The Eating Disorders
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Chapter 39

The Psychoanalytic Treatment of Anorexia Nervosa and Bulimia

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During the past 30 years there has been increasing evidence that anorexia nervosa is a psychosomatic disorder [1-5]. From the psychoanalytic point of view, both historically and currently, anorexia nervosa is a generic term that includes the bulimic as well as the restrictor syndromes [1-5].

Since the beginning of the century, the psychoanalytic literature on this illness has been voluminous. In 1918 Freud [6] noted a neurosis in pubertal and adolescent girls that "expresses aversion to sexuality by means of anorexia." Anna Freud [7] noted the resistance aspect of the anorexic's self-starvation. Extensive bibliographic studies can be found in Sperling [2], Sours [4], Wilson et al [5,88], Bliss and Branch [8], Bruch [9], Dally [10], Kaufman and Heiman [11], and Palazzoli [12]. Deutsch [13] has explored the neglect of psychodynamics in his comprehensive book review of biochemical, endocrinological, ecological, sociological, and psychological research in psychosomatics. Summarizing current psychoanalytic theories of somatization, he underscores the crucial importance of psychoanalysis in research and treatment. I [14] recently noted that the technique of analysis of psychosomatic patients is similar to that of analysts Boyer and Giovacchini [15], Kernberg [16], and Volkan [17], who treat nonpsychosomatic patients suffering from a preponderance of preoedipal conflicts. Sperling largely based her hypotheses on the treatment of children and adolescents [2]. Her findings have been confirmed, refined, and expanded in the analyses of adolescents [18,19] and adults [5,20-25]. The structure of the ego, the split in the ego, the archaic superego, separation-individuation, and the defense of projective identification are among the many areas of research that have been explored since Sperling's death in 1973.

There is a heterogeneous range of anorexic patients with great dynamic structural and genetic variability under the coating of a relatively uniform symptomatology. While constitutional factors of infancy, variations in drive endowment, and gender differences affect each child's development, it is the domineering and controlling personality of the mother (and/or the father) that profoundly warps and inhibits the normal development of the anorexia-prone child [5,88]. All the phases of separation- individuation described by Mahler [26,27] are profoundly affected by parental attitudes. In no clinical case have we observed the constitutional lack of aggression suggested by Kramer [28] in anorexia-prone children. On the contrary, ample clinical evidence demonstrates excess drive repression in these patients, which causes the frequent appearance of habits such as teeth-grinding, head-banging, nail-biting, and thumb-sucking.

As far as psychiatric diagnosis is concerned, anorexia nervosa is a neurotic symptom complex that occurs in a variety of character disorders: hysterical, obsessive compulsive, borderline, and in some cases, conditions close to psychoses. However, even in the most disturbed cases

there is a split in the ego, with areas of relatively intact ego functioning and a capacity for a transference relationship [5,88].

We concur in Thoma's [1] delineation of the syndrome: (1) the age of onset is usually puberty; (2) the patients are predominantly female (although male cases have been reported by Falstein et al [29], Wilson et al [5,88], and Sours [4]; (3) the reduction in nutritional intake is psychically determined; (4) spontaneous or self-induced vomiting can occur, usually in secret; (5) amenorrhea (which is psychically caused) generally appears either before, or more rarely, after the beginning of the weight loss; (6) constipation, sometimes an excuse for excessive consumption of laxatives, speeds up weight loss; (7) the physical effects of undernourishment are present, and in severe cases, death may ensue (7% to 15% die [30]). Wilson et al [5,88] added three further observations: (8) there is commonly a tendency toward hyperactivity, which may be extreme; (9) in females there is often a disproportionate loss of breast tissue early in the disease; and (10) the symptom complex is often accompanied by or alternates with other psychosomatic symptoms (or psychogenic equivalents such as depressions, phobias, or periods of self-destructive acting out that may include impulsive sexual behavior, stealing, or accident-prone behavior). In agreement with Sours [4], we have found that all the physical signs and symptoms of anorexia nervosa, including hypothermia, lanugo hair, hypotension, bradycardia, anemia, and leukocytosis, subside when patients resume normal eating as a result of psychodynamic treatment; however, menstruation may not resume, even though the patient's weight returns to normal limits, if significant unconscious psychosexual conflicts have not been resolved [5,88].

My research and that of my colleagues [88] correlates with that of Halmi and Falk [31] who recently noted that a variety of physiologic abnormalities are associated with anorexia nervosa, all of them caused by self-starvation. In a study of 40 anorexic patients for hematologic, electrolyte, lipid, and serum enzyme aberrations when they entered a treatment study in the emaciated state and again after nutritional rehabilitation, all of the metabolic findings reverted to normal with nutritional rehabilitation. Blood studies show that changes are the result of starvation. Anorexic patients do have a leukopenia but are no more subject to infections than control groups with normal white cells and lymphocytes. Bulimic anorexics are subject to hypokalemic alkalosis. Because of the physiological effects of self-starvation on normal metabolism, these patients induce liver, kidney, and heart disease, which can result in death.

I recently [5,24,25,32,88] presented major new hypotheses about the diagnosis, etiology, psychyodynamics, and technique of treatment of anorexia nervosa. My research [5,33,88] indicates that fat phobia should replace anorexia nervosa as a diagnostic term. These patients do not suffer from lack of hunger, but from the opposite, a fear of insatiable hunger as well as of impulses of many other kinds [1,2,4,5,88].

Psychoanalytic work with restrictor and bulimic anorexics [5,24,25,32,34,88] focused on their intense fear of being fat, body-image disturbance and their fear-of-being-fat complex. Neurotic analysands also evidenced less intensely cathected but clear-cut fear of being fat obsessions and body-image disturbances [5,88]. These findings could with nonanalytic research lead to the conclusion that in our culture most women and certain men, those with unresolved feminine identifications, have a fear of being fat. Normal women readily admit to the fear. No matter how "perfect" a woman's figure may be, if she is told she is fat she will have an emotional reaction out of all proportion to reality. On the other hand, if she is told she looks thin or has lost weight, she will be inordinately pleased.

It is a central hypothesis of my research [5,24,25,88] that restrictor and bulimic anorexia symptoms are caused by an overwhelming terror of being fat, which has been primarily caused by an identification with a parent or parents who have a similar fear of being fat, and that anorexia (fat phobia) is secondarily reinforced by the general irrational fear of being fat of most other women and many men in our culture.

THE FAMILY PSYCHOLOGICAL PROFILE AND ITS THERAPEUTIC IMPLICATIONS

Psychoanalytic reserch with the families of 100 anorexia nervosa patients* revealed a parental psychological profile that appears to be etiologic in establishing a personality disorder in the children, which later manifests itself as anorexia nervosa. Melitta Sperling's analysis [2] of anorexic children and their mothers laid the groundwork for this research with her finding that the predisposition for anorexia nervosa is established in early childhood by a disturbance in the mother-child symbiosis. Four of the six features of the psychological profile correlate with parental attitudes and behavior described by Bruch [3] in 50 cases and by Minuchin et al [35] in 53 cases. Sours [4] confirms these features in his family research. The two features of the profile not described by these authors are usually only uncovered

* I am particularly indebted to Drs. Otto Sperling, Lawrence Deutsch, Ira Mintz, Cecilia Karol, Charles Hogan, Gerald Freiman, Anna Burton, Robert Grayson, and Leonard Barkin for their contributions.

by psychoanalysis, a modality they do not use [5,88].

THE PSYCHOLOGICAL PROFILE OF THE ANOREXIC FAMILY

Although the psychiatric diagnosis in anorexia nervosa cases ranges from neurosis to psychosis and the symptoms offer dramatic evidence of conflict, usually anorexic girls vehemently deny their conflicts. Most often the unhappy parents bring them in for consultation. These parents are usually highly motivated, well-meaning people who will do everything they can for their sick child. It is healthy for a child to grow up in a home where there are rules, limits, and a parental example of impulse control, responsibility, and ethical behavior; however, in their overconscientiousness, the parents of anorexics overcontrol their child. The adolescent anorexic girl is in a situation of realistic and neurotic dependence on her family, so that changes in the parents' behavior and attitudes toward her can be crucial for therapeutic success. Parents may try to withdraw their daughter from treatment prematurely because they cannot tolerate the rebelliousness and antisocial behavior that surfaces when the anorexic symptoms are resolved. They may need therapy themselves to accept the emotional changes in their daughter and to understand certain pathological interactions they have with her. Research on the anorexic families yielded the following six-part anorexic family psychological profile:*

1. All the families showed *perfectionism.* The parents were overconscientious and emphasized good behavior and social conformity in their children. Most were successful people who gave time to civic, religious, and charitable activities. Many were physicians, educators, business executives, or religious leaders, ie, pillars of society.

Parental overconscientiousness was reflected in the exemplary childhood behavior and performance of the anorexic children. Divorce was infrequent, and when it occurred the parents who were conscientious people established residences near each other and continued to be caring, concerned parents.

Two mothers were addicts (one to alcohol, the other to morphine), but their addictions were family secrets and both women were compulsive, perfectionistic college professors who tried to be perfect mothers. Their addictions expressed a rebellion against their hypermoral character structure. Both these addicted mothers had bulimic daughters. My research and that of Sours [4] shows that the compulsively perfectionistic parents of bulimics have more personal and marital conflict than do the parents of abstaining anorexics.

2. *Repression* of emotions was found in every family group; it was caused by the hypermorality of the parents. In several cases, parents kept such strict control over their emotions that they never quarreled in front of the children. Aggressive behavior in the children was not permitted, and aggression in general was denied (eg, one father's volunteer military service was disdained by his family). Most families laughed at the father's assertive male behavior and saw him as the "spoiler" in the sexual relation; the mother was the superior moral figure. The father's authority was diminished further by his busy schedule, which left him little time for his children.
3. The overconscientious perfectionism of the parents in these families resulted in *infantilizing decision-making* and overcontrol of the children. In some of the families, fun for fun's sake was not allowed. Everything had to have a noble purpose, the major parental home activity was intellectual discussion and scholarly reading. It was no surprise that the anorexic daughters hated the long hours of study they felt compelled to do. In therapy, it was difficult for them to become independent and mature and to get rid of the humiliating feeling that they were puppets whose strings were pulled by mother and father.

The last two features of the profile are usually uncovered only by psychoanalysis.

4. Parental overconcern with *fears of being fat and dieting* was apparent in every case. In two families, the mothers dieted and were afraid of being fat; in one of these families, the father was also afraid of being fat and dieted because of colitis.

My research [5,25,32,88] has confirmed Sperling's observations [2] that specific conflicts and attitudes of the mother and/or father predispose a child for the development of psychosomatic symptoms (eg, a mother's overconcern with bowel functions may predispose a child for ulcerative colitis). The specific etiological factor in anorexia is the parental preoccupation with dieting and the fear of being fat, which is transmitted to the daughter by identification. The other features of this profile are also found in the parents of patients suffering from psychosomatic symptoms such as asthma, migraine, headaches, and colitis.

5. *Exhibitionistic parental sexual and toilet behavior,* whose significance was completely denied, was found in every family. Doors in these homes were not locked, and bedroom and toilet doors often

* A useful acronym for the profile is PRIDES. P = perfectionism, R = repression of emotion, I = infantilizing decision-making, D = dieting and fears of being fat, E = sexual and toilet exhibitionism, S = the emotional selection of a child.

were left open, which facilitated the curious child's viewing of sexual relations and toilet functions. The children frequently witnessed parental sexual intercourse. Such experiences, coupled with parental hypermorality and prudishness, caused an inhibition in normal psychosexual development in the anorexic daughters. Many were virginal, sexually repressed girls who feared boys.

Sours [4] does not observe as much exhibitionistic behavior in families of self-starving young anorexics. However, he notes exhibitionistic parental behavior in families of gorging, vomiting anorexics, including frequent seductive sexual behavior by the fathers.

6. In these families, there was an *emotional selection of one child* by the parents for the development of anorexia. This child was treated differently than the other children. Such a choice may result from (1) the carryover of an unresolved emotional conflict from the parents' childhood (eg, the infant may represent a hated parent or brother or sister); (2) an intense need to control the child, so that the child is treated almost as a part of the body of one parent; (3) a particular psychological situation and emotional state of the parent(s) at the time of the child's birth that seriously damaged the parent-child relationship (eg, the child may be infantilized because he or she is the last baby or may be overcathected by a parent who has suffered a recent loss).

The psychoanalysis of the mother's fear-of-being-fat complex can result in the clearing of anorexic (fat phobic) symptoms in an adolescent child, as the following case exemplifies:*

Margaret, a married businesswoman, came to analysis for sexual conflicts and phobias of airplanes, elevators, and subways. A fat-phobic dietician, she was obsessed with weight and dieting and fantasies of being young and beautiful. She kept her figure zealously on the thin side, 10 lb. underweight. Her mother had been chronically 15 lb. overweight, whereas the father, a beautician, had been obsessed with dieting and weight control. In associating to the scales that she weighed herself on daily, Margaret referred to them as her "conscience" and "the law of her father." With the analysis of the transference neurosis in the context of a strong therapeutic alliance, her severe phobic symptoms subsided, but she reported that her 12-year-old daughter was amenorrheic and had symptoms of intense fat phobia (anorexia nervosa).

The analysis of the mother's fear of being fat revealed many conflicts, a most important one being her inability to tolerate any aggression in her daughter. Associations to fat led to a childhood memory of her father telling her she had a "fat lip"; he used to slap her for "sassing him." By the defense of identification with the aggressor, she was repeating the same harsh discipline with her daughter. All roundings of the female breast, buttocks, or "tummy" in herself or her daughter repelled her. As these and other conflicts that had been displaced onto the fear of being fat were analyzed and the mother could accept her own as well as her daughter's femininity, the latter's anorexic symptoms disappeared.

PSYCHODYNAMICS

Much has been written about the psychodynamics of anorexia nervosa. It generally has been observed by analytic authors that there is a flight from adult sexuality accompanied by a regression to more primitive defenses [1,2,5,12,36-44,88]. This regression involves conflict around primitive sadistic and cannibalistic oral fantasies [2,12,41-43]; typical pregenital defense mechanisms are at work [2,5,17,36,42,43,45,46,88].

Sperling [2] notes that unresolved preoedipal fixations to the mother contribute to difficulties in psychosexual development. She feels that anorexic girls displace sexual and masturbatory conflicts from the genitals to the mouth, thus equating food and eating with forbidden sexual objects and activities.

Most analytic authors agree that the regression of anorexic patients is a flight from their own insatiable instinctual needs, which are defended against with primitive defenses of equal force. Sperling [2] has labeled anorexia nervosa "an impulse disorder."

The role of unconscious pregnancy fantasies in the genesis of this illness is almost universally recognized by psychoanalytic authors. The anorexic patient fears and denies these fantasies.

I and my colleagues [5,88] along with Sperling [2] do not agree with Bruch [3,47,48,49], Crisp [50,52], Dally [10], and Selvini Palazzoli [12,41] that a psychoanalytic approach to these patients should be avoided. The experience of our group agrees with Mushatt [53], Blitzer et al [54], Jessner and Abse [55], Lorand [38], Mushat [56], Sperling [2,42,43], Thoma [1], Waller et al [44], Sours [4], Mogul [57], Risen [46], and others, that psychoanalytic investigation is of the utmost importance in understanding this illness, as well as the treatment of choice in most cases.

* This case with minor changes is reprinted from Wilson et al [5,88].

PSYCHODYNAMICS OF ANOREXIA NERVOSA*

In psychodynamic terms, this complex is rooted in unresolved sadomasochistic oral-phase conflicts that result in an ambivalent relationship with the mother. Fixation to this phase of development, with its accompanying fears of object loss, is caused by maternal and/or paternal overcontrol and overemphasis on food and eating functions as symbols of love. This unresolved conflict influences each subsequent maturational phase so that anal, oedipal, and later developmental conflicts also are unresolved.

The unresolved preoedipal fixation on the mother contributes to the difficulty in psychosexual development and the intensity of the oedipal development. As Serpling noted [2] anorexia nervosa fat phobia can be considered a specific pathological outcome of unresolved oedipal conflicts in a child whose preoedipal relationship to the mother has predisposed her to this particular reaction under precipitating circumstances.

The genetic influences on this complex are parental conflicts about weight and food specifically, and about aggressive and libidinal expression generally. In addition, the parents tend to be compulsive, moralistic, and perfectionistic, significantly denying the impact on the developing child of their exhibitionistic toilet, bedroom, and other behavior. Other genetic factors are cultural, societal, and general medical influences, as well as secondary identification with women and/or men who share the fear-of-being-fat complex.

From an economic point of view, the unremitting pressure in bulimic and restrictor anorexics of repressed, unsublimated, aggressive, and libidinal drives, conflicts, and fantasies is a central issue. In the bulimic anorexics the attempt to control drive is manifested by the fear-of-being-fat complex but defective ego functioning results in a giving in to voraciousness as well as to impulse gratifications of other kinds. Then intense guilt inflicted by the archaic superego causes attempts at undoing by self-induced vomiting and laxative use as well as other masochistic behavior. In the restrictor anorexic the same feared drive eruptions are masked by the fear of being fat complex but intact ego controls result in total impulse control brought about by the restrictor's archaic superego.

From a structual point of view, ego considerations are central. In the preoedipal years, the ego of the bulimic anorexia-prone (fat-phobic) child becomes split. One part develops in a pseudonormal fashion: cognitive functions, the self-observing part of the ego, adaptive capacities, and other ego functions appear to operate normally. While the restrictor anorexics in childhood are most often described as "perfect" and have excellent records in school, the bulimic anorexics have more evidence of disobedience and rebellion at home and school. In adolescence there is more antisocial behavior, sexual promiscuity, and addiction. The ego represses, denies, displaces, externalizes, and projects conflicts onto the fear-of-being-fat complex. In many cases, conflicts are displaced onto habits such as thumbsucking, enuresis, encopresis, nailbiting, headbanging, and hairpulling. In other cases, there is a concomitant displacement and projection of conflict onto actual phobic objects. In some patients, anorexia nervosa alternates with other psychosomatic disease syndromes, such as ulcerative colitis [2,5,88]. This split in the ego manifests itself in the intense, psychotic-like denial of the displaced wishes, conflicts, and fantasies. In other words, the split-off neurotic part of the personality is denied in the fear-of-being-fat complex.

From an adaptive point of view, conflicts at each maturational and libidinal phase are denied, displaced, and projected onto the fear-of-being-fat. Conflicts in separation-individuation [53,56] are paramount and are denied by the parents and developing child. Normal adaptive conflict is avoided and denied. Many parents of anorexics raise them in an unreal, overprotected world. Perfectionistic parents impair the ego's decision-making functions with their infantilizing intrusions into every aspect of their child's life. In each case a focus of analysis is on the pregenital object relations, which have been caused by the unresolved parental relationship and the conflicts in separation- individuation.

Unlike Sperling [2], I along with Hogan [5] and Mintz [5,19,34,88] include males under the diagnostic category of anorexia nervosa. Mintz and Welsh [5] have shown that male anorexics have oedipal and preoedipal fixations and unresolved problems in separation-individuation, severe latent homosexual conflicts and a feminine identification, and the same fear-of-being-fat complex seen in the females, which is caused by an identification with the mother and/or the father's fear-of-being-fat.

BODY IMAGE

Anorexic self-starvation, an extreme of asceticism [57], is rooted in a massive preoedipal repression of sadomasochistic oral-phase conflicts that have been elaborated by the ego with new defensive structures at each subsequent libidinal and maturational phase of development. It is the surface of the mother's breast,

* I am indebted to Dr. Howard Schwartz who restated my findings in a metapsychological framework that I have elaborated on in these formulations.

and by extension the figure, that has been projected in the anorexic's body image [Freud 58]. The fear of being fat reflects the terror of oral sadistic incorporation of the breast of mother and later of other objects [5,88].

A few restrictors and a number of bulimics do not evidence a clear-cut body-image disturbance [5,88], although they are all fat phobic. In these cases the ego is healthier, and the psychopathology primarily oedipal.

SPLIT IN THE EGO

To further understand the anorexic ego structure, one has to keep in mind the split in the ego. In 1983 I [88] noted that from a structural point of view, ego considerations are central. In the preoedipal years, the ego of the anorexia-prone child becomes split. One part develops in a pseudonormal fashion; cognitive functions, the self-observing functions of the ego, adaptive capacities, and other ego functions appear to operate normally. The ego suppresses, represses, denies, displaces, externalizes, and projects conflicts onto the fear of being fat complex. *The pseudonormal part of the ego of the abstaining (restrictor) anorexic evidences many of the characteristics seen in compulsion neuroses.* The pseudonormal part of the bulimic ego is an admixture of hysterical and compulsive traits.

Strober's conclusions [59,60] about the differences between restrictors and bulimics correlate with my research. His type-1 and type-2 anorexics, the restrictors, evidence "obsessionality," whereas his type-3 patients, the bulimics, present "a distinctive profile of low ego strength, impulsivity, proneness to addictive behaviors and more turbulent interpersonal dynamics."

FUNCTIONING OF THE EGO

While the restrictor anorexic is capable of controlling the impulse to eat, the bulimic patient is not and consumes tremendous quantities of food. The patient gorges, becomes so frightened of gaining weight that she feels forced to vomit to regurgitate her caloric intake.

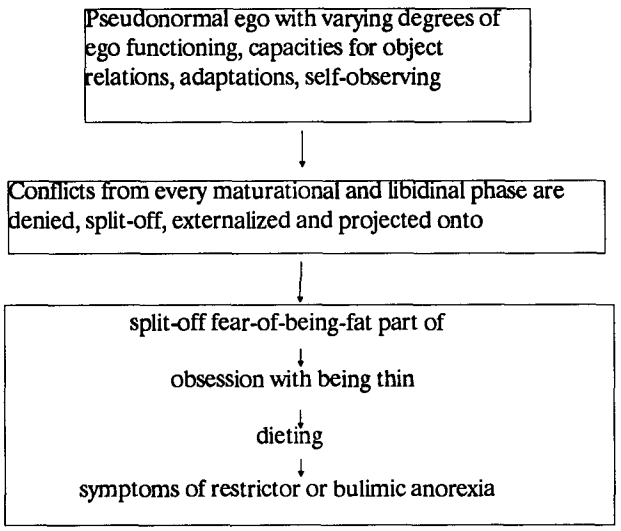
The clinical and psychodynamic relevance of gorging deserves some consideration, because it permits an additional perspective in viewing the patient's feelings, psychodynamics, and personality structure. The restrictor anorexic is able to contain (and overcontrols) the wish to gorge and impulse gratifications of other kinds because of intact ego controls. In a series of publications, I [5,25,34,88] noted that the bulimic patient has strict but ineffective ego controls that are unable to regulate the impulse to eat. This defect in self-control is so threatening to the patient that the slightest gain in weight produces panic, exercising, starving, and vomiting. The bulimic patient who is unable to control eating is also unable to control other impulses, so that one sees sexual promiscuity, delinquency, stealing, lying, and running away much more frequently than in the starving anorexic patient. This defect in ego and superego controls arises in part from identifying with the parents who frequently argue, fight, and act out destructively more often than the parents of the starving anorexics. Thus the superego structure of the bulimic is not as rigid and strict as that of the restrictor.

Restrictor and bulimic anorexia nervosa are symptom complexes that occur in a variety of character disorders: hysterical, obsessive-compulsive, borderline, and in some cases conditions close to psychoses. However, even in the most disturbed cases, there is a split in the ego with areas of selectively intact ego functioning and a capacity for a transference relationship. I have worked analytically with ten bulimic patients and have seen many more in consultation and supervision. Four patients who completed their treatment are illustrative. One adolescent, who alternately abstained, gorged, and vomited, resolved her conflicts in a year's analysis. She was neither amenorrheic nor dangerously underweight. The treatment prevented the development of phobic fear of being fat (anorexic nervosa). Both the second and third cases abstained, gorged, and vomited, but they did not use laxatives. Neither brought their weight down to dangerous levels. Diagnostically, they suffered from mixed neuroses with severe preoedipal conflicts. Both patients, unlike the typical restrictor anorexic, had an abundant psychosexual fantasy life and had masturbated in childhood. Doubts have been expressed to me by experienced analysts about the possibility of analyzing any bulimic. Cases I've analyzed and supervised have experienced a full resolution of their fear-of-being-fat body-image and their obsession with being thin. Long-term follow-up studies in certain cases showed that they were able to face and master the conflicts of self-fulfillment in a career, pregnancy, childbirth, and motherhood. In my experince, if the bulimic anorexic process can be analyzed in *statu nascendi* as in my first case, the prognosis is excellent. However, a longer and more complicated treatment is necessary for the analysis of the rigid layered defenses of the chronic bulimic anorexic [5,88]. Of course, statements about prognosis must be qualified by the psychodynamic diagnosis of the individual case and by the presenting situation. Obviously, if the addicted bulimic is seen when acutely alcoholic and/or under the influence of drugs, all the technical problems involved in the management and treatment of such cases confront the therapist.

What follows is a simplied diagram of the split in the ego in anorexia.

Pseudonormal ego of the restrictor resembles compulsive neurotic

Pseudonormal ego of the bulimic is a mixture of compulsive and hysterical neurotic complexes



TECHNIQUE

The technique of analysis or analytic psychotherapy is discussed with extensive case histories in our recent volumes [5,88]. Although some cases can be analyzed with classical technique, in regressed cases in the first phase of treatment the transference is handled along the principles set forward by Kernberg [16] and summarized by Boyer [15] in regard to borderline cases:

1. The predominantly negative transference is systematically elaborated only in the present without initial efforts directed toward full genetic interpretations.
2. The patient's typical defensive constellations are interpreted as they enter the transference (see discussion of particular defensive constellations below).
3. Limits are set in order to block acting out in the transference insofar as this is necessary to protect the neutrality of the therapist (but with many limitations, see below).
4. The less primitively determined aspects of the positive transference are not interpreted early, since their presence enhances the development of the therapeutic and working alliances (only if we look at these alliances as part of the positive transference—see discussion of limiting transference above), although the primitive idealizations that reflect the splitting of "all good" from "all bad" object relations are systematically interpreted as part of the effort to work through those primitive defenses.
5. Interpretations are formulated so that the patient's distortions of the therapist's interventions and of present reality, especially the patient's perceptions during the hour, can be systematically clarified.
6. The highly distorted transference, at times psychotic in nature and reflecting fantastic internal object relations pertaining to early ego disturbances, is worked through first in order to reach the transferences related to actual childhood experiences (p.176).

The early interpretation of the denial of suicidal behavior (masochism) parallels the technique of Sperling [2] and Hogan [5,88] with psychosomatic patients and correlates with the therapeutic technique used in the therapy of schizophrenic, borderline, and character disorders by Boyer and Giovacchini [15], Kernberg [16], and Volkan [17].

First, one interprets anorexic patients' masochism—their archaic superego and the guilt they experience at admitting to any conflicts. Next, one interprets defenses against facing masochistic behavior; then, when the ego is healthier, defenses against aggressive impulses are interpreted. Such interpretations are inexact; frequently, patients' associations do not confirm the interpretation. These patients have an archaic, punitive superego and a relatively weak ego. The analyst provides auxiliary ego strength and a rational superego [5,15,21,61,88]. Inter-

pretations should be made in a firm, consistent manner [15]. With such patients, the analyst needs to have authority.

These patients' behavioral responses can be interpreted. Patients' dreams have to be used in the context of their psychodynamics. Early in treatment, patients do not usually offer useful associative verbal material, as is also the case in the analyses of children and patients with character disorders [15]. At this stage of treatment, the analyst uses construction and reconstruction to respond to patients'silences.

Because anorexic patients in their projective identifications can pick up almost imperceptible nuances in the tone of voice, facial expression, movements, and even feelings of the analyst, they provoke intense countertransference reactions [5,62,88].

There is a special technique in the analysis of anorexics. The analyst must demonstrate to the patient the need for immediate gratification (the impulse disorder, ie, the primary narcissism) early in treatment [2,5,62,88]. Thus, the patient is shown that the symptoms of restrictor and bulimic anorexia are manifestations of a split-off impulsive part of the ego; ie, the fear-of-being-fat complex.

EGO STRUCTURE AND TRANSFERENCE INTERPRETATION

Analytic technique has to be adapted to the varying defenses of the ego. The bulimic patients use acting out, rationalization, denial, withholding, and lying more intensely and persistently than the restrictors. In many cases once the restrictor's anorexic crisis subsides, the course of analysis is in some way similar to that of a compulsive neurotic. There are of course many varieties of ego structure in anorexic patients. Analytic technique varies with different patients and with the degree of regression encountered. Technique also varies according to the individual style and experience of the analyst. Most of my collegues and I tend to see the patient vis-a-vis in the first dyadic phase of treatment. However, some restrictor and bulimic anorexics can be analyzed along more classical lines with the couch being used from the beginning [5,88].

The technique of interpretation is determined by multiple factors such as the transference and the quality of object relationships. A crucial consideration is the split in the anorexic's ego and the extent to which this split is comprehended by the self-observing functions of the patient's ego. The first phase of analysis involves making the healthier part of the patient's ego aware of the split-off, primitive-impulse-dominated part of the ego and its modes of functioning.

In this early phase effective technique with restrictor anorexics is to interpret defenses (rationalization, denial, etc.) that mask masochistic behavior whereas with bulimics the multiple functions of the patient's gorging, vomiting, and laxative use are interpreted as acting out defenses against the experiencing of affects such as guilt, anxiety, depression, anger, or sexual feelings.

Typical anorexic defenses are: (1) denial and splitting; (2) belief in magic; (3) feelings of omnipotence; (4) demand that things and people be all perfect—the alternative is to be worthless; (5) need to control; (6)displacement and projection of conflict; (7) ambivalence; (8) masochistic perfectionism that defends against conflicts, particularly those around aggression; (9) pathological ego ideal of beautiful peace and love; (1); fantasied perfect, conflict-free mother-child symbiosis.

Both the restrictor and bulimic anorexic make extensive use of the defense of projective identification [15,63-77]. As Wilson et al [5,88] demonstrated, the anorexic projects unacceptable aspects of the personality—impulses, self-images, superego introjects—onto other people, particularly the analyst, with a resulting identification based on these projected self-elements. The extreme psychotic-like denial of conflict of the anorexic is caused by primitive projective identification onto others of archaic destructive superego introjects.

Sperling [2]noted that part of the anorexic's conflicts are conscious. Wilson et al [5,88] emphasize that conscious withholding, rationalization, distortion, and lying are characteristic defenses of the restrictor and bulimic anorexics. This pseudopsychopathic behavior is analyzable [5].

THIRST, HUNGER, AND SAND SYMBOLISM IN ANOREXIA NERVOSA

The anorexic's defensive asceticism stressed by Mogul [57] and Risen [46] is represented in the dreams of these patients by sand symbols. The analysis of sand symbols in the dreams of anorexics is of great importance. Spitz [78] emphasized that infants feel thirst, but not hunger, in the hallucinatory state. I have emphasized [5,79,88] that sand can be used as a pregenital symbol in which repressed oral and anal conflicts are regressively represented. Sand symbolizes oral-phase thirst and/or the formless stool of the infant (diarrhea). Antithetically, it depicts a characteristic anorexic attitude, asceticism—the ability to do without mother's milk, to control impulse gratification.

Sand representations in dreams can symbolize aspects of conflicts and processes that are involved in addictions such as smoking, substance abuse, alcohol,

or food as in the eating disorders. Anorexic self-starvation and dehydration mask and express an Isakower-like phenomenon in that they induce a dry (thirsty) mouth.

For example,* a bulimic anorexic who was becoming aware of the oral phase meanings of her sand dreams reported the following clinical material when she was mourning the recent death of her mother. She had just paid the bill for her mother's funeral and had expressed weary resignation at paying her analytic bill. In her analysis she was trying to analyze three habits—vomiting, laxative taking, and cigarette smoking. She stated: "I have a dry mouth. Yesterday I was so thirsty I drank a quart of orange juice, but it did not help. For years while I have been anorexic I have been thirsty. I would just take a sip of water. When I am depressed I am more thirsty. I was crying yesterday: I miss my mother so much. Why couldn't I make everything up to her? Why did we have to fight so much?"

An interpretation was made that she not only wanted her mother's love but wished the analyst would love her, baby her, and give her gifts as her mother had done. This included not charging her for his services, but giving them as a "present." The patient cried and said, "Yes mother gave me so much—she'd say, 'My money is yours.' I used to try to refuse her gifts, which I do not need, but she made me take them."

The "Little Person" Phenomenon

Volkan [17] described an anorexic patient with a split-off, archaic part of her ego—a "little person." He related this pathological ego structure to the "little man" phenomenon described by Kramer [28] and Niederland [81,82]. In my experience, all psychosomatic patients, including anorexics, have a split-off, archaic, primtive ego. A conscious manifestation of this split-off ego is represented by the fear-of-being-fat complex.

Susan, an impulsive anorexic high school student brought in a series of dreams containing images of an innocent, wide-eyed little girl that reminded her of current sentimental oil paintings that depicted an innocent, raggedly dressed child with tears in her enormous eyes. Susan was beginning to understand that these paintings showed how she tried to come across to people and to the analyst. After these dreams were analyzed, she had a dream of a little prince whom she wanted to control. Analysis showed this little prince to be her "little person"—the archaic split-off ego. The little prince was narcissistic, omnipotent, and magical. That he was male was a reflection of her secret wish to be a boy. For her, males were aggressive and magical while females were innocent, passive, and masochistic. The split-off part of her ego was filled with murderous rage and hatred.

CLINICAL CASES

A Restrictor Anorexic and Her Family**

The R. family came for consultation about their 17-year-old daughter Sally who recently had lost 30 lb and became amenorrheic. Sally's history was typical of the majority of restrictor anorexics. A "good" girl, she was obsessed with the proper behavior, studying, and social achievement. Her father, a very idealistic man, disapproved of his successful business career and always wished that he had been a physician. A workaholic, he delegated the care of his children to his wife, Mrs. R., who divided her time between a social work career and her family. She was overconcerned with lady-like behavior, manners, and proper behavior for her daughter.

Sally's brother Robert, two years her senior, was an easygoing adolescent boy who had a succession of girlfriends, smoked, drank, and enjoyed parties, dancing, and rock music. Although the mother weakly argued with Robert and chided him for his poor performance in school, most of her attention was focused on her daughter. She did everything she could for Sally, helping her with her studies, reviewing her homework, and barraging her with advice and criticism.

The Rs followed a strict routine: meals were always on time, television was rationed to one hour a day, and the major form of relaxation for the parents was intellectual discussion and reading of a serious nature. They never quarreled in front of their children, and in general, they shared the same ethical, social, and political views.

Memories of having witnessed parental intercourse (primal scene) emerged in the course of Sally's analysis. At three years of age, she woke up screaming with nightmares, and in order to quiet her, her mother had her sleep the rest of the night in the parents' bed. It was then that Sally overheard the heavy breathing of intercourse, which she fantasied was an attack by her father on her mother. Other occasions of her witnessing parental intercourse, at 5 and 6 years of age, increased Sally's fear of sexuality. There were no operable locks on the doors in the Rs home. Parental nudity and toilet activities also were observed frequently by Sally, who became inhibited and afraid of boys.

Analysis. As with all anorexics, many different conflicts were displaced onto and masked by Sally's anorectic symptoms. The focus of therapy was upon showing Sally the nature of her overly strict conscience, which demanded perfect behavior in herself and others. In her

* This material is reprinted from Wilson, Hogan and Mintz [5,88] (p. 252-253).

** This case of Dr. Wilson's with minor changes is reprinted from Wilson et al [5,88], p. 36-37.

treatment behavior she was hypercritical; memories and dreams revealed that she had developed this attitude by identifying with her mother's perfectionism.

Both Mr. and Mrs. R. were referred for psychotherapy. Mrs. R. came to understand that she was treating Sally very differently from Robert and that she had been pressuring her daughter to carry out certain of her own unfulfilled aspirations in life. The Rs moderated their overconcern with dieting and weight loss, and they learned how to tolerate and understand the emerging rebellious, critical, adolescent behavior that Sally manifested when her anorectic symptoms subsided. Mrs. R. interrupted her intrusive controlling attitude toward her daughter. The parents also took some vacations without their children for the first time and began to quarrel in front of their children. Operable locks on the bedroom and bathroom doors were installed, and Sally was given a degree of privacy appropriate to her age.

Sally's anorectic symptoms cleared up in six weeks, and she resumed eating, achieved normal weight levels, and began to menstruate again. Two years of analysis were required to resolve her underlying personality disorder.

A Bulimic Anorexic*

Nancy was a 19-year-old student who had been gorging and vomiting for the past five years. She was 5 ft 4 inches and currently weighed 115 lb, although her weight varied between 160 and 98 lb. She stated that when she began gorging she could gain 30 lbs in two weeks. She felt that she could not stop and would eat a gallon of ice cream, an entire chocolate cake, sandwiches, and almost everything in the refrigerator. She ate whatever she found on the shelves, including raw dough. Starving and vomiting resulted in an equally dramatic weight loss. Regular exercise, which included 45 mintues of daily jogging, helped to maintain the weight loss. Menstrual periods were irregular but present.

The patient came from a fat-phobic food-and-weight-conscious family. The father was a rigid, controlling engineer who would slap the patient when he became angry with her. The mother was obese, unable to maintain her own reasonable weight but prone to making insulting remarks about the patient's weight gain. The patient stated that the mother was so fanatic about the patient's weight that she would accuse her of still being fat when she weighed 115 lb. Distortion in the mother's view of her child is not an uncommon finding. The patient had a 15-year-old acting-out sister who fought constantly with the parents. The patient noted urges to stuff the sister with food, and experienced enjoyment watching the sister eat, "as if I was eating." Junk food was never allowed in the house. When the patient began gaining weight, the entire family found themselves on a diet, because the mother limited the food brought into the house.

Early in the treatment the patient realized that when she was upset or depressed she began to eat. As she became increasingly preoccupied and disturbed with eating, her previous worries disappeared. She began to see that eating served to cover up anxieties. Her excessive attachment to the parents became apparent as she recounted dropping out of college in her first year because of stomach aches and feelings of depression. During her bouts of bulimia, the parents would never go out in the evenings. She saw that the gorging kept them close to her. As the months passed she became increasingly aware that she was unable to assert herself with either parent and that she harbored many feelings of resentment toward them. This anger was expressed indirectly against her father by not studying and against her mother by gaining weight. Weight gain was also unconsciously used to terminate relationships with boyfriends when feelings of closeness and sexuality became too threatening.

Analysis achieved a resolution to the patient's bulimic symptoms and insight into the underlying adolescent maturational conflicts.

PROGNOSTIC DIFFERENCES IN RESTRICTOR AND BULIMIC ANOREXICS

Many bulimic anorexics, those who would diagnostically be termed neurotic, give an appearance of healthier (pseudonormal) ego functioning. Since they evidence an admixture of hysterical traits, their emotions are under less repression. They develop a seemingly good therapeutic alliance. Wilson and Mintz [5,34,88] as well as Bruch [3] feel that the prognosis is poorer for the chronic bulimic. Hogan [5,88] sees little difference. In general, because of the lesser degree of acting out and the stronger ego, the prognosis would appear better for the restrictor anorexic; however, in some bulimic cases where the symptoms are of recent development and limited to gorging and vomiting, the prognosis may be favorable because there is a readiness for the expression of affect. It is still felt by many analysts that the hysterical neurotic is easier to analyze than the compulsive neurotic. However, the degree of preoedipal psychopathology is the limiting factor in both the hysterical and compulsive neurotic and the bulimic and restrictor anorexic.

* This case of Dr. Mintz's is reprinted from Wilson and Mintz [33] p. 29.

CURRENT STUDIES

Currently there is a widespread application of psychoanalysis to the treatment of anorexia nervosa. Long-term research is being conducted by the members of the Psychoanalytic Study Group of the Psychoanalytic Association of New York, Inc, an Affiliate Society of The American Psychoanalytic Association, which is composed of psychoanalytically trained psychiatrists specializing in the treatment of psychosomatic disorders. This group was led by Dr. Melitta Sperling from 1965 until her death in 1973; since that time the chairman has been Dr. C. Philip Wilson.

This research has provided a unique opportunity to review and discuss numerous anorexic cases. Particularly important has been the presentation of the psychodynamic treatment of the mother, the father, the siblings, and the spouses of these patients. The combined experience of this study group was recently published in a book: *Fear of Being Fat: The Treatment of Anorexia Nervosa and Bulimia,* edited by C. Philip Wilson, MD, with the assistance of Drs. Charles C. Hogan and Ira L. Mintz [5,88].

Other important ongoing research is being conducted by The Psychosomatic Discussion Group of The American Psychoanalytic Association.* The topic since 1982 has been anorexia nervosa. Technical and theoretical aspects of the psychoanalysis of restrictor and bulimic anorexics have been presented to this group by Mintz [83], Hogan [84], Keith [85], and Hitchcock [86].

Recent psychoanalytic studies have included focus on asceticism [57], the pathologic sense of self [87] and the analysis of an adolescent girl [46]. The use of pharmacotherapy and behavioral techniques pose hazards that may limit their effectiveness in the absence of sustained and careful psychotherapeutic effort with the individual patient and family [88,89,90].

SUMMARY

A review of the extensive psychoanalytic literature shows that most psychoanalysts view anorexia nervosa as an emotional disturbance that emerges as a retreat from developing adult sexuality via a regression to the prepubertal relation to the parents. I presented a number of new hypotheses about the psychodynamics and technique of treatment:

1. Restrictor or bulimic fat phobia should replace anorexia nervosa as a diagnostic term, because these patients do not suffer from a lack of appetite but the opposite,a struggle to avoid being overwhelmed by their impulses, including voraciousness.
2. While the underlying conflicts, their fear of being fat complexes, are similar, the ego of the bulimic is not as perfectionistic and controlling as that of the restrictor, so that it is periodically overwhelmed by not only impulses to gorge but impulses of other kinds.
3. Family psychodynamics, which are viewed as etiologic, were detailed.
4. I summarized new techniques of treatment that focus in the first phase of analysis on the dyadic transference, the failure to free associate, the patient's impulsivity, and the use of denial and projective identification. The importance of understanding sand symbolism in anorexia was emphasized, because it reveals these patients' conflicts over thirst, impulse control, and asceticism. Psychoanalysis or analytic psychotherapy are the treatments of choice for anorexia nervosa. Most patients are seen vis-a-vis in the first dyadic phase of treatment. The parents of adolescent anorexics are usually seen in conjoint therapy by a collegue. The analyst is in charge of treatment, with hospitalization reserved for true emergencies. Medication is contraindicated if analysis is feasible. Our technique of treatment has similarities to the methods used by Boyer and Giovacchini [15] and Kernberg [16] in the analysis of patients with borderline and narcissistic disorders.

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* The research of this discussion group is being published in a book that is in press: *Eating to Live or Living to Eat: The Anorexic Dilemma,* ed. C.P. Wilson, C.C. Hogan, and I.L. Mintz. Riverside, N.J.: Jason Aronson, p. 38.

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