'characteristic' psychopathology emphasizing a fear of fatness has been stressed in more recent accounts of anorexia nervosa . . . but an examination of the literature prior to the 1960s shows little reference to this feature It could be that the earlier observers were not very careful in eliciting and recording their patients' fears and accepted the disorder as resulting from a 'perversion of appetite'. On the other hand it is possible that patients' 'explanations' for why they fail to eat might change with the times and that patients with anorexia nervosa today favour the fear of fatness explanation because of our society's general preoccupation with slimming and perhaps because physicians expect to hear it. (p. 305)

In other words, they bring into question the modern view that a fear of becoming overweight or a "weight phobia" (Crisp, 1977) is the central motivating factor of the illness,

emphasizing instead the reinforcing effects of the starvation state rather than its resulting consequence of thinness. In favor of this view, they note that most individuals with anorexia nervosa find weight loss desirable for a while, but once its undesirable aspects become evident--e.g., sensitivity to cold, weakness, pain when sitting on exposed bony areas--they begin to desire weight gain and become more amenable to treatment. This is, interestingly enough, consistent with Palazzoli's (1978) observation that anorexics are often quite aware of their emaciation and unusual appearance, taking care to wear garments that cover rather than reveal their bony frame.

As we will see, this view that the compulsion to be thin is a more recent addition to the picture is quite consistent with the historical analysis reviewed in the next section of this chapter. We might note, in passing, that this mystifying aspect of the compulsion to fast is vividly depicted in Kafka's (1946) short story "The Hunger Artist." A hunger artist, presumably of the last century, whose profession consists of engaging in public fasting usually for 40 day periods, confesses on his deathbed that he could not help but fast, adding an implausible explanation--"I couldn't find the food I like" (p. 177)--which, like those given by anorexics and hysterical food refusers, has the quality of a rationalization for an unknown compulsion.

In any case, Szmukler and Tantam (1984) argue that the epidemiological data strongly support their hypothesis, since addictive disorders require both a predisposition to the dependency and an exposure to the addictive substance or behavior, leading to a positive correlation "between the level of exposure and the prevalence of dependence" in a given population; this would help explain the very high rates of anorexia nervosa in occupations where slenderness is necessary and dieting frequent, e.g., ballet dancers and fashion models, as well as the recent increase of anorexia nervosa in the culture as a whole, concomitant with the development of a "thinner cultural stereotype of beauty" (p. 306). They also reduce bulimia, when it occurs in individuals with anorexia nervosa, to a secondary phenomenon, resulting from the tension between the state of self-starvation and the physiological drive to eat. However, Szmukler and Tantam (1984) concede that addiction is not by any means the total explanation of anorexia nervosa, adding that

family factors and social/emotional regression certainly come into play. They suggest that further research might help clarify why the state of starvation is gratifying or tension relieving for certain individuals more so than others, something which might be related to brain physiology and specifically to the production of endorphins.

Katz (1985), in an essay on the limitations of our knowledge with regard to the eating disorders, gives considerable credence to the addiction hypothesis, but concludes that no single etiology can be identified and that it is more useful to look at the illness in terms of risk factors, a way of thinking used for many medical illnesses--the greater the number of risk factors present, the greater the likelihood of an individual developing the illness. Katz lists a number of risk factors at the cultural level, the family level and the individual level--the latter including female gender, adolescence, slight degree of overweight, feelings of ineffectiveness and low self-esteem, conflicts and doubts regarding identity and autonomy, a tendency toward bodily perceptual disturbances, a tendency toward overgeneralization and other cognitive distortions, and an obsessional style. Among risk factors for becoming a bulimic anorexic rather than a restrictor would be a substantially elevated premorbid weight, a borderline personality organization (presumably within the narrower DSM-III definition which focuses on affective lability, impulsivity, etc.), and/or a depressive disorder.

It is interesting to note that, for the most part, the authors discussed above attempt to locate anorexia nervosa within the psychiatric taxonomy with only passing reference to its sister illness bulimia and certainly without any theoretical framework for the relationship between the illnesses. As we saw, Rothenberg (1986) viewed bulimia, when occurring in anorexics, as an illustration of the obsessional defense of "doing and undoing," Szmukler and Tantam (1984) dismissed bulimia among anorexics as a byproduct of the tension between starvation and the physiological drive to eat, and Katz (1985) associated it with borderline personality type and/or depression. All three clearly refer to bulimia within the context of anorexia nervosa, rather than as a separate and broader phenomenon that can occur in individuals who do not suffer from anorexia nervosa as well as in those who do.

However, as many clinicians have observed, these distinctions are in actual practice artificially narrow, since at least a sizeable number of patients tend to change categories over time. In a study designed to explore this phenomenon, Holmgren, Humble, Novring, Roos, Rosmark, and Sohlberg (1983) showed this to be very much the case on the symptomatic level and began to sketch out a unifying model--which we will expand upon below. Holmgren et al. (1983) assessed 79 adult patients seen over a 2 1/2 year period at the Psychiatric Clinic of Uppsala University, concentrating on both present symptoms and history of symptomatology. They found considerable overlap in symptomatology between the four subcategories of anorexia nervosa, bulimia, double diagnosis of anorexia nervosa and bulimia, and "anorexic-like" patients (i.e., subclinical level anorexia nervosa). Specifically, 50% of the anorexic patients reported bulimic episodes and the rest reported bulimic impulses; conversely all the bulimic patients were intensely afraid of obesity and showed body image disturbance. Furthermore, and even more importantly, these researchers took a history from each patient and found that 49% of these patients had previously passed through a phase when a diagnosis other than the one currently applicable would have been given. In fact 39 of the patients had alternated between bulimic and anorexic phases in their lives. The authors note that they were able to obtain such longitudinal data because they were dealing with adult patients, whereas many traditional studies have focused on younger populations with a more limited history of the illness.

Holmgren et al. (1983) conclude that the sharp distinction drawn in DSM-III between the two syndromes is artificial and misleading, and that it is more useful to focus on the alternation and indeed conflict between opposite impulses and modes of behavior in these eating disordered patients. They describe this conflict as a "permanent antagonism between, on the one hand, anorectic behavior, i.e., minimized nutritional intake and activities aimed at reducing the effects on the weight of ingested food (exercise, vomiting, purging, etc.), and, on the other, bulimic behavior, i.e., extremely strong interest in and permanent preoccupation with food, expressed in various ways (binge-eating, preparing food for others, reading recipes and food magazines, etc.)"

(p. 11). They view this "Anorexic-Bulimic Conflict" as the central issue. The patient's actual behavior with food and actual weight and secondary physical symptoms simply reflect the specific balance of forces within the conflict at a particular point in time. This broader way of conceptualizing the eating disorders allows the clinician to be prepared for oscillations over time between predominantly anorexic behavior and predominantly bulimic behavior and between underweight and overweight. It eliminates the simplistic tendency to view weight change as necessarily implying positive or negative internal changes or to use it as a gauge of recovery. It also eliminates "arbitrary distinctions between individuals according to weight criteria," focusing rather on a more meaningful internal aspect, the subjective "Anorexic-Bulimic Conflict" (Holmgren et al., p. 11). In short, Holmgren et al. (1983), rather than dismissing one side of the conflict as secondary to the other, view both as equally relevant and begin to suggest a multi-dimensional view, whereby the balance of the forces might vary from patient to patient and from time to time, allowing for shifts in the symptomatic picture.

At this point in our exploration, we can begin to locate anorexia nervosa within the anaclitic/introjective model of development and psychopathology--something which will allow us to resolve many of the apparent contradictions discussed above and to evolve a broader and deeper understanding of the illness. This line of thought has, in fact, already been suggested, although not fully developed. Subsequent to, and following from, Blatt's (1974) initial and seminal differentiation between anaclitic and introjective depression--but prior to Blatt and Shichman's (1983) development of the comprehensive model outlined in Chapter II--Sugarman, Quinlan, and Devenis (1981) put forth a view of anorexia as a defense against anaclitic depression which addresses the underlying basis of the illness from a depth psychology perspective and an object-relations viewpoint. Sugarman et al. (1981) specifically suggest that, due to maternal failure in promoting and tolerating the child's evolving separateness/autonomy/independence, anorexics suffer from a developmental arrest in the separation/individuation process (as described by Mahler et al., 1975), specifically an arrest at the transition from the differentiation subphase to the practicing subphase. Their thesis is that the mother's inability to tolerate

the child's growing motility and early experiences of separating in the practicing sub-phase does not provide the child with the matrix for developing firm internalizations of the maternal representation and, concomitantly, firm boundaries between self and object representations. Furthermore, "a variety of family problems including violation of transactional boundaries and parental under- or over-involvement" contribute to perpetuating this problem and interfere with the consolidation of self and object representations and the boundaries between them as the child matures. This developmental arrest leaves the child cognitively and emotionally fixated "at a level of sensorimotor self and object representations wherein the object can be internalized only as a part of an action sequence at the moment of need satisfaction. Hence objects and the self can be represented only through concrete motor actions" (p. 46). Furthermore, excessive emphasis on early toilet training and bodily control in these families tends to exacerbate this predisposition to "act out internal phenomena at the concrete level of the body" (p. 46).

As a result of all this, the child fails to develop object constancy and remains very vulnerable to object loss and anaclitic depression. She also experiences fantasies of fusion with the mother and, concomitantly, fears of a loss of the self-other boundary. The activity of eating comes to serve as a "sensorimotor representation of the mother." However, as such, it arouses the "dread of fusion" with the mother and thus is followed by another "concrete motor action," namely vomiting, which in turn allows for the ejection of the mother. Thus "alternate vomiting and gorging ultimately serves to prevent the collapse of the tenuous self-other boundary" (Sugarman et al., 1981, p. 47). We might note that this is a reinterpretation of the "doing-and-undoing" defense from an object relations perspective. In any case, adolescence, with its demands for increased autonomy, reawakens and exacerbates this conflict regarding separation and autonomy; while sexual issues are also present, they remain secondary to these identity and object relations issues. We might note that Sugarman et al. refer to anorexia in this description, but appear to be describing bulimic anorexics more than restrictors. On the other hand, one can easily suggest that restrictors simply deal with their fear of fusion in a different manner.

In any case, the crucial contribution of these authors lies in the following points:

- the anorexic patient's vulnerability both to fusion/symbiotic wishes and to depression in reaction to object loss;
- her very limited self-differentiation with poorly defined boundaries, particularly between the self-representation and the maternal representation;
- her tendency to concretize affects and internal object relations via bodily experiences and related action sequences.

We might note that the anorexic's social isolation and her physical enactment of food restriction represent her repudiation of anaclitic needs on all levels. Sugarman et al. (1981) specifically locate the difficulty in the practicing subphase for two reasons: (a) because of its crucial importance for the development of autonomy, as well as that of object constancy, which in turn protects from the vulnerability to severe depression upon object loss; and (b) because of its focus on concrete action sequences, i.e., its link to Piaget's sensorimotor phase.

An interesting point is their description of "good enough" mothering (Winnicott 1960/1965a) at this stage:

The mother who is "good enough" for the infant at this stage is both "there and not there." She allows and encourages freedom, but is available for emotional refueling. This sort of mother walks behind the toddler ready to catch her if she falls, but otherwise is out of sight and mind. Thus, the narcissistic illusion of self sufficiency so crucial to this period is promoted. Only by feeling that the mother will be there can the toddler be secure in being alone. (Sugarman et al., 1981, p. 53)

By contrast, the mothers of anorexics are either "there" too much or too little--or a combination of both, as we will see in the case reported in Chapter III; we will also see in Chapter IV how this description of the good enough mother could be used to describe the stance of the hospital ward during the patient's recovery phase.

Sugarman et al. (1981) suggest that this developmental arrest at "the transitional period between the differentiation and practicing subphases, and at a level of sensorimotor representation" promotes both a vulnerability to anaclitic depression and an infantile personality structure--a personality which, although more primitive, bears

many resemblances to the hysterical personality. This, they suggest, may help to account for some of the confusion between anorexia nervosa and hysterical phenomena.

Sugarman et al. (1981) outline the defensive maneuvers of anorexics in a detailed manner. Specifically, anorexics "strive to reduce their feelings of dependency which threaten to reach symbiotic proportions" by renouncing eating, which after all represents taking in the mother. Their emaciation accentuates their differentiation from others, "at its most concrete and basic level, the body." They experience a sense of mastery over their bodies and act out counter-dependent tendencies by feeding their families. Their hyperactivity defends against boundary loss; it is a desperate effort to remain independent, to fight off "regressive urges." It also serves as a manic defense against the tendency toward anaclitic depression and may furthermore provide a "reparative" experience in light of the restrictions enforced by the parents during the practicing subphase, when a high level of physical activity is developmentally appropriate and expectable.

The hypothesis we will propose, which follows from the view of Sugarman et al. (1981) and the broader model evolved by Blatt and Shichman (1983), is that anorexia nervosa is essentially an exaggerated introjective phenomenon which serves as a defense against severe anaclitic vulnerability, often stemming from a personality which is primarily anaclitic--e.g., an infantile personality, as suggested by Sugarman et al. (1981). Such a personality structure would indeed involve a specific vulnerability to anaclitic depression, particularly in reaction to real or perceived anaclitic loss. Viewing anorexia nervosa in this broader fashion as a cross-over phenomenon between the two developmental lines allows us to resolve a number of apparent contradictions. The close link between hysteria and anorexia stems from the underlying vulnerabilities in the anaclitic sphere that motivate the illnesses and in many patients from an underlying anaclitic personality--as described by Bemporad et al. (1988) and Sugarman et al. (1981). This core anaclitic vulnerability contributes to the focus on food and eating, which are universally understood as representing attachment and nurturance at a very concrete level. It accounts for the fact that anorexia often occurs at adolescence, when such vul-

nerable individuals are faced with the need to separate and individuate at a broader and deeper level. Feeling incapable of this, they make a desperate attempt to do it, which takes the form of an extreme and exaggerated leap over to the introjective line. Indeed, the surface presentation of anorexia nervosa consists of an extreme elaboration--almost a caricature--of the introjective defenses, which accounts for the "obsessive" presentation and the close link to obsessive-compulsive phenomena. In other words, we would strongly concur with Rothenberg's (1986) formulation that "concerns about control and modulation of aggression and rage supersede the apparent focus on attachment and nurturance connected with eating and ingestion" (p. 48) but would disagree with his analysis that the content regarding food and eating is simply superimposed upon these obsessive-compulsive tendencies. We would suggest the opposite, namely that the obsessional introjective tendencies are, in a sense, superimposed upon the anacletic needs and vulnerabilities. This, in turn, accounts for the tendency of anorexics to slip over into bulimia when the defenses weaken or collapse--something we will see repeatedly in the clinical reports discussed in Section B, below. For anorexia nervosa and bulimia simply represent different balance points between the conflicting forces of the anacletic needs and the introjective defenses--as already suggested by Holmgren et al. (1983); specifically, restrictors show a relatively stable defense system while bulimic anorexics oscillate wildly between an attempt at restriction and defense on the one hand and untrammelled experience of and submission to their oral needs (with an oral aggressive component) on the other. This view is also consonant with Bruch's (1973) understanding of all the eating disorders--anorexia, bulimia, and obesity--as closely inter-related illnesses which are based in a deeply flawed sense of self. We might note that focusing on the dialectical movement between the two developmental lines also helps to account for Bemporad et al.'s (1988) observation that many famous hysterics of the past recovered by going to the opposite extreme and pursuing ascetic work-driven lives; they too adapted by crossing over to the introjective line, albeit at a higher level, since their solution was a healthier and more productive one than anorexia; this analysis is consonant with Blatt and Shichman's (1983) viewpoint that hysteria represents a "more advanced" development

than the infantile personality, based on a higher level of development along both the anaclitic and the introjective line.

The link to depression is also illuminated by the anaclitic/introjective model. At the most evident level, introjective depression, along with the obsessive-compulsive syndrome and paranoia, would be one of anorexia's "sister" illnesses within the introjective configuration. At a deeper level, however, the connection is to be found in the introjective mechanisms which underlie anorexia nervosa. These mechanisms will prove central in illuminating psychotic decompensations in the course of anorexia nervosa. They are to be found in the processes of internalization that underlie the illness, i.e., in examining it from the viewpoint of object relations.

Freud (1917/1963), in his seminal essay "Mourning and Melancholia," located the essence of what we would describe as introjective depression--i.e., a depression characterized by intense self-reproach--in a perceived loss of an ambivalently perceived object, which in turn is introjected into the ego and then persecuted by the ego. The result is that the aggression which was originally directed at the object is now directed at the unconscious introject of the object and expressed in the form of self-reproach. Thus, loss, introjective mechanisms, ambivalence, and conflict have been central to the psychoanalytic conceptualization of depression from the very start.

The most cogent object-relations perspective on anorexia nervosa is that of Palazzoli (1978) who locates the fundamental underpinnings of anorexia firmly in the area of distorted processes of internalization, i.e., introjective mechanisms, the specific nature of which is extremely relevant both to the link between anorexia and psychosis and to the case reported in Chapter III. For Palazzoli (1978), anorexia nervosa is based upon the projection of the internalized bad-mother representation into the patient's own body, which is experienced as split off from her mind/self. This is what we might describe as a transitional level of projection, since it is neither fully external nor fully internal. Once the anorexic has established this defense, she then strives to control the internalized bad mother and keep it in check via frantic and drastic efforts to control and keep the body in check.

Palazzoli's theory evolves in a logical fashion. It begins with the point that the more classic, traditional interpretation of anorexia nervosa as a defense against oral-sadistic impulses is clinically inaccurate. Patients whose illness is based in such a defense tend to develop "either delusional ideas about being poisoned, or fears of not being able to eat, or an actual block against food. This block is completely involuntary and is accompanied by severe irritation, a preoccupation with starvation, and intense feelings of physical damage and decay. . . ." (p. 86) By contrast:

[The anorexic] is not the passive victim of a total or sporadic block in her food intake, but reduces it to absurd levels with consistent determination. The most important point is that, once she has consumed food, especially in what, by her standards, are large quantities, she does not feel that her body is being threatened or destroyed, but thinks that it has become bloated, ominous and in the way.

The basic symptoms of anorexia nervosa are therefore: persistent hunger (which is generally disguised and only admitted after long familiarity with the therapist), and a deliberate struggle against it. . . .

In short the body has become a threatening force that must be held in check rather than destroyed. (p. 86)

In other words, like many authors before her (see Chapter I above), Palazzoli differentiates anorexia, with its conscious willful character, from hysterical phenomena based on repression and unconscious defenses against impulses.

Palazzoli emphasizes that the anorexic is not afraid of food, but rather of her body, which is experienced as separate from, and antagonistic to, her "self," her personhood.

To the anorexic, being a body is tantamount to being a thing. If the body grows, the thing grows as well and the 'person' starts to shrink. To fight against the body is thus a desperate fight against reification--paradoxically so, because while refusing to be a thing the anorexic fights her battle not on a spiritual plane, but rather on a purely material one: that of her own body.

The anorexic develops this experience of her body by "equating it" with the negative, overpowering, introjected mother:

I should like to emphasize that the body of the anorexic does not merely contain the bad object but that it is the bad object. From the phenomenological point of view, the body is experienced as having all the features of the primary object as it was perceived in a situation of oral helplessness: all-powerful, indestructible, self-sufficient, growing and threatening. (p. 87)

Anorexia tends to arise at puberty due to the trauma of suddenly bodily change and the developmental demands for separation. The anorexic feels helpless and powerless towards the maternal object. However, once the defensive projection into the body has occurred, the anorexic can begin to act. She can direct aggression toward the body by starving it. Since her feelings toward the bad maternal object are ambivalent and include fascination as well as mistrust, she does not simply abandon or decaject the body, which would lead to somatic depersonalization. Rather "the body-object must simply be kept under control, not be allowed to swell and grow, must be subjected to hard work and strain. The ego becomes an avenger which transforms its master into a slave" (p. 92). Thus the anorexic's insensitivity to her own bodily signals stems from two sources--the experience of insensitive or overly controlling mothering, i.e., a component of developmental arrest, and the defensive rejection of the body that sets in at puberty.

According to Palazzoli, certain aspects vary according to the predominant psychosexual fixations. Patients with strong anal compulsions focus on the fear of losing control over passive impulses and develop an ascetic style. Patients with phallic defenses focus on the competitive aspects--wishes to be admired, to beat rivals, to be strong and unvanquished. Unconscious fantasies of oral impregnation--a classic psychoanalytic explanation of anorexia nervosa--are rare in Palazzoli's experience and, in her view, not due to sexual fears, but rather serve as "a sexual symbol of a more frightening experience, namely that of being invaded and distended by the primary object, that is the mother" (p. 93).

Palazzoli begins to sketch out a link between anorexia and psychosis, referring to anorexia nervosa as a "mono-symptomatic psychosis" and "a special defence structure midway between schizo-paranoia and depression" (p. 94), thus placing it in a Kleinian (Segal, 1969) perspective; she also terms it an "intra-personal paranoia." The fact that the projection occurs into the body, not onto the outside world, is the crucial point which distinguishes anorexia from outright psychosis and paranoia. Another crucial distinction lies in the fact that the incorporated bad object is not split up, but rather "remains whole, just as the body with which it is identified constitutes a whole" (p. 94).

This projection onto the body--one which we could term a "transitional" type--protects against interpersonal delusions and schizophrenia. It also protects against outright depression and suicide by keeping the badness at bay in the body and thus protecting the idealized ego. This is why, upon organizing the anorexic system, patients often shed their premorbid depression; they no longer feel passive and helpless, but rather focus on acting against the body (p. 94). According to Palazzoli this explains the exceptional stability of the anorexic syndrome in its milder forms, where the defense is usually centered on keeping the weight at a fixed minimum that is neither too dramatically thin nor experienced as threatening--"the magic weight" which allows for a minimum level of psychological security and which incidentally may coincide with the minimum weight required for menstruation, thus accounting for many so-called recoveries following brief medical treatments. In summary, Palazzoli provides a specific model for the introjective defenses that underlie anorexia nervosa at the level of internalized object relations; this model highlights the defensive functions of anorexia in relation to psychotic mechanisms.

Blatt and Shichman (1983) stress the "counteractive" nature of the introjective defenses, which results in a "paradoxical" symptom picture, i.e., the symptom tends to express both the underlying need/impulse and the defense in a rather striking fashion. This quality is clearly visible in anorexia nervosa. The anorexic experiences the physical changes of puberty in contradictory terms--they make her look more like her mother via the development of a mature female body and at the same time require that she separate and individuate. She reacts by espousing starvation, which reverses these changes, thus differentiating her body from her mother's at a concrete level, but also providing a retreat into pre-adolescence and an avoidance of social maturity and separation. Similarly, the anorexic rejects nourishment, yet forces it on others; she manifests a fierce independence and extreme control, but maintains her dependency on her family. In time, with the progression of the illness, she may be hospitalized and reduced to total dependency; yet even this is two-sided, as hospitalization can provide some degree of separation from her family. Finally, we might note that the anorexic's emphasis on food

and the body as a locus of emotional expression and interpersonal communication reflects the concrete thinking style characteristic of the introjective pathologies.

Two recent authors illustrate some of these mechanisms at a clinical level in a manner that enriches our understanding of them at a theoretical level. Ceaser (1977) reports on four cases that are particularly illustrative of the close link between depressive mourning, introjective phenomena, and anorexia nervosa. In all four cases, the patient's mother had passed away from cancer some time prior to the onset of the patient's anorexia and had manifested cachexia as an important part of the terminal illness. Each of these women felt responsible, in one way or another, for her mother's death. Anorexia developed considerably later and was precipitated by the onset of sexual activity: "All four patients became anorectic after entering a heterosexual relationship during adolescence when the oedipal rival was no longer alive" (p. 482). Ceaser suggests that these patients suffered from "striking guilt feelings" and "excessive ambivalence" in relation to their mothers, that their guilt was "a superego response to the magical belief that their murderous impulses had indeed killed their mothers" and that, as a result, they attempted to deny the mother's death and their loss of her via incorporation. Indeed, two of the patients showed severe bulimia immediately following the mother's death and a third did so after the death of a mother substitute many years later. Both the gorging and the "relentless pursuit of thinness" were attempts at restitution of the object--the gorging on a very concrete level which equates mother and food and the thinness via an identification with the mother's state of cachexia. Ceaser also notes that denial of loss by incorporation (i.e., gorging) is, in and of itself, an ambivalent act, since the object is devoured and destroyed. The anorexia in all four patients was set off by the reactivation of the threat of closeness and its accompanying fear of loss, which occurred with the beginnings of heterosexual activity. Ceaser's theoretical analysis is very close to the views of Palazzoli (1978) and Sugarman et al. (1981). He views these patients as showing both an intense wish for closeness/merger/symbiosis and an intense fear of it, leading to an intolerance of both closeness and separation, and suggests that full internalization of the maternal object in early childhood was never completed, leaving a persistence of

sybiotic ties and needs. He does incorporate a psychosexual point of view, adding that the retreat from femininity into anorexia at adolescence served to protect these patients from any kind of rivalry or fantasied oedipal victory over the deceased mother, for whose death they already felt responsible. Many of these factors are commonly found in anorexia. What distinguishes these four cases is the added factor of an identification with a mother who literally died of a wasting illness--a parallel to the case to be discussed in Chapter III below. We might also note the progression in these four cases from bulimia, representing untrammelled expression of the anaclitic needs, immediately after the severe loss, to anorexia, representing an extreme introjective defense in response to adolescence, fears of intimacy, and increased oedipal guilt due to sexual activity. While both the bulimia and the anorexia served to deny loss, they did so in different ways; the anaclitic/introjective model helps to illuminate these differences and the reasons why the patients progressed from one illness to the other.

A related and theoretically richer study is that of Friedman (1985), who highlights the phenomenon of "survivor guilt" in anorexia nervosa. As Friedman notes, the concept of "survivor guilt" was first coined by Niederland in reference to holocaust survivors and was later broadened by Modell to apply to "more subtle forms of survival," i.e., to what we might term psychic survival. Modell distinguished two types of survivor guilt--"separation guilt," based on the belief that separating from parent or family will damage or destroy them and "depletion guilt . . . based on the belief that taking is at someone else's expense" (Friedman, 1985, p. 26). These guilt feelings are based in a fundamental human concern for others, a basic "fear of harming the object" which cannot be reduced to a defense against the fear of being harmed by the object (as a classical viewpoint would tend to argue). Friedman eschews the issue of which fear is primary, emphasizing that the concept of survivor guilt provides an "orienting point of view" with powerful explanatory and therapeutic leverage. He adds to this an interpersonal and family systems viewpoint which, rather than focusing exclusively on intrapsychic experience, also emphasizes the "reality" of the patient's interpersonal world. Friedman relates several cases where "parental neediness, vulnerability and, at times, implicit or explicit

blaming" for a desire to separate led the patients to believe that such an act of individuation "had damaged or would damage their parents" (p. 29). In fact, he notes that these compliant patients often masked their separation guilt under a surface of apparent separation anxiety, thus meeting their family's needs and demands. He reports the case of a patient who showed this behavior in a very clear manner as a child and who later had several very severe anorexic episodes, upon making the attempt to separate from her family of origin and later from her husband; these attempts were "characterized initially by an increase in pleasurable and selfish activity and in productivity," but would end in hospitalization for anorexia nervosa. This particular vignette is mentioned since it shows a parallel to some of the events in the case reported in Chapter III. Friedman stresses that anorexia nervosa so often begins in adolescence because this is a time when the need to separate and individuate becomes more pronounced. Anorexics "experience these needs as disloyal and damaging to their parents." Once starving themselves, "it is as if they feel that, since they are no longer 'taking', they owe less compliance" (p. 33). Furthermore, their masochistic self-denying stance, as manifested in their feeding of others, is a way of outdoing the usually masochistic self-denying mother, towards whom they feel guilty; this allows the anorexic to go from feeling guilty and worrying about what she has been taking from others to feeling "implicitly reproachful" and having others worry about her. Furthermore, it helps her deal with her profound fear of incurring her mother's envy--an analysis very much in keeping with Chernin's (1985) "feminist" perspective--by removing any possible cause for it. Also many anorexics have mothers who appear to have little control over their own lives, whether they suffer from overweight, alcoholism or depression; for these patients, self-starvation is "both proof of their separateness from their mothers and punishment for their separateness" (p. 34). From a therapeutic perspective, Friedman emphasizes the need for the patient to begin to realize that separating is not tantamount to murder. Friedman suggests that Charcot's famous cure of the anorexic young girl from Angoulême (also mentioned in Bell, 1985, and Brumberg, 1988)--whose worried parents he sent away and for whom his masterful,

authoritative manner was so persuasive--was in fact a "parentectomy," which showed the girl that separating would destroy neither her nor her family.

To summarize the above analysis--we have located anorexia nervosa within the anaclitic/introjective model as a cross-over phenomenon. An individual with a generally anaclitic personality, usually of the infantile type, and thus vulnerable to anaclitic loss and anaclitic depression, reacts to the need for greater separation at adolescence by making a drastic leap into the exaggerated introjective defensive system of anorexia nervosa. Like all introjective defenses, at the symptomatic level it is counteractive, i.e., a compromise that strikingly expresses both the underlying needs/impulses and the defenses against them. The anorexic accentuates her physical separation from her mother, while remaining childlike and dependent on her parents. She refuses to take in food--a symbol of maternal nurturance--but in some cases (e.g., those reported by Ceaser, 1977), her emaciation is also a direct incorporation of an emaciated mother. By feeding others, she achieves some vicarious gratification, but mainly accentuates separation and outdoes a self-denying mother. She strives for independence, but often winds up helpless in the hospital. At an underlying level, the anorexic system is based on an introjective mechanism--the projection of the internalized bad mother imago into the body, which is kept under tight reign and persecuted, albeit usually not with the intention of totally destroying it. These introjective mechanisms and the role of survivor/separation guilt (Friedman, 1985) are an important link between anorexia nervosa and its sister illness, introjective depression. Anorexia's surface presentation is closely tied to that of another sister illness, obsessive-compulsive syndrome. The underlying anaclitic personality accounts for the similarities to hysteria, and particularly for the desperate need for approval and the wholesale espousal of the cultural values. Finally, like obsessive-compulsive syndrome, anorexia often serves as a defense against more primitive and disintegrative phenomena.

Yet another question arises from this analysis: why this particular introjective phenomenon rather than some other one? Why is it that "good little girls," who seem so incapable of rebellion or simple self-assertion in other areas, should so regularly resort

to food refusal in a last-ditch effort to establish autonomy? The reasons for this are no doubt myriad and complex, as we will see in the next section. They include socio-economic factors, e.g., the fact that food is the traditional precinct of women, the only sphere that is fully under their control, and thus the only gratification they can truly renounce. However, there appears to be a fundamental aspect to food refusal that goes beyond even this. The clues may lie in the basic psychobiological identification between mother/woman and food and in processes of early development. Spitz (1957), in a study on the "genesis of human communication," draws a compelling link between the faculty of refusal/negation and early feeding behaviors. Spitz noted that the "semantic 'No' gesture," which is a widespread symbol for refusal or negation consisting of a back-and-forth horizontal movement of the head, represents a milestone in both cognitive and emotional development. It is acquired around the age of 15 months and is the child's "first conquest of the gestural or verbal symbol of an abstract concept" (p. 99). It is also one of the earliest manifestations of the ego's judgment function and plays a huge role in the child's relationship with his environment. Spitz traces the semantic "No" gesture to two sources. Its motor pattern, he asserts, is derived from the earliest motor pattern of the neonate, the "rooting" reflex. This consists of a back-and-forth horizontal movement of the head elicited when the infant is placed at the breast or when its perioral region is touched; this inbuilt mechanism serves as a scanning behavior; once the lips encounter the nipple, they grasp it and the head movement stops. Rooting itself is a very primitive physiologically based behavior which disappears after a few months, as the child's coordination and visual perception improve so that it can secure the nipple with one sweep of the head. However, at this point, another similar motor behavior appears. Whereas, in the first half year of life, once satiated the infant simply fell asleep, he now begins to indicate satiation by turning "his head from side to side energetically, away from the pursuing nipple" (p. 93). This "avoidance behavior" is motorically similar to rooting, but has the opposite purpose and meaning. Rooting is the source of the motor pattern for both this avoidance behavior and the later semantic "No" gesture. The avoidance behavior is, in turn, the ideational source of the semantic "No."

Spitz substantiates this theoretical analysis with his observation of a 2-year-old girl who, for medical reasons, had been fed through a gastric fistula and had never experienced oral intake. When this child wanted to refuse a social encounter with Spitz, who was attempting to communicate with her--a situation in which a normal child of her age would resort to the semantic "No" gesture--she waved him away, using the same hand gesture that she used to wave away the gastric fistula when she was not hungry. After an operation which allowed her to be fed by mouth, this child developed both the semantic "No" gesture and oral language--an unusual set of events that supports the profound link between the bodily experiences of being fed, object relations and cognitive development. In short, Spitz's observations provide a very clear and concrete link between early feeding experience on the one hand and the faculty of refusal and negation on the other, which helps to account for the power and prevalence of food refusal as a primitive form of self-assertion. As we will see in the next section, anorexia nervosa is a very modern disease, but food refusal, particularly among women, has a long and complex history, which can in turn allow us to view anorexia nervosa from a broader perspective.

3. Anorexia Nervosa Within the Larger Context of Female Self-Starvation Phenomena

The previous section of this chapter located anorexia nervosa within the modern psychiatric compendium. However, it has recently come to light that the illness which we know as "anorexia nervosa" is only the most recent form taken by the much broader phenomenon of female self-starvation in Western culture. In light of the focus of this study, namely the more marginal psychotic phenomena that occur in individuals with anorexia nervosa, and particularly in light of the specifics of the case to be discussed in Chapter III, it behooves us to review this history.

While single-minded dedication to restricted eating in the service of attaining the perfect body configuration is a fairly recent development in Western civilization, female self-starvation for a variety of motives and under a variety of explanations can be traced back to at least the Middle Ages, if not before. A pioneer in this area is Bell's

(1985) study of the striking phenomena of self-starvation among medieval holy women, specifically "the 261 holy women officially recognized by the Roman Catholic church as saints, blesseds, venerables, or servants of God (included in the Bibliotheca Sanctorum) who lived between 1200 and the present on the Italian peninsula" (p. x). Bell found that about half or so of the 170 holy women on whom detailed documentation was available had manifested extreme food restriction and self-starvation behaviors, in a number of cases leading to death from either inanition or its sequelae. On a dozen or so of these women the documentation was extensive and indeed Bell goes into considerable detail, giving a fascinating account of this era. Bell's thesis is that these women manifested "holy anorexia," a phenomenon which he views as the medieval counterpart to modern anorexia nervosa. He argues that their practices far exceeded the usual level of fasting and self-abnegation manifested by those who adhered to the conventional religiosity of the period. Over time these women, partly because of the iron-willed determination which they demonstrated, came to be recognized as exceptionally holy and to be venerated, often after they had achieved the ultimate physical self-destruction.

Bell's description makes it clear that holy anorexia was far from identical to modern anorexia nervosa. The holy anorexic restricted her eating as part of a larger picture of "austerities" and mystical experiences based in a philosophy of self-denial and self-punishment; this generally included extreme self-flagellation and self-mutilation, as well as mystical visions. She sought union with God, pursuing a radical course of spiritual perfection, rather than an individualistic goal of physical perfection. However, Bell tends to stress the parallels rather than the differences between the two phenomena, which lie in the intense struggle for control and autonomy found in both modern anorexics and in these medieval holy women. In many cases, these women espoused their path as a way of avoiding or escaping from an unwanted marriage and then maintained it in the face of tremendous opposition and skepticism from both their families and the church establishment; thus Bell views holy anorexia as based in a rebellion against patriarchal authority:

The medieval Italian girl striving for autonomy, not unlike the modern

American, British, or Japanese girl faced with the same dilemma, sometimes shifted the contest from an outer world in which she faced seemingly sure defeat to an inner struggle to achieve mastery over herself, over her bodily urges. In this sense the anorexic response is timeless. And at least temporarily, it is a real and powerful victory over the only thing western (or westernized) society allows a teenage girl to conquer--herself. But victory leads to self-destruction, and this violates the culture's belief that all its healthy members must exhibit a will to live. In the twentieth century such "deviant" cases are turned over for cure to the physicians, gods of scientific rationality, with very mixed results. In earlier times similar behavior called for the intervention of priests, male guardians of a patriarchal theology that understood woman as Eve in all her wickedness, also with very mixed results. Many were the witches, a few the saints, an unknowable number the "cured" who gave up their destructive autonomy and submitted to a husband or led lackluster single lives, and another unknown number those who starved themselves to death anonymously. (p. 56)

Holy anorexia and anorexia nervosa share a very important quality. In both cases, the women rebel by taking conformity to the cultural ideal to an extreme. This aspect, which leads to initial social reinforcement of their behavior, accounts for the beginning, for what Brumberg (1988) terms "the recruitment phase." Both Bell (1985) and Brumberg (1988) attribute the later chronic phase to the physically and psychologically addicting aspects of self-starvation in individuals whose sense of self comes to be inextricably entwined in this pattern of behavior:

The modifier is the key; whether anorexia is holy or nervous depends on the culture in which a young woman strives to gain control of her life. In both instances anorexia begins as the girl fastens onto a highly valued societal goal (bodily health, thinness, self-control in the twentieth century/spiritual health, fasting, and self-denial in medieval Christendom). Her peers, and especially her parents, pursue this goal with only marginal success, more often than not honoring it only in the breach. She, by contrast, emerges from a frightened, insecure, psychic world superficially veiled by her outwardly pleasant disposition to become a champion in the race for (bodily/spiritual) perfection. Her newly won self-esteem and confidence initially receive the approbation of those she depends upon--parents, teachers, counselors--causing her to deepen her self-denial pattern until it takes over as the only source of her sense of self. Anorexia becomes her identity, and ultimately the self-starvation pattern continues beyond her conscious control. (Bell, 1985, p. 20)

Thus holy anorexia results from the intersection of "the psychological dimensions of self-starvation" and "the cultural imperatives of medieval holiness" (Bell, 1985, p. 21).

Furthermore, according to Bell, holy anorexics successfully challenged the patriarchal forces of their time by their insistence on forging a personal connection with God and thus broke ground along the paths of spiritual development, creating new models for female holiness. Bell never truly addresses the question of why these models

should be centered around self-starvation--a provocative question that will recur in this review. Bell does refer briefly to an earlier work with Donald Weinstein comparing male and female saints and their "differing perceptions of the locus of sin"; they found that "for women, evil was internal and the Devil a domestic parasitic force, whereas for men sin was an impure response to an external stimulus, one that left the body inviolate" (Bell, 1985, p. 16). While this suggests an interesting psychobiological explanation for the apparent predominance of extreme fasting in women as compared to men--an explanation which is consonant with Palazzoli's (1978) theory of anorexia nervosa--Bell does not take this question any further.

Bell's general psychological analysis--as opposed to his specific analysis of individual holy women's vitae--is that the holy anorexic tended to be a youngest child, favored and special in her family, and often experienced the loss of someone close to her; her reaction was to attribute the blame for this loss to her own body, which she viewed as hopelessly corrupt and impeding her salvation. In other words, Bell seems to suggest a Catholic medieval variant of Palazzoli's (1978) analysis, with a component of survivor guilt as per Ceaser (1977) and Friedman (1985). These factors combined with a need for autonomy so powerful that it had to include freedom from both the demands of the body and the strictures imposed by church authorities:

Just as critical as the course of this war against bodily urges, wherein the quest for autonomy is purely internal, is the contest for freedom from the patriarchy that attempts to impose itself between the holy anorexic and her God. . . . The holy anorexic rebels against passive, vicarious, dependent Christianity; her piety centers intensely and personally upon Jesus and his crucifixion, and she actively seeks an intimate, physical union with God. Once she convinces herself that her spiritual bridegroom communicates directly with her and she thereby achieves true autonomy, the commands of earthly men become trivial. Her total dependence upon God's will, ultimately hailed as heroically virtuous by the very patriarchy she is rebelling against, legitimizes her defiance and places her in a position of enormous strength. For in her actions on earth the "will of God" to which she yields is a force she alone interprets and arbitrates. . . . Her will is to do God's will, and she alone claims to know God's will, an assertion not quickly or easily allowed by suspicious male clerics anxious to defend their powers against female interlopers. Only a very few women had the stamina and charisma to sustain such a claim, and even among these holy anorexics there is no reason to suggest that they intended in a careful and planned way to appropriate male prerogatives (a statement that would have to be modified were we to expand our scope to include anorexic heretics). Intentions aside, however, holy anorexics did in fact break out of the established boundaries within which a male hierarchy confined female piety, and thereby established newer and wider avenues for religious expression by

women more generally. Although recovered anorexics usually led satisfying personal lives, it was more often their sisters who starved themselves to death without ever reaching psychological equilibrium and absolute certainty about their autonomy, who spearheaded advances in women's religiosity. (Bell, 1985, pp. 116-117).

Bell's analysis presents a number of difficulties. First of all, Bell classifies these women into three categories. The first group--which includes Saint Catherine of Siena as its most prominent member, pursued anorexia to the point of death. The second group--which includes Sister Veronica Giuliani and Clare of Assisi, the first of the holy anorexics and the founder of the Poor Clares--consists of women who were "cured" usually in a convent, learning to fast in a controlled manner and to "express [their] need for autonomy in more positive ways" (p. xii). The third group consists of married penitents whom Bell categorizes separately because they do not fit the typical picture of adolescent holy anorexia, but whose behavior appears similar to that of the first group. This last category reflects Bell's confusion between the core of the syndrome and what Andersen (1977) would term "presentation" variables, i.e., its usual demographic incidence.

As already mentioned, the practices of these holy women went far beyond the modern illness of anorexia nervosa and generally included extreme self-flagellation, self-mutilation and other "austerities," as well as visions and other hallucinations; however, like the modern anorexic, these women claimed that they could subsist on extremely small amounts of nourishment and continued to engage in tireless action, in the form of "good works." If we may take the same liberty that Bell does in analyzing these vitae from the perspective of modern psychiatry, the flavor is often more that of hysteria (with the exception that these women remained extremely energetic), if not outright psychosis. Indeed, Bell tends to use the term "anorexia nervosa" somewhat promiscuously, even going so far as to assert that the celebrated hysterics Fraülein Anna O. and Frau Emmy von N. (Freud & Breuer, 1895) were also anorexic, whereas we would view them as showing hysterical food refusal as one of many symptoms within the "protean" (Nicolle, 1939) picture of hysteria. Furthermore, Bell--in this book at any rate--does not provide a meaningful control group, e.g., a group of male saints against whose

behavior we might measure the extremes that the holy women manifested.

Finally, Bell engages in a psychological analysis which is quite compelling and also quite problematic. He explains the behaviors of the individual women whose stories he presents in terms of their early upbringing and the conflicts and personality traits that resulted from it. For example, several of the married penitents had a history of early abandonment and in turn abandoned their own children to pursue a path of holiness combined with ferocious self-torture and self-reproach. Catherine of Siena experienced severe losses (notably the deaths of two siblings) which were closely connected to the intensification of her ascetic practices. She was also, according to Bell, favored and indulged as an infant, then suddenly weaned and deprived of maternal attention; later she was frequently reminded of her favored status and of all the sacrifices that had been made for her--very much the interpersonal matrix of "separation guilt" as described by Friedman (1985). Indeed, Catherine chose to live her life of holy anorexia as a "tertiary" residing within her family home rather than as a nun living in a convent. She also combined extraordinary self-punishment and pseudo-humility with tremendous conviction, self-will, and even arrogance, dictating to popes, kings and queens what courses of action she thought they should take; Bell attributes her death to her failure to control the fate of the papacy and an awareness of how much her behavior had been based in self-will. Another interesting story is that of Benvenuta Bojani, who increased her self-tortures drastically at age 16 upon her mother's death; 9 years later, she "recovered" when her father died, but again wasted away and died several years after that, when her confessor was about to be transferred away. These specific examples are mentioned here because of their striking parallels to aspects of the case which will be presented in Chapter III. However, Bell's approach creates a fundamental problem. On the one hand, Bell glorifies these women's behaviors as a protest against the patriarchal order of the time and a determination to forge a new path along the road to holiness and spiritual development--he goes so far as to state that "the suppression of physical urges and basic feelings . . . frees the body to achieve heroic feats and the soul to commune with God," eventually becoming self-perpetuating and leading to death as "a logical, sweet, and total

liberation from the flesh" (p. 13). On the other hand, he subjects these women to a detailed analysis which reduces their behaviors to the consequences of their painful early upbringing and their family conflicts, i.e., to psychopathology. The contradiction is that, if indeed holy anorexia was the counterpart of modern anorexia nervosa and a pathological way of seeking power and autonomy via self-destructive mechanisms, then only the "recovered" anorexics, who appear to be in a minority in Bell's book, can be said to have achieved true emotional and spiritual development; the others should then be considered examples of extremely self-destructive behavior, which was cast in the mold of the culture's belief system and in turn was espoused and venerated, leading to a more and more extreme cultural ideal via a spiral effect. Alternately, if holy anorexia was a legitimate way to achieve spiritual development, then the psychological analyses are somewhat reductionistic and perhaps even blasphemous. Bell tends to straddle the fence on this issue--although he does suggest a historical evolution to be discussed below.

Nonetheless, if we accept Bell's analysis, it supports our model of anorexia nervosa as an extremely exaggerated introjective phenomenon which occurs in response to underlying anaclitic needs and vulnerabilities. Bell himself stresses Catherine of Siena's formidable love affair with the breast, in which--he hypothesizes--she was terribly indulged as an infant and then suddenly terribly deprived, leaving her with an intense longing to return to the period of blissful symbiosis; indeed some of her writings, as quoted by Bell, are quite striking in their use of imagery regarding breast feeding and mother's milk. Davis (1985), in his epilogue to Bell's book, makes the interesting point that the holy anorexic sought a direct connection and union with God (presumably a perfect anaclitic state), while remaining removed from human relationships, just as the modern anorexic maintains an intensely personal relationship with her diet, while avoiding connection with other people. He adds that the urge for connection with others emerges on recovery, taking the form of a wish for symbiotic merger-like relationships, and that the need at this point is for the patient to accept the limitations of actual human relationships. Thus Davis stresses the holy anorexic's intense need for

connection at a fairly primitive boundary-less level (the anaclitic factor), whereas Bell tends to emphasize her quest for mastery and autonomy (the introjective defense).

The most enlightening study of self-starvation in women is that of Brumberg (1988), who takes a broader perspective, tracing the entire history of women's use of the "control of appetite, food and the body as a focus of their symbolic language" (p. 2) from the Middle Ages up to modern times. For Brumberg, "even when an illness is organic, being sick is a social act" (p. 5), and all the more so in the case of mental disorders. Brumberg concurs with Bell's view that women use food and appetite as a form of expression more than men and have done so throughout the history of Western civilization; although she states that this includes feeding and eating behaviors rather than simply starvation and food-restriction, the latter remain the focus of her book. Brumberg takes issue with the tendency to equate the phenomena of female self-starvation in earlier times with modern anorexia nervosa; rather she focuses on the cultural forces that have shaped female self-starvation through the centuries and the ways in which anorexia nervosa, as we now know it, is very much a "cultural artifact" of our time (p. 3), evolving out of the historical forces of industrialization, the development of a middle-class bourgeois lifestyle centered on the nuclear family with a prolonged period of adolescence, popular ideas about gender, class and ideal female beauty, and modern child-rearing practices. Brumberg's book is a detailed account of the transformation process that female self-starvation behaviors have undergone and the forms they have taken along the way--from the "holy anorexia" of the Middle Ages, through the 17th and 18th century "fasting girls," to the Victorian hysterical behaviors, and finally the 20th century illness known as "anorexia nervosa." A notable aspect of this process--and one that is very relevant to the case to be discussed in Chapter III--is the manner in which female self-starvation became separated from the religious and spiritual aspect which was so intrinsic to it in medieval times and which remained prominent until the late 19th century. Brumberg describes this process as "the transition from sainthood to patienthood" or, more technically, "the secularization and medicalization" of female self-starvation (p. 4), a development which turns out to have been an extremely gradual one,

with a long chain of women ensuring the continuity between the holy anorexia of the Middle Ages and modern anorexia nervosa.

Bell (1985) had begun to sketch this out in his description of the decline of holy anorexia in the Catholic world. According to one of Bell's tables, the actual number of women whose holiness received official recognition from the Catholic church showed a general decline from the 16th to 20th centuries. Nonetheless, the percentage that manifested the holy anorexia pattern remained quite high in the 17th and 18th centuries and the behavior continued to appear even into the 20th century. However, Bell suggests that the model of female piety that holy anorexia embodied did show a qualitative decline after the Middle Ages. He bases this view on the assertion that the later post-Reformation vitae lack the heroic mystical qualities and the vitality of the earlier ones and are more didactic in tone, reflecting ever more prevalent concern among male clerical authorities with differentiating sainthood from heresy. This increased scrutiny, in turn, resulted in even more extreme behaviors on the part of those women who passed the test. Furthermore, there was considerably more emphasis in these stories on themes of sexuality and aggression and on the perils faced by women who strike out on their own, reflecting a more misogynistic viewpoint. Over time, the lives of the holy anorexics began to emphasize physical illness as the principal theme; this became "the alternative to heresy, sorcery, or insanity as the male clerical explanation of holy anorexic behavior" (p. 172). Bell also implies that these later holy anorexics showed a "me too" quality--to paraphrase Bruch's phrase regarding modern anorexics (as quoted by Brumberg, 1988, p. 14) and draws a parallel to "19th century American 'hysterical' spinsters and 'chlorotic' female adolescents" (p. 177). Bell takes the opportunity to place spiritual behaviors within a cultural context, in the following manner:

Behavior once deemed to have been supernaturally inspired may well be seen in a different light as the product of human emotional development. Nor is the spiritual achievement rendered any less meaningful because it is human. The holy anorexia of Clare of Assisi or Catherine of Siena was, in its time, both holy and anorexic, a positive expression of self by a woman in response to the world that attempted to dominate her. With the Reformation, however, female religious autonomy came to be seen as heretical or as the work of the devil. Since the Church was passing judgment upon proposed saints, something less negative was bound to emerge, and it did in the model of the suffering holy female, immobilized

and racked by pain. However, while male prelates found this acceptable as proof of saintliness, holy women came to do so less frequently, turning instead to good works. Ultimately even male authority conceded that illness was not saintly, and so holy anorexia disappeared as an inspired mode of religious self-assertion. (pp. 178-179).

By the 19th century, "tireless charity, teaching, and care" began to triumph as the model for "women inspired to outstanding holiness" (p. 179). In short, Bell suggests that the Catholic church experienced a similar process of "medicalization and secularization" (Brumberg, 1988) of female self-starvation as did the wider culture, with the same hysterical forms emerging in the transition phases.

Brumberg (1988) traces this process of transformation as it occurred within the wider culture outside of the Catholic Church. She notes that the term "holy anorexia" is a recent coinage attributable to Bell (1985). The physicians of the 17th and 18th centuries used the terms "inedia prodigiosa (a great starvation) and anorexia mirabilis (miraculously inspired loss of appetite)" (Brumberg, 1988, p. 42) to refer to young women who were popularly known as "miraculous maids"; later, as a more skeptical viewpoint gained sway, they tended to be designated by the more sarcastic phrase "fasting girls." In the earlier modern period, they tended to be young girls from continental Europe, where the Catholic tradition remained strong. Later, in the 17th and 18th centuries, they often came from rural areas or small towns in the British isles. They were generally from a humble background and showed severely restricted eating, often claiming to subsist on very tiny amounts of delicate, almost ethereal substances--which underscored their symbolic purity--or even to abstain completely from oral intake of any kind. These girls--like the holy anorexics of the Catholic world--laid claim to "miraculous fasting," i.e., being able to subsist without food for prolonged periods of time, often years; they also claimed supernatural healing powers. But, unlike the holy anorexics who remained tirelessly active, these young girls often took to their beds in a weakened state (thus showing a more hysterical type of behavior). Their families tended to support their claims, and, by virtue of the popular belief in their powers, they often became quite celebrated, attracting the attention of the press and the public and reaping the benefits of their fame in monetary form. As time went on, authentication of their

claims became a major issue and an arena for the battle between the world view of medicine and scientific rationalism on the one hand and that of religiosity and spiritualism on the other. In several cases watches and investigations were instituted, with both physicians and clergy becoming involved. In at least a few cases, stringent investigation unmasked some degree of deceit, i.e., the sneaking of small amounts of food or liquid nourishment. The 18th century "Fasting Woman of Tutbury," Ann Moore, was found to have done this and made a public apology and retraction of all her claims. The well-known "Fasting Girl of Wales," Sarah Jacob, died in December, 1869, after a watch had been instituted; autopsy produced evidence that she had been fed in small amounts prior to the beginning of the watch. Nonetheless, these cases neither settled the matter nor put an end to the phenomenon. The "brouhaha" centered on the claim of these women that life could be sustained without food, which appealed to spiritualists, but flew in the face of scientific common sense. The Victorian medical establishment was especially uncomfortable with "anorexia mirabilis" as "a distinctive form of female religious empowerment that was incongruent with the material facts of the contemporary world" (Brumberg, 1988, p. 75). What often was ignored in the midst of all this controversy was that, even in cases of deceit, these women did subsist on very small amounts of food, engaging in prolonged dietary restriction. Indeed, investigation did not always find evidence of deceit. For example, Kate Smulsey, the "Fort Plain [New York] Fasting Girl," died in 1885, after claiming to fast for over a year; autopsy indicated that her stomach and intestines were empty and that she had died of tuberculosis. Nor was the phenomenon ultimately confined to rural areas or young women of humble background. Mollie Fancher, first known as "the Brooklyn Enigma" and later as "America's Most Famous Invalid," was from a middle-class background and a major urban center; she was also relatively well-educated. Her illness, which began as "dyspepsia" associated with fainting spells, progressed into apparent conversion symptoms (periodic blindness, deafness, contortion of limbs) and assertion of mystical clairvoyant powers. She claimed to eat little or nothing for 14 years and spent 50 years "in bed," dying in 1916 at the age of 68. She was at the center of a debate between regular physicians who were primarily

concerned with questions of deceit and authentication and neurologists who viewed her behavior as evidence of hysteria. In the end, the neurologists prevailed.

Cases of "fasting girls" were found in American newspaper reports as late as 1910. But, more and more, around the turn of the century these young women tended to appear hysterical rather than holy, both in their own eyes and in those of others:

In the history of female fasting behavior, the nineteenth century was a crucial divide. During those hundred years food refusal was transformed from a legitimate act of personal piety into a symptom of disease. This was a matter of behavior as well as classification. Food refusal because of so-called divine empowerment became so infrequent that it was easily cast as a form of aberrant behavior by the emerging psychiatric specialties. . . . By 1910 the religious delusionary had disappeared entirely from classifications of malnourished individuals. This development suggests that the locus of appetite control and food-refusing behavior had moved from the religious realm to the secular: patients were simply not articulating reasons of faith when they did not eat. (p. 98)

There is a final point to the story: there were, in fact, no "fasting boys." That women and girls, even as late as 1900, continued to claim prolonged abstinence through divine empowerment suggests that secularization may move at different rates depending on gender . . . The existence of fasting girls suggests that some women clung to supernaturalism, belief, and ritualistic practices longer than men. They seemed to have needed, either as ideological sustenance or as opiate (depending on one's point of view), the supports that religion can provide. Deprived of many worldly sources of empowerment, some Victorian girls chose to draw instead on the lingering tradition of anorexia mirabilis. In this way the nineteenth-century fasting girl was a provocative relic, in a secularizing age, of an older female religious culture. (pp. 99-100)

The reason why this female religious culture remained so entwined with food and starvation is a tantalizing question that Brumberg tends to leave aside, as indeed did Bell (1985).

Brumberg takes issue with the commonly held view--mentioned in Chapter I above--that Richard Morton "discovered" anorexia nervosa in 1694; she suggests that the case he reported did not yet show the characteristic pattern we now know as "true" anorexia nervosa; neither was it a case of "anorexia mirabilis," for no spiritual claims were made. In fact, judging by the case report as quoted by Bell (1985), the young woman presented a mixed picture with both anorexic symptoms (hyperactivity and primary amenorrhea) and hysterical ones (fainting fits). Morton attributed the patient's amenorrhea to "a multitude of Cares and Passions of her Mind" (Bell, 1985), thus implying emotional causation.

In any case, the term "anorexia," which literally means loss of appetite, was considered a symptom of many diseases, as indeed it is. The behavior of food refusal was of particular concern in the insane asylums of England and America, where it could take many forms and lead to serious consequences.

In 1859, in the American Journal of Insanity, William Stout Chipley (1810-1880) published the first American description of sitomania, a "phase of insanity" characterized by "intense dread of food." ("Sitomania" and "sitophobia," from sitos, Greek for "grain," were interchangeable terms and they were included as diagnostic categories in American medical dictionaries.)

Chipley's clinical description of sitophobics made the usual distinctions between organic and moral causes, and in the latter category he elaborated the two most predictable types: those who feared poison in their food and those who sustained "belief in a divine command, or other supernatural direction, not to eat." (Brumberg, 1988, p. 106)

Thus, there were individuals who abstained from eating for religious reasons, but they were given no specific diagnostic category other than the broad term "sitophobia" and were generally found in insane asylums. On the other hand, Chipley also observed a different type of food refusal in young women "predisposed to hysteria," who were not fasting girls and whom he also included under the label of "sitophobia":

The sitophobe said she had no appetite or that eating distressed her, but she claimed no special powers. Neither did her parents make or supply any public pronouncements about the duration of her abstinence or her miraculous inspiration. Although sitophobes were the center of attention among close friends and relatives, they did not usually attract press coverage. . . . Chipley believed that sitophobic behavior tied an impulse for extraordinary suffering to a desire for attention. In other words, these girls sought martyrdom. . . . (Brumberg, 1988, p. 107)

These patients tended to come from middle-class backgrounds. Unlike the families of fasting girls, their parents did not concur with their behavior. Rather they sought medical help, but did not want to see their daughters treated in an insane asylum. Many of the girls could subsist outside of the asylums as long as their emaciation did not become too pronounced.

Brumberg (1988) shows how the modern diagnosis of anorexia nervosa evolved out of the medical establishment's socio-economic need for a diagnostic label that could be applied to these middle class girls whose families preferred treatment by private physicians or in private facilities, who in turn pursued their patronage. In fact, the disease was named, almost simultaneously in 1873, by the reputable Paris neurologist

Charles Lasègue and by Sir William Withey Gull, a celebrated London doctor who served as physician to Queen Victoria and her family. Lasègue called it "anorexie mentale," attempting to differentiate it from "anorexie hystérique," and stressed the family dynamics involved in the illness. Gull first referred to it as "hysterical apepsia" and later as "anorexia nervosa," the term which has remained in force. Gull was eager to "stake out" this turf for himself, probably in reaction to the notoriety of "The Fasting Girl of Wales" who had died just three years earlier. These events mark the emergence of anorexia nervosa as a distinct diagnostic label. They also mark its separation from both psychotic and spiritual phenomena, which were now viewed as intertwined when related to self-starvation--an important moment with regard to the subject of the present study.

The anorexia nervosa diagnosis . . . served to separate out the girlhood food refuser from those among the insane who would not eat. Sitophobia, the diagnosis proposed by Chipley in 1859, was a broad and imprecise subcategory of insanity in which adolescent girls were only one component. By contrast, anorexia nervosa was a discrete diagnosis associated with a specific age group and it suggested something important about the etiology of the behavior: lack of appetite was nervous (nervosa) in origin. It was evident, for example, that a patient diagnosed as having anorexia nervosa spoke of no divine commands; she heard no heavenly voices and saw no beatific visions. She was very thin primarily because she refused to eat. Thus, the nineteenth-century physician placed the girl with anorexia nervosa on "the borderline" of insanity. She was not crazy enough for the insane asylum, but she was too sick to remain without medical care. (In the language of contemporary psychiatry, she was neurotic rather than psychotic.) (Brumberg, 1988, p. 112)

Nonetheless, the disease itself, albeit given its modern label, had not yet fully emerged in its present form. Indeed, Brumberg traces the cultural factors which shaped it both during the Victorian era and through the first half of the twentieth century, accounting for the slow process of differentiation between hysterical phenomena and what we now know as "true" anorexia nervosa. The increased incidence of female self-starvation during the Victorian era is attributed to several factors. One is the emergence of the modern bourgeois family. Families began to have fewer children, nurturing them more intensely and prolonging their period of dependency into late adolescence and even early adulthood. Girls in particular were now protected from early marriage or labor outside the home. This led to the development of a "hothouse" atmosphere within the bourgeois household; it added to the "intensity of parental love" and control and in turn gave adolescent girls who refused to eat the power to disrupt their families--a

phenomenon strikingly described by Charles Lasègue. The pressures connected to the importance of making a good marriage and the stringent Victorian ideals of femininity further constricted emotional freedom and expression for these girls, leaving food refusal as an effective and acceptable form of nonverbal expression. This was fostered by parental tendencies to use food as a method of discipline and a way of expressing love. Of course, "the efficacy of food refusal as an emotional tactic within the family depended on food's being plentiful, pleasing, and connected to love"--a view very much in accord with Bruch's (1973) observation that anorexia nervosa is not found in times of scarcity. Furthermore, "refusing food at the family dinner table was a silent but potent form of expression that fit within the Victorian conception of decorum at table" (p. 140).

Brumberg describes how the Victorian ideal of the pale, delicate, "wasting" female (ironically modeled on Lord Byron) produced behaviors that we would now classify as hysterical food refusal and that, at the time, tended to overlap with several popular diagnoses, e.g., dyspepsia (weak digestion), chlorosis (anemia), and neurasthenia (nervous exhaustion), all seen as badges of the ladylike fragility to which Victorian girls aspired. Indeed, the Victorian girl was most concerned with appearing delicate, ethereal, and removed from the crude realities of the body and tended not to eat out of such scruples as a revulsion towards many foods (especially the ones considered "cruder"), stomach pains, and other hysterical types of phenomena. This stands in contrast to the modern anorexic's hardened devotion to athletic activity and insensitivity to bodily pain, which bring her closer to the medieval holy anorexic who engaged in prodigious good works while subsisting on next to nothing. Nonetheless, hyperactivity was sometimes present--e.g., in Morton's account as mentioned above and in one of Gull's accounts; in fact Janet, in his famous 1906-1907 Harvard lectures, stressed the suppression of fatigue and the concomitant feeling of euphoria, which he compared to that of the "ecstatic saints," as central to the dynamics of the illness (Bell, 1985, p. 12).

Brumberg traces the emergence of thinness as an intrinsic part of this ideal of femininity, particularly in the upper classes. Concomitantly, the quest for thinness came to be an observed or ferreted-out motivation in young girls diagnosed with hysterical

anorexia/anorexia nervosa--as seen, for example, in Charcot's celebrated discovery of the "rose-colored ribbon wound tightly around the waist of a patient with anorexia nervosa" (Brumberg, 1988, p. 165). Brumberg also shows how the sociocultural forces of the twentieth century--e.g., the emphasis on woman's role as feeder of the family, on "rational" feeding of children and control of their eating and weight, the changes in the female ideal of beauty--in turn promoted the development of the modern "superwoman" ideal and the spread of eating disorders among young women. Her emphasis on the intrusive control of children's eating as a factor is consonant with the views of Bruch (1973) and Palazzoli (1978), both of whom suggest that the anorexic's inability to tune in to bodily signals is in part a deficit phenomenon, stemming from an early upbringing in which parental control replaced inner bodily cues for hunger and satiation. However, Brumberg also does not minimize the degree to which the culture's espousal of the ideal of the thin superwoman has promoted the development and spread of the illness. In other words, the search for thinness is not simply a rationalization for an addiction to starvation--as Szmukler and Tantom (1984) would have it--but rather a very real motivating force, particularly in the "recruitment" phase of the disease. Brumberg also does not minimize the effect of bulimic urges, promoted by a culture in which food is ever-present and constant snacking--a boundary-less and chaotic manner of eating--has replaced the earlier emphasis on traditional mealtimes, particularly among adolescents and college students. In short, she views the eating disorders as intimately related entities and their spread as symptomatic of multiple and pervasive changes in the culture.

Both Brumberg (1988) and Bell (1985), in their ground-breaking work, illuminate the unity and differences among the various forms of female self-starvation in the course of Western history. The unifying thread, as identified by Bell and Davis (1985), consists of the addictive aspect of self-starvation and the paradoxical combination of slavish conformity to the cultural ideal, allied with entrenched opposition to authority expressed by taking this ideal to its extreme. To rephrase this formulation in terms of our own model, it reflects both the underlying anaclitic neediness, which leads the self-

starver along her desperate search for approval and her wholesale espousal of the cultural values, and the leap into the introjective mode, which leads her to self punishment, denial of all bodily and emotional needs, extreme emphasis on self-definition and self-empowerment through starvation, and extraordinary dedication to her chosen road in the face of any and all opposition. The second aspect of this historical review, which is of specific relevance to the case presented in Chapter III, is the intimate connection between female religiosity and self-starvation phenomena in earlier times and their modern separation, with spiritual reasons for self-starvation coming to be viewed as an indication of psychosis rather than holiness--an issue we will return to in Chapter IV below. The next section of the present chapter explores the clinical literature on psychotic phenomena among anorexics from the modern psychiatric perspective, with an emphasis on the application of the anaclitic/introjective model to individual case reports of psychotic decompensation among anorexics.

B. Review of the Clinical Literature on the Co-occurrence of Anorexia Nervosa and Psychosis

This section will address each of the questions in Chapter I based on the clinical literature on the co-occurrence of anorexia nervosa and psychosis. A summary subsection at the end will review the entire section, with a particular emphasis on Question 3 and the application of the anaclitic/introjective model.

Question 1a: Overall frequency of psychotic phenomena or psychotic illness among individuals with anorexia nervosa (size of the intersection)

Reports regarding the frequency of psychotic episodes or illness among individuals with anorexia nervosa vary, in part due to methods of measurement and definitional issues. Individual case reports have no direct bearing on this question. Thus we are limited to the figures provided by those investigators who have studied these events among clinical populations and will briefly review a few of those studies which most directly address the issue.

Hudson, Pope and Jonas (1984) reviewed the data generated by an ongoing study of 130 consecutive patients (125 women, 5 men) seen between 1980 and 1983 who met DSM-III criteria for anorexia or bulimia at any point in their lives. These patients came from four sources: (a) 25 were inpatients; (b) 66 were outpatients (half self-referred); (c) 20 were recruited through ads for a treatment study of bulimia; (d) 19 were recruited through ads for an interview study. Of these patients, 20 were described as having anorexia nervosa only, 40 as having anorexia nervosa and bulimia, and 70 as having bulimia alone. Thus we can consider that 60 individuals in the total population met the criteria for anorexia nervosa, with or without bulimia.

Seventeen of these patients had displayed psychotic symptoms by DSM-III criteria at some point in their lives. All 17 came from the two clinical sub-samples. Hudson et al. provide data on these 17 patients in table form. From this table, we can determine that 6 patients had a lifetime history which included anorexia nervosa (4 with only anorexia nervosa and 2 with anorexia nervosa and bulimia). Unfortunately, the table is somewhat ambiguous, in that one of the patients, in the section which gives a checklist for psychotic symptoms (the four possible choices being delusions, hallucinations, ideas of reference, and factitious symptoms), is listed as positive only for factitious symptoms. There is no detailed discussion of this in the body of the article, only a mention that in one patient "all of the psychotic symptoms appeared factitious" (p. 422). Thus, in the final analysis, we are left with a count of 5-6 patients with both psychosis and a history of anorexia nervosa, out of 60 with a history of anorexia nervosa. This yields an overall incidence rate of 8.3 - 10%.

Hsu, Meltzer & Crisp (1981) report on 6 patients who developed "schizophrenic illness" in the context of anorexia nervosa. These 6 patients were taken from a consecutive series of 105 female anorexia nervosa patients seen at a London hospital from 5/68 to 12/72. The criteria for diagnosis of anorexia nervosa were similar to those of DSM-III-R (15% weight loss, amenorrhea, "weight phobia") with the addition of an age limit (age of onset between 12 and 35). The criteria for "schizophrenic or schizophreniform illness" were fairly broad (presence of at least two from among a list

including auditory hallucinations, delusions, thought disorder and incongruous affect). Indeed, we can consider that these authors were addressing psychotic symptoms in general and, as we will see below, other investigators have quarreled with the categorization of these patients as schizophrenic and have suggested that they should be classified as suffering from affective or schizoaffective disorder. In any case, of the series of 105 female anorexia nervosa patients, 6 met the authors' criteria for schizophrenic symptoms, yielding an overall incidence rate of 5.71%, a much lower estimate than that of Hudson et al. (1984).

Grounds (1982) focuses on 7 patients admitted to a London hospital between 1961 and 1980 who had anorexia nervosa associated with a transient psychotic episode. These patients came from a series of 139 cases admitted with a hospital diagnosis of anorexia nervosa or bulimia during this 20 year period. All 7 patients carried a hospital diagnosis of anorexia nervosa, and, with the exception of 2, they even met the stringent Feighner et al. (1972) research criteria. All 7 showed at least one psychotic episode, in which there were hallucinations, delusions or marked thought disorder, with symptoms developing over a few days and completely remitting within 1-12 weeks of onset. There were 2 other patients who manifested some psychotic features but were not included in the study--one did not show the mixed symptom picture seen in all the other cases and the second did not show the severity of illness seen in the other cases. Grounds states that, in 2 of the cases included in the study, organic factors were implicated in the psychotic episode; indeed 1 of these cases was considered to be a toxic psychosis due to ampicillin. Thus, in the final analysis, we are left with the figure of 7, plus or minus 2, since 2 cases were omitted because of possible sub-clinical status and 2 others were included but may have been organic in nature. This figure of 7 out of 139 yields an incidence rate of 5%.

Ferguson and Damluji (1988) report on 12 patients with anorexia nervosa who "were found to have, or soon developed, schizophrenic psychopathology" (p. 344). These patients were taken from a series of 200 patients with anorexia nervosa according to DSM-III criteria, seen and evaluated by the authors over the course of 8 years in a pri-

vate practice in California. All "either currently or historically met the DSM-III criteria for anorexia nervosa" (p. 344) and all "currently met the DSM-III criteria for schizophrenia" (p. 345). However, the authors excluded a number of patients whom we would wish to include in our overall incidence estimates--specifically 2 male patients the nature of whose psychosis is not specified and 3 patients "with acute psychoses or psychoses that occurred during the period of weight gain" (p. 345). If we assume that each of the excluded categories is separate from the other and not overlapping, we would wish to add a count of 5 to the authors' total of 12 patients with psychosis. The authors also excluded 2 patients with organic psychoses and 3 patients with bulimia alone, an exclusion which we will maintain. All of this yields, for our purposes, a total of 17 patients with psychotic phenomena out of 195 (subtracting the 5 patients with organic psychoses and with bulimia alone from the sample total of 200), i.e., an overall incidence rate of 8.7%, an estimate intermediate between the lower figures reported by Grounds (1982) (5%) and Hsu et al. (1981) (5.71%) and the higher rate reported by Hudson et al. (1984) (8.3 - 10%). This, however, is a rough estimate; in response to queries regarding figures cited in this article, J. Ferguson (personal communication, March 1, 1989) stated that the overall population was actually between 200 and 250 and volunteered a rough estimate of 6% as the incidence rate of schizophrenia among anorexics from his experience in working with this disorder.

In short, from the reports reviewed above, the frequency of psychotic phenomena or psychotic illnesses among patients with anorexia nervosa would appear to lie between 5% and 10%.

Question 1b: Nature of the intersection -- relative proportion of brief episodes to ongoing illnesses

The sample reported by Hudson et al. (1984) consists of 17 patients (with a lifetime history of anorexia nervosa and/or bulimia) of which 16 showed psychotic symptoms which "appeared attributable to major affective disorder or schizo-affective disorder" and one showed what appeared to be a factitious psychosis (p. 420). The authors do not specifically mention the length of these illnesses; however, as they were

using DSM-III criteria, we can assume that none of these represent brief psychotic episodes. These authors did not do long-term follow-up, as their sample was collected between 1980 and 1983 and their report is dated 1984. However, since all the cases represent ongoing illness, this is not a crucial omission from the point of view of the present question. As noted above, 6 of these 17 patients were anorexics. We can consider that all of this sample showed ongoing illness.

Ferguson and Damluji (1988) chose to focus on the 12 patients in their overall sample of 200 who were female, anorexic and showed ongoing schizophrenic illness. They specifically note the exclusion of 2 patients with organic psychoses and 3 with non-organic psychoses which were acute or occurred specifically during the period of weight gain (exact duration not given). They also excluded 2 male patients whose duration of illness is not specified and 3 patients with bulimia but not anorexia nervosa. Thus--within the limitations of the information provided--we can state that out of their sample of female anorexics with non-organic psychoses (193 cases, as we are including the 3 cases that were acute but excluding the males whose duration of illness was not given, as well as the bulimics and the organics), 1/5 showed transient episodes and 4/5 showed ongoing illness, i.e., a relative proportion of 1 to 4 for transient illness versus ongoing illness. These authors do not mention the length of their follow-up, which would be important in making this distinction.

Grounds (1982) reports 7 cases of transient psychosis in an overall sample of 139 patients. Long-term follow-up data was available on some of these patients, which lends greater weight to the classification of these cases as transient psychoses. The author notes that "the psychotic symptoms were brief in duration, developing over a few days and completely remitting within 1-12 weeks of onset" (p. 110). One patient showed a recurrence of psychosis after she left the hospital against medical advice, but otherwise there were no recurrences "during periods of follow-up between 6 months and 10 years" (p. 110). We might add that the author describes all of the cases as showing a similar clinical picture of a mixed psychosis, which was neither typically schizophrenic nor typically affective. While a duration of 12 weeks is far longer than the DSM-III-R cut-

off point of one month, this consistent clinical picture supports the unitary classification of the 7 cases. Furthermore, the author provides brief individual reports for all 7 cases, from which it can be determined that 4 out of the 7 episodes lasted less than one month and that 3 of the 7 appear to have shown psychotic symptoms over a period longer than one month. One of the latter patients died of cardiac arrest, thus long-term outcome is unknown; the other 2 did recover and remained well 10 years after follow-up, which again supports the classification of their cases as transient illnesses, despite their surpassing the strict criterion of one month's duration. Thus we can consider all of this sample as comprised of transient psychoses.

Hsu et al. (1981) report a sample which is particularly relevant to the question presently under discussion, as the patients within it appear to fall rather clearly into one or the other of our two dichotomous categories (brief versus ongoing illness) and each category shows a certain degree of internal coherence. The sample of 6 cases with psychotic phenomena out of a total of 105 female anorexia nervosa patients is divided in the following manner. In 3 patients the "schizophrenic symptoms" appeared shortly after inpatient admission or when nearing target weight; they subsided rapidly with neuroleptic treatment, which was discontinued shortly after discharge with no recurrence of symptoms. One patient later had a serious relapse of anorexia nervosa and during refeeding again showed thought disorder, but recompensated rapidly with neuroleptic treatment. These 3 patients were given a diagnosis of "primary anorexia nervosa with transient psychotic episodes" (p. 275). The other 3 patients showed onset of psychotic symptoms 1 to 4 years after apparent recovery from anorexia nervosa; their "schizophrenic" symptoms were more persistent and all were on maintenance medication at follow-up, although no overt psychotic features were present at that time. Follow-up is described as "recent"; since the patients were seen from 1968 to 1972 and the report is dated 1981, the length of follow-up appears to be more than adequate to support the classification. Thus this sample appears to show a 1 to 1 proportion of transient psychosis versus ongoing illness, with each of the two categories showing distinct and coherent characteristics, particularly with regard to onset.

Unfortunately, a closer examination of some of the outcome data provided by Hsu et al. muddies the clarity of this distinction to a degree. Of the 3 patients with "transient psychoses" only one appeared to be living a truly "normal" life at follow-up. One lived with her mother and had all of her teeth extracted because of her "ugliness"; another was depressed and made a suicide attempt one year before follow-up (p. 275). Both these patients lived fairly isolated lives with few friends, but did show occupational functioning. One could even argue that the delusion of ugliness leading to tooth extraction was psychotic. However, for the sake of simplicity, we will concur with Hsu et al.'s distinction between the two sub-groups.

On a broader level, it must be noted any answer to the question of the relative preponderance of brief versus ongoing illness remains speculative and anecdotal, since different authors' samples appear to focus on different categories. Being restricted to small, naturally occurring populations with varying sampling biases and diagnostic criteria, we cannot make any generalizations in this area.

Question 2: Ongoing illnesses

This question addresses those individuals with ongoing illness and attempts to determine which type of ongoing illness is predominant and what the relationship is, if any, with anorexia nervosa in terms of both temporal onset and content. Here we will examine both reports of populations and individual cases.

Question 2a: Nature of the ongoing illness

As discussed above, an association has been noted in the literature between affective disorders and anorexia nervosa. This question will explore whether, among individuals reported as showing ongoing psychotic illness, this association appears to hold true. Thus we will be focusing on the classification of the ongoing illness.

The sample reported by Hudson et al. (1984) consisted of 17 patients with psychotic symptoms out of 130 with a lifetime history of anorexia nervosa and/or bulimia. As mentioned above, if we limit the sample to those with anorexia nervosa with or without bulimia, the sample shrinks to 6 out of 60 (with 1 of the 6 showing only

factitious psychotic symptoms). If we now examine these patients for type of psychosis, according to a table provided by the authors, we find 2 cases of Bipolar Disorder, 1 case of Schizoaffective Disorder, and 3 cases of Major Depression (1 of these being the individual whose psychotic symptoms were limited to apparently factitious ones). The authors state that, in the study as a whole, they found no cases of schizophrenia or organic psychosis. We might also note that 4 of the 6 patients were rated as positive for a family history of major affective disorder (first degree relative). None of the patients in the sample as a whole had any first degree relatives with schizophrenia. The authors argue that schizoaffective disorder is closer in nature to affective illness than to schizophrenia and that the study as a whole supports the view of a link between eating disorders and affective disorders and does not support any consistent relationship between eating disorders and schizophrenia.

Hsu et al. (1981) classify all 6 of their psychotic patients (both the 3 showing transient psychosis and the 3 showing ongoing illness) as having "schizophrenia or schizophreniform illness." The requirement for the diagnosis was the presence of "at least two of the following signs and symptoms: nuclear symptoms (voices discussing patient, delusions of control, thought insertion/withdrawal/broadcasting/echo), paranoid delusions, thought disorder, incongruous affect" (p. 273). With the exception of auditory hallucinations and paranoid delusions, these would indeed appear to be schizophrenic-like symptoms rather than affective ones. On the other hand, when we look at some of the data reported, the picture becomes less clear:

Five patients had paranoid delusions of people discussing how fat and ugly they were and avoiding them. Sample of talk from one patient: "The pork (that I have eaten) is growing inside me. It is showing on my skin. People are saying how bad and ugly I look." Four patients had auditory hallucinations of Schneiderian first-rank order of several voices commenting on how ugly, fat, or greedy they were. (p. 273-274)

Such delusions could in fact be classified as affective and indeed mood-congruent with depression. On the other hand, the authors add that 4 patients had formal thought disorder. From the table which lists specific symptoms, we can determine that 2 of these were patients with ongoing illness and 2 with transient episodes. In 1 of the 2 patients

with ongoing illness and thought disorder, the presence of incongruous affect is also noted. Both formal thought disorder and incongruous affect could be seen as arguing in favor of schizophrenia.

On the other hand, the authors themselves note the presence of prominent affective symptomatology in the psychotic sample as a whole. Five patients showed symptoms of depression before onset of the psychosis itself; 2 had made suicide attempts; one became hypomanic with the onset of psychosis. The family history data also leans in the direction of affective disorder, in that there were no immediate relatives with a history of schizophrenia, whereas there were 2 reports of affective disorder and 1 of paranoid illness. The authors themselves assert that "the prominence of affective features in the psychosis of 5 out of the 6 patients was striking" and that "they would all qualify for a diagnosis of schizoaffective disorder according to Kendell's criteria" (p. 276). Furthermore, Hudson et al. (1984) suggest that the patients in Hsu et al.'s (1981) report should be classified as suffering from affective disorder rather than from schizophrenia. Thus the classification of these cases is very much in question.

In contrast to the studies discussed above, Ferguson and Damluji (1988) report a sample with prominent schizophrenic symptoms. The authors stress the presence of the characteristic "negative symptoms"--"blunted affect, poverty of speech, ambivalence, and prodromal deterioration of functioning with isolation, role impairment, and peculiar behavior" (p. 345). The signs of schizophrenia and/or residual symptoms were present for at least six months. Furthermore, outcome was quite characteristic of schizophrenic illness:

The deterioration from a previous level of functioning was seen in all cases, along with social isolation, amotivation, anhedonia, and a thought disorder characterized by concreteness, blocking, and a paucity of thought . . . Poor judgment was universal.

Patients were seen at various stages in their anorexic illness and at different weights. Although there was clinical improvement at high body weights, with increased social contact, less withdrawal, and more ability to function in everyday life, the basic schizophrenic process was unchanged, and their overall social deterioration continued. (p. 345)

According to one of the tables, all 12 patients showed concrete thinking and poverty of speech, and 10 are listed as also manifesting perplexity, paucity of thought, and paranoid ideas. On listings of affect, 12 showed blunted affect, 12 showed labile affect, and 9 showed inappropriate affect. More specifically, the authors assert that all the cases met diagnostic criteria for the disorganized type of schizophrenia, as they showed "marked incoherence, blunted affect, without systematized delusions" and with "fragmentary delusions and hallucinations." They also tended to show "unusual mannerisms, hypochondriacal complaints, social withdrawal, . . . oddities of behavior, . . . extreme social impairment, and an early insidious onset of a chronic course without significant remission" (p. 350). In short, the diagnosis of schizophrenia seems well-supported in this sample.

The cases reported by Grounds (1982) will not feature in this analysis, as they are being considered under the "transient psychosis" category and will be discussed further below. There are several individual case reports in the literature which purport to be of cases in which patients show both anorexia nervosa and schizophrenia. However, a closer examination puts this view into question. Both Sumners and Cohen (1987) and Steinberg (1982) report cases which they consider to show schizophrenia in conjunction with anorexia nervosa, but which we will classify as showing psychotic episodes within the context of anorexia nervosa, although certainly the possibility of a future downward schizophrenic course cannot be ruled out--the first case is difficult to classify and the second one does not include long-term follow-up. These two cases will be discussed in some detail under Question 3 below.

A case of historical interest is the one reported by Dubois (1913); this case is presented as an example of anorexia nervosa as "prodromal" of dementia praecox. However, a closer examination puts the diagnosis of anorexia nervosa into question. On the one hand, the patient, a young girl of 16, appears to engage in volitional food restriction and is notably oppositional with her mother in several areas. On the other hand, she makes somatic complaints of a somewhat hysterical type (abdominal pains), shows no hyperactivity of any kind, and when asked why she refuses nourishment, her response is vague and circumstantial: "that she finds it quite useless to eat, that it

makes her suffer, that she cannot get along with her mother." No mention is made of concerns with weight or body image. This case appears to be the type that Bruch would classify as "atypical" and that we would call "hysterical self-starvation." Furthermore, the later evolution of her psychosis shows prominent mood features with oscillations between manic and depressive periods and also a chronic deterioration of functioning, all of which would probably qualify the patient for a diagnosis of Schizoaffective Disorder.

The conclusion with regard to Question 2a is much the same as for Question 1b. Different authors appear to be tapping different populations. We can only state that two of the three larger studies (Hudson et al., 1984, and Hsu et al., 1981) show a probable predominance of affective or schizoaffective disorders, whereas the third study (Ferguson & Damluji, 1988) shows the reverse.

Question 2b: Temporal relationship between the ongoing psychotic illness and the anorexia nervosa

Hudson et al. (1984) reported 17 cases of psychosis among a series of 130 patients with a lifetime history of anorexia nervosa and/or bulimia. As noted above, this figure was reduced to 5-6 cases among 60 individuals with anorexia nervosa (one of the 6 cases showed only "factitious" symptoms). Ages of onset for both illnesses are given in table form. In 4 cases, onset of anorexia nervosa took place in mid-adolescence (ages 13 to 16) and affective illness developed from 1 to 7 years later. In 2 cases, affective illness developed in mid-adolescence (ages 12 and 13) with onset of eating disorder 5-6 years later. All these patients also carried one or more other psychiatric diagnoses as well, ranging from agoraphobia to obsessive-compulsive disorder, cannabis abuse, borderline personality, histrionic personality, and panic disorder. In the absence of more detailed data regarding the courses of both illnesses and the precipitants involved in recurrences, we cannot draw any conclusions from the data.

Ferguson and Damluji (1988) report on 12 patients with schizophrenia and anorexia nervosa. Unfortunately, much of the data in this article which relates to relative onset patterns is inconsistent--specifically, the tables are not consistent with each

other or with statements made in the text. A request for clarification addressed to one of the authors was only marginally fruitful, as the author no longer had the original data available (Ferguson, 1989). The table which appears to be the most detailed and probably the most reliable source in the article with regard to this question (an impression supported by the author's personal communication) indicates that the onset of anorexia nervosa preceded the onset of schizophrenia in 7 cases, occurred in the same year in 2 cases, and followed the onset of schizophrenia in 3 cases (in 2 of these cases bulimia also appeared before anorexia nervosa). Again, in the absence of more detailed case data regarding courses of illness and precipitating factors, no real conclusions can be drawn. The authors present an "illustrative case report" which is somewhat sketchy and in which the psychotic symptoms appear closely tied to exacerbations of and hospitalizations for anorexia nervosa.

Hsu et al. (1981) provide somewhat more detailed information. As already discussed, their sample of 6 patients with psychotic phenomena is divided into 3 patients with transient psychoses and 3 patients with ongoing illness. Relative onset time is one of the characteristics that appears to separate the two groups, as the 3 patients with transient episodes all showed onset of psychotic symptoms during hospital treatment (in 2 cases shortly after admission and in the 3rd when nearing target weight). On the other hand, the 3 cases with ongoing illness had a very different onset pattern:

In the other three patients the schizophrenic symptoms occurred after apparent recovery (4 years in one and 1 year in the other two) from the anorexia nervosa in terms of weight and menses. However, all three were still intensely preoccupied with weight and dieting, and one was regularly overeating, vomiting, and purging. All were experiencing great difficulties in socializing. (p. 273)

A very rough generalization from the three studies reviewed under this sub-question is that it appears to be somewhat more likely for the psychotic illness to follow the anorexia nervosa than to precede it.

Question 2c: Content relationship between the ongoing psychotic illness and the anorexia nervosa

Hudson et al. (1984) provide a checklist of psychotic symptoms (delusions, hallucinations, ideas of reference, factitious symptoms) but give no information regard-

ing the content of these symptoms, except for a mention that the delusions were "predominantly paranoid" and the hallucinations "predominantly auditory" (p. 421). They go into somewhat more detail regarding symptoms that were considered factitious, but these lie outside the scope of our analysis.

Ferguson and Damluji (1988) also provide meager information regarding the content of the psychoses. In a table of symptoms, they list somatic delusions and note that 10 patients showed delusions concerning weight and 7 showed "other" somatic delusions (e.g., "putrid inside"). In the text, the authors state that 7 of the 12 patients showed non-somatic delusions; when asked about the nature of these, Ferguson (personal communication, March 1, 1989) stated that they "would include paranoid delusions of persecution, involvement in plots and other rather typical schizophrenic delusional systems." In any case, the prevalence of somatic delusions suggests some consistency between the psychotic illness and the eating disorder. The patient described in the "illustrative case report" suffered from hallucinations and delusions, the nature of which is not specified. We are told that "she had multiple ritualistic behaviors; for example, if she vomited some place in the past, she thought she had to again vomit in the same place or with the same food." (p. 349). Ferguson and Damluji (1988) make a few final points that are of interest:

In this population, it is difficult to distinguish between the thought style of the anorexic patient with the body image disturbance and implacable beliefs about food and the delusional belief system of the schizophrenic patient. It is of interest that the delusions of our patients were often somatic rather than paranoid in content. . . .

The sense of self gives the normal person a feeling of individuality, uniqueness, and self-direction and was disturbed in our patients. This loss of ego boundaries was seen in their extreme perplexity about their own identity. The eating disturbances appeared in many ways to organize their life and gave them a sense of identity, if not a meaning to their existence. (pp. 349-350)

This begins to outline the defensive and organizing role that anorexia nervosa can play and suggests that it can serve these functions even in the face of severe mental illness.

Hsu et al. (1981) discuss the content of the psychoses in terms of their total sample (which consists of 3 patients with transient episodes and 3 patients with ongoing illness) and state as follows:

Five patients had paranoid delusions of people discussing how fat and ugly they were and avoiding them. Sample of talk from one patient: "The pork (that I have eaten) is growing inside me. It's showing on my skin. People are saying how bad and ugly I look." Four patients had auditory hallucinations of Schneiderian first-rank order of several voices commenting on how ugly, fat, or greedy they were. Four patients had formal thought disorder. (pp. 273-274)

These symptoms show a fairly clear connection to anorexia nervosa and seem to reflect the projection of critical superego elements. The authors' conclusion bears noting:

[In the three cases with ongoing psychoses] the two illnesses seemed to run separate and independent courses, resolution in one bearing no relationship to the outcome of the other. This we took to be evidence against the view that anorexia nervosa was a prepsychotic state even in these patients.

Nevertheless, we remained intrigued by the similarity in the psychopathology of the two illnesses in our patients. The delusions were invariably related to themes such as food, eating, ugliness, shape, and loss of control, while the auditory hallucinations were of voices commenting on their appearance or greed. Non-psychotic anorectics, although never truly delusional or hallucinatory, were always preoccupied with such themes. . . . To us, the patients appeared to have retained their anorectic psychopathology even in their psychosis. (p. 276)

The issue of content will be addressed in much more detail with regard to transient psychoses (i.e., under Question 3 below) where the data available to us is much richer and thus affords the possibility of a broader and deeper exploration.

Question 3: Transient psychotic episodes

Definition of variables

The reports of transient psychotic episodes tend to be more detailed than those of ongoing illness. This, in turn, affords us the opportunity to apply the anaclitic/introjective model for the purpose of systematizing the data and illuminating the relationship between the anorexia and the psychosis. We will do so by defining four variables, which can vary along the anaclitic/introjective dimension. It is important to note that these variables emerged from an analysis of the case reports themselves, rather than from any a priori reasoning. The four variables are:

1. The precipitant of the decompensation, which can take the following forms:
 - (a) an anaclitic precipitant, consisting of a separation or loss;
 - (b) an introjective precipitant consisting of a direct interference with the anorexic defense structure or a severe intrusion on the boundaries of the self.

We might note that the experience of being hospitalized for anorexia nervosa generally involves both these factors; however, we will find that the emphasis tends to fall on one or the other.

2. The quality of the psychosis:
 - (a) a more organized psychosis centered around specific delusions or hallucinations will be considered introjective;
 - (b) a more chaotic and florid psychosis, often involving loss of cognitive functions and behavior described as infantile or histrionic, will be considered anaclitic.
3. The content of the psychosis:
 - (a) delusions or hallucinations that center on themes of guilt, self-blame, or persecution will be considered introjective;
 - (b) delusions or hallucinations that focus on loss of objects and on interpersonal dynamics will be considered anaclitic.
4. The process of recompensation:
 - (a) a recompensation that centers on the re-establishment of self-definition and self-boundaries will be considered introjective.
 - (b) a recompensation that centers on the re-establishment of connection with others will be considered anaclitic.

In some cases, it will be impossible to make a determination on each of the variables; but, for the most part, we will be able to do so and some degree of consistency will emerge within the individual reports, usually reflecting a clear preponderance of either anaclitic or introjective elements. We will begin by analyzing those articles that address groups of patients, which have already been mentioned in the sections above, and then go on to the individual case reports which, by and large, provide a far richer and more complex data base. This section will be organized around each case or group of cases rather than each subquestion, so as to maintain the coherence of the narratives and allow us to round out each report with a formulation based on the theoretical model. We will also highlight various themes that are not specified in the model itself but that show significant parallels to the case reported in Chapter III.

Hsu, Meltzer, and Crisp (1981)

Hsu et al. (1981) report three cases of transient psychosis, which show consistent pattern of onset and content. In two of these cases, psychotic symptoms appeared shortly after admission to an inpatient anorexic unit, and in the third they occurred as the patient approached target weight during inpatient treatment. Hsu et al.'s view is that these decompensations occurred "in response to being confronted with getting 'better'" (p. 276). From our point of view, the experience of hospitalization generally involves both an anaclitic and an introjective element: (a) separation from the family and the usual home environment; (b) loss of control via direct interference with anorexic behaviors and the defensive functions that they perform. Hsu et al. (1981) focus primarily on the latter aspect, linking these decompensations to their patients' fears of attaining a normal weight; this is especially clear in the case of the patient whose decompensation occurred when nearing target weight. Thus these three cases show a primarily introjective precipitant.

These patients experienced auditory hallucinations of voices commenting on "how ugly, fat, or greedy they were" (p. 274). These hallucinations clearly involve self-blame and are based in mechanisms of projective identification; thus the content of these psychoses is strongly introjective. We can add, with somewhat less certainty, that the psychoses appear fairly organized, i.e., introjective in quality as well. Recompensation is attributed to medication; this does not allow any determination with regard to the psychological aspects of the process. Thus, these cases are introjective along three of our four variables--precipitant, content, and quality of psychosis.

Grounds (1982)

Grounds (1982) reports seven cases of transient psychosis, which stand in clear contrast to those reported by Hsu et al. (1981). Although Grounds (1982) also focuses on the role of the experience of hospitalization in precipitating psychosis, he emphasizes a different aspect of the experience, namely the separation from the family and the usual home environment rather than specific interference with the anorexic behaviors. In six cases, onset occurred during a first hospital admission for anorexia nervosa. We should

note that one of these was considered to be an organic psychosis and that a second case showed possible organic factors. Several of the patients were at a very low weight when psychosis occurred; however, Grounds rules out starvation factors as a sufficient explanation for the decompensations, since "the episodes began only after hospital admission and in five cases occurred after weight gain had commenced" (p. 111). In a seventh case, psychosis appeared during a first separation from home, in the context of a long-standing chronic anorexia nervosa, and in turn led to hospitalization. In summary, the emphasis here is on separation and loss--an anaclitic precipitant.

Grounds (1982) stresses the atypical nature of these psychoses and especially their infantile and regressive aspect. He notes that they "were strikingly similar to each other in their unusual form" (p. 107), which consisted of "a mixed psychosis, which was neither typically schizophrenic nor typically affective in form" (p. 110):

All the psychotic episodes were characterized by a severe disturbance of behaviour, which was usually associated with restlessness and difficulty in sleeping. In every case, there were marked fluctuations in the severity of disturbance, with brief lucid intervals during which the patients would behave appropriately and talk normally, but tend to lapse into incoherent speech and bizarre behaviour when personal subjects were discussed. Invariably, the quality of the patients' behaviour, although severely disturbed, raised doubts about whether they were genuinely psychotic; adjectives such as 'hysterical', 'childish' and 'histrionic' occurred in every case record. Four patients, for example, had episodes in which they were observed to behave 'as if in a trance', staring ahead, mute, inaccessible and gesturing for several minutes. Behaviour was often strikingly infantile: one girl kept clutching a toy rabbit; another (aged 22) posted letters home with 'mummy' written in a childish scrawl on the envelope; one went out shopping for a medical textbook (to allay her hypochondriacal fears) and returned with a textbook on paediatrics. However, despite the diagnostic scepticism induced by this quality of behaviour, the patients were noted to exhibit perplexity and marked incoherence of speech. The thought disorder was not typically schizophrenic or manic in form, and pressure of speech was noted in only one patient. . . .

All the psychotic episodes were characterized by a mood disturbance, with marked lability and tearfulness in 5 cases and fear and anxiety in 3. (p. 110)

Thus the quality of these psychoses can be termed anaclitic. With respect to content, the author states:

In every case, delusions (usually of reference) were present: in 5 patients these were paranoid in colouring; in 1 case hypochondriacal; and in 1 case, both. The content of the delusions reflected family conflicts in 3 cases: 2 patients had fears of pregnancy, and 1 had delusions concerning food. Three patients admitted to auditory hallucinations, but in only one were Schneiderian first-rank schizophrenic symptoms described. (p. 110)

In reviewing the brief individual case reports that the author provides, we can concur with his view that the delusions tended to reflect family conflicts. Only one patient is noted to show "paranoid delusions of reference concerning other patients making critical remarks about her shape" (p. 109), i.e., delusions similar to those reported by Hsu et al. (1981); this same patient later shouted about being pregnant and in love. While all of this is hardly conclusive, the relatively greater preponderance of delusions reflecting family conflicts tends to lie in the anaclitic direction. Recompensation is attributed to neuroleptics or ECT; thus nothing can be said regarding its psychological aspects. These cases can be classified as anaclitic along three of our four variables--precipitant, content and quality of psychosis. This predominantly anaclitic quality stands in contrast to the introjective cases reported by Hsu et al. (1981).

Having reviewed those articles that present group data on transient episodes and having begun to define the two poles of our analysis--an introjective pole, as illustrated by Hsu et al. (1981), and an anaclitic one, as illustrated by Grounds (1982)--we can proceed to review those articles that present individual case reports, where the data tend to be richer and more specific.

Bedoret, Destombes, and Warot 1973)

Bedoret et al. (1973) report an occurrence of transient psychosis in an anorexic which shows a number of similarities to the cases reported by Grounds (1982). "Dominique", age 17, is described as showing the classic symptoms of anorexia nervosa, with onset of dieting a year earlier in response to critical comments from boys. She is reported to have shown "anorexia" at age 5 (probably some form of food refusal) and bulimia with obesity at puberty. More recently she also experienced a period of "professional hyperactivity" followed by "an episode of physical asthenia, labeled as depression"; this led to the recommendation for hospitalization (p. 438). The family conforms to the classic pattern--a domineering mother, whom the patient sought to escape via her work activities, and a devalued father. There is a history of alcoholism and psychosomatic illness in the family. Dominique feels isolated from her siblings and experiences her mother as suffocating. Dominique herself is described in contrasting terms; her

appearance is dramatic--she wears tight black clothing and heavy make-up--yet she is withdrawn, detached, "the good little girl whose parents are bringing her to the doctor" (p. 438). There are indications of conflicts around sexuality; Dominique is reported to have welcomed her amenorrhea as helping her to have "good character" (p. 438).

Bedoret et al. stress the role of the hospital policy of strict isolation from the family in the subsequent onset of psychosis. However, there is a confounding factor, in that Dominique was given the impression by her family doctor that the hospitalization was for the purpose of physical testing and would last 3-4 days, an impression that was never directly contradicted by the treatment team; nor did the team explain any clear conditions for discharge. The policy of isolation from the family was explained, but Dominique herself seemed to not fully understand or believe it. Thus iatrogenic factors were also involved.

Psychosis appeared in the following manner. During the first few days of the hospitalization, Dominique was tense and anxious, with more obvious theatricality and coquetry; she had brought her favorite possessions with her, dolls and a stuffed bear. Dominique tested the staff around feeding issues and attempted to manipulate them with seduction and aggression in efforts to obtain a pass to go home. She questioned the hospitalization, in light of the fact that her physical tests were normal. These developments led up to the decompensation, which began with a transitory obsessional phase:

Upon rereading her comments and the observations of her behavior, one can clearly see the progressive destructuralization of the personality leading up to the psychosis. First the focus is on the environment, which she tries to control in an obsessional mode: time and objects are dissected, everything is noted and written down by her--her possessions, the schedules and nature of the examinations, the detailed composition of her meals. The intensity of the anxiety, masked by histrionic behavior, nonetheless comes through in the formulation of her questions regarding the isolation: "Why do my parents not visit, not write me? . . ." becomes "My parents are dead, tell me they are not dead, my village is dead . . ." (p. 439)

Very rapidly, after a few days of hospitalization, the link between the patient and the external world becomes altered. The attempt to control the environment is followed by a loss of bodily integrity preceding depersonalization and the appearance of a hallucinatory consciousness.

Dominique speaks to us of her fears at the level of the body: "My tension is weak, I have no more tension . . . I am dead, my parents are dead." She expresses a perplexity: "They are going to operate on me in neurosurgery, they have operated on me . . . they have removed my brain, my heart." She experiences a vacuum

directly related to the isolation ("I am prisoner, lost, insane . . .") which presages the depersonalization in the pathological intuition ("Someone is surveilling me, spying on me from the other side of the wall") and the polymorphous delirious storm. There are multiple themes: the theme of death ("Everyone is dead, I know that I will die, I have just eaten"); the theme of guilt and expiation ("I wanted to slim down, I am paying dearly for it, tell them I created crises because of my diet"); the theme of sexuality ("I am not the word that they say . . . , a girl; they say I am pregnant"); mystical themes ("I am a saint, I want to be a nun, I die on the cross, . . . I am resuscitated, it is the end of the world").

The experience of the delirium is intense, variable, alternating with brief moments of clear thinking which are accompanied by major anxiety. (p. 440)

The process of recompensation begins when this frightening break modifies the attitude of the treating team, via "the establishment of closer contacts" (p. 440). Following discharge, Dominique confirms "the primary role of the nurses and the nurturance they provided" (p. 440) in her recovery. She gains weight and is transferred to a nursing home for 2 months where her eating behavior normalizes, but menstruation does not return. No further follow-up is provided.

This case highlights several crucial issues. Dominique appears to meet, at least broadly, the criteria for the diagnoses of anorexia nervosa and transient psychotic episode. She also shows signs of an underlying borderline/narcissistic personality structure, as seen in the repeated descriptions of her behavior as histrionic and dramatic. Dominique's anorexia had occurred as part of an attempt to establish some separation from her mother; it was associated with another introjective behavior, her "professional hyperactivity," and followed upon an introjective precipitant, the classic narcissistic injury of being teased by peers. These extreme efforts at separation indicate, of course, an underlying vulnerability to reengulfment. Dominique experiences this consciously, as she finds her mother "suffocating." When a further separation is imposed by the hospitalization, Dominique experiences severe anaclitic loss and attempts to hold on to the external world and to her fragile identity by ever more drastic introjective efforts, in the form of obsessional behaviors. These efforts prove futile, possibly because the balance for her is so skewed toward the anaclitic line, and she sinks into psychosis.

The florid psychosis shows many classic elements: the decathexis of the object world, preceded by an attempt to salvage its presumably fading cathexis via obsessional

means; the gradual decathexis of self-representations; delusions of reference, of mutilation, of pregnancy, and of grandiosity in a religious mode. One of Dominique's statements is, of course, too close to reality to be a delusion--"I am prisoner, lost, insane" (p. 440). The psychosis is anaclitic both in its quality (regressed and chaotic) and in its content which focuses, at least in part, on object loss.

From the point of view of our model, this episode shows a notable coherence. The precipitant is anaclitic, as the focus is on the separation from the family--a drastic one for which the patient is ill-prepared. However, a complicating factor must be noted, namely the absence of clear communication from the treatment team, which probably left Dominique feeling utterly powerless; this suggests a secondary introjective element. The psychosis is anaclitic in quality and content. Recompensation is attributed largely to the development of a better relationship with the staff and especially to the nurturance provided by the nurses. Thus all four variables are anaclitic. Indeed, Grounds (1982) noted a parallel between this case and the ones he reported, emphasizing the role of separation as a precipitant and the polymorphous quality of the psychoses.

Küchenhoff (1986)

Küchenhoff (1986) reports a case which highlights the role of interference with introjective boundaries and defenses in precipitating a psychotic episode. The patient, a young woman of 24, became anorexic upon first leaving her parents' home. The mother was described as overprotective and unable to separate from her daughter; she had threatened suicide when the patient wanted to take a trip at age 14 and would cry when the patient wanted to go out with friends. Much of the conflict in this mother-daughter relationship had been focused on food and eating from early childhood on; the daughter was viewed as a picky eater and the mother expressed her nurturance via cooking and endless efforts to come up with new dishes. The father was described as distant and absorbed in work. The patient was the youngest child and isolated from her siblings. At puberty, she became rebellious and hostile, but also suffered from guilt--she felt that leaving her mother was tantamount to "mortally injur[ing] her" (p. 546). She experienced violent disgust at sexual approaches from boys. When the patient

left home, she lived with two female friends; with one of these friends she developed a close, "symbiotic," and possibly lesbian relationship. While experiencing this merger-like relationship with a female, she also maintained a fragile separation from her mother:

"The patient does not allow her mother to set foot in her apartment; she has the feeling that the mother could, through her presence, take the apartment from her and annihilate it" (p. 546). It was at this time that the patient became anorexic and was hospitalized for half a year at the Psychosomatic Clinic of Heidelberg.

At first, the patient's defenses remained prominent. She was carefully dressed, kept her therapist at a distance, and controlled the individual sessions with him by focusing solely on her embattled struggles with the ward. On the ward, she resisted all treatment efforts, experiencing them as coercive. As a result, she was transferred to a medical clinic and fed intravenously. Upon returning to the Psychosomatic Clinic, she again lost weight and was "forced to accept a stomach probe." This experience had a very powerful effect on her: ". . . whenever she received the inflicted nourishment by tube, she had the feeling for about half an hour that she was a baby, and that a gigantic mother stood over her" (p. 546). This profoundly regressive experience led up to the psychotic break. After 10 days, the patient "highhandedly removed the tube." She was then restricted to her room; the therapist came there for sessions. One weekend, she ran away from the ward and returned to her parents' home. She spoke to her therapist over the telephone and was able to report her psychotic experience. She believed that a conspiracy against her had been hatched on the ward, under the leadership of the head nurse, the person with whom she was closest. She also reported hearing "uninterrupted voices, several men's voices, who spoke with each other and commented incessantly on her treatment; when she wanted to eat something, one voice would say: 'Now she is gluttonous' or 'Do you see how greedy she is?'; then the other voice would add, 'Yet she is anorexic'" (p. 546). She attempted to get away from the voices by hiding in a closet, to no avail. The patient allowed herself to be convinced to return to the ward, where she was treated with neuroleptics. Her symptomatology receded after 2 weeks. There was another brief decompensation, during which the patient again ran away, but she

returned in short order. After 2 months, medication was discontinued and the patient no longer manifested any psychotic symptoms. She also showed signs of profound internal change. She realized that the voices were not external but rather "represented her psychic reality; she discovered thereby with much affective participation and great anxiety her own neediness, which before this had always been warded off via projection" (p. 546). She began to experience conscious hunger pangs and realized how intensely she had been fighting these feelings in herself. She also "experienced herself as hungry for connection, even 'starving' for contact with other people" (p. 546). She began to loosen her caution in therapy and allow some trust and closeness to take place with her therapist. The patient was discharged; she returned to school and moved to a residential community, where she made new friends. She continued to attend therapy twice a week; in fact, it was possible to conduct an analytically oriented psychotherapy, focusing on her associations and on transference dynamics. No further follow-up is provided.

In analyzing the elements of the case, we can note that the anorexia follows separation from the parental home. The patient suffers from severe separation guilt (Friedman, 1985) connected to her mother's inability to tolerate her growing autonomy. Her anorexia is clearly based in a fragile introjective defense against reengulfment. The power of the anaclitic pull can be seen in the development of the symbiotic relationship with her roommate. The fragility of the introjective separation accounts for her need to maintain a rigid boundary by forbidding the mother from coming to her apartment. The patient undermines her fragile separation by becoming so severely anorexic that she must be hospitalized, thus setting the stage for a regression into dependency. Once hospitalized, she attempts to maintain her introjective defenses--she is distant and controlling; she translates all treatment efforts into struggles over autonomy and experiences of coercion. Tube feeding is instituted; this, in turn, arouses primitive anaclitic needs and fantasies; while no doubt pleasurable in some respects, it is also frightening, and the patient removes the tube. The immediate precipitant of the psychotic episode, however, is the therapist's intrusion into her "room-self," which storms the fragile introjective

boundaries even more than the tube feeding itself. Küchenhoff himself emphasizes the introjective nature of the precipitant, while also noting the way in which it aroused frightening anaclitic needs:

The psychogenic releasers could subsequently be reconstructed. First through the involuntary tube feeding, then through the spatial isolation, the patient was jeopardized in her basic need for autonomy. Additionally, the therapist now came to her in her room, which she experienced as an extension of her bodily self; until then she had wanted to protect the room from all eyes and to have it as her own sphere only for herself. These visits generated an unbearable but not consciously experienceable ambivalence: The penetration into her "body-room" disturbed her self-realm but also mobilized her own wishes for closeness. In the schizophrenic reaction there is now an attempt to reappoint the lost self-boundaries; through the projection in the ideas of persecution the patient is herself again free of needs and without wishes, exclusively at the mercy of the intrigues of others. The therapist remains outside the delusions of persecutions, probably first of all because he had taken a neutral position on the question of the involuntary feeding. In her hallucinations she now experiences for the first time her own powerful oral needs, of course in an entirely distorted manner. (pp. 546-547) [emphases added]

Indeed, the primitive, paranoid mechanisms of the psychosis serve to reestablish the patient's self-boundaries at a more primitive level. The psychotic experience consists of (a) a delusion of persecution involving a conspiracy led by the head nurse, with whom the patient had been close on the ward and who could easily pull for a powerful-mother transference by virtue of her role alone; and (b) auditory hallucinations of male voices criticizing the patient for either gluttony or anorexia. The former appears to be a projection of the bad mother imago, which can no longer be contained via the usual anorexic projection into the body. The voices derive their power from projected superego precursors and reflect both the patient's self-criticism and her dissociated oral needs. These auditory hallucinations are strikingly similar to those reported by Hsu et al. (1981). The psychosis is organized, i.e., introjective in quality as well as in content. Recompensation is linked to the reestablishment of the connection to the therapist. At first glance, this would appear to be an anaclitic factor; however, this process begins when the therapist respects the patient's need for boundaries and control by allowing her to communicate with him over the telephone. Recompensation also involves the reintroduction of previously dissociated or projected anaclitic needs, i.e., an introjective mechanism. Thus it can be classified as mixed anaclitic/introjective.

Küchenhoff views the psychotic episode as serving a positive role in the treatment. He suggests that the patient's needs, both oral and emotional, were fixated and bound in the symptom of the anorexia nervosa; in the hallucination they reemerged in a manner that could be experienced and formulated, if only in projected form; following that, they could be reintrojected and assimilated in the course of treatment. Thus the psychosis served as an "interim step between the somatization of the conflict and the possibility of a neurotic process"; it created an "intermediary space" which allowed for "oral expression and symbolization of conflict," both faculties that are otherwise missing in the anorexic and that are necessary for a psychotherapeutic process to take place (p. 547). This journey from dissociation of needs (in the anorexia) to paranoid projection (in the psychosis) to reintrojection (in the recovery) also illustrates a back-and-forth movement along the introjective developmental line, as discussed by Blatt and Shichman (1983). Küchenhoff's contribution to this concept is the observation that such a regression can serve ultimate progressive functions, allowing the patient to reintegrate her anaclitic needs and thus progress along both lines of development.

In summary, this case is strongly introjective along three of the variables--precipitant, quality, and content of psychosis. The fourth variable, the process of recompensation, involves both anaclitic and introjective mechanisms and demonstrates a rebalancing and reintegration of the two developmental lines.

Cramer and Bovet du Bois (1973)

Cramer and Bovet du Bois (1973) give a detailed report of a prepubescent boy with anorexia nervosa who experiences an acute psychotic episode clearly connected to the dismantling of the anorexic defense. This case illustrates an instance of projection of the anorexic interdiction against eating onto an idealized figure--an important parallel to the case in Chapter III.

"Pierre" is an 11 1/2 year old boy from a close-knit family of French peasant origins. There are three older sisters and a 13-year-old brother. Pierre and his brother shared an almost symbiotic twin-like relationship, involving mutual sex play with an alternation of passive and active roles. Pierre was an avid thumb sucker until age 7 and

never liked meat. The family consists of a domineering mother who runs the family business but insists that "she lives only for her children" and a father who was responsible for the failure of the family farm. Both sides of the family are wary and suspicious of modern life and modern medicine. The maternal grandfather was a "radiesthésiste" (p. 768), a term which is difficult to translate and which seems to refer to some form of magical or spiritual healing. The paternal grandfather practiced herbal healing.

The onset of Pierre's anorexia was tied to a change in the relationship with his brother. Upon undergoing puberty, the brother started "acting like a grown-up" (p. 769), going out with girls and boasting of his sexual exploits. Pierre responded with what his parents described as "a change in personality" (p. 768)--he started quarreling with his brother and refusing to share with him. In response to his brother's espousal of modern life, Pierre withdrew into a fantasy of living as a shepherd. This was followed by a period of sadness, solitude, and withdrawal, some vomiting, and finally anorexia, as manifested in intake restricted to drinking lemonade and chewing gum.

A first hospitalization ended when Pierre complained of the isolation and his parents removed him. He was re-hospitalized at an extremely low weight, "almost cachectic" (p. 770); he showed confusion, motor retardation, and disorientation to time, but was still "in contact". At this point Pierre asserted that he refused to eat because a radiesthésiste who was a family friend had told him that, until he was cured by the radiesthésiste, eating might cause spasms.

The treatment team then took a drastic action, which ushered in a full-blown psychotic episode with notably polymorphous symptomatology:

In view of the desperate state of the child, we managed to get the radiesthésiste to write a letter ordering Pierre to eat: the latter becomes bulimic as soon as he receives the letter. The next day he enters into a delirious phase with a religious component: he sends everyone to hell. His thinking alters, he expresses impressions of bodily disintegration; he looks at his hand as if it were an object. He says he is transformed into caca (feces), that he wants to become very tiny. "I don't know if I must eat myself or eat other people." He also says "I am whole, I exist . . . my brother exists . . ." "A cup, that exists."

He has language difficulties (stammering), apraxias (cannot manage to button himself), he cannot name simple forms (triangles), can no longer write his name or calculate; he has losses in recent memory.

He draws himself with a body that is absolutely thread-shaped and enormous hands and feet. . . . He also says that he is a little pea and a little bread.

[Another] drawing represents his father as having totally fluid contours and an absence of the lower portion of the body

His mother, on the other hand, is better defined: organs float in the abdominal cavity, the alimentary canal leads directly from the mouth to the genitals; in fact, to a penis

While his brother is represented with a large and substantial body he represents himself as string-shaped and small

The religious delusions persist; he broaches sexual themes, speaking of girls who do dirty things, after he has penetrated with his finger the genital parts of a female doll.

He speaks of his desire to lead a natural life, not a modern one, with animals in the mountains.

He apologizes for being so gluttonous. Little by little (between 5 and 12 days after the beginning of the delirium), he becomes observant with regard to his delirium, and regains his orientation and his ability to write.

He speaks of his brother: "it is he who has changed, who has passed the age, grown up . . . his personality changed." Then he insists on the fact that some people are for the body (his brother), others for the mind (himself). He also insists on what differentiates him from his brother: his brother likes cars, the city, everything that is modern; he, Pierre, loves nature. (p. 770)

Thus Pierre's recompensation appears to occur spontaneously and is linked to the establishment of an identity diametrically opposed to that of his brother. Upon recompensation and weight gain, Pierre's parents remove him from the clinic. They place him in the care of the radiesthésiste, who massages his back three times a week for a month. A year and a half later, he is described as doing well and having passed puberty.

This case is striking in several respects. The anaclitic loss of the symbiotic twin-like relationship to the older brother appears to be the precipitant of the anorexia. Indeed, Cramer and Bovet du Bois stress the combination of selfobject loss and gender identity issues that this involves for Pierre:

It seems that the identity of Pierre was always fragile and that it needed to rely--for its maintenance--on a symbiotic identity, a fusion with the admired brother. In this twin-like exchange, Pierre could assume both passive and active roles in turn (as in the strip-tease). It appears that the withdrawal of the brother resulted in a powerful narcissistic disequilibrium; all of a sudden Pierre had to be

self-sufficient and assume his own identity just as he was approaching puberty. It seems that up until then he could delegate to his brother the masculine identity--while continuing to participate in it in fantasy in alternation with his brother. Now he can only define his identity by differentiating himself to the maximum from his brother. His brother is big, stout, sexual; he will be thin, little, asexual, as one can see in the drawing which represents both of them. This movement is equally defensive toward the heterosexuality awakened by puberty.

The catalyst of the regression is thus the loss of the brother as an extension of his identity, as alter ego (cf. Kohut), masculine, strong, active on behalf of his own self.

The anorexia must play an important defensive role against an oral aggression directed toward the brother who has abandoned him and--behind the image of the brother--toward the mother.

But what is interesting is that the anorexia seems to protect against a greater regression yet, because it is when he begins to eat that he becomes frankly psychotic. (pp. 770-771)

Thus Cramer and Bovet du Bois suggest that the psychosis, which begins a day after the onset of bulimia, results from the dismantling of the anorexic defense against oral rage. However, this analysis omits several crucial steps in the process. Upon feeling abandoned by his symbiotic twin--and we might note that twinship is one of the forms of the mirroring selfobject as described by Kohut (1971)--Pierre seeks refuge in a drastic attempt to separate and establish an identity of his own; the fragility of this identity can be seen in its stark opposition to that of the brother. When this introjective effort is insufficient to cope with the pressure of the anaclitic forces, Pierre resorts to the more drastic introjective defense of anorexia nervosa, which does indeed serve to defend against oral rage as well as against oral and anaclitic need. Upon being hospitalized (or possibly before that--the information is not clear in this regard), Pierre shifts his focus from the frustrated grandiose self, abandoned by its mirroring/complementary twin, to the idealized parental imago; he projects this imago onto the figure of the radiesthésiste, who is most suited for the role by virtue of his professional similarity to the maternal grandfather and thus, by extension, his connection to the powerful mother. The projection of the anorexic interdiction onto this idealized figure is an introjective mechanism, consistent with anorexia's introjective nature. It is, however, an atypical one in comparison to the classic mechanism described by Palazzoli (1978)--the projection of the bad mother imago onto the body; consistently enough, there is no mention of

conscious effort to attain an ideal body shape in Pierre's case, although certainly he welcomes the outcome of being "thin, little, asexual."

There is some suggestion of psychotic behavior at the beginning of the hospitalization--confusion, motor retardation, and disorientation; this raises the issue of the role of starvation factors in the psychotic break. Nonetheless, the florid psychosis only develops after the following sequence of events. No doubt frustrated by Pierre's anorexic behavior and by his justification for it, the treatment team arranges a deus-ex-machina intervention--a letter from the radiesthésiste ordering Pierre to eat. This order, bearing the power and authority of the idealized figure, is obeyed. Pierre drops the anorexic defense and is flooded with anaclitic needs and oral rage. This manifests first as bulimia, followed by psychotic disintegration and massive regression, affecting even the autonomous cognitive functions of the ego.

In their analysis of Pierre's psychotic experience, Cramer and Bovet du Bois stress the loss of self-object differentiation and the regression to very early stages of infancy with a focus on the primitive oral cavity:

The regression is . . . spectacular: the autonomous functions serving the praxias, cognition of forms and numbers, speech, the sense of time and space, are abolished.

The sense of self is practically swept away: he constantly asks himself whether he exists, confuses himself with excrement or foods: he has almost eaten himself!

The difference between "self" and "non-self" is abolished. "I don't know if I must eat myself or others". In a general way, his sense of form, of limits, of gestalts is abolished. There is an almost total dedifferentiation of the notion of self (and of object).

It is interesting to note the importance that he accords to hands and feet, and the particular interest that he takes in his hand. A hypothesis imposes itself: we know the importance of the hand in the course of the evolution of the concept of the "bodyself"; the hand becomes the continuation of the mouth to form the primitive cavity, the first nucleus of a sensorimotor organization that marks the beginning of the integration of the Ego. . . . In the regressive states--the hypnagogic states for example--the hand is often experienced as enormous, and the mouth is often the receptacle of enormous masses, reproducing the exchange of sensations between hand, maternal breast, and oral cavity in the first trimester (Isakower phenomenon . . .).

It would thus seem that the regression entails a state of very primitive organization where the image of the body is essentially centered on the combination mouth-hand, while the rest of the body is almost virtual, represented as it is by a thread. In his drawings of himself, the mouth is not even represented, nor the

details of the face: there is only a circle in the place of the face, which one could interpret as evidence that the face is reduced to a mouth (represented by the circle). (p. 771)

The recompensation appears to occur spontaneously, as the observing ego is recathected and the defenses come back into play. Pierre again seeks refuge in an identity that is strongly contrasted with that of his brother and that eliminates large aspects of the masculine gender identity, as well as providing a schizoid defense of isolation and a re-identification with the family of origin. He also shows signs of anorexic thinking--the stark opposition and duality of the mind and body, with valuation of the former and contempt for the latter. The anorexia itself remits spontaneously, more or less in tandem with the psychosis. The "laying-on-of-hands," if we may call it that, on the part of the idealized radiesthésiste no doubt plays an important part in this as well. Indeed, the connection to this idealized figure may help to account for the more adaptive introjective adjustment at this point in comparison to Pierre's pre-psychotic functioning; Pierre can be said to have successfully replaced the lost mirroring selfobject with an idealized selfobject who can be present for him.

This case demonstrates a dialectical interaction between anaclitic and introjective elements. The precipitant of the anorexia is an anaclitic one--the loss of the symbiotic twinship. First Pierre attempts to establish a fragile separation from his brother and then, as this is insufficient to resist the anaclitic pull, he intensifies the introjective efforts via the anorexia. The anorexic defense is then entrusted to the projection of the idealized parental imago--an introjective mechanism, albeit an atypical one in comparison to the classic anorexic projection described by Palazzoli (1978). The treatment team's intervention results in the sudden dismantling of the anorexic defense structure, which looses the anaclitic forces and needs; thus the precipitant of the psychosis is introjective. The psychosis itself is polymorphous and chaotic, i.e., anaclitic in quality. Its content centers on themes of boundary loss (confusion between self and other, male and female) and on the oral cavity; thus its content is anaclitic. Recompensation occurs via a return to introjective mechanisms--the re-establishment of an identity very much in contrast to that of the brother. There are, of course, underlying anaclitic aspects to the

recompensation as well, in the form of the connection to the idealized radiesthésiste and the avoidance of the separation from the parents that adolescence generally calls for.

In summary, the sequence is as follows: an anaclitic loss (the loss of the symbiotic twinship) is followed by an introjective defense (first the opposite identity and then, as this proves insufficient, the anorexia); the sudden dismantling of this defense (an introjective precipitant) leads to an eruption of anaclitic needs and a chaotic, anaclitic psychosis characterized by boundary loss on many fronts. The patient recompensates via the re-establishment of an introjective defense structure--the return to an identity diametrically opposed to that of his brother. Overall, the case illustrates a back-and-forth movement between an introjective adjustment both prior to and following the collapse into profoundly anaclitic psychosis.

Steinberg (1982)

Steinberg (1982) reports a case, like that of Pierre, involves the loss of a symbiotic twinship as the precipitating factor of anorexia nervosa. The case report describes two monozygotic twin sisters who showed onset of anorexic behavior at age 10, with separation and the eruption of rivalry as central factors. One twin eventually stabilized with an anorexic adjustment, whereas the other manifested several psychotic episodes.

The family background and family dynamics are central to the evolution of this case. The parents, "Mr. and Mrs. L.," were both of German extraction and from Bohemia in Eastern Europe; both came from a strict religious and traditional background. The mother had been frustrated in her ambition to become a teacher like her older stepsister and carried a severe complex, which she later manifested by placing tremendous stress on school performance and professional achievement in her children. The parents' marriage began rather dramatically during World War II. Mr. L., who was a soldier in the German Army, was seriously wounded 3 months after the wedding. A piece of shrapnel tore up his lower jaw, injuring the trachea and oesophagus. Due to his condition, his wife was allowed to live with him in the military hospital. At first, he could only be fed via nasal tube. After a year, he was able to take liquid nourishment

by mouth. For 12 years, he wore a "speech cannula" (p. 186) and underwent 40 operations. The outcome of this was that he could "articulate well and . . . take in foods of normal consistency after chopping them up into small pieces, with a special set of tongs" (p. 186). However, he continued to experience breathing difficulty and to wear a mandibular prosthesis; his appearance remained seriously marred.

Mrs. L.'s devotion in caring for her husband in the hospital and particularly in feeding him played an important part in saving his life. Mr. L. overcame his impairments and became very successful, first in East Germany and then again after emigrating to West Germany. A daughter and a son were born when the parents were in their early 30s. The twins "Pia" and "Maria" arrived when both parents were over 40. There were some early developmental difficulties--specifically, late speech in both children, which was attributed to a taciturn infant nurse, and rhythmic rocking and headbanging around age 2, which was particularly prominent in Maria. However, the family also spoke of a childhood "without difficulties" (p. 187), as is often the case with anorexics. The twins were given identical clothes and room furnishings, but Maria was considered to be more intelligent and Pia was seen as more delicate and artistic. Maria appeared to be the leader and Pia the follower.

As the older siblings entered late adolescence, the parents' relationship with them became very conflictual. Mr. and Mrs. L. were especially displeased with the oldest daughter's choice of interpreting as a profession. The anorexia of the twins began insidiously around this time. The two 10-year-old girls, who were in the process of enrolling in a parochial girls' school, had begun to copy the dieting of their older sister, a practice they hid from their mother. This "thinness-cure" began to lose its quality of "child's play" after an occurrence which the parents viewed as both the starting point and cause of the twins' illness. In the fall of 1971, the girls took a school admissions exam; Maria passed, but Pia failed, possibly because the school did not look favorably upon admitting a set of twins. This resulted in the first separation of the twin sisters, a separation that they had not chosen and for which they were not prepared. This event was accompanied by the emergence of a clear rivalry between the two girls, which

focused on the pursuit of the "elfin figure" (p. 188). Pia was more "steadfast" in this pursuit, whereas, according to the parents, Maria had "to eat more because of her heavier school load" (p. 188). Pia showed increasing ill humor and open aggression toward her sister; she secretly kept up with her sister's homework. These events led to a first referral for family therapy, where Pia's depression and her resentment toward her twin sister were noted. However, little changed; Maria continued to attend the preferred girls' school and Pia found herself lagging one year behind, in a large city high school.

Two years later, at age 13 1/2, Pia again showed a severe anorexic state. The precipitant is not clearly identified, but two changes are noted. First, the twins had attained puberty. Secondly, the mother's older stepsister, now a retired schoolteacher, had been brought out of East Germany and had rapidly become involved in the family life in a manner that appeared to promote strife. She had "placed herself in an almost 'mother-in-law' role over Mr. L." (p. 189) and had undertaken the task of enlightening the twins with regard to menstruation and sexuality. She blamed their parents for not having prepared them for this; their problems in school and their delayed development she placed at the feet of Mr. L., toward whom she expressed contempt: ". . . how can one expect healthy children from a sick father . . ." (p. 189). The quarrels became so severe that she was forbidden to come to the house when Mr. L. was at home. These events, in turn, led Mr. L. to withdraw further into his work, while beginning to talk about a premature retirement. He also showed severe psychosomatic behavior, which was very upsetting to the twins: "Dramatic attacks of breathing difficulty, during which he struggled for air while lying on the ground and said goodbye to his family, occurred ever more often" (p. 189). Mrs. L., for her part, became more and more absorbed in cooking and took up a natural foods philosophy, which the twins also espoused and which the father condemned. This is the series of family developments that led up to Pia's recurrence of severe anorexia with clearly depressive mood at age 13 1/2. The family returned to the clinic, where the mother's role in fostering both the rivalry between the twins and Pia's food refusal was noted--she dramatically reproached Pia for attending a less impressive school than Maria and for not eating breakfast. An

apparently half-hearted course of family therapy was undertaken--it extended over a year, with only 10 visits, which were held at the family's home as the parents refused to travel to the city.

Maria's anorexia emerged a year later at age 14 1/2 and was precipitated by an event that she experienced as a fall from grace and a role reversal in relation to her twin. When Maria was 14, in the spring of 1975, Mr. and Mrs. L. removed her from the parochial school and sent her to the "modern-language" high school attended by Pia; they did this "for Pia's sake" (p. 190), as her school performance had dropped considerably since her relapse. Maria began to manifest food restriction and shortly thereafter "the symptoms of a severe anorexia nervosa", combined with night bingeing (p. 190). She also became amenorrheic and failed to pass her class at the end of the year. With the emergence of Maria's anorexia, Pia's stopped, and she again gained weight; however, both girls were described as "depressive, shy, and anxious" (p. 190). This was followed by yet another reversal. In the fall of 1975, apparently at the mother's insistence, Maria once again returned to the girls' school, which led to the reappearance of outright anorexia in Pia, so that briefly during the fall of 1975 both girls were anorexic at the same time. Resistance to family therapy, manifested in the mother's seeking out numerous "nutrition cures" (p. 191) for the twins, continued unabated.

In the fall of 1976, at age 15, Pia began to attend boarding school so as to pursue a specific course of study. From that time on, she was home only on weekends and vacations. She continued to show recurrences of anorexia and also developed bulimia. However, her separation from the family seems to be a marker; from that point on, the development of the twins diverged. Maria remained at home, where she felt increasingly isolated and emotionally burdened: "Sometimes I cannot sleep for hours, because I reflect on how things are at home, how everything should go. Now it all depends on me . . ." (p. 191) Mr. L. finally requested his early retirement in the fall of 1976, to take effect the following summer. However, Maria's hope that her father would now be calmer and more available to her was not fulfilled. In the spring of 1977, her brother failed an important school exam for the second time. This set off intense

family strife, with constant loud quarreling and mutual accusations. Maria's efforts to intercede only resulted in dragging her into the conflict. Furthermore, "she felt herself increasingly abandoned by her twin sister, not understood, and even betrayed, as Pia would not believe that they attempted to hush up the strained relations during her visits" (pp. 191-192).

This concatenation of factors led to the first eruption of psychosis in the spring of 1977, which was precipitated by a sexualized interaction with her father:

Two weeks after her brother's test failure, Maria L. became for the first time clearly psychotic. Her father had invited her to a stag party, during which he markedly devoted himself to her, contrary to his custom, and introduced her as a "young lady." Suddenly Maria began to speak in a confused manner: "... If the winches were to blow out of all four directions, I would win a big battle. ...". The condition was ascribed to the wine; allegedly the girl had consumed alcohol for the first time that evening. Yet, during the days that followed, states of absolute clarity alternated with such psychotic states of confusion; at school Maria became noticeable. During a home visit on the part of the youth-therapist called in to help, the mother tried to downplay Maria's clearly psychotic state, joking around with the girl and lapsing into a cheerfulness completely inappropriate to the situation, such that the therapist at first thought of a *folie à deux*. The father was convinced of the irreparable nature of the situation and spoke of how he had written Maria off and how he himself had died inwardly. The son, who was present, blamed the mother for Maria's condition, whereupon the mother humiliated the son, to the point where it was unbearable. Maria reacted to this with the outcry: "... Lice and fleas, here there is nothing but dust in the air ...". After the therapist had addressed the hostilities among the family members, Maria lapsed into a crying that appeared understandable and spoke of great anxiety. Only after 3 days had elapsed did the parents agree to an inpatient admission to the Psychiatric University Clinic (summer, 1977). The admitting physician noted an amotivational-catatonic picture. Maria appeared oriented to person and place, but not to time and situation. In addition, when she spoke, her thinking was incoherent: "... I'd like to go to the Lustsee [Pleasure Lake?], it would of course be better, everyone would play together, I'd like the yellow ball and then homeward ...". It was hardly possible to establish interpersonal contact--Maria turned away from the examiners and spoke in the opposite corner. Disturbances of the self and the personality in the sense of a limited object differentiation were described. Mood was downcast. The physician had to take great pains to obtain anamnestic information from the parents, who were present at the admission; in Maria's presence, they spoke nearly exclusively of their son, in spite of repeated reminders that it was their daughter who was coming for admission. (p. 192)

Maria's physical condition was good and her weight adequate. Within a few days of treatment with Haloperidol, she no longer showed thought disorder or other psychotic symptoms. She was discharged after 2 weeks.

Following his retirement in the summer of 1977, Mr. L. devoted himself to artistic pursuits, specifically to making bathroom tiles commemorating each of his war injuries and operations. In the fall of 1977, Maria was sent away to a distant boarding school. Within a short time, she became severely anorexic, with attacks of bulimia and spontaneous vomiting. After a few months, she returned home, where she retained her "nutrition regime" (p. 193) which consisted of refusing to eat breakfast or lunch. The parents later reported what may have been a very brief psychotic episode in the early summer of 1978, possibly connected to Maria's severe emaciation; the symptoms faded away without any intervention. A second attempt to place Maria in a boarding school in the fall of 1978 brought no stabilization. She showed repeated anorexic episodes, severe isolation, and poor school performance. In the fall of 1979, when Maria was 18, yet a third attempt was made; this time Maria was sent to the same boarding school as her twin sister. After a few weeks, Maria could no longer keep up; she appeared very depressed and seemed to be trying to induce the same feelings in her sister, to the extent that the family feared she might jeopardize Pia's independent functioning. Consequently, Maria was brought home. Her return to the family was accompanied by an exacerbation of anorexic behavior, with daily vomiting, severe weight loss, and "restless overactivity," including much physical exercise and intense studying--she planned to become an interpreter like her older sister. A variety of somatic cures were attempted. Finally, in a very weakened state, Maria presented at a medical clinic but refused the suggestion of an inpatient admission.

This severe anorexic state shaded very gradually into psychosis in the following manner. Two weeks after her appearance at the medical clinic, Maria suffered an "attack of weakness" (p. 193) and this time was admitted to the clinic with cachexia and walking disturbances, which appeared to be "catatonic" in nature. Drastic measures were taken to improve her nutritional state--feeding through a "stomach probe" with "drip infusions"--but these had no effect on Maria's psychotic state. "Within 2 weeks the full picture of a catatonic stupor developed" (p. 194), and Maria was transferred to the

psychiatric clinic. Upon arrival on the ward, she "lay in a rigid posture on a stretcher, her bones drawn up, her hands held angled in front of her abdomen, her head lifted up above the pillow." She remained apathetic as her mother attempted to feed her a carrot. Finally, the mother was asked to leave, which she did reluctantly and "with heavy heart". Maria remained indifferent to her surroundings. "In an unnaturally high, monotonous voice, she called, in drawn-out screams, to the ward nurse; sometimes she also whimpered." No cause could be determined for this condition, which continued for 3 days. Maria remained in bed and was fed through a "stomach-lingering probe."

After a few days the stupor began to loosen itself; there appeared disturbances in the form and content of thought; there was no evidence of hallucinations. The delusional thoughts were clearly connected to the psychic core of the anorexia and to the family dynamics. Upon Maria's being asked why she was not able to eat the food that was brought to her in bed--the stomach tube had been removed after 3 days--there followed the first intelligible remark, in a childlike, monotonous tone: "At midday I didn't want to eat at all, because otherwise the marriage would have been ruined." Despite careful questioning, Maria returned to motionless silence and appeared distant in her consciousness. Months earlier she had injured the nail bed of her thumb; the nail now began to detach itself in an unattractive manner. Thereupon she said: "The nail has become inflamed because I was so sick. Then my father died in it; he is at my friend's house in the sky, Mr. Jesus, whom I share with my sister." After a longer pause: "Yes, I am really already glad that my mother comes to visit. But I am really not glad that she only brings me food . . . She should bring me love. . . (she cries for a long time). . . Everyone gets more. . . To whom does mother give more? . . . To Pia (she cries hard) . . . To Pia she gives more; everything falls in her lap. For me she brings only food . . . My sister would have had it better in the hospital . . . " "Why then is this?" " . . . She has a more delicate nature, I am much more hardy. I am a nestling." (Since childhood, the twin sisters have given themselves the pet names "firstborn" and "nestling".) "I am un-independent as ever, I have to let myself be nourished by the family . . . Ah, my aunt wants to come . . . Now then, I am anxious to know, because she has always brought me something to eat, and now she wants to speak with me . . . " Without transition, Maria lapsed again into anxious brooding, began incomprehensibly to utter long drawn-out screams, and could not be diverted. (p. 194)

The family made all sorts of disruptive attempts to intervene in the treatment. The mother had to be stopped from holding Maria in her arms like an infant and speaking to her in babytalk, and also from smuggling food onto the ward. The situation relaxed when Maria began to eat. However, she quickly went from eating to compulsive eating, and the staff had to step in to prevent an overly rapid weight gain. Within a week, under medication, the psychotic symptoms abated, but an attempt to reduce medication led to a recurrence. Maria remained psychotic for over 4 weeks. She also

remained isolated from other patients and did not participate in the life of the ward. Food quantities were regulated for her, and an effort was made not to focus excessively on the food theme. Visits from Pia seemed to be experienced as positive. Pia herself was anorexic and showed odd ideas, but did not manifest true psychosis. Psychological testing on Maria yielded a far lower IQ score than had been found during the first hospitalization 3 years earlier--98 as opposed to 130. Recompensation and discharge led to a return to the pre-psychotic picture, with outright anorexia, clear rivalry toward her sister, denial of illness, resistance to treatment on the part of both Maria and the family, and open quarreling between Maria and her mother. No long-term follow-up is provided.

This very rich and detailed case report lends itself to the following analysis. The L. family, in many ways, conforms to the classic picture of an anorexic family. Specifically noted are the following characteristics: excessive emphasis on eating as a matter of survival, connected in part to the father's war experience; the mother's heroic feeding role; the mother's dominant position in the family, which she denies; the mutually symbiotic upbringing of the twins, leading to fragile identity formation; the extreme stress upon achievement stemming from both parents--the mother whose ambitions were frustrated and the father for whom success is a compensation for disfigurement; the failures and parental rejections of the older siblings. The twins appear to fit the traditional picture of compliant "good little girls," at least until the outbreak of anorexia which serves as their first act of volitional self-assertion.

Both twins clearly show, at one time or another, the symptoms of anorexia nervosa; as the author notes, the onset of these symptoms is tied, in each twin, to a "protest" against the other twin seeming to be favored. This intense rivalry ensues upon the first demand for autonomous functioning--the need to establish an identity outside of the symbiotic/complementary twinship (a parallel to the case of Pierre). Once the other twin is no longer experienced as an extension of the self, she is seen as a rival for the very scarce supplies of affection and approval from the mother. On the surface, the

rivalry focuses on the pursuit of the "elfin" figure, but at an underlying level it centers on the issue of academic placement, which is viewed as a direct reflection of the mother's favor. The anorexia serves narcissistic and introjective functions in the attempt to establish separation. It includes an identification with the rebellious dieting older sister--an expression of rage at the mother--and an identification with the father whose survival was attributed to the mother's diligence in feeding him when he was unable to eat on his own--an expression of the need for the mother's nurturance.

The first occurrence of anorexia nervosa is that of Pia, at age 10; this episode appears to remit spontaneously. Two years later, Pia shows another outbreak of anorexia, partly in response to puberty and partly in response to the changed family configuration. It is likely that the arrival of the mother's stepsister fuels the rivalry between these two, which in turn, via projection and unconscious parallel processes, fuels the rivalry between the twins. The increase in family tensions plays a part as well. After 6 months, Pia's anorexia and poor school performance lead to another change. Maria is taken out of her school, presumably for Pia's sake; she retaliates by espousing anorexia, while Pia, on the other hand, feels favored--at least briefly--and goes into remission. Six months after that, at the mother's insistence, Maria is returned to her girls' school and Pia again becomes anorexic, so that both girls are simultaneously anorexic. The message in this family is that the power play of anorexia combined with school failure works, at least some of the time.

A year later, Pia is sent to boarding school. Six months after that, the brother fails his exam, and the family fighting escalates drastically. Maria's first psychotic episode follows upon her feeling abandoned by her sister and overwhelmed by the family strife; it is directly precipitated by a highly sexualized interaction with her father--all anaclitic precipitants. This first episode is less acute than the later one, but quite similar. Maria appears "catatonic" and "amotivational," which suggests a quality of anaclitic depression. Her verbalizations (which are analyzed in detail below) focus on family dynamics. Thus the psychosis is anaclitic in both quality and content. This

episode remits rapidly after a few days of medication. Maria returns to her attempt to rely on introjective mechanisms, i.e., to recurring anorexia. Indeed, her anorexia appears to show periodic exacerbations tied to the repeated attempts to send her to boarding school, i.e., to repeated separations from home (again anaclitic precipitants). Maria finally returns home after having failed at Pia's boarding school--a narcissistic injury to her fragile sense of self that leads her to resort to ever more desperate attempts at introjective functioning in the form of more extreme anorexia and frantic activity.

Finally, after this long and painful progression, Maria again develops a serious psychotic episode, which this time lasts over a month. The anorexia shades very gradually into psychosis largely because Maria attempts to maintain her introjective defenses as long as possible, only giving up and collapsing into catatonic behavior when she can no longer avoid hospitalization. While her state of cachexia at this time could be a factor in the onset of the psychosis, the author notes that the "hasty removal of the cachectic state in no way led to the disappearance of the catatonic symptomatology" (p. 199). Once she emerges from catatonia, Maria's behavior is childlike and very regressed; her verbalizations are profoundly expressive of both individual and family dynamics--these will be reviewed in detail below. Once she begins to eat again, Maria rapidly tips over into bulimia; indeed, the introjective defenses are still out of commission. However, upon recompensation and discharge, she reinvokes them, returning to her prior fragile introjective adjustment based on anorexia nervosa, rivalry with her sister, and quarreling with her mother.

The verbalizations during the two psychotic episodes call for a closer examination. In the first episode, unable to directly speak her mind and no longer able to contain her feelings via the bodily concretization of anorexia, Maria decompensates and resorts to metaphoric speech. Her first psychotic utterance occurs during the stag party: "If the winches were to blow out of all four directions, I would win a big battle" (p. 192). Since the winches cannot possibly blow out of all four directions, this can be interpreted as an expression of Maria's extreme feelings of hopelessness in the face of

the impossible task she has undertaken--that of making peace in a family torn by massive strife and riddled with narcissistic rage. Indeed psychosis, like suicide, can serve as an escape from a hopeless situation. When the family reacts to the psychosis in their usual manner, i.e., with mutual recrimination, Maria utters "Lice and fleas, here there is nothing but dust in the air" (p. 192)--expressing her opinion of their behavior. Finally, while the reference to the "Lustsee" is unclear and may involve sexual issues, the second part of Maria's last statement clearly expresses a fantasy of returning to a state of family harmony and childhood carelessness: "I'd like to go to the Lustsee, it would of course be better, everyone would play together, I'd like the yellow ball and then homeward" (p. 192).

The second episode, which occurs 2 1/2 years later, begins with catatonic behavior--the ultimate form of passive resistance and even more powerful than anorexia nervosa. This is replaced by disturbances in the form and content of thought, with delusional verbalizations. Maria's first comment, in response to being asked why she does not eat, is that "otherwise [if she had eaten] the marriage would have been ruined" (p. 194); this clearly expresses her attempt to hold the family together via her illness. Her second, less coherent verbalization speaks of her father's death; this theme is probably connected to both death wishes and fears regarding his impending demise, something he certainly fostered via his dramatic attacks of breathing difficulty accompanied by "last goodbyes." This comment also expresses a fantasy of reunion with both father and sister. Maria's later statements about her mother, her aunt, and her sister clearly express her intense yearning for love and nurturance from her mother, her envy of her sister whom she views as favored, and her own rage at being dependent yet unloved. These utterances bypass the classic anorexic preoccupations with food and weight, cutting through to the deeper issues, including the substitution of food for love. This is the author's view as well:

The "anorectic content" of the catatonic schizophrenic psychosis allows us in the present case to think of a continuous process. The psychosis can suddenly articulate all that which in the still "normal" state of anorexia nervosa may not be articulated. For the first time an intelligible, full-of-feeling request is formulated: "I am

not happy that mother only brings me food, she should bring me love." The psychosis appears as the breakdown of a resistance, as the capitulation of the sthenic powers of the anorexia. (pp. 202-203)

To recapitulate the sequence of developments in the case from the point of view of the interplay of anaclitic and introjective factors, in both twins the anorexia is precipitated by events that arouse anaclitic needs--loss of the symbiotic twinship, feeling less favored by the mother--and that call for a greater degree of introjective development in the form of more independent functioning--something the twins feel quite incapable of doing in any way other than a very pathological one. The anorexia is closely tied to the rivalry between the twins, a rivalry that is fueled by the anaclitic need for the mother's favor. The author himself stresses the political aspect of the anorexia in both twins, the way in which it serves as an "act of protest" on the part of one who feels powerless. Thus, once again, anorexia proves itself to be an exaggerated recourse to introjective mechanisms in individuals who are driven by urgent anaclitic needs and whose capacity for higher level introjective functioning is very limited.

The precipitants of Maria's first psychotic eruption are anaclitic ones--family strife, feeling abandoned by Pia who has left for boarding school, and, most immediately, the sexualized interaction with the father at the stag party. The psychosis itself shows catatonic behavior with the flavor of an anaclitic depression. Its content consists of verbalizations directly connected to the family dynamics. Thus this first episode is anaclitic on three counts--precipitant, quality, and content of psychosis. Upon emerging from this episode, Maria returns to her anorexia, i.e., to her fragile introjective defense.

This, however, does not work very well for her. Repeated separations (anaclitic stressors) lead to exacerbations of this attempt to rely on introjective functioning via ever more drastic dieting and frantic activity. Eventually, as the "sthenic" powers of the anorexia collapse, Maria again decompensates--specifically when she is hospitalized for weakness, cachexia, and a suggestion of catatonic "walking disturbances." This is followed by severe catatonic withdrawal, and then by a regressive, anaclitic

psychosis with childlike behavior and strikingly direct expression of anaclitic needs and concerns. Not surprisingly, when Maria begins to eat, she rapidly tips over into bulimia, as all introjective defenses have been abdicated. However, upon recompensation, she returns to the fragile introjective adjustment represented by the anorexia. Thus this episode follows the same pattern as the first one--anaclitic precipitants lead to a psychosis that is strongly anaclitic both in quality and content, followed by a fragile introjective recompensation. Long-term follow-up is not available. However, the severity of the family pathology, the massive denial of illness, and the adamant resistance to treatment on the part of both Maria and her family certainly do not rule out a chronically psychotic course; chronic anorexia nervosa would appear to be a given.

Escande, Gavral, and Girard (1975)

Escande et al. (1975) report three cases of anorexia nervosa, two that show "subacute" psychotic episodes and one that demonstrates a "psychotic organization" of the personality, i.e., one we would term borderline. All three cases are fairly sketchy; only the first two fall within the scope of this report.

The first patient, Jeanine (age 25), shows three acute episodes of anorexia nervosa at ages 20, 23, and 25, along with more chronic anorexia during the intermediate periods. The first episode occurs when she is living at home; the second is precipitated by the loss of her job. Four months into the second attack, at a very low weight and possibly around the time that she returns to live with her parents (unfortunately the chronology in the report is vague), Jeanine is hospitalized for a "subacute psychotic state with delirious aspects", which recedes with medication and ECT. The description of her psychotic state is as follows:

Consciousness is altered: she is distant, distracted, almost perplexed, interrogating herself on her identity, frequently repeating: "Who am I?" The feelings of unreality are associated with an experience of depersonalization. She compulsively seeks a mirror to act as a looking-glass to verify her identity, but the glass sends back "an image of a dragon". There is also a persecutory experience with "delirious intuition": "They are mocking me at work . . . They look at me in a funny way."

The affective tone is sometimes that of acute anguish, sometimes that of detachment. (pp. 383-384)

After recompensation, Jeanine is anorexic on and off for the next year. She improves when she finally moves into her sister's house. A year later, she marries and becomes pregnant, at which time (age 25) she begins to lose weight again and is brought in for treatment; with medication and supportive therapy, the anorexic relapse attenuates itself. Other symptoms appear, in the form of obsessive washing rituals.

Jeanine's history is that of a "solitary, obstinate" (p. 384) child who showed school failure and enuresis. Her older sister is a successful physician afflicted with a bilateral limp due to childhood polio. As a child, Jeanine suffered unfavorable comparisons to her sister in school. The mother is a housekeeper. Jeanine remains ambivalently dependent on her mother and has had open struggles about food with her since puberty. She appears conflicted with regard to sexuality and especially with regard to her pregnancy.

There are several problems with this case. The diagnosis of anorexia is not detailed in any way. The psychosis itself is "subacute." The authors are vague regarding the precipitant of the psychotic episode, although they do imply a connection to Jeanine's returning to her parents' home--an introjective precipitant centering on a loss of autonomy. With regard to the content of the episode, we note ideas of reference, although they are not particularly "anorexic"--people "mock" her, but there is no mention of greed or body image. The experiences of depersonalization and identity diffusion could be considered aspects of a severe borderline state. The most clearly psychotic symptom is the vision of the dragon in the mirror, but even here we cannot be fully certain as to whether this is a true visual hallucination or simply metaphoric speech.

Bearing these limitations in mind, we can offer the following schematic analysis. Both the second episode of anorexia nervosa and the psychotic episode that follows upon it show introjective precipitants--Jeanine's loss of her job and her return to her parents' home, respectively. The content of the psychosis is primarily introjective--a focus on identity issues and persecutory ideas. Jeanine's difficulty tolerating the merger aspect of pregnancy is also an introjective characteristic, as is the description of her as a

"solitary, obstinate" child. Indeed, the authors, in their theoretical analysis, stress Jeanine's search for independence from the maternal imago, highlighting both the introjective features of the case and their defensive functions in relation to the powerful anaclitic urges. Upon recompensation, Jeanine returns to anorexia nervosa. In short, while the data is sketchy, the case appears to be introjective along all four variables.

The second case reported by Escande et al. (1975) is that of Nicole, a nurse whose first attack of anorexia occurs at age 19. Nicole described her mother as gentle and affectionate, but always watching over her, especially in the area of food. Her father, a former soldier and functionary, was "very scrupulous and intolerant of messiness or dirtiness"; he was also extremely jealous and possessive (p. 385). He punished Nicole frequently and also took over her sexual education. He requested a professional transfer after surprising her, at age 17, in the act of kissing a boy. Nicole had shown early signs of potential anorexia, in the form of dislike of her body and some weight loss. Her first episode of anorexia occurred at age 19 after her father obtained his professional transfer; this resulted in a first hospitalization. One year later, Nicole had a relapse, followed by a return to normal weight with persistent amenorrhea. A few months before the psychotic attack at age 23, Nicole began having problems getting along with the other nurses at work and experienced persecutory fears--she felt that her co-workers did not like her and were watching over her.

The subacute psychotic state appears in September, 1972, during a hospitalization on a medical service for an intestinal infection with fever. The psychosis is polymorphous, dominated by a massive and permanent anguish, delirious ideas of poisoning, of surveillance, and of guilt: "You have drugged me . . . , I want the whole world to believe that they are watching me and that I take my medicine, search my bag, I am not hiding anything . . . , you know my file and I am ashamed of that because I am a nurse" There is neither confusion nor visual hallucination; consciousness is sometimes distant, but the most common experience is that of hyperanxiety, with anaclitic attitudes at moments. The guilt themes are rarely accompanied by the global experience of affective pain characteristic of melancholia. She also presents obsessions of dirtiness, manifested in frequent requests for sponges and disinfectants so as to wash the tub and her clothing, yet without the experience of compulsion. (p. 385)

The psychosis remits with ECT and chemotherapy. Nicole remains affectively distant and amenorrheic; she terminates therapy when hormonal treatment is suggested.

While this case presents many of the same problems as the last one, it also provides a little more information on which to base an analysis. The anorexia appears connected to the sexualized, overly enmeshed relationship with the father and to his punitive abandonment; thus, its precipitants are anaclitic. Prior to the psychosis, Nicole showed some referential ideas regarding her co-workers--feeling watched by them as she had felt watched by her mother. The immediate precipitant of the psychosis is the medical hospitalization for intestinal infection with fever at normal weight; this could involve both organic factors and feelings related to loss of control. The latter would be especially acute for a nurse, accustomed to the active caretaking role rather than the passive patient role. Certainly Nicole's verbalizations support this view. The enforced abdication of control constitutes an introjective precipitant. The psychotic state is "sub-acute," although from the description the anxiety appears more intense than in Jeanine's case. Despite the authors' description of it as "polymorphous" and "anaclitic," the psychosis seems fairly organized. The delusions, while not directly connected to anorexia nervosa, do focus on loss of control, surveillance, and guilt, i.e., introjective themes. The obsessions with cleanliness and dirt are consistent with these themes and appear to be based in an introjective mechanism--an identification with the abandoning father, as well as self-punishment for the "dirty" behavior that drove him away. Upon recompensation, Nicole returns to emotional isolation, i.e., what would appear to be a fragile introjective adjustment. In short, this case, like the last one, can be classified as introjective along all four variables.

Sumners and Cohen (1987)

Sumners and Cohen (1987) report the case of a male patient whom they present as showing "anorexia nervosa and schizophrenia" independently. However, a close examination of the case puts the diagnosis of schizophrenia into question, in favor of a possible diagnosis of transient or schizophreniform episodes; in the final analysis, the classification of this case remains ambiguous and problematic. Concerns about weight had first appeared in this young man at age 12, along with puberty and sexual concerns,

manifested in regular masturbation and bisexual attractions. At 16, while doing well in school but experiencing severe tension at home, he began to diet, lost a great deal of weight partly through purging behaviors, and lost all interest in sex. "He dieted to lose weight and rejected what he saw as the only thing his parents offered him, namely food." This led up the first psychotic episode:

He was referred to a child psychiatrist who was concerned that, although he showed no psychotic features, he might be an incipient schizophrenic because of his detached attitudes. He was started on trifluoperazine but became confused and was admitted to hospital. He was discharged home after a week because no clear evidence of mental illness was found. He felt humiliated by being made to eat dinner and then being taken to the toilet. Later that night he jumped through his bedroom window because "nobody could mistake that message". Resulting abdominal wounds required a temporary colostomy. A few days later he developed ideas that the hospital staff were plotting against him, his thoughts were being read by the nurses who also controlled him physically, and the hospital radio was used to send special messages to him. Catatonic features and thought disorder were present, and he was treated with thioridazine and trifluoperazine. He was discharged after 2 months on trifluoperazine when he was eating more and his weight was increasing. (p. 436)

The patient returned to school. One year after discharge, before entering university, he became ill again, with renewed food restriction and the delusion that people read his thoughts. He recompensated rapidly under medication. Later that year, he started university and met a male partner. He continued to binge and use laxatives but maintained a reasonable weight and was off medication by the time he graduated university. At age 24, he presented for treatment because of his male partner's concern about his unhappiness and social isolation. He was not working and spent his time cooking and housekeeping. He had concerns about a healthy diet but binged when feeling down. He had a distorted body image and recognized that he had paranoid attitudes, which the authors describe as "not of delusional intensity" (p. 437). With supportive therapy, he began negotiating to take over the running of a bed and breakfast funded by his parents.

The evidence in favor of anorexia nervosa and later bulimia nervosa is fairly convincing, but the case for schizophrenia is a far more ambiguous one. The authors' view is that the patient presented "Schneiderian first rank symptoms in the absence of coarse brain disease"--namely, thought insertion (by the hospital radio) and somatic pas-

sivity (physical control by the staff)--as well as "the presence of thought disorder, catatonic features, and a probably premorbid schizoid personality" (p. 437). This is accurate. However, there were only two periods of truly psychotic functioning at age 16 and age 17 respectively, the first lasting about 2 months, although the patient remained on medication after that, and the second also very brief. The outcome data are ambiguous; the patient is off medication and has some insight into his paranoid attitudes, which are not of delusional intensity; his functioning is somewhat marginal but still adequate, as he graduates, lives with a male partner, and plans to run a business. All of this could argue in favor of a schizotypal personality with brief decompensations into psychosis of a schizophrenic type.

The authors address the question of the relationship between the "schizophrenia" and the anorexia nervosa and conclude that, since there is a 6-month gap between the onset of anorexia nervosa and the psychosis, they appear to be independent on a temporal basis, i.e., neither appears to arise mainly as a consequence of the other. They note that, in the case of the first episode, the patient had just undergone surgery and was at a low body weight; while this might suggest physical factors or possibly a "postoperative psychosis" (p. 438), they argue that the recurrence a year later does not support this diagnosis. They also note that the second episode, like the first, occurred at a very low body weight, but add that the persistence of paranoid ideation at a normal weight suggests schizophrenia rather than a psychosis tied to physical factors. However, one could as easily argue that the paranoid attitudes reflect an underlying paranoid-schizoid personality.

The onset of psychosis is interesting. It is not entirely clear whether the patient's anger is directed at the hospitalization and the family's intrusive interference with his eating behaviors or at the discharge with "no clear evidence of mental illness" (p. 436)--certainly his behavior seems designed to contradict that diagnosis. On the other hand, florid psychosis follows a colostomy, certainly a very intrusive procedure, particularly for someone with concerns about food, weight, and digestion. The content

of the psychosis is indeed classically schizophrenic--paranoid ideas about plots, delusions of thought broadcasting, and delusions of control, along with catatonic features and thought disorder.

The authors' view that the anorexia nervosa and the psychosis are entirely separate, independent illnesses is arguable. While the anorexia predates the psychosis, both psychotic episodes occur at low weight and both seem to remit in tandem with some degree of remission from the anorexia nervosa, while under medication and along with a transition into bulimia. Outcome shows ongoing eating disorder and ongoing paranoid-schizoid personality traits.

From the point of view of our classification, the patient shows a schizoid detachment. In the first episode, he develops a paranoid psychosis in response to apparent interference with his autonomy and his anorexic behaviors. A year after discharge, he again becomes ill, showing both anorexia nervosa and paranoid delusions of people reading his thoughts. Upon recompensation he shows primarily paranoid-schizoid personality traits. All of these factors can be broadly classified as introjective.

Summary of Chapter II, Section B

In reviewing studies that attempt to arrive at an estimate of the incidence of psychosis among anorexic populations (Question 1a), we found that the prevalence rates varied from a low of 5% (Grounds, 1982) to a high of 10% (Hudson et al., 1984). Since all these studies depend on naturally occurring populations which may be subject to all types of referral biases, even if we discount issues related to diagnosis and classification, we must consider these figures rough estimates at best.

In attempting to examine the question of the relative proportion of brief episodes versus ongoing psychotic illness in these populations (Question 1b), we found that each sample was very different, which again probably stems from referral and measurement practices. Hudson et al. (1984) reported a sample that showed only ongoing psychosis. Ferguson and Damluji (1988) reported a sample that showed a relative

proportion of 1 to 4 for transient versus ongoing illness. Grounds (1982) reported a sample of 7 transient psychoses. Hsu et al. (1981) reported a sample of 6 cases that showed a 1 to 1 proportion. No generalizations could be made in this area.

In examining reports of cases of ongoing illness for the purpose of determining type of illness, with a specific focus on schizophrenic versus affective illness (Question 2a), we came up against the same issues of sampling and definition. Hudson et al.'s (1984) sample was entirely affective, if we accept their assumption that Schizoaffective Disorder can be grouped with the affective disorders. Hsu et al. (1981) classified their sample as showing schizophrenic symptoms, but noted a prominence of affective symptomatology as well and suggested that a diagnosis of Schizoaffective Disorder might be just as appropriate. Ferguson and Damluji (1988), on the other hand, described their sample as classically schizophrenic. Individual case reports which purported to describe patients with anorexia nervosa and schizophrenia were, upon closer examination, found to be problematic. The patients described by Sumners and Cohen (1987) and Steinberg (1982) can, upon closer examination, be classified as showing brief episodes. Dubois's (1913) patient seems to have suffered from hysterical self-starvation rather than true anorexia nervosa.

Our examination of the temporal and content relationship between anorexia nervosa and ongoing psychotic illnesses in patients who manifest both phenomena was equally inconclusive. With regard to the temporal question (Question 2b), we could impressionistically say that it appeared somewhat more probable for psychosis to follow upon anorexia nervosa than to precede it. With regard to content (Question 2c), both Ferguson and Damluji (1988) and Hsu et al. (1981) noted what we might call a certain degree of consistency or even "interpenetration" between the two illnesses. Ferguson and Damluji (1988) pointed to a prevalence of somatic delusions among their patients and spoke of the difficulty distinguishing between the "thought style" of the anorexic and the delusional belief system of the schizophrenic. They also pointed out the important organizing function that the eating disorder seemed to serve for their patients. Hsu et

al. (1981) reported auditory hallucinations of voices commenting on the patients' greed or their appearance and remarked that "to us the patients appeared to have retained their anorectic psychopathology even in their psychosis" (p. 276).

The exploration of the case reports of transient psychotic episodes (Question 3) was far richer and afforded the opportunity to apply the anaclitic/introjective model to these decompensations. The following four variables were defined: (a) the precipitant of the decompensation, a separation or loss (anaclitic) versus an interference with the defensive, controlling, and boundary-setting functions of the anorexia nervosa (introjective); (b) the quality of the psychosis--organized (introjective) versus chaotic (anaclitic); (c) the content of the psychosis--delusions or hallucinations centered on themes of guilt, self-blame, or persecution (introjective) versus delusions or hallucinations related to loss of objects or interpersonal dynamics (anaclitic); (d) the process of recompensation, with an emphasis on self-definition (introjective) versus an emphasis on connection with others (anaclitic).

Hsu et al. (1981) reported three cases of transient psychosis, with onset shortly after inpatient admission in two cases and upon nearing target weight in the third. Hsu et al. viewed these decompensations as defensive regressions in the face of "getting 'better'" (p. 276)--in our terms, as a reaction to interference with the defensive functions of the anorexia. These patients experienced auditory hallucinations of voices commenting on "how ugly, fat, or greedy they were" (p. 274). The psychoses appeared relatively organized. No data was available regarding recompensation. Thus these cases were introjective along three of our four variables--precipitant, quality, and content of psychosis.

Grounds (1982) reported seven cases of transient psychosis, with an emphasis on separation from the family and home environment as a precipitant. These psychoses were all described as mixed or polymorphous, and the patients as particularly childish, regressed, and histrionic. There appeared to be somewhat of an emphasis on family conflicts in the delusions. No data was available regarding recompensation. Thus these

cases were anaclitic along three of our four variables--precipitant, quality, and content of psychosis.

To proceed to the individual case reports, Bedoret et al. (1973) reported a case very similar to those reported by Grounds (1982). "Dominique", a narcissistic/histrionic adolescent with tenuous separation from a dominant mother, developed a psychotic episode a few days into inpatient hospitalization for anorexia nervosa, in response to separation from her family (the primary anaclitic precipitant), with some contribution on the part of the ambiguous communication from the treatment team which left her feeling imprisoned and powerless (a secondary introjective precipitant). The psychosis was polymorphous and showed many classic delusions, with a focus on object loss. Recompensation was attributed to the re-establishment of positive interpersonal contact and particularly to the nurturance provided by nursing staff. Thus the case was strikingly consistent in its anaclitic quality along all four variables.

Küchenhoff (1986) reported the case of a young woman of 24 who developed anorexia nervosa upon establishing a tenuous separation from a needy and domineering mother, as noted particularly in her feeling that the mother could take her apartment away simply by setting foot in it. The patient responded to tube feeding with a profoundly regressive fantasy of being a baby in the face of a giant mother--in other words, her anaclitic needs, which had been dissociated in the anorexia, were brought to consciousness. After removing the tube, she was confined to her room. The precipitant of the psychosis was the therapist coming to her room for sessions--an experience of intrusion into her "room-self" which threatened her fragile identity (an introjective precipitant). The patient's psychotic experience was introjective both in its degree of organization and in its content--delusions of persecution by a maternal figure and hallucinations of critical voices commenting on her greed. The recompensation involved the re-establishment of contact with the therapist, in a very bounded manner over the telephone, as well as the reintroduction of her anaclitic needs for both food and contact with other people; thus it was classified as mixed anaclitic/introjective. In summary, the

case was introjective on the first three variables and mixed on the last. This case was also notable for the evolution from dissociation of the anaclitic needs in the anorexia nervosa, to paranoid projection in the psychosis, to reintroduction in the course of recompensation, with the recovery ultimately demonstrating a reintegration and rebalancing of the two developmental lines.

Cramer and Bovet du Bois (1973) reported a case of an 11 1/2 year old boy which demonstrates a dialectical interaction between the two developmental lines. "Pierre" showed onset of anorexia following the rupture of a symbiotic twin-like sexualized relationship with his older brother; thus the anorexia occurred in response to anaclitic loss; it also followed upon an unsuccessful attempt to cope with the loss and the need to function independently by establishing an identity diametrically opposed to that of the brother. Upon hospitalization, Pierre attributed his refusal to eat to an interdiction on the part of a family friend who was a radiesthésiste (some type of faith healer), i.e., his anorexia was based in a projection of the idealized parental imago (Kohut, 1971)--clearly an introjective mechanism, albeit a different one from that described by Palazzoli (1978). The treatment team arranged for a deus-ex-machina intervention by obtaining a letter from the faith healer ordering Pierre to eat; this resulted in a sudden dismantling of the anorexic defense (an introjective precipitant), demonstrated in bulimia followed by a floridly polymorphous psychotic regression, with massive self-object dedifferentiation, abrogation of autonomous cognitive ego functions, and primary process verbalizations directly related to boundary loss and a focus on the oral cavity. Thus the psychosis was clearly anaclitic in both quality and content. Recompensation, which seemed to occur spontaneously, was centered on the re-establishment of an identity dramatically opposed to that of the older brother, i.e., a return to an introjective defense structure, with a secondary anaclitic component consisting of the connection to the radiesthésiste and the avoidance of separation from the family. Thus Pierre's case illustrates a back-and-forth movement between an introjective adjustment both prior to and following a collapse into profoundly anaclitic psychosis.

Steinberg (1982) reported the case of Maria L., an identical twin who showed several brief psychotic episodes in the course of anorexia nervosa. As in the case of Pierre, the onset of the anorexia nervosa was linked to the rupture of a symbiotic twinship (an anaclitic loss). This led to an eruption of rivalry for the mother's affection, with the less favored twin expressing rage and protest via a rejection of food and a pursuit of the "elfin figure" (p. 188). The anorexia was also based in an identification with the rebellious dieting older sister and an identification with the father, who many years earlier had been wounded in the jaw and whose survival had been due in part to the mother's diligence in feeding him when he was unable to eat on his own. Thus the anorexia occurred in response to an anaclitic loss and was strongly introjective in its defensive functions, serving as a way of insuring a tenuous separation via rivalry and incorporating both a wish to be nurtured by the mother as the father had been and a rejection of her nurturing. The first eruption of psychosis in Maria followed upon her feeling abandoned by her sister and overwhelmed by family strife; it was immediately precipitated by a sexualized interaction with her father--all anaclitic precipitants. The psychosis was anaclitic in its catatonic-amotivational quality and in its content--verbalizations focusing directly on family dynamics. Upon recompensation, Maria returned to her anorexia, i.e., her fragile introjective adjustment. Two and a half years later, another episode evolved gradually out of a severe anorexic state; it resulted from the chronically maladaptive patterns of interaction in the family and "the capitulation of the sthenic powers of the anorexia" (p. 203). This second psychotic episode included outright catatonia, followed by very childlike, regressive behavior; the delusional utterances were strikingly expressive of the underlying family dynamics and of Maria's anaclitic needs for love and nurturance from her mother. When Maria began to eat, she rapidly tipped over into bulimia. Upon recompensation, she returned to her earlier fragile introjective adjustment. Thus both episodes follow the same pattern: anaclitic precipitants leading to psychosis that is anaclitic in quality and content, followed by a return to fragile introjective functioning.

The cases reported by Escande et al. (1975) were ambiguous with respect to diagnosis and vague with regard to clinical data. The first patient Jeanine showed a subacute psychotic episode, possibly in response to returning to live with her parents--an introjective precipitant involving a loss of autonomy. The most interesting element of Jeanine's psychosis was the possible visual hallucination of "an image of a dragon" in the mirror; there were also delusions of reference with an introjective quality. Both the quality and content of the psychotic episode would appear to be introjective. Recompensation took the form of a return to anorexia nervosa. Thus all four variables were classified as introjective.

The second patient Nicole showed a subacute psychosis characterized by delusions of surveillance and guilt and obsessions with dirt and cleaning, i.e., introjective content. Despite the description of the psychosis as "polymorphous," it appeared quite organized, i.e., introjective in quality. The likeliest precipitant appeared to be the loss of control involved in being a hospital patient rather than a nurse, i.e., an introjective factor. Nicole recompensated into an apparently anorexic adjustment with interpersonal distance and isolation. Thus again all four variables were classified as introjective.

Sumners and Cohen (1987) reported a case that presented considerable diagnostic difficulties. While they considered it to be a case of schizophrenia, one could as easily consider it a case of psychotic episodes in the context of a paranoid-schizoid personality. The patient, a young man of 16, had been hospitalized because of concerns on the part of a psychiatrist about his "detached attitudes." After discharge from the hospital, while being closely watched in relation to his eating and bowel habits, he jumped out of a window, resulting in abdominal wounds and a colostomy. A few days after this extremely intrusive procedure (an introjective precipitant), he developed delusions of persecution. Upon recompensation, he showed a paranoid-schizoid personality. Thus all four variables were classified as introjective.

Table 2 summarizes the above analysis. In all of the cases, quality and content of psychosis were congruent. Furthermore, in most of the cases, the precipitant and

process of recompensation--when they could be assessed--were congruent with the quality and content of the psychosis as well. There were only two exceptions to this. In Pierre's case, a dialectical interaction occurred between the two developmental lines, with the precipitant and post-illness functioning being classified as introjective and the psychosis itself as strongly anaclitic. In the case of Küchenhoff's patient, the recompensation was classified as mixed anaclitic/introjective; it involved a rebalancing and reintegration of the two lines of development and demonstrated a true progression into recovery. We might also note that the sample as a whole supported our theoretical analysis of anorexia nervosa as an exaggerated introjective response to anaclitic loss and/or anaclitic vulnerability.

Table 2**Summary of Chapter II, Question 3**

	Precipitant of Psychosis	Quality of Psychosis	Content of Psychosis	Process of Recompensation	Overall
Hsu, Meltzer, & Crisp (1981) (3 cases)	I	I?	I	--	I
Grounds (1982) (7 cases)	A	A	A?	--	A
Bedoret, Destombes, & Warot (1973) "Dominique"	A	A	A	A	A
Küchenhoff (1986)	I	I	I	A/I	I
Cramer & Bovet du Bois (1973) "Pierre"	I	A	A	I	Interactive
Steinberg (1982) "Maria L."	A	A	A	I	A
Escande, Gayral, & Girard (1975) "Jeanine"	I?	I	I	I	I
"Nicole"	I?	I	I	I?	I
Sumners & Cohen (1987)	I	I?	I	I	I

A - Anaclitic Type

I - Introjective Type

A/I - Mixed

Dashes - Insufficient Information

Hypotheses

The following hypotheses emerged from both the review of the theoretical literature on anorexia nervosa and the review of the clinical literature on psychotic experience among anorexics:

1. Anorexia nervosa is based in exaggerated introjective mechanisms and serves as an introjective defense against anaclitic needs. It often follows an intensification of anaclitic needs resulting from anaclitic loss; alternately, it can result from the developmental demands at adolescence for greater separation and autonomy in an individual whose personality is strongly skewed towards the anaclitic line and who is thus incapable of higher level introjective functioning.
2. Decompensation into psychotic experience in the context of ongoing anorexia nervosa is due to a failure of this introjective defense structure. The failure can be precipitated by:
 - (a) a direct interference with the introjective defensive functions of the anorexia or an experience of intrusion upon the fragile boundaries of the self (an introjective precipitant), or
 - (b) an intensification of the anaclitic needs, usually in the form of a severe anaclitic loss (an anaclitic precipitant).
3. The psychosis that results can be either:
 - (a) an anaclitic one, resulting from the complete dismantling of the introjective defense, or
 - (b) an introjective one consisting of a psychotic exaggeration of the anorexia nervosa or a regression along the introjective line into more paranoid functioning.

An anaclitic psychosis is anaclitic in both content and quality, i.e., it is centered on delusions or hallucinations relating to interpersonal needs and dynamics; its form is chaotic, with boundary losses, expression of raw anaclitic needs (e.g., bulimia), or outright anaclitic depression (catatonic-like behavior). An introjective psychosis is organized in quality; its content centers on themes of persecution and guilt.

4. **A true recovery--rather than simply a recompensation into anorexia nervosa or other forms of fragile, introjective functioning--ultimately involves a rebalancing and reintegration of the two developmental lines.**

CHAPTER III

CASE REPORT

A. Introduction

This chapter relates the case of "Sylvia." All the names in this report have been changed in order to protect confidentiality; identifying data have been removed with the exception of Sylvia's ethnic background, which was judged to be clinically relevant to important aspects of the case.

I was fortunate enough to treat Sylvia during my internship year on a residency training ward of a large psychiatric hospital. I first became involved with her in October, 1985, when she joined the therapy group which I co-led. In January, 1986, I became her individual therapist. The treatment was terminated in August, 1986, due to my completing the internship year and leaving the hospital.

When I first became acquainted with Sylvia, she was approximately 48 years old, a divorced Jewish female from a middle-class family, who had been hospitalized continuously for nearly 7 years for refusal to take any kind of nourishment by mouth. This behavior was grounded in the belief that God wanted her to fast to repent for her sins. In the early phases of her illness she had been severely emaciated, but by the time I met her she was maintaining an adequate weight of approximately 110 pounds via naso-gastric tube feeding. Originally, this had been forced upon her, but for approximately 5 years she had been a willing and active participant, inserting the tube herself once a day under medical supervision and feeding herself twice daily. She continued to believe and maintain that it was God's will that she "fast" and had come to refer to her present form of behavior as "fasting."

Before recounting the history of the illness, I would like to give a brief description and mental status of the patient, as she appeared in October, 1985. Sylvia was a petite middle-aged woman, with very pale skin and wavy dyed-blond hair cascading to her shoulders. She had a youthful face and manner and could at times be described as

girlish and flirtatious. Her facial features were striking and she remained lovely despite an appearance of ill-health--her skin was very pale, at times pasty, and her teeth appeared to be in very poor condition. Most of the time she was carefully groomed and made up with an almost doll-like quality, but occasionally she would appear in a bathrobe, without make-up, looking pale, listless and dishevelled. She was verbal and articulate and made good eye contact. She was also polite, considerate, warm and caring towards others. She related well to both patients and staff and showed a great deal of tolerance for a broad range of people and behaviors. On the ward she exercised a position of leadership and responsibility, both as an old-timer and as someone whose reality testing was generally good. There were no signs of formal thought disorder. Speech was of normal rate and rhythm. Affect was generally appropriate, with the exception that Sylvia tended to maintain an ever-present smile in the face of pain or anger. Mood was depressed, even hopeless--Sylvia spoke of wanting to go to a nursing home, where she could wait to die. Sylvia's lifestyle was quite sedentary and she was often lethargic, partly due to considerable medication. She would occasionally fall into a stuporous reverie in the midst of group or individual therapy sessions. There was, at times, an eerie contrast between her depressed mood and her forced grin-like smile. There were no hallucinations and only one delusion--that it was God's will that she "fast." This was experienced as a sense of conviction rather than an auditory hallucination. There were a few possible exceptions to this, but none very convincing--e.g., on one occasion, she had claimed to hear the voice of God, but when her therapist had confronted her with her fear of being discharged from the hospital, she had responded, "I don't want to eat." Intelligence was at least average and insight into everyday matters was quite good. On the other hand, judgment and insight in areas related to food, eating, or the delusion were clearly impaired.

The rest of this chapter will relate the history of Sylvia's illness, followed by her social history, an account of the treatment during the year in which I worked with her, and a report of her post-discharge status.

B. History of Present Illness

This section is based largely on the hospital records, with some additions provided directly by Sylvia in the course of our work together; as much as possible, these are identified as they appear.

Sylvia was transferred to our facility from a private hospital in January, 1979, with the fixed delusion that she must abstain from eating or drinking for 40 days to exorcise devils from her body and to repent for her sins. Her illness had begun approximately 1 1/2 years earlier, when she was 40 years old, following the death of her mother and two siblings. Her mother had died at approximately age 76, 2 years after suffering a massive stroke which had left her paralyzed and confined to a nursing home. Prior to her death, Sylvia's mother had been paralyzed in the mouth, unable to speak and needing to be spoon fed. Her death was at times attributed to malnutrition and at other times to kidney failure and/or leg amputation, possibly secondary to the stroke, and/or to unmanaged hypertension; the report apparently varied from one family informant to another and from one telling to another. Sylvia herself recalled crying only once for this loss--after looking at her mother's body in the coffin and seeing "how thin she looked". Just prior to the mother's death--possibly months apart, but again the information is unclear--Sylvia's brother and sister had committed suicide, the brother by jumping in front of a train and the sister by an overdose. Originally there was considerable denial in Sylvia's family regarding the circumstances of these two deaths--in the earlier hospital records staff members reported that the sister had died by "choking on food" and that the brother had fallen in front of a train, but alluded to suspicions of suicide. As the records progressed, the deaths were more often referred to as suicides. By the time of our treatment, Sylvia was very clear about this and indeed provided some of the details in the Social History below.

Sylvia, who had fasted periodically since age 15 as a means of controlling her weight, began once again to abstain from food in order to relieve the "anxiety" and "pressure" that she felt. She and her husband had joined a born-again Christian move-

ment and frequently held Bible meetings at their home. According to Sylvia's report, her husband suggested that she try fasting for a day or so to calm her nerves. (As we will see below, Sylvia was at times quite adept at inducing others to give advice and it is possible that she may have been the initiator here rather than her husband.) At the time, Sylvia felt depressed, "hassled," and overwhelmed by the strain of raising two small children. She recalled reading a passage from the Bible which suggested fasting to purge oneself of impurity and sin and to rejuvenate one's health--much later, during our work together, Sylvia cited this passage as "Come to me with all your heart, fasting, weeping, grieving and rend your heart, not your garments" (The Book of Joel, Chapter 2, Verse 12-13, as per the American Bible Society). In any case, Sylvia tried fasting for a few days and felt physically and emotionally better; she experienced increased energy and libido and decreased irritability and moodiness. She tried fasting again a few more times for 2-3 day intervals and found it increasingly difficult to return to eating. In fact, eating seemed to cause her overwhelming anxiety--she would experience shaking, insomnia, and feelings of guilt. She began to believe that God wanted her to fast to repent for her sins. Later, Sylvia spoke of having set out to fast for 40 days--a goal that she explained by referring to Christ's 40 days in the desert.

On Thanksgiving Day, 1977, following a lengthy fast (39 days according to one hospital's records; 21 days according to our records), Sylvia was hospitalized for the first time on the advice of her pastor. The diagnosis was anorexia nervosa. This was the beginning of a series of brief hospitalizations, eight in all over the course of the next year; these ranged in duration from 1 night, to 3 weeks, to 3 months on two occasions, and took place in a total of four different facilities. Sylvia would call her father when she was so weak that she could no longer walk and he would come and take her to the hospital. Once there, she would respond to threats of force-feeding by the resumption of eating, but always with the intention of stopping again when discharged. During this period, 13 different medications were tried, but all were discontinued due to patient resistance and complaints about side effects. During the last of these hospitalizations,

which lasted 3 months and led to transfer to our facility, Sylvia was placed on high doses of neuroleptics, with little or no effect, and was awarded the diagnosis of chronic paranoid schizophrenia.

In January, 1979, Sylvia was transferred to our hospital for continued refusal to eat. Upon transfer, she was described as well-related, but appeared to be in severe denial with regard to the seriousness of her situation--the crises in her family, the severity of her illness, and the physical dangers of her behavior. During the early period of hospitalization, Sylvia at times accepted food via spoon feeding and some medication, but much of the time refused both. She was described as demanding and manipulative, creating power struggles on the ward around feeding issues, and fomenting conflict among the staff--pitting therapists, doctors, lawyers, nurses, and therapy aides against each other. She was obsessed with her fears regarding medication and possible side effects. She would resort to all kinds of deceit in order to avoid eating, e.g., giving her food away to other patients, spitting it out, exchanging plates, or wearing extra clothes when being weighed. She saw herself as a "fat person" as well as a "bad person." She remained very concerned about her appearance and conscientious about her grooming and make-up. Numerous treatment plans were instituted in the attempt to get Sylvia to eat, but none was effective.

Sylvia's weight fell to a low of approximately 84 pounds (the reports in the records actually range from 79 to 84 pounds) at the end of February, 1979. Tube feeding was introduced. Sylvia was at first quite resistant to this--she pulled the tube out and agreed to eat, but this resolution did not last long. In March, 1979, Sylvia was placed on suicide precautions and was described as quite psychotic. She was irritated, agitated, and depressed; she attacked a nurse, claiming that the nurse had killed her children. She maintained her intention to fast in order to cleanse her body of the evil spirits which had possessed her for her wrong doings; when asked about these wrong doings, she would speak of having abused her children. Indeed, this aspect of the delusion--Sylvia's belief that she had to fast for 40 days in order to exorcise devils and

repent for her sins--was specific to the early period of the illness. Even then there were times when Sylvia spoke only of God's will. On one occasion she said that the Lord had told her not to eat until she reached 62 pounds. Over time, mention of devils or evil spirits decreased, ceasing entirely after Sylvia's ECT treatments (see below) and coming to be replaced by the firm conviction that God wanted her to fast.

In early April, 1979, feeding via naso-gastric tube was instituted on a regular basis. Sylvia continued to refuse medication. Nonetheless, her physical and mental condition improved, as her weight became more normal. In fact, psychological testing, which had been attempted in February but interrupted due to Sylvia's physical and emotional state, was now completed (the results of the testing will be discussed in Chapter IV below). In April, Sylvia was described as tolerating tube feeding fairly well, i.e., with passive acceptance; she was also described as quite regressed--she was not socializing and seemed to enjoy her "infantile" status. Still the staff noted a decrease in the power struggles on the ward, adding that Sylvia seemed more related and no longer actively "psychotic."

In May, 1979, Sylvia began pouring food into the tube herself, in the presence of a nurse or therapy aide. At first Sylvia was fed pureed foods and later nutritional supplements (Sustecal or Complete B), along with milk, juice, and water. The nursing staff noted that Sylvia seemed to look forward to the tube feedings--she enjoyed the attention that she got and the feeling of exerting control over the process. They even suggested that she seemed dependent on and attracted to the tube itself, experiencing it as a source of pleasure. At this time, Sylvia was also described as working constructively in therapy. On the other hand, she seemed to be withdrawing into the safety of the ward. She resisted going off the ward and had begun to actively relinquish the outside world, urging her husband to divorce her "for his own good," refusing most visitors, and telling her father to sell her clothing. Later, in our work together, Sylvia described having destroyed her identification papers and her most precious possessions, e.g., a fur hat given to her by her older sister Roberta who had committed suicide. Sylvia con-

tinued to be plagued by memories of "evil actions," to see herself as a child abuser, and to try to convince everyone that she was evil and should be sent to jail; she even insulted others in her attempts to prove herself "bad." She spoke of feeling hopeless and described the hospital as a "waiting room to Hell," where she was waiting to die as "just punishment" for her sins. She spoke of fasting as the only way to maintain control, saying she had used it to control her temper in the past and had found it more effective than drugs or alcohol for that purpose. The hospital records contain a very poignant letter written by Sylvia herself, dated June, 1979, in which she confessed to "abusive" behavior towards her two young sons in clear, detailed, and lucid terms--e.g., striking them in moments of anger or frustration and making either insufficient or excessive attempts to get them to eat normally. She also confessed to several abortions and to having taken stimulants against medical advice during an earlier pregnancy which resulted in a premature birth followed by the child dying shortly afterwards. The letter is a powerful testimonial to how intensely conflicted and overwhelmed Sylvia felt in her role as mother and caretaker and how much guilt she suffered over this in the early stages of her illness.

Around this time, the staff began taking steps to obtain permission to medicate Sylvia against her will and also discussing the possibility of electroconvulsive therapy [ECT]. Sylvia was extremely ambivalent with regard to medication and seemed somewhat more receptive to the idea of ECT, although she generally refused both. Some ambivalence about the tube was mentioned as well--she occasionally refused it; the rest of the time she accepted it "because it was forced upon her," but had to be watched as she might otherwise discard her feedings. This state of affairs continued through the summer and fall of 1979. Meanwhile, Sylvia became more active on the ward and was elected president of patient government.

In November, 1979, Sylvia reversed herself on the issue of tube feeding, protesting that she found the procedure degrading and dehumanizing and that walking around with the tube protruding from her nose caused her to feel shame and embarrass-

ment. She took legal measures to refuse tube feeding and the hospital repeatedly obtained permission to tube feed her against her will. The hospital records underline the powerful effect of authority in this regard. Sylvia routinely protested, but, when informed that the Director of the hospital had been granted the authority to impose tube feeding pending permission from the Regional Office, she would "settle back quickly and accept the procedure without a fuss"; she was described as "respond[ing] to the authoritative voice" (Hospital Records, 11/29/79).

In December, 1979, Dr. T., a psychiatrist affiliated with the hospital, was called in to consult on the case. He diagnosed an atypical psychotic depression with pathological grief reaction, an atypical anorexia nervosa, and a character disorder with masochistic features; he recommended a trial of ECT, in light of the atypical affective illness and mood congruent delusions which had proven resistant to medication. Permission was obtained for ECT against the patient's will and, from May through June, 1980, Sylvia received a course of 20 ECT treatments. Over the next few weeks, Sylvia stated that it was no longer God's mandate that she fast; she admitted a desire for food, but expressed fears of eating and a feeling that she should fast to expiate her sins. Around this time, she began to introduce the tube herself under medical supervision--a practice she maintained for the next 6 years. The records also note that in June, 1980, Sylvia ran away for one night and had to be returned to the hospital by her brother; for several days following this, she refused the tube--thus her behavior at this point in time remained chaotic and unpredictable, in contrast to the stable and consistent adjustment that she later developed.

In July, 1980, Sylvia was transferred to a new residency training ward that was just being established by Dr. T.; in fact, she was chosen as the first patient for the new ward by Dr. T. himself. An immediate transference took place, both to the ward and to Dr. T. Sylvia's socialization, self-care, and mood improved dramatically shortly after the transfer. She began eating normally in early July, became involved in ward activities, and was elected president of patient government on the new ward. In our

work together, Sylvia described this as a 3-week period during which she ate and lived with a good deal of abandon, going out to lunch or dinner daily with her father--a kind of "date" where they would eat, drink, and laugh together--and having an affair with a male patient on the ward.

The hospital records from this period describe Sylvia as "an attractive, petite, well-groomed middle-aged woman whose former vivaciousness about life appears to have worn thin". On the surface, she was "rather heavily made up and seductively dressed" and appeared "well related, friendly, cooperative, and energetic," but was "at times demanding and manipulative." Despite her declarations of anxiety and depression, the staff found her moods "difficult to assess because of a fixed gracious smile, regardless of the painfulness of the topic under discussion." This was seen as evidence of shallowness and emotional unreality, with "a suggestion of underlying profound sadness, emptiness, and hostility." Although on the whole her thinking was clear and coherent, her perceptions of people and events closely related to conflictual areas was so variable from one moment to another as to suggest breaches in reality testing. There were no signs of thought disorder, but she did display "idiosyncratic overpersonalized responses to proverbs and similarities, e.g., a table and chair are similar because they are both used for sitting down to eat." At times, she voiced insights that the staff judged as "profound" but she did so without any affect--e.g., "I think I was inwardly glad that my mother and brother and sister were gone because now I could have my father all to myself" (Hospital Records). In short, from our point of view and with the benefit of hindsight, Sylvia appeared brittle and superficially compliant, as seen particularly in the pseudo-insight into her oedipal dynamics, with denial of the converse side of this experience, namely her very real terror of having her father to herself which is amply supported by the later evolution of the case.

In any case, now that Sylvia was eating, plans were made to discharge her to her father's home. Three weeks after she had begun to eat, Sylvia once again stopped.

In fact, she manifested a severe regression--the first of two such marked regressions into deeper psychosis. The descent into this regression was a gradual one:

As treatment progressed into the month of August, although [she] continued to eat and to take an active part in ward activities, her behavior, affect, and reality testing became increasingly eccentric and caricatured. Her make-up became quite garish and her mask-like face took on a penetrating nightmarish stare. [She] seemed more hostile and negativistic. As individual sessions continued to gently probe areas of emotional sensitivity, however, [her] "façade" began to disintegrate. She became quite panicky and began to misinterpret reality in a frightening paranoid and referential manner. The nurses were lying about how many sanitary napkins they gave her; a male patient whom she had had sex with was going to be arrested, she had led him into evil. She had selfishly spent her father's money on lunch for this friend. [Sylvia] pulled up her skirt in individual sessions to display her overweight thighs and swollen stomach. [She] threw away her cosmetics and gave away possessions. [Her] bizarre disorganized behavior quickly subsided as [she] sank into a deep depression. She became sullen and withdrawn, began to neglect self-care, and stopped eating in mid-August 1980. [She] appeared drawn and gaunt and would lie on the floor in a fetal position for hours on end. She was poorly related, avoided eye contact, and displayed marked psychomotor retardation and paucity of speech. Her logical thinking remained contaminated by intrusions of primary process material, vague paranoid ideation, referential thinking, delusions of guilt, and nihilistic thinking. There was no evidence of true auditory or visual hallucinations, although in her initial panic, [she] had fleetingly reported both, in the hypnagogic state.

[Sylvia] is presently nearly mute, with psychomotor retardation. She stares blankly into space for long periods. Her thinking appears to be confused, at times, with evidence of vague paranoid ideation and ideas of reference. [Her] guilty ruminations, about professed past and present misdeeds, which have adversely affected other peoples' lives, surface intermittently. [She] is nihilistic and negativistic, professing not to know why she isn't eating or why she is refusing medication and treatment. She takes a passive masochistic stance, helplessly inviting unpleasant interventions yet refusing all offers of help. (Hospital Records)

When Sylvia's weight fell to 98 pounds, tube feeding was reintroduced. It continued nearly uninterrupted from this time (late July/early August 1980) until early 1986 (see below). Sylvia herself reported to me that she had broken her fast for one day during these years on a Yom Kippur holiday, the "Day of Atonement" during which observant Jews are expected to fast--yet another example of her intensely ambivalent feelings about her ethnic background. It should also be noted that the term "fasting" had by this time taken on the rather unique meaning of feeding by tube rather than by mouth.

Following the severe regression described above, new medications were introduced and discharge plans were shelved. Over the next several months, Sylvia gradually

emerged from the regression. While still refusing to participate in most activities, she once again conversed with patients and staff, contributed sporadically in ward meetings, and spoke with her father and husband over the phone. She spent most of her time reading novels. She continued to refuse food, haggle over medication doses, and ask repeatedly to go to "the chronic ward, where hopeless cases--like me--belong." There was some sense that Sylvia was beginning to experience her depressive feelings on a more integrated level. In individual therapy, she was described as "realer"; she could at times share painful experiences with her therapist and seemed more pensive and more concerned about the seriousness of her situation. Nonetheless, "individual sessions retain[ed] an elastic quality," with a close warm sharing session being followed by "a distant, stubborn, or refused session, or the profession of guilt, lying or manipulating." Thus "each positive inroad evok[ed] a masochistic reprisal so that the establishment of a therapeutic alliance [was] constantly undercut" (Hospital Records).

By November, 1980, Sylvia had settled into a steady depression, as seen in the following description:

[Sylvia] is emaciated and worn and carelessly attired. . . . [she] appears overburdened by the cares of the world. . . . She sits quietly reading, whiling away the empty hours. . . . [She] expresses feelings of overwhelming sadness, emptiness and hopelessness. . . . She describes feeling as if her body is dead and no longer feels as though it belongs to her. Only her mind is left and she continues to think on. She is "like a vegetable," living a vegetative existence. She is horrified by the grotesque image of the ill-kept woman with the tube whom she sees when she looks in the mirror, but somehow is paralyzed to rectify the situation. (Hospital Records)

Sylvia's memory of recent events--the deaths in her family, her children's lives, and her own hospital course--showed a "faraway cloudiness" which the staff attributed to "mas-sive repression."

Sylvia's first therapist on the training ward was scheduled to leave the ward on June 30, 1981, due to the end of the year's rotation. In January, 1981, this therapist gave Sylvia an ultimatum--unless Sylvia started to eat in April, they would have to terminate in June. Sylvia reacted by becoming more negativistic and pulling back from individual sessions. Various attempts were made to discharge her by the summer, e.g.,

to an adult home, but all these plans failed due to her daily naso-gastric tube insertion, which required medical supervision.

Shortly after the departure of her therapist at the end of June, Sylvia began once again to decompensate--her second marked regression into deeper psychosis. Although she did not attempt to discontinue tube feeding as the staff had feared, she did show increasingly primitive behavior:

[Sylvia] remained fairly stable for approximately 2 weeks [after the departure of her first training ward therapist]. Slowly she began making "confessions" first of a mild nature and then increasingly regressed and delusional material emerged. At present [Sylvia] believes that she has had "oral and rectal sex" with two of her infant children. She believes that she smears and chews her own feces on a daily basis. She is hostile and provoking with other patients. She is obsessed with what she believes to be a "wrong" body fat distribution and pulls up her skirt and pulls down her pants to show both patients and staff that "something is wrong with my fat ass."

In another chart note, Sylvia was described as "confessing sins--both real and delusional--many of which [were] told in vulgar language and all-too-vivid detail," "yelling out racial slurs," and "occasionally undressing" in public. She also became "increasingly withdrawn" except when making her confessions. Although she denied hallucinations, she "at times appear[ed] to be responding to voices." Her speech became tangential and logical thinking was at times replaced by "primary process material, vague paranoid ideation, delusions of guilt and nihilistic thinking . . ." (Hospital Records, 8/81). Over the next few months, Sylvia emerged from this regressed state and again began functioning more adequately on the ward; it is not clear whether this emergence should be attributed to medication changes and/or to her developing a connection to her new therapist.

Over the next few years, Sylvia showed less difficulty adjusting to therapists leaving and being replaced by new ones; she formed strong ties to the ward itself and particularly to the nursing staff, who were very stable. In this fashion she adapted to what Dr. B., a consultant on her case (see below), was later to characterize as the pattern of repeated "seduction and abandonment" inherent in being a long-term patient on a training ward. This is not to say that there was no reaction--indeed, in July 1982 she

refused the tube for a while in response to just such a loss--but on the whole her reactions were briefer and far less drastic than the first one had been.

In March, 1982, Sylvia developed severe bowel obstruction, due partly to tube feeding and partly to the side effects of her medications; this required a brief stay at a nearby medical facility. Upon her return to the ward, an attempt was made to eliminate the tube via a trial of behavior modification designed to induce progressive desensitization to oral intake. Sylvia went so far as to introduce a spoon into her mouth, but would not let food pass her lips. The bowel problem was solved by the addition of Metamucil and Colace to her medications. In June, 1982, Sylvia became willing to brush her teeth and go to the dentist--thus allowing certain objects to pass her lips, so long as she did not have to swallow. Around this time, her therapist and Dr. T. took her to visit the graves of her mother and siblings in order to help her work through some of her mourning. This occurred around the time that adoption proceedings for her children were getting underway (see Social History below).

Over the years, a number of behavioral treatments were attempted. According to the records, a program based on the "Premack Principle" was instituted in early 1983. The goal was to gradually approximate eating, by making a low probability behavior, i.e., one seen as leading up to normal eating, contingent upon a high probability behavior--in this case, tube feeding which Sylvia "had developed into a ritualized art," as her therapist put it. The scheme was as follows. A task would be set, e.g., brushing teeth, chewing gum, holding water in mouth, etc.; if the task was completed under supervision, Sylvia would be allowed to place the tube and feed herself as usual; if the task was refused, she could place the tube herself, but a doctor would feed her 1500 calories by tube for lunch--a rather punitive measure from her point of view, in light of the high caloric content for one meal. If she should then refuse to allow this feeding, she would not be allowed to insert the tube at all and thus would be deprived of her medications--she was, by this time, very attached to her medication regime. Also, if her weight should fall below 95 pounds, the program would be suspended and she would

be force-fed on a daily basis. This program had a limited success. Sylvia did carry out a number of the tasks. On several occasions she refused, but each time she would comply the next day, following "renegotiation" of the task. At the end of his training year, the therapist who had begun this program concluded that "paradoxical treatment (i.e., 'giving up on her') might be a fruitful approach . . . " (Hospital Records).

The next year's therapist continued this program with a crucial modification. In order to avoid confrontations and power struggles, which he viewed as very destructive, he allowed Sylvia to choose the required tasks. Interestingly enough, the tasks were never refused and "she generally chose tasks of slightly increasing difficulty," e.g., keeping water in her mouth, chewing gum, sucking on hard candy--as we will see below, this is very similar to what Sylvia did on her own initiative during our treatment in 1985-86. Only once during the course of this program did Sylvia's weight fall below 95 pounds; this occurred when Sylvia got angry after being told she could not stay alone in the treatment room while feeding, i.e., in response to something she experienced as an intrusion on her privacy and autonomy.

The following year (1984-85) yet another behavioral program was attempted. According to Sylvia's report to me during our work together, she was requested to eat Cheerios five times a day and force-fed a can of Complete B (a nutritional supplement administered via the tube) each time she refused to ingest a Cheerio--all in all a punitive experience for her as it caused her to gain weight. In yet another treatment--again according to Sylvia's report--the plan was that a different staff member would meet with Sylvia every hour in order to get her to swallow one Cheerio. On the second day of the program, when she was being supervised by Dr. T., Sylvia swallowed two Cheerios, but after this she refused to continue the task. In summary, behavioral treatments proved unsuccessful to the degree that they encroached on Sylvia's sense of autonomy. On the other hand, to the degree that she was allowed to control the process, Sylvia did take the opportunity to overcome certain limited fears related to oral intake.

To return briefly to Sylvia's relationship with Dr. T., she appeared to experience a powerful oedipally-tinged transference toward him, consisting of a mixture of idealization and erotic feelings, against which she defended herself by avoiding situations where she might be alone with him--e.g., she never took advantage of his offer of individual sessions during one of her therapists' vacations. Sylvia also maintained a very positive attachment to the nursing staff of the ward. In turn, she was clearly a "special" patient to both the ward and the hospital as a whole--a status which was demonstrated in part by a powerful investment in efforts to "get her to eat." For example, dieticians made numerous attempts to engage Sylvia in menu planning and offered to supply anything she might want. Much later, in 1986 when Sylvia had begun to eat, the head dietician of the hospital, having heard of this development, made a spontaneous visit to see if she could be of help. Sylvia also reported to me that, on two separate occasions, two different hospital directors came to see her and personally tried to persuade her to give up her symptom.

Some time in late 1984, one of Sylvia's doctors began to involve Sylvia's older sister Miriam in the treatment. Miriam had been out of touch with Sylvia for many years and lived in another state; she had visited Sylvia for the first time in 1982. Miriam began calling Sylvia regularly and visiting several times a year; she participated in family sessions and brought Sylvia gifts of clothing and make-up. This greater degree of involvement on Miriam's part began at a time when Sylvia's father had suffered a bout of serious illness and was unable to visit.

In general, although there was little alteration in the primary symptom, Sylvia's overall behavior improved greatly during these years. By fall of 1985, Sylvia was settled in her hospital life. She inserted her naso-gastric tube each day, under medical supervision. She would then tube feed herself twice a day with a maintenance liquid diet consisting of Complete B, juice, milk, water, and medications. She was on a relatively potent combination of Mellaril, Trazodone and Benadryl, as well as Hydrocil or Metamucil to promote elimination. She generally inserted the tube around noon for her

early feeding; she then left it in all day, walking around with it taped to her nose and the external end taped to her shoulder. She kept it in all day rather than inserting it twice a day in order to minimize scarring of nasal tissue, which was already severe in one nostril. She would remove the tube after her evening feed at around 7 P.M.

Apparently, Sylvia experienced considerable shame at being seen wearing the tube; nonetheless, she wore make-up and took good care of her appearance. She maintained a weight of approximately 110 pounds, which was a little higher than the goal of 105 pounds specified in her treatment plan and quite adequate for her height. She led a very sedentary life and may have suffered from a low rate of metabolism induced by fasting--she constantly complained of being cold and wore a lot of clothing even in warm weather. Sylvia had been amenorrheic since 1977, i.e., around the onset of her illness, with brief periods of return of menses with weight greater than 110 pounds. It is unclear whether the amenorrhea was primary or secondary to the original weight loss. Sylvia had had no menstruation since 1981, i.e., approximately age 44. By fall, 1985, demanding and manipulative behavior had long since disappeared. Sylvia was one of the most popular patients on the ward, as she was attractive, courteous and kind, cared for her personal appearance, and was understanding and supportive toward both staff and other patients. She participated in a number of activities on the ward and went out on regular monthly passes to the beauty parlor in a nearby shopping area. In short, Sylvia had become a model patient, with the sole exception that she continued to refuse to take food or drink by mouth.

C. Social History

Much of this section is based on information obtained directly from Sylvia in the course of treatment. Most of the facts were confirmed in the hospital records. However, some of the dates and ages had to be estimated, as the information in the records was at times inconsistent.

Sylvia was the youngest of six siblings, born and raised in an outlying borough of a large city. Both her parents immigrated to the U.S. from Eastern Europe as adolescents in the early part of the century. They started a very successful retail business--they were both extremely hard and dedicated workers, who rarely rested and spent little time at home. Sylvia's father was described as a temperamental and choleric man, who could also have tender moments. Her mother was described as a fanatic housekeeper, very "house-proud" and extremely controlling. Sylvia recalled that her mother would work 6 days a week in the store and dash in at night to prepare dinner without even removing her coat. Sylvia described her mother as "the harder one" and her father as "softer." She stated that her parents were extremely devoted to each other--her father never even considered remarrying after the mother's death--but remembered overhearing loud fights about sex, which she said her mother disliked and often refused. She had reason to believe that her father carried on a sexual relationship with a rather plain shopgirl who worked in his warehouse.

The couple had six children over a span of 18 years. Yet they did not enjoy the presence of children. Sylvia's mother in particular did not like having small children underfoot; she would not allow the children to bring friends home or have pets. In later years, Sylvia's mother insisted that her grandchildren be boarded out to strangers when her daughters returned home to live, as they often did between their various failed marriages.

The family lived in a Christian neighborhood and was quite isolated, as the parents were mistrustful of Christians. Sylvia attended public schools and socialized with her neighbors. She recalled having one friend during childhood, a young Irish Catholic girl whom her parents disliked on ethnic and religious grounds. Sylvia and this girl were close friends for years until the girl moved away, after which they never saw each other again.

Life in the family was characterized by intense demands for achievement within limited spheres of endeavor, coupled with a constant stream of verbal abuse and

denigration emanating largely from Sylvia's father. His favorite refrain was, "Six out of six, no damn good, you'll all end up in the gutter." There was occasional physical abuse as well. Miriam's psychiatrist once described the family in terms of a racing metaphor: "They broke your legs and then bet on you."

When she was little, Sylvia was the apple of her father's eye, being the youngest and extremely pretty. She later reported having felt rejected at around age 7, when her parents became obsessed with the performing careers of two of the older siblings. Sylvia's brother Michael (12 years older than she) bore the hopes of the family for fame and success. Sylvia recalled that her parents would follow him to resort nightclubs on the weekends, leaving her with a neighbor. She also recalled that they would constantly play an album he had made at a very high volume "so that the neighbors should hear it." On one occasion, Sylvia protested that she needed to get to sleep as she had school the next day; she was verbally assaulted and physically beaten for having dared to complain. Indeed, any child who dared to disagree with Sylvia's father was generally beaten or threatened with expulsion from the house, even into adulthood. These threats were occasionally carried out, e.g., on Sylvia's eldest sister Roberta.

The family was severely enmeshed. Sylvia recalled that all the children slept in one large room, the two boys in one big bed and the two girls in another (the two eldest children had by then left home). This was certainly not due to poverty, as the apartment was large and there was household help. This situation continued well until the middle brothers were into late adolescence and early adulthood. Sylvia's mother also continued to bathe her sons into their teens, claiming this was the only way she could be certain that they washed behind their ears.

Sylvia, like her eldest sister Roberta, was prized for her looks. She won beauty contests as a child and her picture was displayed in the local photographer's shop window. Her tender moments with her father revolved around eating--he would come home late at night and they would snack together in the kitchen, making "extra special" ice cream sundaes. From approximately age 5 to age 15, Sylvia was cared for by a

Catholic housekeeper Maria, who was a nurturing figure to her. Maria's attentions were primarily dedicated to Sylvia, as the other siblings were older and more able to take care of themselves. Sylvia recalled pleasurable outings with Maria--going to church where Sylvia would take communion, to the movies, and out to eat. Sylvia always had an early dinner alone with Maria in the kitchen, thus escaping the regular dinner table scenes that would take place between the parents and the other children. Early on in her hospitalization, Sylvia stated that she had pretended to favor the housekeeper, in order to make her mother jealous and to hide her feelings of need for her mother. Sylvia believed that her mother had wanted to abort her.

Some time in early adolescence, Sylvia became very concerned about her weight--she described herself as a chubby teenager of 130 pounds and recalled being teased for it by her brothers' friends. Around age 15, she began dieting, probably in a rather drastic manner. As best can be determined, this renunciation of food appears to have occurred both around the onset of puberty and around the time that Maria left the household. The change in Sylvia's eating patterns was accompanied by a certain estrangement from her father, with whom she no longer shared the joys and intimacies of ice cream sundaes. Upon Maria's departure, Sylvia joined the family dinner table. During dinner, her father would eat voraciously, while at the same time lighting into one child with an intense stream of criticism and anger--often at the instigation of the mother, who, Sylvia felt, was deflecting his anger away from herself and onto the children. The other children would sit by helplessly, afraid that any attempt to ally with the victim would lead to the fury being directed at them. The attack would continue as long as Sylvia's father was eating, even through his tea and cookies in the living room, and would cease abruptly when he finished his meal and retreated into his newspaper. Sylvia recalled that the abuse began to be directed at her once she had started dating and wanted to go out with young men who were not Jewish. Early on in her hospitalization she also reported that she herself, although a popular teenager, had always preferred her father; she added that no man was ever good enough for her in his eyes.

These events appear to mark the onset of an anorexic-bulimic eating pattern that continued throughout Sylvia's adult life. Over the years, Sylvia resorted to severe dieting, occasional fasting, use of purgatives, amphetamines, and occasional bulimia with forced vomiting. At various times, she abused alcohol, amphetamines, and benzodiazepines (e.g., Valium, Librium). During much of her adult life, she controlled her weight by taking only coffee during the day and eating one light meal at night, yet preparing elaborate meals for her husband and children. Following her first marriage, she briefly reached 188 pounds, but for most of her life she maintained her weight at 100 to 108 pounds.

Sylvia's adult life followed a very borderline pattern, with a number of brief but intense involvements with men, usually lasting 2 to 3 years and usually involving marriage and children. All in all, prior to hospitalization, Sylvia had had four husbands (all Christian), one live-in relationship, five children, one other child that died shortly after birth, three abortions (one a therapeutic abortion), and two suicide attempts by overdose following the end of her first and second marriages.

To start at the beginning, Sylvia had her first affair in high school, with a young man who was half Jewish and half Catholic, to whom she was engaged for a while. At age 17 or 18, before finishing high school, she met and married a 25-year-old Catholic jazz musician. Her mother did not disapprove of the match, as the young man's father was prominent in the community. Sylvia converted to Christianity at this time. Sylvia and her first husband had a son and a daughter, born when Sylvia was approximately 19 and 20, and one child that was born prematurely at 6 months gestational age and died shortly after birth. The couple lived in her husband's parents' home and was largely supported by her husband's father. Her husband went out drinking with women, leaving her alone to care for the children, and eventually Sylvia discovered that he was both unfaithful and bisexual. She left him and found herself alone, caring for and supporting two children on a secretary's salary. This period lasted somewhere between 3 and 9 years. Sometime during this period Sylvia had a 2-year live-in rela-

tionship with a Jewish man--according to her report she was unable to obtain a divorce--during which time she had an abortion.

Some time in her middle to late 20s, Sylvia married her second husband, a foreign-born scientist, and together they moved to another state. Within a week after their move, she gave up her two children to their paternal grandfather, who was moving with his entire family to another region of the country; she did this partly because her new husband resented them, despite his earlier promises to care for them. At this time she also found herself pregnant. Eight months after giving birth to a daughter, Sylvia went back to work full-time, so as to help support her husband through graduate school. However, her husband treated her with contempt; he was disappointed that she was not intellectual like his friends and resented his family responsibilities; he was also unfaithful. As a result of all this, Sylvia left him and returned to her parents' home. She then lived at home, working as a secretary and boarding her daughter out during the week. She was particularly heartbroken and depressed after the end of this second marriage, drinking heavily and taking tranquillizers for about 2 years. After a year or so, partly out of a desire to have her daughter with her again, she married a handsome "mama's boy" neighbor, who worked in a blue-collar capacity. This husband was clingy, dependent, and violent; he was also bisexual; with his mother they made "a threesome". Three years later, Sylvia left him; shortly afterwards, he became mentally ill and was hospitalized.

Sylvia's daughter lived with her until she was 11 years old, by which time Sylvia was probably already married to her fourth husband. At that point, feeling overwhelmed by her daughter's behavior problems--the child was uncontrollable, refusing to bathe or attend school--Sylvia sent her to live with her father who had moved to another region of the country. Sylvia's daughter apparently did well after that. She visited Sylvia during her first hospitalization. Sylvia refused to have further contact with any of her children after that time; she later attributed this to her shame at being in the hospital.

Sylvia's fourth marriage, around age 35 or 36, was to a man who worked nights in a sales capacity, was a recovering alcoholic, and suffered from both colitis and agoraphobia. He was unable to leave the house except to go to work; thus Sylvia had to take care of all his other needs. His impairment became progressively worse over the course of their marriage. They had two sons, born when Sylvia was approximately 36 and 38. Sylvia was taking Librium during this last pregnancy and for about a year and a half afterwards. When her illness began, the eldest son was described as having temper outbursts and the youngest as developmentally delayed--he did not speak and was not toilet trained at age 2. Later, the eldest was diagnosed as hyperactive and the youngest as autistic; these diagnoses only took place after the children had been made wards of the court, some time into the period of Sylvia's illness. In our sessions, Sylvia reported having been aware that the children were difficult and more problematic than her earlier ones--indeed, life was quite unmanageable, as she described it--but having complied with her husband's refusal to admit that anything was wrong. Sylvia attempted to cope with this impossible family situation by running herself all the more ragged, caring for both husband and children as well as holding down a job. She felt extremely burdened and resentful toward her husband, who did nothing to help at home and even demanded that she keep the children quiet during the day so he could sleep. Interestingly, in our sessions, Sylvia described a household in which no one ate normally: her husband suffered from stomach problems and ate only turkey sandwiches, in small portions at that; neither of the two children would eat, despite Sylvia's heroic attempts to get them to do so--the youngest in fact refused all solid food and was still being bottle fed at age 2; and, by this point, Sylvia herself was probably fasting as well. As already mentioned, Sylvia experienced her brief hospitalizations as longed-for respites from this extremely stressful life. In our work together, Sylvia also mentioned a brief attempt to leave her family and live on her own in another part of town; this, however, ended when she again became severely emaciated and had to be taken to the hospital by her father.

During the hospitalization that led to transfer to our hospital, Sylvia introduced her husband to a fellow patient whom she had befriended. This woman became involved with and eventually married Sylvia's husband, after he and Sylvia had divorced. The divorce took place several years later, probably due to delaying tactics on the part of both Sylvia and her husband. Sylvia at times pushed her husband quite actively to divorce her and remarry so that she would not "make him and the kids suffer any more". At other times, she felt jealous and upset about the situation. In June, 1978, Sylvia's husband placed the children in foster care, which led to diagnosis of their illnesses and their being made wards of the court. Several years later, in late 1984, adoption proceedings finally went through. Sylvia's husband stopped visiting early on in her hospitalization, partly due to feelings of guilt about her illness and partly due to a fear of his own anger at her and his enmeshment with her--he reported that his colitis would act up when she fasted. However, he continued to call and even send flowers for many years thereafter.

As burdened as she had been in caring for her husband and children, after the deaths of her mother and siblings Sylvia had offered to take her father in as well. He had refused, insisting that she should come to live with him instead. After the mother's stroke, a number of relatives had attempted to live with him and care for him, but all had found this an impossible task. Both Michael and Roberta had committed suicide. The family maid had suffered a nervous breakdown. Sylvia found it impossible to directly refuse her father, but was terrified of living with him.

Throughout most of the first 7 years of Sylvia's hospitalization in our facility, until his death at age 86 in January, 1986, Sylvia's father was quite attentive. He would visit regularly every other Sunday, bearing several boxes of donuts, in the hope that Sylvia would eat with him. He would insist that she "stop this nonsense", i.e., start eating, get herself discharged, and come to live with him, so that she could care for him and type his memoirs, a fate which terrified her--something she was only able to admit after his death. On the other hand, Sylvia's father was not very cooperative with attempts to

involve him in family meetings during the week--some time prior to 1982, he attended three family sessions and then refused to come again. As already mentioned, there was a 3-week period in July of 1980 when Sylvia ate; during this time, her father came nearly every day to take her out to a lively lunch or dinner, which they shared along with drinks and laughter. This period was followed by the attempt to discharge Sylvia to her father's home, which resulted in the resumption of fasting. Sylvia herself said that her father was always the principal man in her life, with her husbands very much in second place. Interestingly, one last social fling prior to a long period of withdrawal took place during that same 3-week period, with a male patient on the ward who continued to pursue her for many years after his own discharge from the hospital. From that time on until Sylvia herself left the ward in 1987, there was little or no involvement with men, although certainly not for lack of opportunity. During the year that we worked together, Sylvia began to enjoy spending time with female friends, showing little interest in dating and stating that she wanted to devote her energies to taking care of herself.

Sylvia's work history was similar to her social history in that it consisted of numerous brief but intense job involvements. In high school, she followed the secretarial course, as her father wanted her to do, and was a good student. During her adult life, she held numerous responsible secretarial positions. The chart mentions that she either left to seek better opportunities or on a few occasions was dismissed due to alcohol abuse. Sylvia herself described a pattern where she usually worked in a driven and perfectionistic manner to earn the respect and praise of her bosses, doing things twice as fast as was expected of her; this would lead to their piling more and more work on her, until she suddenly had enough and quit, at which point nothing could possibly induce her to return.

Despite all the pain and chaos of her existence, Sylvia did not become seriously involved in therapy at any time prior to her hospitalization. There was one course of treatment during the period of independence that followed the end of her first

marriage, with a therapist whom she recalled in somewhat positive terms; indeed she listened when this therapist told her that she was too thin. Sylvia ended this treatment, feeling she was ready to be on her own. There was another course of treatment which developed out of one of her sister Roberta's suicide attempts. Sylvia had taken Roberta to the local emergency room and both were admitted to a psychiatric ward as a "family" and strongly urged to continue in therapy after discharge. Roberta did not continue, but Sylvia did return for a year. Neither of these experiences appeared to have had any lasting effect.

Sylvia's siblings and their histories deserve a few words. Her oldest brother Leon (18 years older than she) became a successful businessman. Throughout his adulthood, he called his father every day, but never went to see him--i.e., he was both a dutiful, attached son and one who maintained a distant, presumably fragile separation.

The next child Roberta (16 years older than Sylvia) was very beautiful and very dependent on her mother; she was also a pill junkie and chronically suicidal. There were innumerable occasions when Sylvia or her mother would come upon Roberta half-dead and drag her to the local emergency room to be revived; this resulted in numerous brief hospitalizations, including several at our hospital. Roberta would always manage to get discharged fairly soon after admission. Roberta had several marriages and three daughters, one of whom died of a drug overdose. Roberta finally killed herself at age 56, during the time when she was living with her father and caring for him after the mother's stroke; she was also going to the nursing home every day during this period in order to care for and feed the mother, a service for which her father paid her. Roberta died of an overdose, choking in her father's arms. Sylvia had loved Roberta very much and had always looked up to her.

The next sibling Michael (12 years older than Sylvia) was the hope of the family. He was a singer and had some success performing on the local ethnic nightclub circuit. He was also an alcoholic who made several suicide attempts and became brain damaged at age 30 following a suicide attempt by drug overdose. After that, his mother

maintained him in his own apartment near the family home and sent food up to him every day. After the mother's stroke, Sylvia's father terminated this arrangement and brought Michael back home to live with him. Some time after that, Michael committed suicide at age 52 by jumping in front of a train which decapitated him. Sylvia herself linked both suicides, as well as the nervous breakdown of the family maid, to having to live with and care for her eternally irascible and critical father.

The fourth child Nathaniel (7 years older than Sylvia) became a successful salesman working for his brother Leon, but suffered from compulsive gambling and alcoholism. Lastly, Sylvia's closest sibling Miriam (5 years older) was also slated to be an entertainer. She too had problems with drugs and alcohol. She was in therapy for many years. After the end of her first marriage, she moved to another state with her daughter, where she developed a successful business and remarried. Miriam, Leon, and Nathaniel are the three siblings who did not die or become hospitalized, i.e., the "survivors" in the family.

D. Course of Treatment

My involvement with Sylvia began in the fall of 1985, when I came on the ward, and particularly in October, when Sylvia joined a therapy group that I was co-leading. At the time, she was in individual treatment with Dr. M., a psychiatry resident. Unlike prior therapists, Dr. M. had abandoned the idea of attempting to alter the symptom; she had accepted Sylvia's way of life and had focused on trying to effect a discharge to a nursing home, a plan which had failed due to the requirement for medical supervision of Sylvia's daily n-g tube insertion. Some of the staff continued to engage in a battle of the wills with Sylvia in an attempt to get her to relinquish the symptom--an old and rather entrenched interaction between all of the participants and clearly a reproduction of her family dynamics, which she no doubt played a strong part in inducing. There was also talk of possible transfer to a chronic ward--this was a complex issue on the ward, involving a number of the long-term patients and tied to hospital-

wide administrative pressures. Meanwhile, some time in the fall, Sylvia had begun sucking on hard candy, at times surreptitiously and at times openly; this candy was generally brought in by Lucille, a domineeringly maternal female patient with whom Sylvia had formed a friendship and whom she later compared to the housekeeper who had raised her. Sylvia's mood at this time was very low-key; she appeared depressed and spoke of wanting to go to a nursing home or a chronic ward and wait there to die.

In November, in an attempt to break the stalemate, Dr. B., a paradoxical family therapist, was called in to consult on the case. Dr. B. interviewed first the ward staff, then Sylvia and her father. He focused on both family and ward dynamics. He described Sylvia and both her parents as "starkes" (Yiddish for tough, strong-willed people), alluding to the battle of the wills between Sylvia and her father. Dr. B. felt that we, the ward, were holding on to Sylvia and providing her with a very loving environment because of our attachment to her. As a result, he gave us the following assignment. We were to have a weekly ritual lunch with Sylvia, attended by all the people who loved her and perhaps one or two who did not, during which we would tell her how much we cared for her, how much we wanted her to remain on the ward, and how unhappy we would be if she left us. In Dr. B.'s words, our assignment was to "make the covert overt." The lunches began in late November and were held nearly every Monday through the following August; in fact, they became an institution on the ward. Sylvia was never required to eat; over the months, there were only a few brief attempts to press her to do so, which were rapidly given up, when the purpose of the lunches was reiterated. Interestingly enough, the nursing staff, who were deeply attached to Sylvia, very rarely attended the lunches. Dr. T. and myself were the most constant participants. As other staff (social work, psychiatry residents) left or moved to other rotations, Sylvia was empowered to choose their replacements. The staff members who participated came to look forward to the lunches and made a special effort to bring delectable dishes to be shared; thus both the meal itself and the social occasion created a very welcome break at the beginning of the week. Needless to say, the lunches also

provided Sylvia with another demonstration of her special status on the ward--in this sense too they could be said to "make the covert overt."

From the beginning, I felt a special kinship and closeness to Sylvia and was one of those who would come to her defense in rounds and other staff discussions, e.g., arguing that she did not belong on the list for transfer to a chronic ward as she was beginning to show some improvement. Possibly for this reason I was assigned to be her therapist in January, when Dr. M. left the rotation, something that Sylvia and I were both very happy about.

Meanwhile, in early December, Sylvia's father had had a stroke and been hospitalized. She had begun going out on weekly passes to visit him in the hospital. Around this time, she had also begun to munch somewhat surreptitiously on tortilla chips, while, of course, continuing to take the tube for her liquid nourishment, her fluids and her medications. At the end of the first week of our working together in individual treatment, Sylvia's father died. Sylvia seemed to take this rather calmly; she spoke about feelings of loss and sadness, but with little affective charge and sometimes with a big smile on her face. The funeral, which Sylvia attended, was the occasion of a somewhat joyful family reunion. Sylvia had not seen or spoken to her brothers in years and was pleasantly surprised to find them and their families behaving towards her in a warm and welcoming manner; they, for their part, were pleasantly surprised by her well-groomed appearance. Notably, no one took any notice of Sylvia's abstaining from food and drink; she herself much later reported having felt tempted to eat at this meal.

From the start of our work together, I felt a strong need to take a neutral stance in relation to the symptom, and to avoid focusing directly on it. I had a good sense of how oppositional Sylvia could be when pressured, how frightened she was of being controlled--while, of course, courting this as well--and how invested she was in winning any battle of the wills, which for her would become a battle for the survival of the self. I saw that she induced people into just such types of battles, recreating her family situation, and felt that the task for both the ward and myself was to stay out of

these kinds of struggles with her. At this point, Sylvia was also beginning, very tentatively, to experiment with new behaviors, i.e., taking food by mouth, and I felt that any attention on our part to this behavior would frighten her; she would become afraid of people having expectations of her, placing demands on her which she might not be able to meet, and of the hospital trying to discharge her--there is, of course, a parallel here to her father's high expectations and his threats of expulsion from the family home. For her part, Sylvia seemed to be quite ambivalent about "pleasing" us as her surrogate parents, and not eating seemed, at least in part, an act of rebellion that she needed in order to maintain a tenuous separation and identity; of course, it also afforded her the right to remain on the ward, thus maintaining connection as well. Clearly, any change had to come from within; it could not be based on compliance due to fear of rejection or abandonment, as this would surely backfire. It was important for her to know that I had no investment in her eating or not eating, that she did not have to eat to give me "naches" (a Yiddish term for pleasing one's parents, giving them joy) or starve to hurt me.

From a psychodynamic and technical perspective, taking a neutral stance reduced the opportunity for Sylvia to act out her conflicts on an external level through projection and externalization--"these people want me to eat, I don't want to eat"; it forced her to confront her conflicts as internal ones, which she would have to resolve for herself. This would require reconciling her desire to eat, her fear and guilt related to eating, her wish to be thin, etc. With both her father's death and our withdrawal from the battle, she would more and more have to experience this as an internal dilemma. Also my hope was that, once she was in some conflict, we would be able to develop a real therapeutic alliance rather than a false one based on compliance. Thus from the beginning I made it clear to Sylvia that I would not try to get her to eat or not eat, but would simply talk with her, try to understand her experience and help her understand it better as well.

During the early period of our work together (January into late February), we were mainly involved in feeling each other out and beginning to form a relationship. I was quite wary of the treatment becoming focused on the symptom; thus I generally did not rise to the bait when Sylvia would bring up the fact that she was eating, and our sessions covered many areas of Sylvia's life. However, in this section of the report, the focus will be on the primary symptom and the changes it underwent, as most of the other material has been presented in the earlier background sections.

After her father's death, Sylvia began to eat with progressively greater abandon; in fact, she described herself as "being on a binge." She ate only "junk food" at the time, mainly bags of candy bars, while continuing to take liquids and medication by tube. Rather than belittling her fears about overeating, I empathized and made it clear that I respected her concerns. Indeed, I felt that they were well-founded and that her anorexia might consist in part of a desperate attempt to stave off uncontrollable eating. Sylvia was very relieved by my response. This, I believe, was due to the fact that I respected her fears and thus sided with the defenses rather than with the powerful oral urges that threatened to overwhelm her.

In the beginning, I did make a number of comments intended to educate Sylvia about eating disorders and addictive behavior. Only a small portion of this seemed to have any impact. Sylvia had a history of bulimia; I reminded her of this and she took great delight in having her illness relabeled as "bullmania," as she called it. She had also learned at her father's funeral that one of her favorite nieces had suffered from bulimia. I spoke of fasting and overeating as both being addictive behaviors, noting the "high" that goes along with fasting. I tried to make a distinction between eating and bingeing, one that Sylvia eventually came to grasp, although quite slowly--at first, she seemed to have little or no concept of reasonable, permissible, healthy eating. I also noted that Sylvia had taken the route of an "alcoholic" solution to an eating disorder--since she never started to eat, she never felt the addictive "turn-on" and was never faced with the problem of stopping or moderating her intake--a simple solution certainly, but one more

appropriate to alcohol or drug addiction than to an eating disorder. I especially tried to emphasize that the overeating and the fasting were two extremes that powered each other, with excessive deprivation leading to excessive indulgence and vice versa. As I was trying to avoid focusing too heavily on the symptom, I usually broadened these remarks to speak to Sylvia's life as a whole, referring to the contrast between her "superwoman" identity when she had cared for an agoraphobic husband, a hyperkinetic child and an autistic child, as well as holding down a job and offering to care for her father, and her state of utter dependency in the hospital. Sylvia agreed that she always did things by extremes and had little or no concept of moderation.

Sylvia was quick to warn me that her eating could stop at any time--indeed she spoke of it as a force entirely out of her control--and to remind me of her belief that God wanted her to fast. Undoubtedly she did not trust me and was afraid I might decide that she was ready for discharge. For my part, I showed no inclination to push her in this area and did not pick up the bait when she would bring up plans for life outside the hospital; in fact, I felt that these were neither sincere nor realistic at this point and largely a testing behavior on her part. Sylvia also seemed to feel that a great deal of attention should be paid to her eating. She would often announce that she had eaten something or was eating on a given day, as if expecting a flush of pleasure or applause. I made a point of responding in a rather neutral, even indifferent manner, saying things like "Whatever you're into," "That's nice," or "It's up to you."

On the other hand, I was very interested both in understanding Sylvia's past and being admitted to her inner world. Sylvia engaged in two common defensive behaviors that had the effect of distancing her from me. The first consisted of shutting down, becoming oblivious to her surroundings, and withdrawing into her inner world, with a look of intense grief on her face. This behavior occurred frequently in group and occasionally in individual sessions. When I asked about her thoughts during these periods, she could recall very little, yet in a round about way she went on to reveal many of the painful circumstances of her last marriage, adding that she retreated into her inner

world because there she could be herself and did not have to be nice as she did on the outside. Another defensive pattern lay in the perpetual smile that Sylvia wore, regardless of how painful the topic she might be discussing. Both these behaviors decreased somewhat during the treatment, as Sylvia became less dissociated and a little more able to express painful, angry, or otherwise "unacceptable" affects.

I made one exception to my resolution not to give Sylvia directives. The day I returned from a week's vacation at the end of January, I was told that she had been eating food while wearing the tube and that this presented a danger of choking. Thus I had to tell her that she was forbidden to eat while wearing the tube. Naturally I made it clear that this rule was being promulgated for medical reasons. A few sessions later, Sylvia briefly expressed a feeling of resentment about the rule, after admitting to a small infraction with soft custard. This only served to confirm the feeling I had all along of a deeply entrenched oppositionalism based on a need to assert her omnipotence in the only area of her life that she felt she could control, her oral intake. My response was to joke with her about her need to be defiant and oppositional. In general, taking my cue from Dr. B., I made it a policy to react with a kind of appreciative joking to communications relating to Sylvia's oppositionalism, her power dynamics with the ward and the hospital, and her status as a special patient. This came very naturally as we settled into a warm and somewhat symbiotic relationship that allowed for humor and mutual laughter in the sessions. In turn, this allowed Sylvia to recognize and openly admit her oppositionalism and the power that resided in her symptom.

Sylvia became fascinated with my eating. She felt that I, like the other staff members at the lunches, was "in control," whereas she was bingeing uncontrollably. She envied my weight and was curious about what I ate and particularly about the liquids I drank. At this point she was eating junk food by mouth but taking liquids only by tube; thus thirst was at times quite uncomfortable for her. I contrasted the incredibly high standards she set for herself with the more human ones "we mere mortals" tried to meet. She denied her superiority, insisting that she needed to meet such high standards because

she was in fact so much lower, so much more sinful. The nature of these sins was something she did not want to discuss in detail; when asked about them, she would generally allude to the abandonment of her children.

In early February, there was a period of surprising openness to new insights, during which Sylvia was struck by the realization that she had indeed begun eating after her father's death, just as he had predicted she would. She admitted that she would have been terrified to eat while he was alive, since he would have jumped to the conclusion that she was well and insisted that she come live with him. She said she felt safe on the ward, safe and unpressured, and realized how burdened she had been by her responsibilities just before the onset of the illness and how much she had wanted to be free of them. There was little talk of God and a striking lucidity during this period.

Late February ushered in the next phase of the treatment. Sylvia was beginning to feel quite upset about her weight gain. She had gone up to 139 pounds, which to her was huge; indeed, it was noticeable and people throughout the hospital became aware of the change in her appearance. She began trying to fast, but could not do so for more than a few days at a time; she saw this as a failure to fulfill God's will due to weakness on her part. It was also the first time since adolescence that she found herself unable to lose weight at will. She had begun to have some notion of the distinction between eating and bingeing, but felt that neither eating moderately nor even dieting was possible for her, that she could only lose weight by engaging in an extended fast. It should be noted that Sylvia used the term "fasting" to mean refraining from oral intake and using the tube for liquids, medication, and possibly some nourishment as well, i.e., the term as used in this context has a rather esoteric meaning. Yet, interestingly enough and despite all her concern, over time Sylvia's eating did moderate itself, seemingly without direct effort on her part.

Meanwhile, the Monday lunches had become rather elaborate gourmet affairs, where the participants enjoyed both the company and the food. Sylvia was fascinated with the food, often asking questions about it and wanting to help serve it. She herself

continued to eat food, though never in the presence of staff and certainly not at the lunches, but would not swallow liquids under any circumstances. She began speaking about the lure of liquids in terms of tremendous longing--she described the agonies of thirst and the incredible attraction she had felt for the ice cold water we had consumed at one of the lunches. She mentioned that, when fasting prior to her hospitalization, she would often keep ice by her bed, within sight, almost as if to test herself--rather like Gandhi's practice of sleeping next to voluptuous young women in order to test his commitment to celibacy. Whenever Sylvia spoke of "God's will," I would generally rephrase it in terms of "your God"--thus attempting to make it a less absolute and more relative concept; however, I did not as a rule attempt to explore the delusion, partly because I found it somewhat daunting and partly to avoid being drawn into theological debates.

Meanwhile, two other patients, Lucille and Pat, who were Sylvia's closest friends on the ward, had slowly begun coaxing her into eating "regular" food, as opposed to junk food. She later described this process to me in very poignant terms. Lucille would smuggle onto the ward whatever foods she thought might tempt Sylvia--at her own peril, as this was forbidden. Pat, in turn, persuaded Sylvia to try "real food" for the first time; having smuggled a sandwich out of the dining room, Pat gently coaxed Sylvia into taking just one bite of the bread, then just one bite of the meat, and so on, until she had eaten the sandwich. It is very significant that her two helpers were peers and not parental figures; this made the act of eating with them much less portentous and threatening than it would have been in the presence of staff members. Indeed, as we will see, Sylvia progressed very gradually from less threatening eating situations to more threatening ones, always warning us at each step of the way that she might not continue and that we ought not to have any expectations of her.

In a session toward the end of February, Sylvia spoke about how she only ate food that patients or their families brought up to the ward in "brown paper bags," never dining room food. I joked with her about "official" versus "unofficial" food; she renamed the latter "black market food," i.e., clearly forbidden--a good sign as it showed

that she could begin to admit her oppositionalism and even joke about it. A few days later Sylvia said that, if she could eat three meals a day, she would, but felt this was impossible for her; still, her comment showed that she was beginning to have a concept of "normal eating." A few weeks later, in early March, Sylvia announced to me that she had eaten dining room food the night before, thanks to a member of the staff who had brought a tray out to her. Incidentally, I was quite impressed with the degree of sensitivity that some of the therapy aides showed toward Sylvia's needs for both freedom and limits and the variation in those needs over time. For about a week after she started eating "official" food, therapy aides brought trays out to her and allowed her to eat dinner quietly and alone, almost surreptitiously. After a week, they put an end to this special treatment; Sylvia then began going into the dining room when she wanted to eat dinner, although she tended to complain about how unpleasant a setting it was, with people rushing through meals and showing poor table manners. The week during which the therapy aides accommodated her was, I believe, enough time to allow the new behavior to take hold, without making it too intimidating or too official.

At this point, Sylvia had stopped bingeing and was eating more moderately, while continuing to take the tube for liquids and medications. However, having gained 30 pounds over 2 months, she was trying very hard to fast. She usually could not manage to do so for more than a few days and so tended to alternate between eating on some days and fasting on others. I felt that this kind of back and forth experimentation was both natural and expectable; thus I adopted a policy of "benign neglect" and the ward followed suit; in fact, I often did not know whether Sylvia was eating or not at any particular time and felt it was of little importance.

At about this same time, in early March, Sylvia began expressing both hopefulness and a sense of alliance with me. Even when speaking of her pain and depression, she would spontaneously add statements like, "Don't worry, we'll get through this, we'll work it out somehow, we'll get through this together." Also our talks about her family and her past broadened and deepened and she was able to reveal more in the ses-

sions. She described very different feeling states, depending on whether she was eating or fasting. When eating, she "felt more"; when fasting, she felt deadened and missed the taste of food, which was a real novelty to her--indeed, she was refreshingly enthusiastic about the simplest things, such as tunafish sandwiches and hamburgers. Yet she resented experiencing active internal conflict over whether to eat or not and at moments longed for her earlier uncomplicated fasting. I usually relabeled this conflict as a positive development, a sign that she was grappling with the issues.

At times, Sylvia would offer to do something out of a desire to comply with what she perceived as my wishes; I would respond by joking with her, saying, "No thanks, don't scare me, I know you'd make me pay for that one later," adding that it was more important to me that she make her own decisions than that she please me. I also joked with her about her special status on the ward and her job training residents and interns--a very real position as one of the senior patients. One time, she threatened to fast out of spite, as she was angry at staff members for forbidding a special privilege; I pointed out that she wanted to hold a gun to her head in order to threaten them. In this way, I attempted to pick up on the power dynamics of her symptom, but always in a light and uncritical manner, and one that revealed my enjoyment of her rebellious side. In turn, she began to be more open about her oppositionalism and to joke about it. One time, she told me that, if I were to tell her to fast, she would probably eat, and vice versa. She also expressed gratitude for the fact that I did not tell her what to do, even though she had originally wanted me to.

This middle period was one of greatly oscillating moods. Sylvia was often in despair over her weight, her inability to fast, or the pain of missing the food when she did fast. Adjusting to life at a higher weight was a very tall order for her, although she did fairly rapidly make it down to 128 pounds or so. At times, she retreated into isolation, refusing to go downstairs and meet friends. I often pointed out how strict she was with herself--how, rather than feeling good that she was no longer bingeing, she would reproach herself for eating a sandwich. Sylvia's concerns with her weight were very

much tied to her wish to be loved and appreciated by her family, for whom she felt her appearance was central. Her sister Miriam was due to visit some time in the spring and Sylvia became very concerned as soon as she realized her weight gain. While she knew on a rational level that Miriam too had put on some weight, Sylvia still felt that she had to be thin to face her family and this contributed to her distress.

A very interesting development took place in March. Sylvia began expressing fears that I would disapprove of her for not fasting, that I would see her as a "weakling." This demonstrated that I was no longer seen as someone who might take her symptom away from her, but rather that she felt free to project her own punitive superego onto me; this was a crucial step in the process which, over time, allowed her to begin to introject my own more tolerant and forgiving attitudes (see Chapter IV below).

Until this time, Sylvia had continued to take fluids only by tube and indeed had refused to even discuss the question of why drinking was such anathema to her. Yet, 2 weeks after she had begun to eat official food, the problem suddenly resolved itself. On St. Patrick's day, Sylvia had two meals of corned beef and that night awoke with terrible thirst; despite her intense fear and her shame before God, she drank some water. She later described having felt humiliated and frightened by the power of the urge to drink and very afraid of taking the first swallow; interestingly, in the same session, she expressed feelings of guilt about enjoying the session itself. In any case, from that time on, Sylvia began taking fluids by mouth on the days when she was eating and found particular joy in drinking coffee, which she adored. She still would not take medication by mouth and adamantly refused to discuss the issue; in fact, she very directly said, "Don't push me," and I respected her wish. Thus she still needed the tube for her medicine. The eating at this point appeared to have moderated itself, something which Sylvia attributed to our work together. She began saying things like, "I'm human, I like to enjoy some food occasionally like other people"; she added that, if it were time for her to fast, God would make it easy and not hard--in other words, her God was becoming a little gentler and more reasonable. About a week after she had begun

drinking liquids, I asked Sylvia to associate to the concept of liquids and her only response was "no-nos"; a little later in the same session, she spoke of the fact that two of her husbands had been bisexual.

On several occasions, I had expressed some surprise about the fact that, for many people, fasting or dieting generally involves abstaining from food but taking liquids, whereas for Sylvia liquids were somehow more problematic than solid food; in fact, this was to become more of a practical issue later, when she was ill or when the weather became warmer and the risk of dehydration was greater. Sylvia explained that, whenever she would drink a cup of coffee in the morning, this would be such a "turn-on" that she would then have to eat for the rest of the day. In other words, the decision point was usually that first cup of coffee, which was felt to have such overwhelming power that it determined whether she ate or fasted for the rest of the day.

At this time, I suggested to Sylvia that we begin meeting three times a week rather than two. I had wanted to do this for some time, but had held off for fear of pressuring her. Sylvia reacted enthusiastically and later told me that she had interpreted my suggestion as a sign that there was real hope for her, that we had not given up on her.

In early April, I was out sick for a week. I returned to find Sylvia weak and dizzy, lying in bed and having fasted all week. She was also a little more preoccupied than usual with the delusion. Sylvia admitted to having missed me, but not to any feelings of anger relating to my absence. While my week's illness had clearly resulted in a regression, my return was followed by a forward spurt. Two days after I came back, Sylvia went downstairs for coffee with a group of other patients and enjoyed herself thoroughly, meeting her former boyfriend and generally loving her role as belle of the group. On her return, she asked me if she could forego her noontime tube and medications, as she did not want to spoil her good feelings by taking the tube; naturally, her medical back-up and I both agreed that this would be fine. She then came to our therapy group in an unusually lively mood and was flirtatious, provocative, and a little

challenging towards my male co-leader, rather like an oedipal-aged girl might be with her father. The next day she said that she felt God loved her even when she did not fast. Within a few days she was expressing a desire to apply for a higher level of privileges, something she had not done in years, so that she could go downstairs in the afternoon as well as the morning and would thus be free to make her own decisions as to whether to eat or not, rather than depending on the good graces of other patients to get her food when she wanted it. She added that she was tired of putting the responsibility on others and on God for her decisions and that she thought her sister would love her even with the added weight.

The following Monday, Dr. T. was absent from our ritual lunch; the participants were Sylvia, myself, and a social work trainee. For the first time, Sylvia ate at the lunch. It was not surprising that she started on a day when Dr. T. was away and only junior staff were present, as eating with Dr. T. clearly held great significance; however, she did eat the salad Dr. T. had left for us, expressing much delight with it.

About a week after the first time that Sylvia had chosen to forego her noontime medications, I raised the question with her of decreasing them. I had wanted to do this for months, as Sylvia was on a good deal of medication which I did not feel was necessary and which seemed to contribute to her afternoon drowsiness; I had also discussed the question with Dr. T. who agreed with me. However, I had held back for fear of pressuring Sylvia, who was very attached to her medication regime. I shared with her my observation that, on the days she did not take the morning medications, she appeared livelier and more awake and suggested that we might consider making a slight reduction. First Sylvia reacted with anxiety to the idea of any change in her medications; then she offered to do whatever I wanted. I joked with her about the price of such an offer and suggested that she think it over for a while, adding that we could talk about it again and see how she felt and assuring her that I would not make any change unless she truly wanted it. Eventually, over several weeks, we discussed the topic a number of times and Sylvia came to express a real willingness to try some changes.

During the rest of the spring, we very gradually decreased her morning medications, making each change only with her full consent; we finally discontinued the morning medications in July, very much at her request; she had, by then, come to recognize that they made her drowsy all day long and was tired of that. Sylvia's willingness to begin this process was based in part on her trust in my judgment and this gave me a sense that I could occasionally risk a suggestion or two, as long as I explained the rationale and did not pressure her. For example, later on in the summer, when Sylvia would become faint because of fasting, I would explain that this might be due to dehydration and that she would do well to take some liquids, be it by tube or by mouth, and she would generally heed these types of suggestions.

The rest of the spring was marked by both an overall pattern of steady growth and the expression of extremely disparate feelings on Sylvia's part. At times, there almost seemed to be two Sylvias, one lively and hopeful and the other despairing and a prophet of doom. Sylvia herself felt that the changes in her mood were tied to whether she ate or fasted--that when she ate she was cheerful and happy, looking forward to her coffee and her social outings, whereas when she fasted she was depressed and despairing. She added that she had vastly different feelings about the tube during these two states. When eating, she continued to insert it at night for her evening medications, but hated to put it in as it felt "all dry" in her throat. On the other hand, when she was fasting, it "went down smooth and easy." I myself did not observe the correlation between her eating behavior and her moods as powerfully as she did, but was aware of great oscillations between hopefulness and despair, with the despair usually focusing on her inability to fast for any length of time and on her weight. At this point, Sylvia's sister Miriam announced that she planned to visit in mid-May and this fueled Sylvia's wish to lose weight and fast all the more, something which at times she continued to justify via the concept of "God's will." One time, I joked with Sylvia, saying I was grateful to be one of the "faceless millions" rather than singled out by God as she was; she was struck by this phrase and quoted it back to me on numerous occasions. One day she spoke of

being sick of the tube and said she might just have to be heavy when her sister came; the next day, she said thinness was more important to her than anything. I had, for a while, been pointing out the high price she was willing to pay for thinness. I responded to this half-jokingly by saying, "Well, we may as well give up on you, the ward can relax, you won't be going anywhere"; a little later, Sylvia told me she was angry at me for that comment, something I saw as a very positive sign, an indication that she was becoming more invested in recovering from her illness. For the first time in many months, Sylvia expressed a wish to be out of the hospital and was able to fantasize a life on the outside in a way that seemed more real than her talks about this early on in the treatment.

On May 1st, Sylvia came into her session very depressed, saying that she had nothing to look forward to and that, if she had any pills, she would take them; the despair, as usual, was connected to her inability to lose weight. Feeling a little desperate myself, I spoke for a while about the fact that many people struggle with an eating disorder and learn to control their weight over the course of a lifetime. She gazed at me fixedly in a dazed manner and asked how I remained thin. I did not answer her directly but told her I probably could not eat as much as she thought I could--she had a fantasy that some people could eat large quantities of food and not gain weight. This session was followed by a 5-day fast, which ended when we next met. While I had noticed a tendency for her to fast during weekends and other breaks in the treatment, this time there seemed to be a clear connection to my absence and possibly to my suggestion that I did not lead a charmed existence with regard to weight and food. While I did not fully understand what had occurred at the time, in retrospect this was probably a harbinger of a similar but much more drastic episode that was to occur in July, as will be seen below. In the same session, Sylvia also explored transference feelings toward other patients in our therapy group, specifically her fear of a very rageful and violent female patient who reminded her of her father; she shared both suicidal feelings and her fear of being "consumed" by this woman's hatred.

Our exploration of Sylvia's past continued to be very rich. In early May, Sylvia admitted she had felt relieved when her mother got sick and had said to her husband, upon returning from a visit to the nursing home, "At least her mouth is shut." She recalled that, at the beginning of her illness, she used to fast behind her husband's back and felt he did not care enough to check up on her. She described her early brief hospitalizations as restful havens in comparison to her chaotic home.

Interestingly, Sylvia showed a remarkable capacity to confuse information about her weight. Although she was losing weight, she believed she was not and would forget or rather revise her earlier weights downward. When I pointed this out to her, she tended to dismiss the observation.

In mid-May, Sylvia surprised us by eating at a ritual lunch where she, myself, and Dr. T. were the participants; this was the first time that she ate with Dr. T. and it was very significant in light of her father's wish that she should eat with him and her oedipal feelings for Dr. T. This experience brought up a great deal of fear that Dr. T. might press for her discharge. I reassured her that this was not the case; in fact, at her request, I had asked him to promise her another year on the ward so that she could make a gradual and smooth separation, and he had agreed. Nonetheless, she continued to worry about possible pressure to leave. Sylvia also expressed fears about her sister's visit and asked me to arrange a shorter pass rather than a longer one. In other words, unsure of her own ability to set limits, she asked for my help in doing so. I agreed to do as she asked. In general, I was supportive whenever she felt that she wanted to put the brakes on her progress, as I respected her sense of her own timing; for her part, she usually rewarded this trust by progressing as steadily as she could. Nonetheless, I continued to point out to Sylvia the way in which she used her obsession with weight to limit her life and to avoid both pleasurable experiences and painful feelings. Despite her depression, which increased as her sister's visit approached, she agreed to keep an open mind about the pass; later, when the visit was postponed, Sylvia asked me not to let her to get out of seeing her sister. In other words, since I had supported her fragile

ego in its attempt to regulate the situation, she could trust me as an auxiliary ego that would help and not overwhelm.

One Monday, we had a very stimulating lunch where Sylvia again ate with Dr. T., myself, and her medical back-up, a male doctor whom she liked; this was followed by a session in which a great deal of oedipal material surfaced. Sylvia recalled the 3-week period in 1980 when she had eaten and been daily taken out to lunch or dinner by her father. She spoke of being "unfaithful to him with all those husbands," adding that he had always been her "best date."

Sylvia expressed happiness with the fact that she was becoming more assertive, adding that she could do this on the ward because no one threatened to throw her out, as her father had done as soon as she disobeyed him in any way. She recalled that she had always wanted long bond hair, just as she had had in childhood; she had been able to allow herself to actualize this wish a few years into her hospitalization. On the ward, Sylvia gravitated towards female friends and expressed the view that she was, for the first time in her life, content not to be with men, wanting to devote her energies to herself instead.

The delusion continued to show more flexibility--Sylvia now felt that God forgave her when she went down for coffee. In late May, she recalled how she used to feel that God did not want her to wear make-up. Then, one day in 1982, she, Dr. T., and her therapist had been on their way to visit her mother's grave and she had felt quite conflicted about whether to wear her lipstick; she had been about to remove it, when Dr. T. had told her that it looked nice. From that time on, she had continued to wear make-up, which in fact was a very important part of her identity. I pointed out that there had been a change in her feelings about God's will, precipitated by Dr. T.'s remark. She agreed, adding that her father too could overcome God--she used to call him when fasting during the first year of her illness and he would take her to the hospital. A little later in the session, Sylvia asked if I believed in God. I responded, "What do you think?" and she said, "I think you do, but your God is kind and gentle."

One day we made an amusing discovery. I learned that Sylvia usually received her medications separately from the other patients and before they did, just as at home she had been served dinner earlier and separately from the other children. In her own words, "I have things just the way I want them here, why should I leave?" Interestingly, she saw me as having the power to force her to leave the ward and begged me to reassure her that I would not do this, but rather extend her right to stay--something I had already requested, in any case.

During the month of May, Sylvia was faced with a difficult problem in dealing with assertion and anger. An extremely disturbed patient harassed her constantly with verbal invectives, usually of an anti-semitic nature or else a very personal one, and this constant stream of vitriol reminded her of her father's worst moments. Sylvia finally got so angry that she hit the other patient with her pocketbook, a rather unusual gesture for her, but one that she felt good about; in light of the extraordinary provocation and her usually mild demeanor, the staff did not punish her for this. Sylvia felt that, if her sister Roberta had been able to fight back, she would not have had to commit suicide. In the long run, Sylvia forgave this patient, once the patient came out of her severely disturbed state and again behaved in a friendly manner; in fact, Sylvia's magnanimity towards other patients was quite striking on several occasions.

A problem related to Sylvia's continuing to take medication by tube came into focus as her sister Miriam's visit drew nearer. Miriam had invited Sylvia to travel to her part of the country and stay with her for a week. I suggested to Miriam that an overnight pass in our city on the occasion of Miriam's visit might be a more appropriate first step. Miriam agreed. When I presented this idea to Sylvia, she started out to say no, but stopped herself and said she would think about it; eventually, she decided that she wanted to do it. Since insertion of the tube was, theoretically at least, supervised by a physician, she would either have to take her evening medication by mouth or do without it, if she were on an overnight pass. We explored her fears about taking medication by mouth; she expressed the belief that the side effects would be stronger, and I explained

to her why this could not be the case, while adding that I was not taking a stand as to whether she should take the medication by mouth or not. The issue was tabled as Miriam's visit was again postponed.

I was due to leave the ward in mid-August. A serious rift between us came up in early June, just around the time that termination was beginning to loom on the horizon. Our therapy group was due to stop meeting at the end of June, and a group of psychiatry residents were also finishing their rotation at that time--two events that were the first harbingers of the more complete termination that was due to take place 2 months later. On June 10, patients and staff attended a ward picnic together. As in prior years, Sylvia helped with the cooking, but for the first time she also partook of the food. At one point she tried to serve me several hamburgers and frankfurters, urging me to take a lot--generally speaking, Sylvia had a tendency to push food on people. I demurred, in fact a little abruptly, and accepted only one hamburger. The next day, Sylvia was very upset with me, convinced that I was not a light eater or simply thin as she had thought, but rather a "dieter." She saw my presumed dieting as a reproach--if I watched what I ate, how much more so should she. She had been looking forward to my eating a big meal, as this would legitimize her doing so too, and she saw this as expectable picnic behavior; she was very angry and disappointed that this had not taken place. She also began to obsess a little more than usual about her excess weight.

Four days later, Sylvia began a fast that lasted 30 days, during which she took fluids and medication by tube and ingested nothing by mouth. During the early part of this fast, she took no nutritional supplements and thus her caloric intake was extremely low. In sessions, Sylvia admitted that she was fasting in part to avoid feeling my impending loss; she even said that she had not truly experienced the loss of her father and still felt as if he was around. A few days later, she added that she was holding on to the fasting and the illness because of my leaving. We discussed her feelings about my behavior at the picnic, which appeared to have given her the needed impetus to get back on her fast. We talked about the parallel between my refusal of her food and the

behavior of her two young sons towards the end of her last marriage and how hurt she had felt in both cases--in fact, I learned more about this period of her life than I had known up to this point. Nonetheless, Sylvia continued to fast. There was a slight improvement, after Sylvia asked for a pass to go to the beauty parlor in the nearby shopping center, as she usually did every month or so. I expressed some concern as to whether she could handle this without fainting, particularly since she had mentioned feeling faint while walking on the hospital grounds. She insisted that she would be fine and begged me not to sabotage her pass; I agreed, albeit with some reluctance, and she then volunteered to take one can of Sustecal a day and continued to do so throughout the rest of this extended fast.

Meanwhile, I continued to discuss what had occurred at the picnic, as well as the impending termination, although the latter was a topic Sylvia preferred to avoid. I made numerous attempts to point out that Sylvia was jumping to conclusions regarding the events at the picnic, that there were a number of possible explanations for my behavior--e.g., the heat, the quality of the food--all to little avail. I finally resorted to telling her directly that I had been feeling queasy because of the heat and the long bus ride, and this seemed to heal the rift a little. Still, Sylvia continued to fast and admitted that she might continue beyond her original goal of 21 days, that she was thinking of more days yet and a lower weight than she had originally planned.

At one point, we were discussing how fasting led Sylvia to give up other joys as well, e.g., the social aspects of going down to the cafeteria for coffee, and indeed resulted in an almost complete abnegation of life; Sylvia said, "Well, if I can't have you, I may as well not have anything else." This telling statement suggests that fasting was both a way of grieving and a way of holding on to the object--both mourning my loss and outdieting me, since she now saw me as a dieter. In the same session, Sylvia explicitly said that my not eating at the picnic had given her the strength to give up eating. When she referred to my "giving up food," I pointed out that I had done no such thing, but rather had had a good dinner that night. This reminded Sylvia of a time

when she had been kinder to herself, taking herself out to nice Italian dinners after work. From this time on, she began asking me fairly regularly about my eating habits--did I ever eat a sandwich for lunch, did I like a nice Italian meal, and so on--and I answered her questions as directly as possible. Sylvia also began suggesting that I take myself out to a good dinner or inquiring as to whether I had had lunch, in short mothering me. I tried to accept this as graciously as possible and generally reassured her that I was indeed doing these things.

As the rift healed and as we began to confront termination in a more real fashion, the work deepened. Sylvia was able to discuss painful incidents from her past--e.g., her three abortions and some of the pain of her second marriage. She spoke of having picked her husbands for their looks and then recalled a very poignant incident from her childhood. She had gone to visit the family of her beloved housekeeper Maria on their farm; Maria's brother, a priest, drew the children aside and brought out two balls, one shiny and colorful and one plain, and asked each child to choose; Sylvia naturally chose the shiny ball, which turned out to be a dead ball without bounce, whereas the plain one was a perfect Spalden. In this metaphoric fashion, Sylvia was beginning to recognize the high cost of the narcissistic values that had governed both her family and her own life.

We also explored the power dynamics of Sylvia's symptom, how she could control the hospital by getting sicker, how she might be trying to control me or even get back at me for leaving by getting sicker--I recalled her earlier threat of getting back at staff members by fasting. At first, I had to keep bringing up the termination and pointing out that it was a subject whose emotional impact we were both avoiding. In fact, I often admitted to Sylvia that I too did not want to talk about it, but added that, if we did not talk about it, it would be much more painful in the long run, that the only way to make something good of this experience and this pain was to work it through. The impending loss reminded Sylvia of the loss of her children. At one point she was able to say to me, "Maybe eating isn't the real problem," an insight that I felt was very impor-

tant, as indeed the eating and fasting obsessions served tremendous defensive and organizing functions for her. I had taken to frequently pointing out how she would turn to these topics whenever something painful, such as termination, was being discussed; she herself was becoming more aware of this and more able to catch herself in the process. We also spoke of the ascetic aspect of her beliefs, the severity of her God, the fact that fasting and thirst made her feel "godly." I pointed out that, while I had been briefly more godly at the picnic--at least in one sense--my behavior on the whole would never satisfy her God. The converse of this--that I had also fallen from my pedestal by appearing to be a dieter--was not discussed.

Together we slowly began to experience the pain of the termination and our talks about it started to have some emotional reality. Sylvia became more demanding, wanting me to take care of numerous concrete matters for her. I, for my part, found myself willingly doing so, feeling that I wanted to do everything I could for her while I was still there. However, I also pointed out that we were both running around in a somewhat hypomanic fashion, making arrangements so as to avoid the pain of the termination. Sylvia tested my loyalty, requesting passes for the beauty parlor and for her sister's visit, yet telling me that she was weak from fasting and planned to continue to fast through the passes. I expressed my concern, but got them anyway. Sylvia shared more painful memories from her last marriage and the period just prior to hospitalization, when neither her husband nor her children would eat the food she prepared, and she herself was trying to fast and felt that her husband was even encouraging her to do so. She began saying that she was thinking of eating again and missed food, even adding that what she was doing to her body was not normal. Following this, she asked whether I ate lunch, and did I ever eat a sandwich, a whole sandwich. I told her that I did and sometimes a big dinner as well. In other words, Sylvia was again trying to internalize a more permissive view of me. This occurred on a Thursday. Sylvia's sister was due to arrive the following Monday and join us at the ritual lunch; Sylvia was planning to fast through all of this. On Friday, Dr. T., hearing of her plan, took her aside

and told her quite directly to "stop this craziness"; Sylvia immediately agreed to eat with us on Monday and gleefully came and told me about it. Clearly some form of permission, particularly from a higher authority, was just what she had needed.

Sylvia's pass with her sister was a great success. The ritual lunch was delightful. Sylvia spent the night in her sister's hotel room after shopping all day, seeing a movie, and going out to dinner with their brother Nathaniel, who was thrilled that she ate dinner with them. Another breakthrough had occurred the morning of her sister's visit, just prior to the ritual lunch. Suffering from a headache and not having enough time to insert the tube, Sylvia had taken two Tylenol tablets by mouth--this being the first time she had taken any form of medication by mouth in 7 years. That night, while out with her sister, she did not take her evening medication. The next day, returning from the pass exhausted and overexcited, she took some Benadryl by mouth, so as to be able to rest. The day after the visit, Sylvia told me that she was planning to take her evening medication by tube, even though she was eating through the day; when I questioned the logic of this, she easily saw my point and decided that she could take the medication by mouth, as there was no other reason to insert the tube that day. A few days later, the treatment team having dragged its feet on discontinuing her morning medication entirely, Sylvia came and begged me to take care of this, as she was tired of sleeping through the day. Sylvia also began planning a week-long trip at the end of the summer to visit her sister. In short, the visit was followed by a spurt of growth on several fronts.

Nonetheless, there were some difficulties as well. Sylvia felt some pressure from her sister to perform--to get discharged and go to work--and she was quite nervous about the planned trip. I concentrated on lowering her expectations of herself and, similarly, when conferring with her sister over the phone, I suggested that, even if Sylvia only stayed for a few days, the trip might be considered a success. In response, Sylvia decided she wanted to stay for the entire week--rather than trying to resist perceived pressure from others, she could now express her own eagerness.

In a session toward the end of July, Sylvia started by saying that she wanted to lose 10 pounds. I was struck by the fact that I did not believe that she would stop at 10 pounds. Indeed, Sylvia clearly suffered from a number of body image distortions, as already noted in her earlier hospital history; in a very early session, she had guessed my weight quite accurately, yet felt she should weigh 78 pounds "because [she had] bigger bones. . . ." At this point, I shared my view that she would always feel fat, be it at 110 or 95 or 85 pounds, and she agreed. She recalled feeling fat when others described her as a skeleton; she remembered missing the fasting, looking forward to it, reassuring herself with the prospect of fasting even when eating. I then amended my earlier formulation, saying to her that I had been wrong in the beginning, that she was not so much addicted to eating as she was to fasting, that fasting was the drug that made her feel safe, calm, and, most importantly, numb. She was very struck by this insight and somewhat reassured, as it allayed her fears of being addicted to eating; in fact, she tended to eat quite moderately on the days that she ate and I pointed this out to her repeatedly. In relabeling the fasting as the addiction, I was trying to work toward making it more ego dystonic. I felt that, if she understood this "enemy within" and knew that it would always beckon to her as a drug does to an addict, she could more easily develop some distance from it and some ability to resist its pull.

We had another ward trip, this time to a ball game, on the hottest day of the year. Sylvia had planned to fast that day and sat in the sun, visibly wilting. Again Dr. T. intervened and told her to go and get something to drink; I was very grateful for this, since she clearly needed to be told, but as her therapist I did not want to be the one to do so. I came upon her near the soda concession, barely able to stand long enough to drink a soda. She later expressed gratitude for Dr. T.'s intervention, adding that she had needed someone to give her permission to have a drink. She said she had been sitting there, in the sweltering heat, asking God how he could possibly expect this of her, and added, "maybe God speaks through doctors sometimes."

I continued to encourage Sylvia to separate her life decisions from her eating decisions, something which she did more and more often. At this point, she was fasting off and on for the purpose of losing weight, but continued to socialize, to participate in ward life, and generally to live her life. She was able to laugh when a doctor from another ward referred to her present size as "human." Sylvia also began talking a little more realistically and more enthusiastically about plans for the future. She spoke of going to a residence after discharge and of wanting to do some type of work in a hospital; we came up with the idea that she might work as a hospital volunteer for a while and see how she liked it. Although her sister had invited Sylvia to move to her part of the country and had offered to help her settle there, Sylvia preferred to remain where she was and maintain some independence from her family. Together we began, somewhat hypomanically, to make arrangements for the week-long trip to visit her sister, but we were able to reflect on the defensive as well as useful aspects of what we were doing. Sylvia had destroyed all her identification papers early on in her hospitalization and I now arranged for her to get new ones. She also went to the dentist for the first time in several years.

On August 1st, Sylvia told me that she had awakened that morning wanting coffee very badly and that God had told her it would be all right to eat that day, as she clearly was not up to fasting. She had then consulted two other female patients, who had both said, "If you can fast, fast, but if not, it's okay for you to eat." In other words, the entire ward had somehow learned to tune in to Sylvia's needs and be supportive of her. Although her weight had increased slightly, she was not too concerned. Concomitantly, she was able to talk in a very real way about the pain of my leaving and the loss that this would represent.

In what I saw as a mature and wise move, Sylvia decided to wait to take her trip until a week after I left the ward, so that she would have time to adjust to my absence before going off on her vacation; indeed she had spoken on a number of occasions about her pattern of delayed reaction to loss. She planned to eat for a few days on

the trip and to fast for a few, albeit without the tube. During our last weeks together, we were able to experience the pain and sadness of the termination. Sylvia was also able to express gratitude for the work we had done and the changes she had been able to make in her life. She recalled how wearing the tube all day had protected her from life and especially from the temptations of food and men, and noted how much richer her life was now. She also requested and was awarded the highest level of ward privileges, an action she had postponed for a very long time and which I experienced as a kind of parting gift to me. We reminisced about the year. I tried to prepare her for the termination, telling her that in the future she would need to do for herself some of the things I had helped her to do, such as stand up for herself and say no to pressure. Sylvia remembered this injunction and put it into practice by becoming more assertive with other patients, who tended to impose on her generosity by borrowing money and belongings. She talked about how she felt compelled to ask others for advice, especially when trying to decide whether to eat on any given day; I remarked on her need to induce others into telling her what to do, something that could at times backfire, resulting in their pressuring her or telling her something she did not want to hear. Sylvia spoke about the way her family focused on her looks, even her sister Miriam, and how much this bothered her, particularly now that she was getting older. She resented the pressure her brothers were putting on her to undergo a cosmetic procedure and successfully resisted it. In short, she was beginning to divorce herself, at least a little, from the narcissistic values of her family. Sylvia also admitted to having felt very relieved when her father had died--relieved that she no longer had to lie and say, "Yes, Pop, I'll get discharged and come live with you," when she never had any intention of doing so. I asked if she could simply have refused him; she did not feel this was possible. On the other hand, she also missed his practical help and his caretaking, but noted that I had filled in for him and that this had mitigated the loss; she added that I had actually been better than her father, because I had taken care of her without pressuring her, criticizing her, or calling her names. I emphasized the importance of holding on to that part of me

within her and beginning to take care of herself as I had taken care of her--and as she had, in the past, taken care of others. I expressed my trust in her forward direction and in her own sense of timing.

My last Monday on the ward, Sylvia and I went out to get her new identification papers; she then treated me and one of the therapy aides, with whom she was very close, to a big Italian lunch. She was pleased to see that I ate a hearty meal, and overall we had a lovely day. During our last week together, Sylvia began to talk about leaving the ward by December. I emphasized the importance of using an internal barometer, that the issue was not whether she was eating or not, but rather her own inner sense of readiness. On that Wednesday, we had another ward trip. This time, Sylvia fasted, saying she felt depressed about my leaving and wanted to mourn it. Later that evening, she ate dinner. In our session the next day, Sylvia said that God had told her that she had not done the right thing by fasting at the picnic, that fasting should be done "quietly, not making a big thing in front of people." I reframed this as reflecting the fact that her fasting had separated her from others, from the experience that the rest of us had shared.

In our last session, Sylvia said she was no longer "into fasting," that she now found it difficult and did not know what she would do in the future. We agreed that Sylvia would help me pack up my office later that evening. When I went to find her in order to do this, she was wearing the tube, having inserted it to take her evening medication and liquids; she said she had briefly forgotten about our plan, although she had been thinking about it all day. She did help me pack and we said our goodbyes on the ward.

The following week, I returned to the ward to complete some paperwork, as I had told her that I would, and found her prostrate in bed with sciatica pain and wearing the tube all day, but still eager for her trip. I joked with her, saying she had known I was coming and was doing this for my benefit. We said a very tender goodbye and agreed to stay in touch.

A few weeks later I received a postcard from her and called her up. She was elated about the trip, which had gone very well; she reported that she had eaten the entire week and had had a great time. She surprised me by talking about discharge within a few months. She asked about continuing to work with me and I told her, as I had months earlier, that this could probably be arranged at a clinic some distance away. Whereas earlier she had felt daunted by this, she now thought it would be no problem and asked me to look into the matter. A week later, I called to tell her that this could indeed be arranged. This time she pulled back, saying it might be a while before she was ready, and we had a very brief conversation. A few months later, I was planning to visit the ward for the retirement party of one of the nursing staff and called Sylvia to tell her of my plan. She was in a very optimistic mood. She informed me that she had just begun working as a volunteer in a local hospice for the terminally ill--helping the cantor no less; indeed, she had overcome obstacles in order to do this and had shown resourcefulness, courage and persistence. It is worth noting that Sylvia had arranged this first work experience entirely on her own, i.e., she had not gone through the usual hospital channels such as the rehabilitation therapists, something she did do later on, and very successfully at that. As usual, she had taken the first steps on her own, remaining very much in control. The next day, I spent a few minutes visiting with Sylvia. She looked well, seemed to be in good spirits, and was clearly moving toward discharge.

E. Follow-up and Outcome

This section is based on documentation in the hospital records and on a conference with Sylvia's present outpatient psychotherapist.

Sylvia remained on our ward until February, 1987, when she was transferred to an open, transitional ward in the hospital. During our work together, she had been very resistant to the idea of moving to this ward. She had held the view that, on this ward, patients had to be out doing things all the time, i.e., that it was a place of "pressure," in that sense a return to her earlier life. Clearly this view had changed, as Sylvia

was quite eager for the transfer by the time it occurred. The change was probably due to several factors--Sylvia had been aware that Dr. T. himself would be leaving the ward for another hospital position by the summer; a very close friendship had developed between her and another patient Frances, who had left for the transitional ward and had encouraged Sylvia to follow; and, no doubt, the issue had been addressed in her therapy.

On the transitional ward, Sylvia was described as "cheerful, even overly optimistic," paying a great deal of attention to her outward appearance and still quite weight conscious; she would get depressed over small weight gains and at times would eat only one meal a day with coffee throughout the rest of the day. Her moods were described as fluctuating "from a cheerful-hypomanic extreme on one end, to an anxious depressive dysphoria on the other." Although occasionally voicing suicidal ideation, she was convincing when she stated her lack of intention of following through and appeared eager to carry on with life. At times, she seemed "overly concerned about losing control" and asked staff members to apply restrictions, even though she did not seem truly interested in acting out. She maintained "some quasi-delusional ideas about the religious meaning of her eating behavior" (Hospital Records).

While on this ward, Sylvia became involved in an outreach client-worker program to feed the homeless. This program had been started by several patients on the ward, after one of them had become very upset by the plight of the homeless which he had witnessed in the course of a ward outing to the nearby center city area. A number of patients had begun saving their snacks and going on outings to distribute this food to the homeless. Later they expanded the project, obtaining contributions of left-over food from nearby businesses. Sylvia volunteered to work on this project three mornings a week, while continuing to serve as a volunteer with the terminally ill at a nearby hospice--where, incidentally, her former problem of being too efficient and getting overloaded with responsibility did surface.

In February, just before her transfer to the transitional ward, Sylvia had visited her sister Miriam for a week. While there was little mention of this visit in the

records, it later emerged in her therapy that Sylvia found the visit difficult, due to her sister's constant attempts to focus on and improve her appearance.

On the transitional ward, Sylvia joined a program designed to arrange for a gradual transition to supervised housing in the community, with patients moving out together in groups of two or three. She planned to move with her close friend Frances. Frances began to date a former hospital patient, and Sylvia began dating his brother Louis.

For 3 weeks during the summer, Sylvia ate only Sustecal, possibly out of a desire to lose weight and possibly in response to a transfer from her former training ward therapist to an outpatient therapist connected to the transitional ward. By September, Sylvia had accepted a client-worker position in the hospital as a secretary. Earlier, in our treatment, she had expressed much anxiety about the idea of going back to work as a secretary, claiming to have lost her secretarial skills after the ECT treatments she had received in 1980; clearly, by the fall, this resistance had been overcome.

Toward the end of her stay on the transitional ward, Sylvia's moods stabilized. While she continued to express some anxiety about discharge, she also felt more confident and somewhat elated at the prospect. In the end, she and Frances had to wait a long time for their supervised apartment; thus, by the time of discharge, Sylvia was both eager and impatient. She was finally discharged in October, 1987, nearly 9 years after admission. Her discharge diagnosis was: Axis I: Recurrent major depression with psychotic and anorectic features in remission, Axis II: Borderline personality disorder. She continued on the same medication regime that had been in force since we had reduced her medication on our ward in the summer of 1986 (Mellaril 100 mgs, Trazodone 300 mgs, Benadryl 75 mgs). She and Frances adapted well to their new home. Sylvia continued to date Louis, a man somewhat younger than she, who was employed in a blue collar capacity and lived with his large extended family, by whom she felt accepted. The client-worker program to feed the homeless blossomed, via a large government grant, into a non-profit organization with a board, a budget, and

approximately 25 part-time employees. Sylvia became both a member of the board and an employee. She was asked, on a number of occasions, to speak to psychiatric conventions and governmental agencies on behalf of both this program and the program that sponsored her supervised housing. While expressing nervousness to her therapist beforehand, she always carried out her role as spokesperson very well and seemed to derive gratification from doing so. In November, 1989, when the housing program decided to move her roommate into a less supervised setting, Sylvia determined to get her own apartment, which she did within the next month, marshalling considerable resourcefulness in the process. She also continued to receive weekly outpatient therapy with the same therapist she had been seeing since September, 1987.

Sylvia's outpatient psychotherapist described a very interesting, albeit brief, regression that had occurred in August, 1989. This episode began while Sylvia's therapist was on vacation. Louis's family took in two infants and, somehow, Sylvia either volunteered or was volunteered--or possibly induced others into volunteering her--to help Louis's mother care for the two children. Once this had happened, Sylvia felt very put upon, but was afraid to back out, lest she lose the love and respect of her boyfriend and his family. Sylvia's response to the pressure she felt as a result of this situation was to try to break up with Louis and to return to "fasting for God." In fact, the episode was a clear parallel to the onset of her illness, when she had responded to the combination of loss and overresponsibility in precisely this fashion. However, rather than taking this process to its logical conclusion and getting rehospitalized, Sylvia somehow got word to her former transitional ward through her roommate that this regression was taking place; meanwhile, her therapist returned from vacation, and Sylvia was able to work through the issues in therapy--i.e., to explore her resistance to simply saying no and relinquishing the role of the shining star who saves the day. Finally, she was able to refuse to care for the two children; while this resulted in her spending less time with her boyfriend's family, it did not seem to hurt their relationship. Thus the potentially serious regression was aborted. A few months later, Sylvia was able to say to her

therapist that the fasting was not really for God, but rather her way of staying on a diet and that she now felt that God wanted her to be happy.

Sylvia's outpatient therapy has focused on her narcissistic issues. Her therapist described her as a "closet narcissist," i.e., one who appears humble and masochistic, but derives grandiosity from the uniqueness of her suffering and the reflected light of the object to whom she attaches herself--in Sylvia's case, God the father. Sylvia's entire life prior to hospitalization had centered on trying to be her father's special little girl by being perfect. Since his demands were impossible to meet, she wound up feeling that she was worth nothing and that her imperfection would cause her to lose the connection to the adored and idealized object. In fact, for Sylvia, being perfect meant taking care of everyone else, as well as being beautiful and stronger than any bodily urge or need. These narcissistic issues, which formed the focus of her outpatient therapy, appeared to have replaced the guilt themes that had been so prominent early on in her illness. Sylvia's need to be perfect was a frequent topic, as were her family's narcissistic values. Concomitantly, Sylvia distanced herself from her family, finding their constant demands that she improve her appearance and their perpetual harping on her physical flaws very distressing.

In the therapy itself, Sylvia remained protected, terrified of closeness and intrusion; her therapist described her as keeping "a glass wall around herself" and often maintaining control by ending the sessions first--just as she had managed to leave the training ward before Dr. T.'s departure--thus avoiding the passive experience of being abandoned. Her rage remained largely unexpressed. However, she was functioning well on her job. She enjoyed learning new skills and meeting the occasional pressure from her boss, a somewhat narcissistic figure himself, whom she could idealize, at least to a degree. She had developed a supportive network, consisting of her closest friend Frances, her other friends, her boyfriend Louis and his extended family, and her outpatient therapist. Louis himself appeared to be very accepting and indeed to idealize Sylvia. While Sylvia had given up considerable notoriety and specialness when she had

relinquished her symptom and her "special patient" status in the hospital, she had developed other islands of specialness, specifically her role as a spokesperson for two programs. In short, she seemed to be maintaining a balance between obtaining narcissistic gratification in the world and working on her narcissistic needs in the treatment.

CHAPTER IV

ANALYSIS

A. General Formulation and Analysis of the Case

1. Diagnostic Issues

In the course of her several brief hospitalizations and her long-term hospitalization at our facility, Sylvia carried a variety of diagnoses. These included, in more or less chronological order: anorexia nervosa with hysterical personality; chronic paranoid schizophrenia; atypical psychotic depression with pathological grief reaction, atypical anorexia nervosa and a character disorder with masochistic features; atypical major depression with atypical eating disorder and borderline personality disorder. With the benefit of considerable hindsight, we can begin to sort out these diagnoses and the evidence in favor of them.

The original diagnosis of anorexia nervosa was awarded during Sylvia's early brief hospitalizations. At that point in time, the diagnosis was somewhat arguable. On the one hand, Sylvia showed a number of fairly typical anorexic behaviors. She experienced fasting as soothing; it allowed her to feel calmer and more in control; conversely, eating aroused anxiety. Under threat of force-feeding, Sylvia would resume eating, but always with the intention of returning to fasting--in this fashion she showed the typically compliant and deceitful behavior often found among addicts and anorexics (Szmukler, 1987; Szmukler & Tantam, 1984). On the other hand, her fasting was motivated by a specific delusion which, at the time, did not seem directly connected to concerns with weight and body image, but rather to a deep sense of guilt. This crucial factor argues against a pure or typical anorexia nervosa at this point in the illness. It would be more accurate to say that Sylvia displayed an atypical anorexia nervosa consisting of a number of anorexic traits and behaviors in the context of a psychotic elaboration.

Sylvia's behavior during the early period of her hospitalization at our facility supports this view. She showed typically anorexic denial of the physical dangers of her behavior. She also showed many of the typical subterfuges that anorexics use in order to avoid eating and gaining weight--e.g., giving food away, spitting it out, exchanging plates with other patients, wearing extra clothes when being weighed. She spoke of herself as "fat" and clearly suffered from body image distortion. Her concerns with weight appeared within the delusion itself, e.g., when she stated that the Lord had told her not to eat until she reached 62 pounds. In these ways, she did show an underlying anorexic substrate, but again the delusion requires that we view her anorexia itself as either atypical or subsumed, at that point, under the psychosis to which it was so closely tied.

When we examine Sylvia's history prior to her illness--while the evidence in this area is less substantial and largely based on Sylvia's own report--we can say with some degree of certainty that she manifested, at the very least, an anorexic lifestyle through most of her adult life, if not an outright subclinical or mild anorexia nervosa. She showed the typical picture of a "good little girl" concerned with being perfect and pleasing others. Onset of dieting occurred, typically enough, during adolescence and at least in part in response to some weight gain which resulted in disparaging comments from boys. Through much of her adult life, Sylvia maintained her weight by eating sparingly, often one meal a day with coffee through the rest of the day, and occasionally resorting to laxatives, vomiting or amphetamines. She was, like many anorexics, dedicated to feeding others and tended to push food on them. There was also a tendency to be very active in her periods of over-responsibility, when she cared for house, husband, and children while holding down a job. The absence of amenorrhea and the lack of direct treatment--with the exception of the expression of concern on the part of Sylvia's first therapist about her low weight--would tend to indicate that this anorexia was largely of sub-clinical level. Other manifestations of eating disorder included occasional bulimia and the report of a brief period of obesity early in Sylvia's first marriage.

Andersen (1977) suggests several useful ways of defining the category of "atypical anorexia nervosa." He argues quite cogently that it is both conceptually and pragmatically appropriate to distinguish between the patient's "presentation"--meaning age at onset and mode of initiating weight loss--and the patient's "syndrome," i.e., collection of symptoms. Both of these variables can be either typical or atypical. Basing his analysis on Feighner et al.'s (1972) rather strict Research Diagnostic Criteria, which exclude individuals with onset after age 25 or with any dual diagnosis, Andersen defines a typical presentation as that of a young female under age 25 with onset of weight loss via dieting and with no preceding psychiatric or medical illness. Furthermore, Andersen defines two types of atypical syndromes--qualitative and quantitative, with the latter referring to the degree of severity. Within this classification, Sylvia's original entry into anorexic behavior at adolescence was largely typical, although her syndrome remained quantitatively atypical by virtue of its relatively mild, subclinical level. Sylvia's severe illness which brought her to the hospital was, on the other hand, atypical in every way: atypical presentation (middle aged female; onset tied to delusion); qualitatively atypical syndrome (absence of hyperactivity, presence of major depression and of a delusion); and quantitatively atypical syndrome, as Sylvia's total abstinence went far beyond the practices of even the most severe typical anorexic.

The label of hysterical personality, which was awarded during the early brief hospitalizations, is not fully accurate, but carries some meaning. For one thing, the onset of Sylvia's anorexia in adolescence was not purely connected to adolescent weight concerns, but was also tied to the loss of her beloved housekeeper and to some distancing from her father and their highly sexualized relationship--the role of oedipal issues in Sylvia's illness was an important one, as we will see below. Furthermore, Sylvia's chaotic life history--consisting of a pattern of brief, intense work involvements and brief, intense relationships with men, as well as abortions, suicide attempts, drug and alcohol abuse, and anorexic/bulimic behaviors--argues for an overall borderline level of adjustment and even for the more specific DSM-III category of Borderline Personality

Disorder; as we saw in Chapter II above, Blatt and Shichman (1983) consider this to be the anaclitic form of borderline personality organization, which would make it closely related to the hysterical personality and to the more primitive infantile personality.

Thus far, in examining Sylvia's severe illness, we find considerable support for the diagnosis of an atypical anorexia nervosa (or an atypical eating disorder, if one prefers the broader term) and an overall borderline personality organization. On the other hand, the diagnosis of chronic schizophrenia is not supported. Sylvia showed good prodromal functioning. During the illness itself, even in her most regressed states, she remained in contact, had no hallucinations, and showed no signs of formal thought disorder; her apathy, even at its worst moments, never reached catatonic proportions. Her delusions were never bizarre, nor in any way Schneiderian (Taylor, 1972). With the exception of the two brief decompensations into deeper psychosis, she remained well-related and showed generally good reality testing except in areas touching on her illness--food, weight, and the delusion itself. Finally, the positive outcome of the case, with a slow but steady return to adequate levels of occupational and social functioning, argues against the presence of a schizophrenic illness.

The diagnosis of Sylvia's severe illness as an atypical major depression with mood-congruent psychotic features is strongly supported. The important role of three major losses--her mother's death and the suicides of two siblings--in precipitating the illness is notable. The psychotic identification with the mother, who, according to Sylvia's report, literally starved to death, is a striking feature. The absence of hyperactivity during the illness itself is to be noted. While never an exercise buff, Sylvia had indeed manifested "professional hyperactivity" (to borrow a term used by Bedoret et al., 1973) in her periods of over-responsibility, but throughout her hospitalization she was, if anything, lethargic. In her physical presentation and in the thoughts she voiced about herself and her future, she certainly appeared depressed, at least through the fall of 1985.

The question of whether Sylvia might qualify for the diagnosis of Schizoaffective Disorder needs to be addressed. As already noted, DSM-III (APA, 1980) takes the

straightforward approach of defining Schizoaffective Disorder as a residual category "for those instances in which the clinician is unable to make a differential diagnosis with any degree of certainty between Affective Disorder and either Schizophreniform Disorder or Schizophrenia" (p. 202). The manual adds quite emphatically that, before resorting to this category, the clinician should consider all the other possible alternatives, "particularly Major Affective Disorders with Psychotic Features" (p. 202). By contrast, DSM-III-R (APA, 1987) stresses the temporal relationship between the schizophrenic symptoms and the mood symptoms in defining Schizoaffective Disorder. It reserves the category for "conditions that do not meet the criteria for either Schizophrenia or a Mood Disorder, but that at one time have presented with both a schizophrenic and a mood disturbance and, at another time, with psychotic symptoms but without mood symptoms" (p. 208), excluding illnesses caused by organic factors. It also stresses that the mood symptoms should not have been so brief as to be unimportant and allow a diagnosis of Schizophrenia. As already noted, Sylvia did not show any truly schizophrenic symptomatology. Her delusion was mood-congruent, centering on guilt and self-blame. The affective symptoms, while less severe later in the illness--due in part to ECT and medication and in part to overall improvement in her condition--were present most of the time and closely tied to her delusion and her food refusal. Later in her illness, she herself made this connection when she described two strikingly different mood states--a cheerful, optimistic mood on the days when she ate and a depressed, affectless state on the days when she fasted. Thus the delusion and the affective symptoms were not independent on a temporal basis, and Schizoaffective Disorder can be ruled out in terms of both DSM-III and DSM-III-R criteria.

In summary, the most appropriate diagnostic formulation for Sylvia's illness, within the modern psychiatric diagnostic system, consists of major depression with a mood-congruent psychotic delusion, atypical anorexia nervosa or atypical eating disorder, and a character disorder reflecting a borderline level of personality organization, with prominent narcissistic, hysterical, and masochistic features. The illness itself fol-

lowed upon a history characterized by an anorexic lifestyle in the context of a borderline personality.

Results of psychological testing, on the whole, confirm this diagnostic summary. Sylvia was originally tested in November, 1977, during her first brief hospitalization. The records of this testing, which took place at another hospital, are brief; they only state that there was no thought disorder and that her Full-Scale IQ was in the low average range. In light of the overall impression she gave of at least average intelligence, it seems likely that cognitive functioning would have been depressed by both her cachectic state and her mental disturbance. Sylvia was again tested in the spring of 1979 at our facility. She achieved the same Full-Scale IQ score as in the earlier testing; however an examination of the data shows a very large discrepancy between her Verbal IQ, which fell in the average range, and her Performance IQ, which fell in the borderline range; this may well have been due to psychomotor retardation secondary to depression. The report of this 1979 testing concludes that Sylvia's "character structure up to the current episode was that of a Borderline Personality." The report describes "adequate, albeit conventional, immature, and pollyannaish" functioning on structured tasks, associated with difficulty maintaining boundaries and the prevalence of borderline defenses on unstructured tasks. Her illness itself, in light of "her current alienation from reality, the fixity of her delusion and the potential for self-destructive behavior," was seen as having "a psychotic dimension."

2. Sylvia's Illness as Seen from the Broader Historical Perspective of Female Self-Starvation

The preceding constitutes a "cross-sectional" analysis from the perspective of modern psychiatry. If, however, we step back and take a broader historical view, Sylvia's illness offers a tantalizing set of diagnostic possibilities. Her delusion combined with other atypical aspects of her illness tends to make her a throwback to an earlier time. Unlike the fasting girls of the 17th and 18th century, Sylvia claimed no

miraculous powers, but she did deny the need for food. Her calling to fast was based in a religious belief like that of the holy anorexics, who also sought redemption via austerities; like many of them, she undertook this route to salvation after experiencing severe losses, i.e., at last in part due to survivor guilt (Friedman, 1985). Like these holy women, Sylvia remained active through the first part of her illness. On the other hand, once hospitalized, she became quite lethargic, possibly due to medication and possibly as a consequence of allowing herself to experience her very deep depression; at this point, her behavior more closely resembled that of the 17th century miraculous maid or the Victorian hysteric than that of either the medieval holy anorexic or the modern classic anorexic. Probably the most accurate one-word diagnosis would be sitophobia of the religious variety (Brumberg, 1988, p. 106).

All of this raises a provocative question: Had Sylvia been born in an earlier century, would she have been revered rather than committed to an asylum for the insane? Would she have prevailed in the struggle to forge a personal path to holiness via her self-starvation, as Bell (1985) would say of Catherine of Siena, among others? To put it differently, can we view her as a case of holy anorexia or anorexia mirabilis living in the wrong era? Or, to turn the question around, what entitles us to label her behavior as insane rather than miraculous, to deny her claim of a special relationship to God, and to view her God as a manifestation of her illness? The question is complex and can be addressed on many levels. From the historical and cultural perspective, it is indeed possible that in another era Sylvia's behavior might have been viewed as holy or, for that matter, as an instance of either illness or demonic possession. Most likely all three views would have been put forth, and eventually one would have prevailed, entitling her to the fate of victim, witch, or saint, as the case may be. But the fact remains that all classifications and all illnesses--indeed all individuals--exist within a given time and place, a cultural context. As Brumberg (1988) notes, it is as inappropriate to consider Karen Carpenter (the well-known popular singer who died of the sequelae of anorexia nervosa in 1983) a saint as to consider Catherine of Siena an anorexic, and even the espousal of a

rationale for fasting more common in another era would not entitle Sylvia to escape the strictures of her own. Her atavistic tendencies notwithstanding, she must remain a creature of her time. But neither does this entitle us to take a dismissive attitude towards her spiritual strivings and to consider them psychotic without pausing to examine the justification for doing so.

Agosin (1991) addresses precisely this question, i.e., the criteria for distinguishing between mystical and psychotic experience, which can, in actual practice, present in a confounding manner. The basis of this analysis lies in Jungian psychology, which views the unconscious as composed not only of the "personal unconscious" dominated by the forces of sex and aggression (i.e., the traditional Freudian unconscious), but also the "collective unconscious" with "its libidinal energies tied up in archetypal and religious imagery" and the "archetypal Self" which represents the intersection of the individual spirit and the divine. From a Jungian perspective, the frequent presence in acute psychotic episodes of "religious elements side by side with sexual and aggressive fantasies" is explained in terms of the flooding of the ego by both the personal unconscious, on the one hand, and the collective unconscious and the archetypal Self, on the other. This flooding follows upon a turning inward, a withdrawal of libido from the outside world and a decathexis of outer objects--as it does in the traditional psychoanalytic explanation. The crucial difference is the addition of the collective unconscious and the archetypal Self to the picture, which allows for a very different perspective on psychosis. As Agosin (1991) notes, "according to John Perry, a Jungian who worked with acute psychotic patients, the turn inward is an attempt at healing and renewal by an injured sense of self; the ego turns to the archetypal layer of the psyche to repair a debased image of itself" (p. 9). Clearly this makes sense only if one views the archetypal layer as being composed of more than simply the Freudian id with its primal urges.

This turning inward is where the commonality between psychosis and mystical experience lies:

Another experience (apart from psychosis) where the Ego opens up and merges with the archetypal layer of the psyche, and especially the Self, is mysticism. I speak of mysticism as a state of union. The union of the human (Ego) and the Divine (Self). Since psychosis and mysticism seem to involve similar psychological processes, how do we distinguish one from the other? Are the great mystics of the past the psychotic patients living presently in State Hospitals? And would the patients I care for have been considered great saints in the past? Is the mystic psychotic? Is the psychotic patient a misunderstood mystic? (p. 9)

This is precisely the troubling question that Sylvia's case raises, particularly in light of the recent literature on holy anorexia discussed in Chapter II.

Agosin (1991) outlines the characteristics that psychotic and mystical experiences have in common and those that they do not. This analysis will allow us to examine Sylvia's belief--which up to now we have termed her "delusion"--so as to determine where it lies along these dimensions. The characteristics that psychotic and mystical experiences share are the following: an intensely subjective experience with a completely inward focus, i.e., the decathexis of the external world discussed above; a sense of "noesis," i.e., the feeling that something great and deeply significant is occurring; an "ineffable quality," i.e., an experience which cannot easily be described in words; a loss of ego boundaries--the experience of being one with the universe, i.e., an expanded sense of self; a distortion in the experience of time such that "only the present exists"; perceptual changes, including heightened sensory awareness and hallucinations; intense affective experience; an altered state of consciousness; lastly, and perhaps most importantly, both psychosis and mysticism are based in an "attempt at renewal, transformation and healing" via "an attempt to borrow the energy and images of the archetypal layer of the unconscious to heal a broken sense of self" (p. 13).

The differences that allow us to distinguish between these experiences are as follows. "The mystic reduces his/her sense of self to a minimum," seeing "himself or herself as a grain of sand in the immensity of the universe," whereas the psychotic becomes extremely self-centered and grandiose, viewing "himself/herself as omnipotent and omniscient"; this in turn "leaves the psychotic person isolated, alone, cut-off from all of society and the world." The mystic "sheds ego-identity" but nonetheless maintains a

strong and firm ego, able to function in the world, whereas the psychotic generally cannot manage the basics of daily life. The mystic becomes increasingly serene, focusing on the eternal aspects of the universe, whereas the psychotic's attention is fragmented and dominated by the changing surface of experience. The mystic welcomes change, whereas the psychotic rejects it, clinging to the familiar. The mystic's thought processes are clear and coherent, whereas the psychotic's are disrupted. The mystical experience shows few aggressive or paranoid elements, whereas the psychotic experience is often dominated by them. Mystical hallucinations tend to be visual and have a positive affective valence, whereas psychotic hallucinations tend to be auditory and are often either frightening projected unacceptable thoughts or "projected superego condemnations." The mystical experience is time limited and often brief, whereas psychosis can become chronic. Most importantly, the mystical experience leaves the individual "more connected and involved with the world", more appreciative, loving and compassionate, whereas psychosis tends to narrow the possibilities for connection and to leave the psychotic more self-involved, with little energy left for anything else.

How does this classification apply to Sylvia's case? The information regarding Sylvia's subjective experience in the very early stages of her illness is sketchy. We know that she found fasting soothing and energizing; this, as already noted, is common in those predisposed to starvation-dependence. There is no report of mystical experience; rather the record states that resumption of eating would lead to overwhelming anxiety, with shaking, insomnia, and guilt feelings, and that Sylvia then began to elaborate the belief that God wanted her to fast to repent for her sins. This brief account conveys almost none of the qualities of the mystical or even mystically psychotic experience as described above. The one exception is that Sylvia's psychosis was based in an "attempt at renewal, transformation and healing," as seen in her adamant shedding of the False Self (Winnicott, 1960/1965a) she had elaborated and in its final outcome. On the other hand, Agosin's (1991) criteria for differentiating between psychosis and mysticism allow us to classify Sylvia's illness as psychotic without great difficulty. During her illness,

Sylvia became extremely self-involved and cut-off from the world. She was unable to function adequately or care for her basic needs. Lethargy and resignation were more characteristic of her than serenity. She did not welcome change; in fact, her regressions into deeper psychosis occurred in reaction to change or the threat of change. Sylvia's thought processes tended to remain coherent, but aggressive and paranoid elements were clearly present, both in the fragmented version of the delusion (the demons) and in the more primitive beliefs elaborated during the brief regressions. There were no hallucinations. However the illness did become seriously chronic. Finally, the immediate consequence of the illness was a psychotic one--a narrowed connection to the world and an increase in self-involvement. Indeed, Sylvia's relationship with her personal God was so completely limiting that, in the depths of her illness, she could allow no other input from any source; this claim of an exclusive understanding of God's will allowed her to maintain a veiled grandiosity and omnipotence. It was, in fact, a crucial moment in Sylvia's recovery when she began to show enough flexibility and humility to seek connection with other people and to check her perceptions of divine guidance with them. This process--which will be described from a broad psychodynamic perspective in Section 3 and from the perspective of her internal God representation in Section 4--can also be seen as an evolution from psychosis to some degree of human and spiritual connection, which did indeed lead to renewal and healing.

3. Analysis of the Historical Evolution of Sylvia's Illness

This section examines the history of Sylvia's illness from a broad psychodynamic perspective.

Sylvia maintained a borderline level of functioning throughout her adult life, until her breakdown at the age of 41. She showed a chaotic life history with brief, intense work involvements and equally brief, intense relationships with men usually leading to marriage; there were numerous pregnancies, three abortions, two suicide attempts, some drug and alcohol abuse, and some degree of anorexia and bulimia since

early adolescence. At age 41, Sylvia developed a major depression, centered on a specific and delimited delusion. This delusion was tied to an atypical eating disorder which at first consisted of severe fasting and later evolved into exclusive and voluntary tube feeding for a period of 5 to 6 years.

Sylvia's family set the stage for a borderline level of personality organization with a strong narcissistic focus. The family was extremely enmeshed, providing little emotional security and little opportunity for growth and autonomy. All of the siblings remained ambivalently tied to their parents even into adulthood--including the eldest, whose separation appeared predicated on never seeing his father but calling him daily. The combination of very high expectations and constant denigration created a double bind situation conducive to the development of low self-esteem coupled with grandiose ambitions--as Miriam's psychiatrist once put it, "they broke your legs and then bet on you." In other words, the family lived by extremely perfectionistic standards in the service of grandiose narcissistic ideals, with much venting of narcissistic rage when these ideals were not met. Sylvia learned at an early age that her only truly valuable asset was her appearance and that security lay in currying a man's favor--first her father's, lest he throw her out of the house, and later that of her husbands who could provide a roof over her head and thus rescue her from her parents' home.

Yet another double bind centered on the issue of religious and ethnic identity. The family lived isolated from other Jews in a primarily Christian neighborhood, but the parents objected to Sylvia socializing with Christians. Sylvia's only experience of good mothering was at the hands of a Christian housekeeper. Sylvia's conflicts regarding her ethnic identity appear as a recurrent motif throughout her life and her illness.

Sylvia's anorexia began, typically enough, in adolescence. The immediate stimulus was a narcissistic injury--being teased for her chubbiness by her brother's friends--indeed one that threatened her in her most significant area of narcissistic gratification, her appearance. Onset of dieting also seems to have occurred around the time that the housekeeper Maria left the family home. Thus, giving up the pleasures of the

flesh appears from the very start to have been associated with mourning a lost object. Even then dieting may have had a soothing and counterdepressive effect on Sylvia, just as fasting did in the early period of her severe illness. Throughout her life, Sylvia coped with painful emotions by resorting to a variety of avoidant mechanisms; dieting and fasting provided a way to "contain" feelings of emptiness and loss by converting them into physical sensations, i.e., concretizing them and taking them out of the realm of emotional experience.

The onset of Sylvia's anorexic behavior also appears tied to the onset of puberty and to some distancing from her father. Her involvement with him throughout her life was highly sexualized as well as connected to the pleasures of eating. As a child, she shared ice cream sundaes with him in the kitchen. His fury turned upon her when she began dating--ostensibly because he disapproved of her choice of Christian boyfriends, but more likely due to a deeper jealousy than that. Indeed, Sylvia's almost exclusive choice of Christian partners was overdetermined, reflecting both fears of incest, a yearning for the good mother she had lost when Maria left the household, and an attempt at separation via exogamy. Sylvia herself stated in so many words that her father had been her "best date" and that she had been "unfaithful to him with all those husbands." She also mentioned that he had preferred her a little heavy. Thus the anorexia estranged Sylvia from her father on many levels and provided some measure of protection against the dangerous incestuous wishes, which no doubt became more powerful and frightening at the onset of adolescence. These wishes must have been quite close to the surface in a family where there was generally little respect for privacy and individual boundaries, as well as little impulse control. Furthermore, eating and rage were closely associated in Sylvia's father's behavior--his most "biting" criticism and anger occurred at the same time as his voracious consumption of dinner. Thus abstaining from food easily became a way of controlling dependency needs, sexuality, and aggression.

Throughout her life, Sylvia oscillated between extremes of over-dependency and over-responsibility. Sylvia's need to continue to have children despite her difficul-

ties caring for them can be attributed to early unfulfilled dependency needs and conflicts around dependency issues. Sylvia, like many teenage mothers--something she came close to being in her first marriage--could briefly project her dependency needs onto her children, but would later become overwhelmed by their demands and the impossibility of obtaining nurturance for herself. This would lead to a periodic return to childlike dependency on her family--going home to live with her mother, an act that required, not coincidentally, the abandonment of her own children. Sylvia's conflicts about dependency are equally well illustrated by her behavior on her jobs, where she would begin by demonstrating "super-responsibility"--fulfilling all her bosses' needs and then some--only to throw it all over when the scale tipped too far in the direction of her own unfulfilled needs and her rage at being exploited. This typically borderline pattern of intensely enmeshed involvement in jobs or relationships followed by a sudden and extreme pulling out--in Guntrip's (1969) term, an "in-and-out" pattern--was based on splitting as a prominent defense mechanism, with early idealization of husbands or jobs, followed by devaluation and rage. The same inability to maintain relationships over time was probably responsible for Sylvia's not staying in therapy. Also connected to this pattern were her inability to express anger or be assertive in any way, her need to please others at all times, and the creation of an ever-present smiling, acquiescent False Self based on sheer terror; Sylvia had, after all, grown up in a home where the slightest disagreement led to threats of expulsion or even to actual expulsion.

The period that preceded the onset of Sylvia's illness was one of tremendous strain in the family as a whole. It is not clear precisely when Sylvia and her husband became involved in the born-again Christian movement; but it seems likely that this would have been tied to the mother's illness. Indeed, her mother's incapacitation left Sylvia in the position of the "oedipal winner," the one to walk off with the father's affections--something which could easily spark off terror, guilt, a need to expiate and "be born again," and a need to create a greater degree of separation between herself and her Jewish family. Sylvia's attraction to Christianity as representing the good mother

Maria may have played a part in this as well.

Sylvia progressed from Christianity to fasting--which can be seen as serving some of the same functions, and more effectively. First of all, it allowed her to concretize her conflict regarding her mother. Her refusal to engage in oral intake can be seen both as a defense against incorporation of the bad, dangerous mother as symbolized by food and--simultaneously and even more powerfully--as the opposite, for Sylvia's starvation was in good part based on an introjection of the mother who, after her stroke, was left with a paralyzed mouth, unable to eat on her own and needing to be spoon fed by Sylvia's sister Roberta--a parallel to the cases reported by Ceaser (1977), who, indeed, notes that, at a fantasy level, introjection serves both to preserve and destroy the object. This identification with the mother may also have included a wish to be cared for by Roberta, who, being 18 years older than Sylvia, represented a weak but kind mother-figure. Secondly, fasting served to protect Sylvia from her father. In this context, it is interesting to note Sylvia's report that fasting allowed her to feel more sexual, in contrast to the typical anorexic who diets to be rid of her sexuality. This is consistent with the view that, for Sylvia, fasting created some distance between sexuality and incest and is another instance of the hysterical traits that tended to be more prominent in Sylvia's illness than in typical anorexia. We can also note that Sylvia's choice of 40 days as her fasting goal suggests a grandiose identification with Christ; it is, interestingly enough, the same period of time that Kafka's (1946) hunger artist chose to fast.

From the point of view of secondary gain, Sylvia's illness was quite profitable from the start. It earned her attention from her irascible and demanding father, who would come running to her rescue rather than expecting her to care for him. This too suggests an identification with the recently lost sister Roberta, who constantly had to be rescued and taken to the hospital following her numerous suicide attempts. It also earned Sylvia frankly pleasurable respites from an unbearable and unmanageable life, in the form of brief stays at private hospitals with distinctly spa-like qualities. Most of all, it saved her from the terrifying duty of caring for her father whose demands she felt

incapable of refusing. Later, secondary gain became the primary force holding the symptom in place.

Sylvia's hospitalization in our facility brought forth several new developments. At some point prior to the transfer, she had fully embraced the illness and given up her life, to the point of renouncing her husband and setting him up with another woman. The way she went about doing this reflected both masochistic self-abnegation--giving up her family "for their own good"--and her need to be rid of the burden and responsibility that they represented; which of these two aspects was primary and which defensive is arguable, although the intensity of Sylvia's later guilt suggests that the wish to be rid of them was primary. Still, Sylvia went further yet--at some point early in her stay at our hospital she destroyed her identification papers and her most precious possessions, including a fur hat given to her by Roberta. These actions suggest a wish for death and rebirth, for a wholly new identity, much as a nun might give up her name and her worldly possessions before taking her final vows. In Winnicott's (1960/1965a) terms, this would represent a last ditch effort to save some shred of the True Self by destroying the False Self that had ruled her life up to that point.

It is likely that the intense and active efforts that were made to save Sylvia from her own self-destructiveness early on in her hospitalization were experienced as an act of love--a reassurance that she could regress as deeply as she wished and still be cared for and kept alive. In other words, her obstinacy was in good part a testing behavior; by not giving up on her, by continuing active treatment and active involvement in the early years of her hospitalization, Dr. T., the ward, and the institution showed that they could provide the "holding environment" (Winnicott, 1960/1965b) she so desperately needed, that they would not throw her out, however obnoxious her behavior. Nor would they allow her to die, as she felt her father had done with Michael and Roberta; in this sense, they took over the role that Sylvia's mother had played in the family. While the seeds of a positive maternal transference may have been planted by these circumstances, being chosen as the first patient to start Dr. T.'s new training ward,

i.e., being recognized as "special," no doubt fostered the positive father transference to Dr. T. that remained in force through the rest of Sylvia's hospitalization. These developments were responsible for the rapid improvement that took place during Sylvia's first few months on the training ward; this was, indeed, a "transference cure," based on compliance and a need for approval, coupled with a fear that she would have to sell her soul to get it. This improvement was followed by an attempt to discharge Sylvia to her father's home, a plan that was doomed, as this was precisely the fate that her hospitalization was designed to save her from. And, indeed, this attempt was followed by a severe regression. At this point, it must have become clear to Sylvia that eating meant discharge and reengulfment into the frightening, sexualized merger with her father, in which he would control and rule her life--a fate that she saw as leading to either death or madness. Her other choice was tube-feeding. In this sense, Sylvia's adaptation to tube-feeding was a life-saving response to the demand of the system that she display a prominent symptom or be discharged.

Sylvia's second regression followed the departure of her first training ward therapist, i.e., the loss of a specific attachment figure. After that, Sylvia seemed to transfer her attachment to the ward as a whole, becoming less deeply involved with individual therapists and more able to take their departures with relative equanimity. The ward provided her with a loving and consistent environment, especially once her behavior had improved and she had become a docile, loveable child rather than a rebellious and temperamental one. It offered her some degree of security for the first time in her life--someplace where she felt free to begin to express, however tentatively, her True Self. Sylvia herself said that she could behave in an assertive manner because she did not fear expulsion. This sense of safety allowed her to experiment with her identity, as illustrated in the actualization of her wish for long blond hair, as she had had in childhood.

Nonetheless, through many of these years, attempts continued to be made to "get Sylvia to eat," very active attempts that failed as predictably as did her father's

efforts to get her to eat donuts with him. They foundered because Sylvia's survival as an autonomous being, a True Self, was at stake in the battle of the wills that had developed around her eating. It must be emphasized that this battle was necessary and essential. Had it not developed, Sylvia would have felt that people did not truly care whether she lived or died; in fact, that is exactly how she had felt about her husband's indifference to her fasting early on in her illness. However, over the years, the battle had become entrenched and was in need of resolution. Capitulation, from Sylvia's point of view, continued to signify death, both on a psychic level--giving in to the controlling, overwhelming father imago, ceding to him the one area which she had been able to keep from him, namely control over her oral intake--and on a real level as well, since discharge to Sylvia meant having to live with her father and care for him, a fate which she saw as leading to madness or suicide. The powerful combination of these fears provided an unusual degree of motivation for maintaining the symptom. By continuing to press her to give in and eat, the ward had come to represent both the bad father as well as the good mother/father figure. Sylvia, for her part, could calmly maintain her adjustment to life on the tube, as she had succeeded in externalizing her conflicts about oral intake and thus did not need to grapple with them on an internal level. Indeed, the unconscious countertransference induction that had taken place is strikingly illustrated in the parallel between the ward's attempts to get Sylvia to eat Cheerios and her father's attempts to get her to eat donuts--for, after all, what are Cheerios but miniature donuts?

When I began working with Sylvia, the pressure had largely lifted, as all active attempts to alter the symptom had been abandoned. Sylvia had succeeded in being accepted on her own terms within the very nurturing atmosphere that the ward had developed over the years. Not coincidentally, the symptom had begun to show signs of weakness--Sylvia had started sucking on hard candy brought in by a maternal, domineering patient whom she later compared to her childhood housekeeper. The paradoxical concepts introduced by Dr. B. were crucial in helping to break the stalemate. Indeed, the primary factors responsible for the breakthroughs that took place during the

early part of our work together were the death of Sylvia's father, the neutral and non-directive attitudes that both the ward and I adopted toward the symptom, the role of the ritual lunches in making the ward countertransference to Sylvia overt rather than covert, and the work that we were able to accomplish in the treatment, which is discussed in greater detail in Section 4 below.

Upon her father's death, Sylvia made verbal expressions of grief, but showed little emotional impact. It was only towards the end of our work together that she was able to admit to a great feeling of relief, as well as a sense of loss. She no longer had to lie to her father every time he called, saying "Yes, pop, I'll start eating soon and get discharged and come live with you," knowing full well that she had no intention of doing these things and that in fact they terrified her. Most likely the absence of a powerful reaction to this loss, in contrast to prior losses, can be attributed to a combination of this sense of relief and to the fact that the ward, hospital, and therapeutic relationships with staff had by this time replaced her father as her support structure; Sylvia's renewed relationship with her sister seemed to afford her some measure of comfort as well.

As the treatment went on, Sylvia expressed gratitude on a number of occasions for my neutral stance and my abstaining from directive statements; she expressed relief at feeling no sense of pressure, although she admitted to having at first wanted me to "be a mother or a sister" and tell her what to do. For my part, I felt that neutrality was crucial in order to avoid being sucked into a recreation of the family dynamic around the fasting. I believed that a neutral and even indifferent attitude toward the symptom on the part of both myself and the ward would allow the battle of the wills to defuse itself and leave Sylvia free to take new steps and experiment with new behaviors. It would also present her with the necessity of experiencing and working through conflict on an internal level rather than through projective identification and acting out. An attempt was also made to separate Sylvia's food behavior from other issues. Dr. T.'s assurance that Sylvia would be able to remain on the ward for another year after she began to eat in a relatively regular fashion was very important in this regard; it divorced

the anxieties related to new oral behaviors from those connected to the idea of discharge. It also reassured her that we would not throw her out in response to her becoming more autonomous as her father might have, that she could separate at her own pace. For my part, I encouraged Sylvia to divorce decisions about eating from other daily decisions, such as plans with family and friends. Lastly, by communicating that my relationship with her would remain constant regardless of whether she ate or not, I made it clear that I sought a true therapeutic alliance, not one based on false compliance. Indeed this alliance developed over time, as Sylvia became more motivated to take risks and expand her life, as well as to overcome her defensive avoidance in the sessions.

The tube played a crucial role in the dynamics between Sylvia and the hospital. As long as she used the tube, Sylvia could not be discharged, nor even transferred to another ward, since the chronic wards did not have the medical staff available to supervise daily tube insertion. It also served important internal functions. Indeed both the tube and the internal figure of God served as transitional objects (Winnicott, 1953/1971) for Sylvia. The transitional role of the God representation is a universal one and will be explored in Section 4 below. The tube, on the other hand, was a very primitive and concrete transitional object, testifying to the depth of the regression required for Sylvia to shed her False Self and allow her True Self to emerge. As already noted, the ability of the hospital and the treatment staff to tolerate and contain this regression was crucial for Sylvia's ultimate recovery. The very nature of the nasogastric tube supports Winnicott's view of transitional objects as originating in early oral phenomena and suggests that Sylvia regressed to a stage that precedes the usual transitional object stage. Sylvia's eventual self-feeding by tube was a compromise between remaining in a state of passive-receptive oral dependency and simultaneously taking charge of the feeding process. In this rather unique fashion, Sylvia transformed a passive and very raw experience of physical intrusion into a process that was under her own control--in other words, she herself made the experience a transitional one. In fact, the tube was clearly both "me" and "not-me" (Winnicott, 1953/1971) in a very concrete

fashion--when Sylvia would spend her days walking around with it inserted and taped to her nose, it seemed very much a part of her physical being, so much so that one hardly noticed its presence. Finally, the ward's policy of "benign neglect" allowed the tube to "lose meaning" and be "relegated to limbo" (Winnicott, 1953/1971), as concrete transitional objects do in the normal course of events.

We might note that, from a more classically Freudian perspective, there is a sexual aspect to the insertion of a naso-gastric tube, which may be related to early childhood fantasies of gastric pregnancy and to an upward displacement of genital fantasies. Sylvia's refusal of oral intake had one rather peculiar aspect--a particular fear and renunciation of liquids. Liquids can be seen as symbolic of "mother's milk," or alternately as connected to fellatio fantasies; in this context, it is interesting to note that, when asked to associate to "liquids," Sylvia responded "no-nos" and later in the same session spoke about two of her husbands having been bisexual. During our work together, I was interested to learn that the medical staff who were required to observe the tube insertion often experienced it as a very private act with vaguely sexual or scatological qualities, which often left them feeling uncomfortable about this duty. However, as interesting as these sexual connotations may be, they remain far less significant than those aspects of both the tube and the delusion that relate to identity, autonomy, and narcissistic needs--as indeed Sugarman et al. (1981) note with regard to the significance of sexual issues in anorexia nervosa.

Finally, from the perspective of an addictive eating disorder, tube feeding offered Sylvia a solution alluring in its simplicity--by imitating alcoholics who, once they espouse sobriety, need never pick up a drink again, Sylvia chose to avoid the difficult challenge of moderating her eating in the face of the "turn-on" associated with oral intake. Thus the tube provided an "all-or-nothing" solution to a problem that usually requires dealing with more difficult gray areas. And Sylvia tended to function in extremes, viewing moderation of any kind as alien.

A number of the changes that took place during the course of treatment were

tied to the relationship between Sylvia and myself, in both its transferential and reparative aspects. The latter will be discussed in Section 4 below, which addresses the progressive tempering of the God representation. The transferential aspects were connected to narcissistic issues and to the close link between fasting and loss. This link was highlighted by Sylvia's reaction to my week-long illness in April, when she returned to tube feeding, and to my impending departure, which impacted on her in June, when she began an extended fast. In Kohut's (1971) terms, the loss of the transference selfobject threatened her with self-fragmentation; she reacted by regressing to behaviors designed to shore up her fragile boundaries, namely fasting and reconnecting to her two transitional objects, the tube and the internal God representation. This pattern was well entrenched; from early adolescence on, Sylvia had coped with loss via food restriction, i.e., by punishing and depriving herself. She expressed this very consciously after the June picnic, when she was able to say, "If I can't have you, I may as well not have anything else." As we saw in the reports of Ceaser (1977), Friedman (1985), and Bell (1985), this response is hardly unique and may even have a universal core. In any case, an attempt was made, during the termination phase, to work through these feelings of loss; it is to be hoped that this involved some working through of the unresolved mourning in Sylvia's history as well--the losses of her housekeeper Maria, her mother, her siblings, her father, and her children; certainly she felt this to be the case in relation to the loss of her father, as she mentioned that she was only truly beginning to experience it when facing my impending departure.

Another aspect of the narcissistic transference can be seen in Sylvia's catastrophic reaction to her de-idealization of me subsequent to the picnic, when she suddenly perceived me as a dieter rather than magically in control or magically thin. There were other transferential aspects to this as well. Having grown up in a culture where feeding is equated with love, Sylvia was very prone to press food on people and interpreted refusal to eat her food as a rejection, be it on my part or that of her children. Interestingly enough, she never saw the irony in the situation--namely, that

having food pressed on her was what she most resisted. Nor did I point it out, feeling at the time that this was too sensitive a topic, in light of her disillusionment with me and in light of the impending termination. In any case, the de-idealization, combined with the impending abandonment, led to the eruption of rivalry--she would "outdiet" me--and also left her in a state of severe selfobject hunger, which naturally enough, she handled by fasting and by reconnecting to God. However, by then, the momentum toward recovery was sufficiently powerful that this regression was fairly short-lived.

In the final analysis, it would appear that, over the course of the 9 years that she spent in our facility, Sylvia underwent a "reparenting" experience. Harsh as a hospital may be, it is structured, predictable, consistent. Furthermore, our ward was blessed with a stable and very caring staff, who formed deep attachments to the patients and who treated Sylvia as a beloved and favored child. Sylvia and I shared a warm and symbiotic relationship; for my part, I certainly experienced it that way--I often found my sessions with her very soothing and at times could not remember which one of us had said what, as we often completed each other's sentences. Nonetheless, most of the work of the symbiotic period had been accomplished in the years that preceded our treatment. When I began working with her, Sylvia had reached a stage where struggles over autonomy, issues of identity, and oppositional processes held sway. These, in turn, had created an impasse. At this point, the extraordinary confluence of events consisting of Dr. B.'s paradoxical intervention, the death of Sylvia's father, the defusing of the battle over the symptom, and the work that we were able to accomplish in the treatment combined to resolve the impasse and allow development to proceed.

4. The Evolution of Sylvia's God Representation in the Course of Her Illness and Recovery

This section focuses specifically on what we have termed Sylvia's "delusion"--her belief that God wanted her to "fast"; it traces the evolution and resolution of this belief and the concomitant transformation of her internal God representation. These

developments occurred via processes of internalization and externalization and help to illuminate some of the transferential aspects of the treatment and the relationship between Sylvia's psychosis and her eating disorder.

Unfortunately we know very little about Sylvia's beliefs prior to her illness, i.e., about the early nature of her God representation. No mention is made of any interest in religion in childhood or adolescence. All we know is that Sylvia converted to Christianity at the time of her first marriage, i.e., upon her first attempt to leave her family of origin. Many years later, she became involved in a born-again Christian movement, probably around the time of her mother's illness, i.e., at a time in her life when her outer adaptation was stressed to the limit and severe object loss was impending or had already occurred. Thus it would appear that Sylvia reactivated the God representation--brought it "out of the toolbox," as Rizzuto (1979) would say--as a life-saving response to severe loss and the consequent threat of disintegration of the self. The active involvement in Christianity may also have included an effort to distance herself once again from her Jewish father and to contact the good object representations connected to her Christian housekeeper Maria. Even more importantly--to shift the emphasis from the term "Christian" to the term "born-again"--Sylvia's False Self defense (Winnicott, 1960/1965a) had begun to fail her; her False Self was beginning to abdicate and more and more desperately seek some opportunity for the rebirth of the True Self. Born-again Christianity may have seemed to offer such an opportunity; however, it did so without providing the possibility for regression that Winnicott (1960/1965a) emphasizes as crucial to the process. Thus Sylvia had to "up the ante" and take fasting even further than her sect could condone.

As she sank further into her illness and her severe depression, Sylvia appears to have turned her focus away from God in favor of the demons/evil spirits that she felt inhabited her body. This development is a particularly relevant one from the perspective of Palazzoli's (1978) theory of the internal dynamics of anorexia nervosa. As discussed above, for Palazzoli, the central dynamic of anorexia nervosa is the projection of

the powerful bad-mother introject into the body. Palazzoli stresses that, in anorexia nervosa, the introject is not fragmented; the anorexic's relationship with the introject is one of ambivalent fascination--she wants to control it via starvation but not to destroy it. It is precisely these characteristics of the anorexic defense structure that make it a "mono-symptomatic psychosis" and a "special defense structure midway between schizo-paranoia and depression" (Palazzoli, 1978). Sylvia's illness was based in an identification with the lost mother, who starved to death due to being paralyzed in the mouth--indeed, just as it was difficult for spoons to pass the mother's lips, Sylvia herself refused to allow a spoon to pass hers. However, the bad mother introject was so toxic that it had to be both fragmented and re-projected onto imaginary (and transitional) demonic figures. This process represents a regression--in Kleinian terms (Segal, 1969)--from the depressive position to the paranoid-schizoid position and a large step beyond anorexia nervosa. Logically enough, Sylvia also went beyond the attempt to control these "demons in the body" via food restriction--rather she hoped, by starving them for a magical number of days, to extrude them entirely. While Rizzuto (1979) states that the Devil is always a phallic creature formed largely from paternal representations, our theoretical analysis attributes the source of these demons to the bad maternal representation. This is based partly upon a theoretical notion--Palazzoli's view of the internal dynamics of anorexia nervosa--and partly upon a clinical fact, namely the onset of severe depression subsequent to the loss of the mother. We might note, however, that two other losses had also occurred--that of Roberta, the older sister who fulfilled maternal functions, and that of Michael, the rival and winner in the struggle to capture parental attention. The contribution of these losses is difficult to ascertain. On the other hand, we do know that Sylvia reacted with conscious anger to her mother's illness--"At least her mouth is shut"--and then proceeded, via her illness, to visit the same fate upon herself, quite possibly as a punishment for this thought.

The elimination of the mention of devils in favor of a belief in "God's will" occurred subsequent to the ECT treatment; thus it may have been connected to an

amelioration of the depression; it was also around this time that Sylvia began to self-introduce the tube, i.e., that the tube became a true transitional object. In any case, this change marked a significant alteration in the delusion. In Kleinian (Segal, 1969) terms, Sylvia had progressed from fragmentation ("bits") to splitting, that is to say, to opposing "good" and "bad" whole objects--God was good, Sylvia was sinful and bad. While this was only a step in the direction toward the depressive position, it certainly brought her closer to depressive guilt and also to narcissistic grandiosity. The focus was no longer on the incorporated demons taking over Sylvia's body, but rather on a personal pipeline to God himself--a punishing God, but God nonetheless, that is to say, an exalted father who did, after all, single her out. Thus we see a transition from fragmented maternal introjects to a unitary and more integrated idealized paternal imago--"God the father" in the Judaeo-Christian framework which Sylvia chose. As both Rizzuto (1979) and Jones (1991) would suggest, this God clearly fulfilled selfobject functions along both narcissistic lines of development (Kohut, 1979). However, the mirroring component connected to the grandiose self was submerged under the idealized parental imago--Sylvia derived her grandiosity from her unique connection to God. God's choosing Sylvia marked her as "special," just as her father's favor had done. In fact, this special favor together with the fierce nature of Sylvia's God and in conjunction with the Judaeo-Christian view of a patriarchal God figure provide the principal data for locating the sources of Sylvia's God representation in primitive paternal representations. Furthermore, as Jones (1991) would suggest, the God representation also served the hermeneutic purpose of making sense of a world in which such massive losses and severe pain can occur--by taking all the badness into herself, Sylvia established some degree of magical control and made sense of what might otherwise appear senseless. Not only was God her transitional object--in her view, she may have been his, to be pummeled and loved at the same time. Certainly there is a parallel to the reasoning underlying Catherine of Siena's increased austerities upon the death of her sister and the bargain that she made with God when her mother lay seriously ill--that he should allow her mother to survive and visit pain upon her

instead (Bell, 1985). While Catherine's culture looked upon her behavior differently, this method of coping with loss by reactivating childhood magical omnipotence and taking all the badness upon oneself in an effort to make bargains with God, make sense of his apparent cruelty, and turn it into a form of special treatment, bears a strong similarity to the internal process of Sylvia's illness.

In Sylvia's case the God representation must have "been abandoned as a meaningful transitional object" (Rizzuto, 1979) at a very early stage of development, as it drew upon fiercely primitive superego components as well as fulfilling archaic selfobject functions. In the course of treatment, Sylvia's God representation underwent significant changes. These will be traced in detail, so that the process of change can be subjected to careful examination. The first major compromise occurred when Sylvia came to accept tube feeding and to refer to living on the tube as fasting, i.e., as consistent with God's will. This inroad probably began to occur when tube feeding was instituted on a regular basis, against Sylvia's will and via the invocation of fairly high levels of authority in the mental health system. God's will, at that point in time, could only be modified in such a fashion; indeed Sylvia herself stated that she could accept tube feeding precisely because it was forced upon her. A smaller inroad occurred in 1982, upon the occasion of a visit to her mother's and siblings' graves in the company of Dr. T. and her therapist. Sylvia had been about to remove her lipstick--feeling it was against God's will to wear it--but had allowed Dr. T. to persuade her to keep it on. On this occasion and on the relatively less charged topic of make-up, Dr. T. had apparently carried sufficient authority to modify her view of God's will.

There were also occasions, over the years, when Sylvia would briefly return God "to the toy box" (Rizzuto, 1979), replacing the delusion with simple anorexic or self-punitive concerns. In 1980, following her ECT treatments and at around the time that she had begun to insert the tube on her own--i.e., the point at which the tube began to serve as a true transitional object--Sylvia had stated that it was no longer God's mandate that she fast, adding that she was afraid to eat and felt she should fast to

expiate her sins. During the early "honeymoon" phase of our treatment, Sylvia also made relatively little mention of God and was able to own the powerful secondary gain motives that had helped to fuel and maintain the illness.

The alterations in Sylvia's view of God's will that took place during our work together highlight the role of processes of internalization and externalization. These changes seemed to occur largely without any direct work on the issue, i.e., at a semi- or sub-conscious level, which is consonant with the view of the God representation as a transitional object. Early on in the treatment, I began to respond to Sylvia's statements about God's will in terms of "your God"--without, however, any undue emphasis. I also contrasted the high standards she set for herself with those the rest of us "mere mortals" or "faceless millions" attempted to meet. While I did this with only a little conscious awareness of the process, in retrospect these comments stemmed from a desire to introduce some sense of relativity into her beliefs and also to allude to the tremendous narcissistic power of Sylvia's personal pipeline to God--specifically, to the inverted narcissism of a punishment of such extreme and super-human severity. This implicitly involved raising the possibility of a more human God and a more human lifestyle. More importantly yet, it involved some communication related to boundaries--to a separation between Sylvia and myself, between her view of God and mine. In retrospect, this may have begun to lay the ground work for internalization, as internalization is based upon some beginning awareness of separation and, conversely, it is impossible to internalize that with which one feels merged.

The earliest sign that processes of internalization were beginning to take place was a rather paradoxical one. In March, Sylvia had begun to project the disapproval of her as a "weakling" for not being able to fast onto me. In retrospect, this process of projecting her own superego components onto me in turn allowed her to introject and begin to identify with my more permissive views. Indeed, shortly after this, on the night of St. Patrick's Day, Sylvia began to drink water, after overcoming her feelings of shame and fear before God. Following this, both her concept of God and her self-

concept began to show a distinct evolution--she spoke of God in gentler, more benign terms and began to say, even if a little defensively, "I'm human, I like to enjoy some food occasionally like other people." Thus the changes in the God representation and the self representation occurred very much in tandem.

The regression into fasting and bedrest which occurred in early April, during the week that I was out sick, was accompanied by a return to a somewhat greater preoccupation with the delusion. Upon feeling abandoned by me, Sylvia had reactivated the punitive God representation--another example of its function as a transitional selfobject which could help maintain the cohesiveness of the self when object loss increased the danger of disintegration. My return was followed by a striking growth spurt--in behavioral terms, an expansion of social activity (going downstairs for coffee), an ad hoc relinquishing of noontime medications, and flirtatious oedipal type behavior; more importantly, Sylvia stated that "God loves me even when I don't fast." Within a few days, she applied for a higher level of privileges and expressed a desire to make her own decisions about eating, saying that she was tired of putting the responsibility on others for her decisions and that she thought her sister would love her even with the added weight. Thus her sister too was now viewed as more benign and accepting. This was followed within a week by Sylvia's eating at a ritual lunch and eventually by an agreement to a gradual reduction in her medications subsequent to my raising the issue, i.e., a new openness to suggestions from others. These changes in the self, object, and God representations following my return reflected a softening of the introjective "walls" that Sylvia had built around herself and God in order to keep other people out.

Over the next few months, Sylvia's conflicts about eating were more and more experienced on an internal level, along with fairly pronounced mood oscillations--almost a pull between choosing to live versus choosing the depression and the illness. The God representation was less prominent at this point. Sylvia was still very upset about her weight and, when pressed, would justify her wish to fast via "God's will"; at other times, she would say that she would just have to be heavy when her sister came to visit.

Probably the most poignant moment in the treatment occurred in May, when Sylvia's effort to identify with me and to introject aspects of my God representation was directly expressed in her question, "Do you believe in God?" and in the answer that she herself supplied: "I think you do, but your God is kind and gentle."

Surprisingly, the major rift that occurred between us following the June picnic and that resulted in a prolonged fast was not accompanied by a regression into the delusion. Sylvia admitted to fasting out of a wish to avoid experiencing feelings related to my impending loss. She was able to explore the parallels between my refusal of her food and that of her children. She also expressed her disillusionment with me as a "dieter" and her competition with me, as well as her self-punitive way of coping with loss and grieving--"If I can't have you, I may as well not have anything else." She could even say that my not eating at the picnic had given her the strength to give up eating; in other words, she could directly address the incorporation of me as the non-eater, without involving the God representation. This stands in contrast to her earlier identification with her starving mother, when the God representation had played a crucial role, and may be due to the fact that our termination could be discussed and mourned.

In the treatment the termination period was both a very productive and a very difficult time. I eventually managed to dissociate myself from the masochistic dieter image by telling her that I had not given up food but rather had had a good dinner after the picnic. Over the next few weeks Sylvia began to "mother" me, asking about my eating habits, and in turn I accepted this mothering, allowing her to symbolically feed me, although she would not yet feed herself. This back and forth conversation about my eating habits illustrates in a very concrete fashion the incorporative aspects of the introjective dynamics that were at work. As we were more and more able to address the pressing issue of termination and look at the defensive functions of the eating and fasting obsessions--"Maybe eating isn't the real problem"--we were also able to indirectly address Sylvia's narcissistic stance, e.g., in my pointing out that I had been briefly more "godly" at the picnic but that in general my behavior would never satisfy her God.

Ironically, by appearing to be a dieter, I had also been less godly than she had wanted me to be; the power of her disillusionment with me testifies to her intense hunger for idealized selfobjects.

Eventually, Sylvia was able to say that she missed food and that what she was doing was not normal; she also began asking a lot of questions about my eating--i.e., she appeared to be making a clear effort to again internalize her more permissive view of me directly around the issue of food. This occurred the Thursday before the lunch with her sister; the next day she was able to accept Dr. T.'s order to "stop this craziness" and agree to eat with us at the lunch. This was followed by several breakthroughs--taking medication by mouth, eating dinner with her sister and brother, and discontinuing morning medications entirely.

By July the delusion had become far less prominent and in turn we were able to begin to examine the anorexia itself--both the addiction to the soothing aspects of fasting and the distortions in body image that comprised it. This occurred in tandem with crucial changes in the God representation. At the ball game, Dr. T.'s intervention was successful and Sylvia was able to say, "Maybe God speaks through doctors sometimes." On August 1st, Sylvia experienced God as telling her that it was okay to eat, as she was not up to fasting; even more importantly, she sought out and obtained confirmation and support from two female patients. Thus God had progressed from speaking through doctors to speaking through peers, and Sylvia no longer assumed that she knew God's will but rather sought out human opinion as well--both these developments reflect a crucial change from Sylvia's earlier narcissistic stance when God had spoken to her alone, with occasional concessions to very high and impersonal levels of human authority. At our last picnic, Sylvia fasted but later expressed regret, voicing the view that this had set her apart from others and had been contrary to God's will. In short, she was truly rejoining the human race.

Later, on the transitional ward, Sylvia was noted to maintain "some quasi-delusional ideas about the religious meaning of her eating behavior." Nonetheless, her

progress in the social and vocational areas was exemplary. In the summer of 1987 there was a 3-week return to liquid food, possibly connected to a change in therapists, but no mention was made in the records of any delusional aspects connected to this. After discharge, there was a notable regression in August, 1989, when Sylvia again began "fasting for God." However, with the intervention of her support network and the return from vacation of her therapist, this regression did not become full-blown. The circumstances that led up to it (as discussed in Chapter III above) were strikingly similar to those that had preceded the original onset of the illness--reacting to loss by volunteering to nurture others, then feeling burdened and put upon, and resorting to a drastic method of shoring up boundaries via withdrawal from others and fasting. A few months after this regression, Sylvia was able to say to her therapist that the fasting was not really for God, but rather her way of staying on a diet--i.e., to resolve the delusion into anorexic concerns--and that she now felt that God wanted her to be happy. The fact that the God representation in its earlier form had remained available to be brought out at the time of this regression does put the depth of Sylvia's recovery somewhat into question. On the other hand, it may simply testify to the multi-layered nature of the representation and the "archival" capacities of the psyche, which in safeguarding its potential for regression must safeguard its earlier components in order to have something to regress to. Certainly the rapid resolution and return to a more nurturing deity is as significant as the potential for regression and testifies to the presence of more positive internal object, self, and God representations. Overall, the close link between the self, object, and God representations--the way in which all three evolved in tandem--supports the views of Rizzuto (1979) and Jones (1991) regarding the selfobject and hermeneutic functions of the God representation. And the process whereby the God representation was modified via the internalization of the positive therapeutic object relationships conforms to the model of therapeutic change described by Jones (1991). To paraphrase Sylvia's own words, God did indeed speak through people.

B. Analysis of the Case in Terms of the Anaclitic/Introjective Model of Personality and Psychopathology

This section will analyze the case from the perspective of the anaclitic/introjective model, applying the variables defined in Chapter II to both Sylvia's overall illness and her regressions into deeper psychosis. The parallels between her case and those discussed in Chapter II will also be addressed.

1. Analysis of the Case Itself

The onset of Sylvia's anorexia during adolescence appears to have been precipitated by a narcissistic injury, being teased by her brother's friends--in our terms, an introjective precipitant. However, a closer look also reveals powerful anaclitic forces. The first of these would be the loss of the housekeeper Maria. As we have seen, throughout her life, Sylvia coped with loss via starvation and deprivation--as she said in response to our impending termination, "If I can't have you, I may as well not have anything else." The second anaclitic precipitant involved the onset of puberty, which threatened to intensify the frighteningly sexualized relationship with her father. Anorexia helped to render her less attractive to him and to distance her from him--a shoring up of the introjective boundaries in response to an anaclitic pull. This is a classic anorexic scenario, as discussed in Chapter II.

Sylvia's adult personality was of the type that Blatt and Shichman (1983) consider to be the anaclitic subset of borderlines--she showed affective instability, with intense but unstable interpersonal relationships. Consistently enough, Sylvia manifested bulimia as well as anorexia during her adult life. She also showed an oscillation between extremes of dependent and counterdependent functioning. This chaotic quality stands in contrast to the adamantly stable defense she evolved in the course of her lengthy hospitalization.

Sylvia's psychosis was precipitated by severe anaclitic losses--the deaths of her mother and siblings. Sylvia responded to these losses by resorting to intensified intro-

jective defenses--identification with and incorporation of the starving mother figure, refusal of oral intake, i.e., shoring up the boundaries of her body to an extreme degree, tremendous emphasis on control and autonomy, and reactivating the internal God representation of her childhood. However, the symptom of food refusal also contained a disguised expression of her anaclitic needs, since it allowed her to become so helpless and dependent that first her father and later the entire mental health system would have to step in to rescue her. Thus Sylvia's psychotic elaboration of the introjective defense of anorexia nervosa showed the characteristic introjective emphasis on counteractive defenses. While to outsiders it appeared seriously maladaptive, from Sylvia's point of view, it clearly provided the only adaptation of which she felt capable at the time. Even the fragmentation of the introject into persecutory demons that occurred in the early period of the illness remained an introjective phenomenon in that it was largely paranoid in quality.

For much of her life, Sylvia had dealt with her conflicts over her anaclitic dependency needs by projecting them onto others and playing the caretaker, a role that would periodically break down; this, in turn, would result in Sylvia's giving up her children and returning home to live with her mother. Early on in her lengthy hospitalization, Sylvia dealt with these needs via dissociation and denial--creating conflicts on the ward, engaging in constant battles, resisting the help that she so badly wanted and needed, although she did surrender to it if sufficiently high levels of authority were invoked. The symptom of tube feeding, as it evolved over the years, also represented a compromise between anaclitic and introjective needs--Sylvia allowed herself to be fed, indeed in a very regressive and intrusive fashion, yet she managed to take control of the process and bring it into the realm of her own autonomous functioning.

The delusion itself was based in introjective processes, i.e., unmetabolized introjections and re-projections, be it of fragmented maternal representations or idealized paternal ones. Sylvia's illness was also introjective in its degree of organization, its stability over time, and its emphasis on guilt and self-condemnation. In other words,

Sylvia's depression was clearly an introjective phenomenon--despite, or perhaps because, of the presence of powerful anaclitic precipitants. We might note that it was also motivated by both survivor guilt in relation to her mother and separation guilt in relation to her father (Friedman, 1985). Indeed it would seem that the only way Sylvia felt able to refuse her father's demand that she move in with him was by becoming severely ill and getting hospitalized, i.e., being more helpless than her father himself. This dual basis for the illness, consisting of the primary anaclitic factor in the form of the loss of the maternal figure and the secondary introjective factor of the need to distance from the paternal one, presents a clear parallel to the two factors that motivated Sylvia's anorexia in adolescence--the loss of Maria and the need to distance from her father.

Sylvia's regressions, with one exception, all follow the same pattern as her overall illness. They were largely introjective in quality and content, but tended to occur in response to anaclitic precipitants. In addition to the two more specific and dramatic regressions in 1980 and 1981, we can note a period earlier in her hospitalization where Sylvia showed some degree of regression. In March, 1979, Sylvia was described as quite psychotic and was noted to attack a nurse, saying the nurse had killed her children. The theme was aggressive; the mechanism was one of projection of guilt and aggression; the form was organized--thus the overall picture was introjective. In this case, no specific precipitant can be identified, other than perhaps low weight and the introduction of tube feeding about a month earlier, which could be considered an introjective precipitant in its intrusive aspects and an anaclitic one in its regressive arousal of anaclitic needs.

The two more defined regressions into deeper psychosis occurred in 1980 and 1981. The first occurred in response to the threat of discharge, i.e., the threat of an anaclitic loss. This threat also involved the fear of being forced into the terrifying sexualized merger with her father; thus it had an introjective element as well, since Sylvia felt completely incapable of maintaining any self boundaries in the face of her father's demands. The first part of this regressive period was very introjective--it was marked

by hostility, negativism, paranoid ideas, and guilt. However, this was followed by a more apathetic period, when Sylvia was often found lying on the floor in a fetal position, a quality more characteristic of anaclitic depression. Thus, during this regression, Sylvia attempted to shore up her fragile self boundaries by increasingly extreme and paranoid introjective means; as this effort failed, she lapsed into a deeper depression with a more anaclitic flavor, where she neglected self-care, lay on the floor in a fetal position, and avoided contact with others. Sylvia's gradual emergence from this regression appears to have been attributed to a combination of new medications and the ward's shelving of all discharge plans, i.e., the removal of all threats of loss and expulsion, an anaclitic factor. But this emergence also took the form of a return to the primitive introjective functioning that characterized of Sylvia's overall illness, with isolation of affect, guilt themes, maintaining a distant connection to her therapist, and resigning herself to a living death within the context of her allegiance to God's will. Thus emergence from the regression can be characterized as mixed anaclitic/introjective.

The second regression, which occurred in 1981, took place in reaction to an actual anaclitic loss--the departure of Sylvia's first training ward therapist. This regression manifested itself in more primitive delusional material of a very introjective nature--themes of guilt, aggression, and anality in the form of fantasies of oral and rectal sex with her children, smearing feces, and repetitive confessing of these "sins." Nonetheless, it remained largely organized. Sylvia's emergence from this state of regression appears to have been attributed to medication changes and developing a connection to the new therapist--again, an anaclitic factor. But, as before, she returned to her basic introjective illness.

Finally, we need to look at the prominent role of processes of projection and introjection in both the formation of the delusion and its eventual modulation and resolution, since these constitute the fundamentally introjective factors in Sylvia's illness. Sylvia's most recent regression, which took place in 1989, is very interesting from this perspective. Faced with an anaclitic loss in the form of her therapist going on vacation,

she either volunteered or induced herself to be volunteered for responsibilities she did not truly want. These responsibilities involved catering to the dependency needs of small infants. Thus, as had been her pattern in the past, she projected her anaclitic needs, which were intensified by the anaclitic loss of her therapist, onto others and attempted to fulfill them in a pseudo-altruistic fashion. This method failed due to her rage at her own unmet needs, i.e., because it involved giving up too much on the introjective plane, too much sacrificing of the self to others. This led to a reintensification of the introjective boundaries, albeit on an extreme and pathological basis--Sylvia regressed to the primitive introjective defense of refusing oral intake, to the relationship with the primitive God representation, and to an attempt to withdraw entirely from the relationship with her boyfriend, the connection to whom was now threatening her fragile self-boundaries. This time, however, she had a sufficiently positive connection to others and sufficient trust in them to ask for help; this in turn kept her from falling into a severe relapse and being rehospitalized. In other words, thanks to sufficiently positive anaclitic ties to therapist and friends, the regression into primitive introjective mechanisms was aborted at an early stage. However, this also involved Sylvia's obtaining support for asserting her needs and her boundaries in a more positive and healthy manner, i.e., directly refusing to care for the children. Thus this last emergence from a period of regression, like the previous ones, combined anaclitic and introjective elements. The overall illness, which had begun with a primitive introjective reaction to anaclitic threats, had ultimately resulted in progress along both developmental lines and in a rebalancing and reintegration of the two lines.

The variations that occurred in the course of the illness illustrate a back-and-forth movement along the introjective line. Sylvia's basic illness consisted of an introjective depression at a psychotic level. Her several decompensations into deeper psychosis, as well as the more primitive form of the delusion itself (the demons), represented regressions along the introjective line into more paranoid functioning. Upon recovery, the introjective depression was replaced by a narcissistic adjustment--the post-

illness period with its emphasis on "specialness." This conforms roughly to the concept of the introjective continuum as described by Blatt and Schichman (1983), with paranoia at the lowest level, followed by obsessive-compulsive syndromes at the middle level, and introjective depression and narcissism at the upper level. There was only one brief period when Sylvia's illness appeared to cross over into the anaclitic line--during the severe regression in 1980, when Sylvia went from paranoid thought content to lying on the floor in a fetal position. In summary, Sylvia's illness was largely confined to the introjective category, with a back-and-forth movement within this category, and with one instance of crossing over into anaclitic depression in the depths of regression.

On the other hand, as we noted earlier, the case also illustrates a dialectical interplay between the two developmental lines, in that the arousal of anaclitic needs consequent to anaclitic loss was followed by a recourse to extreme introjective defenses--anorexia in both its simple and psychotic forms. And conversely, recovery--both from the brief regressions and from the overall illness--involved a rebalancing and reintegration of the two developmental lines. Ultimately, thanks to the reparatory experience on the ward, Sylvia was able to experience her separateness without fearing that she would be thrown out of the safety of her adopted home. The tube feeding that had originated in an adamant battle for autonomy had evolved over the years into a stable identity. Sylvia had also developed more positive and trusting relationships with others and had begun to mourn her losses and overcome her terribly maladaptive ways of coping with loss. The aborting of the last regression in 1989 via the supportive ties to her friends, her former transitional ward, and her outpatient therapist and via the work in the area of self-assertion illustrates the importance of progress along both developmental lines in preventing the maladaptive recourse to exaggerated introjective defenses when faced with anaclitic loss.

The analysis in this section is summarized in Table 3.

Table 3
Summary of Chapter IV, Section B
Sylvia's Illness

	<u>Precipitant of Psychosis</u>	<u>Quality of Psychosis</u>	<u>Content of Psychosis</u>	<u>Process of Recompensation</u>
Ongoing illness	A	I	I	A/I
March, 1979	A/I?	I	I	--
1980 regression	A	I*	I	A/I
1981 regression	A	I	I	A/I

A - Anaclitic Type

I - Introjective Type

A/I - Mixed Anaclitic/Introjective

Dashes - Insufficient information

* With regression into anaclitic depression

2. Comparison to the Cases Discussed in Chapter II, Section B

This section examines the parallels between Sylvia's illness and the cases discussed in Chapter II, Section B, both in terms of the anaclitic/introjective model and in broader psychodynamic terms as well.

Sylvia's illness is somewhat unusual with respect to the distinction between ongoing illness and brief psychotic episodes which was delineated in Chapter I. On the one hand, from the point of view of duration, Sylvia's illness was clearly an ongoing affective disorder rather than a brief episode. Indeed her psychosis was remarkably consistent over time and remarkably resistant to all early interventions. On the other hand, secondary gain was a very important factor in maintaining the psychosis and possibly even in instituting it; we have no way of knowing how long the illness might have lasted without these factors, i.e., would the illness have resolved itself sooner if it had been possible to remove Sylvia's fears of returning home to either her husband or her father. Furthermore, Sylvia experienced two brief regressions into deeper psychosis that can be conceptualized as decompensations within the context of her ongoing illness. Lastly, upon closer examination as noted in Chapter II, a number of the cases reviewed cannot be easily classified as brief or ongoing, either because they tended to show recurrences or because long-term follow-up data were not available. On the whole, the articles which discuss ongoing illnesses do not provide the type of clinical data required for a meaningful dynamic exploration. Thus, while the distinction between brief and ongoing illness was useful in establishing a classification for the analysis in Chapter II, it is less significant in this context and will be put aside, in favor of an examination of the parallels between all of the cases discussed in Chapter II, Section B and that of Sylvia.

Hudson et al. (1984) reported six cases of anorexia nervosa in conjunction with affective disorder. However, they gave little specific data. The most striking points are the relatively high prevalence of a polysymptomatic picture in their patients, which suggests a borderline level of personality organization, the fact that all of these patients were classified as having affective disorder, and the high prevalence of major affective

disorder in their first degree relatives. These constitute the parallels to Sylvia's case.

Ferguson and Damluji (1988) limited themselves to patients with schizophrenia and anorexia nervosa. Since the diagnosis of schizophrenia can be excluded in Sylvia's case, there are few points of comparison. However, we might note Ferguson and Damluji's (1988) observation that the eating disturbance, for their patients, served an organizing function, giving them "a sense of identity, if not a meaning to their existence" (p. 350). We could easily say the same for Sylvia's delusion and symptoms during the period of her illness, which testifies to the powerful introjective functions of both anorexia nervosa and Sylvia's atypical form of the illness.

Hsu et al. (1981) discussed three patients with ongoing illness and three patients who appeared to show transient episodes. In the three cases with transient episodes, the precipitant was either hospitalization itself or nearing target weight--precipitants we have classified as introjective--which constitutes a major difference in comparison with Sylvia's case, where the precipitants tended to be anaclitic losses. All these cases showed prominent introjective symptoms, in the form of auditory hallucinations--voices commenting on "how ugly, fat, or greedy they were." Overall, these psychoses appear less organized than Sylvia's illness. This suggests that the degree of organization of Sylvia's illness was at least partly a function of the use Sylvia made of her unitary God representation to contain such superego projections, i.e, it supports the view of the God representation as serving crucial selfobject functions in helping to maintain the cohesiveness of the self (Jones, 1991; Rizzuto, 1979).

Grounds (1982) reported seven cases of transient psychosis in anorexia nervosa. These cases stand in contrast to Sylvia's illness in terms of the floridly polysymptomatic and disorganized nature of the psychoses, which we have described as strongly anaclitic. On the other hand, the precipitants were largely anaclitic, as they were in Sylvia's case.

Having covered the articles dealing with ongoing illness, we can proceed to a more detailed examination of the individual case reports discussed under Question 3, which provide a much richer fund of clinical data. The case of Dominique (Bedoret et

al., 1973) shows a number of parallels to Sylvia's case. Dominique, like Sylvia, showed onset of anorexia nervosa in adolescence, apparently in response to critical comments from boys, but more deeply connected to conflicts about separating from a domineering mother. Dominique's transition from a period of "professional hyperactivity" to "an episode of physical asthenia, labeled as depression" recalls Sylvia's oscillations between extremes of over-responsibility and dependency. Dominique, like Sylvia, displayed a compliant, passive, "good little girl" façade with massive dissociation of aggression. On the other hand, Dominique's relationship to sexuality was a more typically anorexic one--she valued amenorrhea as a protection against sexuality, whereas Sylvia claimed to feel more sexual when fasting. Sylvia showed many of the same testing and manipulative behaviors in the early period of her hospitalization as did Dominique, albeit not with the same motives--Dominique truly yearned for discharge while Sylvia dreaded it or at any rate was quite conflicted about it. Dominique's psychotic episode was brought on by the separation from her family, combined with a severe loss of control. Similarly, Sylvia's two regressions into deeper psychosis were precipitated by the threat of losing her new family, the ward, in 1980 and by the loss of her therapist in 1981.

Dominique's psychosis was a floridly anaclitic one, marked by a hallucinatory consciousness and multiple themes, with a focus on loss of objects and disintegration of self representations. Even in her deeper regressions, Sylvia remained more organized, thanks to the strongly introjective focus of her illness. Dominique's recompensation was linked to the establishment of close, nurturing ties to nursing staff--very much the same role that the ward as a whole and especially the ward's nursing staff played in Sylvia's case. However, Sylvia's recompensation also involved introjective factors, as the hospitalization ultimately provided her with an opportunity to establish an identity and self-boundaries.

The case reported by Küchenhoff (1986) shows a number of important parallels to Sylvia's illness. Küchenhoff's patient expressed her conflicts connected to separation and merger with her mother more overtly than did Dominique or Sylvia, as seen

in her fear that her mother could take away her apartment simply by visiting it and in her symbiotic relationship with her roommate. This patient certainly suffered from severe separation guilt (Friedman, 1985) in relation to her mother, as did Sylvia in relation to her father. The patient's manipulative behavior in the hospital was similar to Sylvia's at the start of her hospitalization. Like Sylvia, this patient showed prominent narcissistic traits, with much emphasis on caring for her appearance, and intense conflicts regarding autonomy, with treatment efforts being experienced as coercive. This narrative is especially relevant because it involves the use of a tube and reports the conscious regressive anaclitic fantasies that were aroused in the patient by this experience. Küchenhoff's patient removed the tube and was then confined to her room; this was followed by an experience of intrusion even more powerful than the tube feeding itself via the therapy sessions being held in her room. This precipitated the psychotic decompensation, which took the form of paranoid fantasies and hallucinations of critical voices. By contrast, Sylvia was already psychotic when tube feeding was introduced. She too appeared to enjoy it, but expressed intense conflicts about it. Indeed, about a month after the introduction of tube feeding, Sylvia regressed into paranoid thinking and attacked a nurse, claiming that the nurse had killed her children. This March 1979 regression resembles the one that Küchenhoff's patient experienced, in that an intrusion on the boundaries of the self was followed by an attempt to reestablish them via paranoid processes, i.e., a regression along the introjective line into more extreme and more primitive introjective efforts. Ultimately, however, Sylvia took control of the tube feeding process, which changed the nature of the experience for her. Another difference is that Sylvia's two later regressions occurred not in reaction to intrusion and loss of control, but rather in response to the threat of separation from the safety that the hospital had come to represent. In fact, it is likely that Sylvia was more afraid of the potential loss of control that would ensue from discharge--both in terms of her own self-destructive impulses and the threatening, sexualized merger with her father--than of any loss of control imposed by the hospital. Nor was she unjustified in this regard,

as the history bears out her uncanny ability to take control of the hospital environment and turn it to her advantage.

On a broader level, Sylvia and Küchenhoff's patient are both examples of a psychotic illness serving an overall progressive function. Both eventually came to reintroject their dissociated needs for oral satisfaction and for interpersonal connection. Sylvia too showed a progression from dissociation of anacletic needs in her anorexic adulthood, to projection in her illness, to reintrojection in the process of recovery. Both Sylvia and Küchenhoff's patient ultimately recompensated and recovered via a controlled reestablishment of positive ties to others and a rebalancing the introjective and anacletic elements in their lives and personalities.

The case of Pierre, reported by Cramer and Bovet du Bois (1973), shows a number of very interesting parallels to aspects of Sylvia's illness. Pierre's anorexia served as an introjective defense against the anacletic loss of the symbiotic twin-like relationship to his brother--just as Sylvia's anorexia was in part precipitated by the loss of the beloved housekeeper Maria. Like Sylvia, Pierre attributed the interdiction against eating to a figure that we can describe as the carrier of the projected idealized parental imago. His projection was probably not a psychotic one, as he made use of a real person rather than an internalized figure and as there may have been some reality to the interdiction itself. While Sylvia was able to slowly and gradually alter and metabolize her projection within the context of a relatively unthreatening environment, Pierre had a very different experience--a sudden dismantling via external intervention. In both cases, this dismantling was accompanied by bulimia, as the previously contained oral urges were let loose--in Sylvia's case this occurred during our early work together. In Pierre's case, quite possibly because of the sudden and externally motivated dismantling of the defense, the result was a full blown florid psychotic episode with a "spectacular" regression affecting cognitive as well as emotional functioning. Cramer and Bovet du Bois suggest that this regression was focused on the very early stage of infancy characterized by a cathexis of the primitive oral cavity; this is quite interesting in light of Syl-

via's early fascination with the experience of tube feeding. Indeed Pierre drew himself as a threadlike figure, which is reminiscent of the actual thread-like form of the nasogastric tube leading directly from the hand to the stomach, without having to encounter the usual boundary functions of the mouth. In this sense, Sylvia's symptom again combined two opposites--a real exaggeration of the mouth as boundary, which allowed nothing to pass her lips, and a complete bypassing of it via the tube. Pierre's case, like that of Dominique, supports the view of anorexia in all its introjective aspects serving as a protection against a disintegrative and more anaclitic psychosis. In Sylvia's case, the very introjective and organized psychotic delusion, on which her atypical eating disorder was based, served much the same purpose.

The case of Maria L. (Steinberg, 1982) shows a number of points in common with Sylvia's illness. Maria's family, like Sylvia's, placed tremendous stress on achievement, with extreme criticism and venting of narcissistic rage when these perfectionistic standards were not met; Maria's mother, like Sylvia's, tended to dominate via her aggressive nurturing. The anorexia of the twins included a component of identification with the mutilated father who, following his war injury, was fed first via nasal tube and later by his wife--a clear parallel to Sylvia's psychotic identification with her deceased mother who had been paralyzed in the mouth following a stroke.

For both Pia and Maria L., the precipitant of the anorexia was the loss of the symbiotic twinship, which resulted in the eruption of rivalry focused on attaining the "elfin" figure. This recalls both the onset of Pierre's anorexia as discussed above and Sylvia's reaction to the rupture in our merger-like relationship following the June picnic, when she became aware of our impending termination and also suddenly perceived me as a dieter and a rival.

The concatenation of factors which led up to Maria's first psychotic episode is similar in several respects to the set of circumstances that led up to Sylvia's illness. Maria too felt abandoned, tremendously burdened with family responsibility, and reacted to a frighteningly sexualized interaction with her father--all anaclitic precipitants with a

secondary introjective component of boundary infraction. Maria's last psychotic episode seemed to result from the failure of her repeated bouts of anorexia and previous psychotic episodes to serve as an effective cry for help. Similarly, Sylvia's brief episodes of fasting were ineffective in altering her situation in any real way and she too had no choice but to "raise the ante" and plunge further into her illness. In Maria's case, bulimia appeared during the course of treatment in the last episode, specifically after Maria emerged from the most catatonic phase of her psychosis. We might note that the catatonic aspect, with its abdication of all introjective efforts, was also seen in Sylvia's most regressed phase in the summer of 1980. However, Maria throughout her psychotic episodes largely abdicated the introjective defenses, whereas Sylvia took them to ever greater lengths in her illness. Finally, Maria emerged from psychosis only to return to a fragile anorexic adjustment, whereas Sylvia's lengthy illness led her to another level of recovery.

As already noted, the cases reported by Escande et al. (1975) present many diagnostic ambiguities and are somewhat sketchily reported. The primary parallel in the case of Jeanine is a very broad one--the overall introjective quality of the case. In the case of Nicole, we might note the role of the sexualized relationship with the father and that of his abandonment in the onset of anorexia.

The case reported by Sumners and Cohen (1987) presents many diagnostic problems and offers few parallels to Sylvia's case, other than perhaps the aspect of bodily intrusion involved in the colostomy, which is similar to, but more severe than, the bodily intrusion involved in tube insertion. This patient's psychosis had numerous schizophrenic qualities, which may be attributable to his underlying paranoid schizotypal personality. Sylvia, in comparison, showed a higher prodromal level of functioning along both developmental lines and a more anaclitic type of borderline personality; she also maintained a far more effective level of defense even within her psychosis.

Sylvia's case supports the hypothesis that the content and quality of the psychosis tend to be congruent. In her case, both were strongly introjective. On the

other hand, the analysis carried out under Question 3 above led us to note that the precipitant of the decompensation and the recovery factors were in most cases also congruent with the content and nature of the psychosis. The major exceptions to this rule are the cases of Pierre (Cramer & Bovet du Bois, 1973), of Küchenhoff's (1986) patient, and of Sylvia. Pierre and Sylvia's illnesses both illustrate a cross-over between the developmental lines, as indeed does anorexia nervosa itself. Pierre responded to a primarily introjective precipitant with a floridly anaclitic psychosis, whereas Sylvia did the opposite, reacting to anaclitic precipitants with an extremely introjective illness. Both Sylvia and Küchenhoff's patient showed a recompensation that combined elements of both developmental lines and demonstrated progress along both lines.

D. Limitations

This study suffers from a number of significant limitations. As already noted in our review of the literature on the co-occurrence of psychosis and anorexia nervosa, psychosis is by its very nature a naturally occurring phenomenon. Psychosis in the context of anorexia nervosa remains fairly rare--5 to 10% by the available estimates. Clinical populations are subject to tremendous sampling biases, only some of which can be ascertained; these include those biases stemming from referral practices and those stemming from diagnostic methods. Furthermore, the type of psychodynamic analysis that this study has attempted to accomplish requires in-depth clinical data, which are not always available, particularly on large numbers of patients. Both the data collection and the analysis are highly subjective. Finally, our review of the literature consisted of a detailed examination of a small cross-section rather than a complete search.

The central data contribution of this report concerns one individual history, and a rather unique one at that. As already noted, it is a case that straddles the distinction between brief episodes and ongoing illness, that was never purely a case of typical anorexia nervosa, and that was shaped, in part, by powerful secondary gain factors. Furthermore, the theoretical foundations of the analysis were evolved *ex post facto*, con-

siderably after the actual treatment. Thus the data gathering which occurred during the treatment was of a somewhat happenstance nature, partly due to the absence of theoretical perspectives to orient it and partly due to clinical considerations. For example, as Rizzuto (1979) suggests, the nature and evolution of the God representation can be very useful in illuminating the internal object world; however, no specific inquiry was made in this direction during the treatment, partly out of my own ignorance and partly out of an instinctive sense that, as a transitional object, the God representation should be left alone as much as possible. Similarly, I did not specifically chart Sylvia's food and tube behavior, as I felt that to do so would run counter to the policy of benign neglect that was central to the treatment. While this made good clinical sense, it certainly had a limiting effect on data collection.

In short, since the heart of the analysis focuses first on several individual case studies in the literature and secondly on one individual case study provided herein, it suffers from both the limitations and the strengths of precisely this kind of clinical data. It remains an exploratory study. The variables defined in Chapter II emerged from the analysis of the literature, have not been tested in any experimental sense, and remain quite subjective in their application. The intention was to lay the groundwork for an understanding of anorexia nervosa as an introjective defense at the theoretical level and to extend this understanding to the psychotic decompensations that result upon the failure of this defense. To the degree that the proffered model has helped to clarify, highlight, and systematize the data, it has been successful. However, any kind of wider application or statistical validation remain to be accomplished.

E. Conclusions

In the preceding sections of this chapter we presented a broad diagnostic and dynamic understanding of Sylvia's case, an in-depth exploration of the processes of internalization and externalization that underlay her illness and recovery with a specific focus on the evolution of her delusion and her God representation, and finally a

systematic analysis of her case from the perspective of the anaclitic/introjective model, drawing parallels to the other cases which had provided the clinical base for extending the model to psychotic decompensation within anorexia nervosa. We reviewed the ways in which Sylvia's case supported the theoretical model of anorexia nervosa as an exaggerated introjective defense against intensified anaclitic needs and specifically the ways in which her psychotic illness as a whole represented an exaggeration--or to use Escande et al.'s (1973) term--a "psychotization" of anorexia nervosa precipitated by an extreme intensification of anaclitic needs due to severe anaclitic losses.

To briefly reiterate this analysis, we saw that Sylvia's anorexia initially began as a response to a narcissistic injury, but more importantly served as a defense against her anaclitic needs--for her unavailable mother, for her lost housekeeper, for her dangerous and engulfing father. Sylvia's history clearly illustrates a decompensation into psychosis following upon the failure of the anorexic defense structure--the collapse of the "sthenic" powers of anorexia nervosa, as Steinberg (1982) would phrase it. In Sylvia's case, the anaclitic forces--consisting of both severe anaclitic losses and powerful disavowed anaclitic needs--were so overwhelming that the failure of the anorexia is hardly surprising; indeed Sylvia's fasting after her mother's death was from the start quite drastic and tinged with psychosis, i.e., it rapidly went beyond anorexia. Sylvia's case is an outstanding example of an introjective psychosis, which took the form of an exaggeration of anorexia nervosa on both the external and internal levels. Her brief decompensations into deeper psychosis tended to involve regression into more primitive introjective mechanisms, i.e., paranoia, with one exception of a brief collapse into anaclitic depression. Sylvia's recovery is very much an example of a rebalancing and reintegration of the two developmental lines. As we discussed above, the manner in which her last regression in August, 1989 was aborted is a striking illustration of this.

Sylvia's history is especially interesting in light of Palazzoli's (1978) analysis of the introjective mechanisms underlying anorexia nervosa. To use Palazzoli's terms, Sylvia's psychosis was indeed--for the most part--a "mono-symptomatic" one, albeit one

that clearly went beyond the usual scope of anorexia nervosa. It took "intra-personal" projection and "intra-personal" paranoia one step further than anorexia nervosa generally does. On the symptomatic level, it involved more extreme starvation than anorexia nervosa does; on the internal level it involved both a fragmentation and "demonization" of the bad mother introject, which goes beyond the anorexic's simple projection. Later, as the recovery progressed, the demons were replaced by the projection of the idealized parental imago onto the God representation, a punitive but also loving figure evolved from paternal object representations. In Kleinian terms (Segal, 1969), this reflected progress from the paranoid-schizoid position towards the depressive position. Indeed, this process probably went along with a return to a more anorexic projection of the unitary bad mother introject into the body, since Sylvia's weight concerns returned over time. We might note that the reintegration of both Sylvia's introjects (God and the unconscious projection of the maternal imago into the body) occurred in tandem with each other and with her coming to tolerate a normal weight, i.e., that her psychosis and her eating disorder tended to be closely linked. In the course of the recovery process, Sylvia's concrete transitional object, the naso-gastric tube, was came to "atrophy," as concrete transitional objects do in the course of normal development, while the God representation tended to be "returned to the toy box," as Rizzuto (1979) would say. Sylvia's case is also consonant with the views of Winnicott (1960/1965a) on the necessity of extreme regression when the False Self defense is pronounced.

Sylvia's illness was rather unique, in that it involved both severe regression and simultaneously an overall maintenance of defense via the psychosis. Indeed, the recovery process consisted of a slow and gentle dismantling of this psychotic defense structure, with Sylvia remaining very much in control of the process. The recovery was also centered on a reintegration and rebalancing of the anaclitic and introjective developmental lines. At times this involved the pendulum swinging towards the anaclitic needs, as seen in the appearance of bulimia; this supports Holmgren et al.'s (1983) view of the eating disorders as lying on an interconnected continuum and our own analysis of

anorexic behavior and bulimic behavior as representing the introjective and anaclitic poles of this continuum. The capacity of the ward to tolerate this swinging of the pendulum was crucial and allowed for its eventual settling down at a healthier balance point.

What are the clinical implications of this study? Our review of the clinical literature on cases of psychotic experience in anorexics allowed us to conceptualize two broad scenarios: (a) an introjective psychosis which represents an exacerbation of the introjective defense of anorexia nervosa at a more primitive, psychotic, and paranoid level, and which can indeed be termed a "distillation" or "psychotic crystallization" (Escande et al., 1975) of anorexia nervosa ; and (b) an anaclitic psychosis which results from a complete disintegration of the anorexic defense with the ego becoming overwhelmed by anaclitic forces and needs. The first category included the cases reported by Hsu et al. (1981), Küchenhoff (1986), Escande et al. (1975), Sumners and Cohen (1987), and, most strikingly, the case of Sylvia. The second category included the cases reported by Grounds (1982), Bedoret et al. (1973), Cramer and Bovet du Bois (1973), and Steinberg (1982).

Several questions arise from this classification. First of all, can we determine what factors are implicated in the development of an anaclitic psychosis rather than an introjective one? Secondly, what is the implication of this distinction for long-term prognosis? Both questions are difficult to answer in light of the very small nature of our sample and the lack of control over data gathering, which in many cases did not include long-term follow-up. Indeed only Hsu et al. (1981) and Grounds (1982) can be said to address the issue of long-term outcome; our own report covers an 11-year period (1979 - 1990), but follow-up only includes approximately 2 years after discharge from the hospital. With these caveats in mind, we might suggest that the occurrence of an anaclitic versus an introjective psychosis may depend in part on the underlying balance of forces in the personality and specifically the degree of investment in exaggerated introjective defenses. Sylvia had a long investment in recourse to such defenses in the

form of self-starvation through much of her adult life; this recourse had remained erratic until then, but under the pressure of the severe losses which precipitated the illness it had become entrenched, serving as a last line of defense against disintegration and complete defeat. Another factor might be the process leading up to the psychosis--in Sylvia's case the psychosis developed over a period of many months, as did the family crisis which began with the mother's illness and led up to her death and the siblings' suicides. This stands in direct contrast to the cases of Dominique (Bedoret et al., 1973) and Pierre (Cramer & Bovet du Bois, 1973), where the stressors were sudden and severe and where the dismantling of the anorexic defense structure was striking and dramatic, resulting in a floridly anaclitic psychosis. Furthermore, in both these cases, iatrogenic factors were involved--in Dominique's case, the unexplained separation from her family and in Pierre's case the arranged letter from the radiesthésiste; in fact, these decompensations occurred during treatment for anorexia nervosa. Sylvia, on the other hand, was already psychotic before undergoing treatment; indeed, one might suggest that she exerted some degree of control over her own decompensation.

The question of prognosis is even harder to address than that of differential etiology. We can note that, in the case of Sylvia and in that of Küchenhoff's patient (both strongly introjective psychoses), the psychosis served a progressive function, allowing for the ultimate reintegration of the anaclitic needs and rebalancing of the two developmental lines. In both these cases, the patient was able to exert some control over the recovery process. Küchenhoff's patient did so via the escape from the hospital and the telephone conversation with the therapist. Sylvia, of course, excelled in this area--she took control of the tube feeding process and eventually, via her symptom, was able to exert considerable control over the circumstances of her hospitalization so that she could experience a long, gradual, and unpressured recovery. To put differently, it became clear over time that allowing Sylvia to remain in control of the recovery process was very beneficial, as first noted by her 1983 therapist. In this sense, the ward and the hospital provided her with precisely what Sugarman et al. (1981) describe as "good

enough" mothering (see Chapter II above)--a presence that is available on demand but non-intrusive, allowing for as much autonomy as possible.

Nonetheless, despite the positive outcome in these two cases, we would hardly advocate regression into psychosis as a therapeutic measure. Psychosis is a development that can and often does result in a pernicious outcome with a downward progression, as seen in Maria's case, and as such it remains an outcome that most clinicians would prefer to avoid. The cases of Dominique and Pierre, where the psychosis followed upon the sudden dismantling of the anorexic defense, would tend to argue in favor of proceeding with caution and a good deal of respect for the functions that anorexia serves. Indeed Sylvia's treatment during the year we worked together and during the entire hospitalization was characterized by considerable respect for her illness; Sylvia was able to experience a lengthy reparenting that allowed her to let go of her symptom very gradually and progressively, entirely at her own pace. Nonetheless, she still experienced a period of bulimia, which indeed was part and parcel of allowing herself to experience her anaclitic needs. In this sense, our report very much supports Holmgren's et al.'s (1983) model of the Anorexic-Bulimic Conflict and suggests that such oscillations are to be expected and may indeed be a necessary part of the recovery process. More broadly, it suggests that, for any true recovery to take place in anorexics whose entire mode of coping is so much based upon an exaggeration of the introjective aspect and a repudiation of anaclitic needs, a fundamental rebalancing must take place; this very likely will involve some swinging of the pendulum, at least for a while, and probably very far in the other direction. An understanding of this process may help to mitigate the terror that this phase is bound to arouse in the patient and may help the clinician to weather it with equanimity as well.

Certainly, the individual variations between all the cases and the complexity of the factors involved argue in favor of further study, particularly in larger numbers--be they larger numbers of individual case reports. It might be useful to attempt to develop rating scales along the lines of our four variables, which in turn, via reliability studies,

would allow some testing of the distinction we have drawn between introjective and anaclitic psychoses, i.e., would begin to answer the question of whether this distinction carries a reasonable degree of validity. More importantly, long-term follow-up studies would allow us to begin to answer the question of its predictive power--the issue of prognostic differentiation discussed above. Another line of inquiry would consist of a study of other cases of "religious sitophobia"--patients who justify their food refusal on moral or religious grounds--from both the present time and prior eras; it would be interesting to explore these patients' use of the God representation and the processes of internalization that underlie it. It would be interesting to note whether--and to what degree and in what proportion--such patients also show anorexia nervosa; this in turn might help expand our understanding of the link between anorexia nervosa, other forms of food refusal, and psychosis.

From the broader human perspective, Sylvia's story is one of near-death and rebirth. Led to the point of desperation after severe losses and the progressive failure of a life built on falsehood, Sylvia chose to starve her False Self. She built a huge wall around herself--a barrier of negation and abnegation which allowed nothing to pass into her body or her mind. Within that barrier, she devoted herself to the one relationship that held meaning for her--the relationship with her internal God representation. The maintenance of this introjective barrier allowed her to regress but not disintegrate. Gradually, thanks to the compromise she evolved of "living on the tube," thanks to the respect for her boundary that she was able to enforce, and thanks to the nurturing object relationships that she was able to internalize, Sylvia slowly emerged and returned to life; she let go of her narcissistically exclusive relationship with a punishing God, evolved a gentler view of God, and rejoined the human race. In Sylvia's case, the poet's axiom held true--"...nothing can be sole or whole/That has not been rent" (Yeats, 1933/1956).

Postscript

As of July, 1991, Sylvia remains out of the hospital. She continues to live in her own apartment, to work for the non-profit organization mentioned in Chapter III, to date Louis, and to attend weekly therapy sessions. She has continued to fast periodically for purposes of weight control. There was a recent period during which she began to fast more continuously and more drastically. Upon confrontation by her outpatient therapist and the attending psychiatrist of her former transitional ward, Sylvia agreed to give this up and instead embarked on a popular diet centering on the use of a liquid food supplement. Thus her eating disorder remains an active concern.

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