A RETROSPECTIVE STUDY OF SIX CASES OF PRIMARY ANOREXIA NERVOSA IN YOUNG FEMALES

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A RETROSPECTIVE STUDY OF SIX CASES OF PRIMARY ANOREXIA NERVOSA IN YOUNG FEMALES

A clinical research project submitted to the Institute for Clinical Social Work in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Social Work

By

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A Retrospective Study of Six Cases of Primary Anorexia Nervosa in Young Females

Abstract: The outpatient treatment records of six young females diagnosed as having primary anorexia nervosa were reviewed in relation to 14 variables. Ten of the variables focused on the anorectics' important relationships; three provided data on the attitudes of mother and daughter toward femininity and/or sexuality; and one listed unexpected reality events of birth and early infancy. These particular factors were selected in order to explore issues common to all six cases in response to the two research questions:

1. What are some separation-individuation issues that contribute to the etiology of primary anorexia nervosa in young females?

2. What behavior in latency may obscure separation-individuation problems in the pre-anorectic girls?

The ages of the subjects at the point of referral ranged from 10 years 3 months to 14 years 7 months. An analysis of the research data pointed out that the mother-daughter relationship was one of the most important factors influencing the development of the psychopathology. The role of the father was not well delineated in the records and probably was under-rated.

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Introduction

> It must be understood that when reference is made to the mother's adaptive capacity this has only a little to do with her ability to satisfy the infant's oral drives, as by giving a satisfactory feed. What is being discussed here runs parallel with such a consideration as this. It is indeed possible to gratify an oral drive and by so doing to violate (author's emphasis) the infant's ego-function, or that which will later on be jealously guarded as the self, the core of the personality. A feeding satisfaction can be a seduction and can be traumatic if it comes to a baby without coverage by ego-functioning. (D. W. Winnicott, 1965, p. 57)

It is difficult to explain the regression that takes place at the onset of anorexia nervosa in young females. Although all adolescents evidence some manifestations of instinctual, ego and superego regression intermixed with their genital strivings, the anorectic's regression is less fluid. The resurgence of oral and anal conflicts, the weakening of the superego and the impaired reality testing of the ego appear more fixed. The enigma of it is that the regression takes place without evidence of early deprivation or over-indulgence that would provide a magnetic pull to an oral fixation point. The early histories do not necessarily present stressful interaction with either feeding or toilet training. It would therefore appear that the eating disturbance that comes on the scene in early adolescence has little to do with "giving a satisfactory feed" but rather evolves out of some kind of non-satisfactory ego coverage for the feed. The fact that no serious symptoms develop before puberty when a serious psychiatric disorder startles the family is another part of the enigma.

It is this incongruency between pre-anorectic functioning and the serious disabilities of anorectic functioning that piqued the author's curiosity about the etiology of this syndrome. Whatever psychopathology may have existed prior to the onset of the anorexia was not readily apparent to the parents or the teachers during the latency of the anorectic-to-be. In obtaining the historical data on the pre-anorectic functioning of cases, it became almost routine to hear glowing reports about the young female from both the school and her family. The popular conception of the pre-anorectic as "the best little girl in the world" (Levenkron, 1979) was certainly validated from a behavioral point of view. Academic achievement was almost uniformly excellent and discipline problems seemed not to exist. Additionally, the pre-anorectic was often elected to class office and was well represented in school activities. With each successive case in which the author became involved, the disparity between the functioning of the model child and the self-starving adolescent became more evident. This raised many questions about the developmental continuity of the anorectic female. How did it happen that the little girl who seemed to perform so well in latency could present such a serious psychiatric disturbance at the threshold of adolescence?

It was in response to the unexpected break in developmental progression and the resulting regression that the investigator began to formulate the research questions. In doing this the object losses and/or environmental changes that were reported as preceding the onset of the anorexia were important. Data collection from nine cases of primary anorexia nervosa (Table 3) showed the omnipresence of object loss (Table 1), sometimes accompanied with environmental change,

preceding the onset of the anorexia. This led the investigator to incorporate the developmental process of separation-individuation into the research questions. Although a failure in individuation is frequently inferred in the literature, there have not been systematic case studies to try to determine any specific components of the separation and individuation process that may be pathognomic for anorexia and yet seemingly benign for the latency that precedes it.

CHAPTER I

Purpose of the Project

The purpose of the research project is to examine six case histories of young (under 16 years of age) anorectic females in psychotherapy to explore possible answers to the questions below.

Research Questions

1. What are some separation-individuation issues that contribute to the etiology of anorexia nervosa in young females?

2. What behavior in latency may obscure separation-individuation problems in the pre-anorectic girl?

Discussion of Research Question No. 1. Of the six cases to be studied, each one presented a cluster of object losses or losses of a familiar environment or both as preceding the beginning of the self-starvation (Table 1). On the surface some of the separations did not appear to be very important. In many cases it was a neighborhood girlfriend; sometimes it was the departure of an older sibling to college. Among the more serious losses were the break-up of a marriage and the departure of one parent from the home. Although some sadness would be expected in the breaking of any of these ties, the onset of a serious psychiatric disorder appears to be out of proportion to the trauma experienced unless there was some predisposition to separation problems from earlier developmental stages. The regression of ego and superego to oral and anal levels in conjunction with the prominence of separation issues certainly suggest that some developmental snags crystallized within the separation-individuation continuum. Current literature on anorexia refers to this in a general way but there have

been no detailed studies to search out some specifics of the deficiency within the historical data and the dynamics of the psychotherapy.

Discussion of Research Question No. 2. The popular stereotype of the latency of the anorectic-to-be is the perfect little girl in the perfect family. The family psychopathology that can be hidden within this stereotype has been discussed in the literature on family therapy of anorectics (Minuchin, et al., 1978; Palozzoli, 1974). What has not been systematically explored is how the pre-anorectic can appear to maintain her psychic equilibrium during latency and then regress so drastically in early adolescence in the face of losses and separations. From the clinical picture of the developmental impasse that ensues, the anorectic appears undefended against the losses and separations except through regression. The aim of the research project is to study the available data of the latency period of the six cases to try to determine why any deficiencies in separation and individuation were not more evident in latency.

Statement of the Significance of the Project

Frequency and Mortality

Anorexia nervosa as a diagnostic category has been used with increasing frequency in the past 15 or 20 years. Because it is a syndrome rather than a disease entity there are no official statistics on the apparent incidence within any government health agency. However, psychiatrists who specialize in this disorder have individually reported it as on the increase not only in the United States, but in England, Italy, France, and also Australia and Japan. Literature on the subject from every theoretical persuasion has been proliferating in the journals and even in popular magazines of current events such as Life. Although

much has been learned about the psychogenesis of the syndrome, treatment is still considered very difficult and anxiety-provoking to the therapist. The mortality rate is still reported within the literature from three to 10 percent and the percentage for whom treatment is only partially successful is considerably higher, ranging around 30 to 40 percent. The definition of "successful" is defined differently by different investigators which makes it difficult to know whether this is an over or under-estimated figure (Hsu, 1980).

Importance for Early Intervention

As with any disequilibrium of the psychic system of the individual and the family, the earlier the treatment the better the prognosis. If in latency certain behavioral manifestations can be recognized as possibly leading to anorexia, there is a greater possibility of earlier intervention and a better outcome. Once the anorectic girl has invested the thinness of her body with the many different levels of significance it can have for her and once she becomes accustomed to her self-starvation and the power it provides her within the family, it becomes a very difficult therapeutic process to rebuild from the regression to more effective methods of coping.

Relevance of the Project to the Field of Social Work

The search for common factors which may be relevant in the "socioemotional development" (Bowlby, 1982, p. 669) of young anorectic females contains a social work orientation within the methodology itself and also within the area to be investigated. From the turn of the century when child guidance clinics were first established to serve juvenile court populations, the social worker on the team* was concerned

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*The team has traditionally consisted of a social worker, a psychologist and a psychiatrist.

with presenting, in a developmental framework, an integrated view of the child's life experiences as an attempt to provide some clues as to the causes of the current disturbances. An important aspect of the social worker's contribution to this work has been a psychodynamic understanding of the family interrelationships so far as they could be known, and, in particular, an investigation of the child's tie to the mother. In many ways the retrospective, ex-post-facto research which is the approach of the study being presented here resembles the longitudinal approach of traditional child guidance clinics preliminary to diagnosis and treatment planning. Whatever the findings of the research turn out to be, the areas chosen for exploratory study fall within the concerns of the social work profession.

CHAPTER II

Review of the Relevant Literature

Anorexia nervosa was first conceptualized in the medical literature as a mental disturbance of unknown etiology. Dr. Richard Morton, a London physician, who is credited with the earliest report, published a description of an 18-year-old cachectic girl in 1689 which has become famous in the annals of the history of anorexia. His clinical observations of the phenomenology presented by the young female have been corroborated many times in the intervening years. A comparison of his description of the anorectic's behavior and attitude as he observed it coincides very well with the DSM-III criteria for anorexia and with Bruch's descriptive criteria for the disorder. Quoted below is Morton's vivid description of an 18-year-old starving female as excerpted by Bruch (1973) from his medical report entitled, "Phthisiologica: Or a Treatise of Consumptions."

> In the month of July she fell into a total suppression of her Monthly Courses from a multitude of Cares and Passions of her Mind, but without any Symptom of the Green-Sickness following upon it. From which time her Appetite began to abate, and her Digestion to be bad; her flesh also began to be flaccid and loose, and her looks pale. . .she was wont by her studying at Night, and continual pouring upon Books, to expose herself both Day and Night to the injuries of the Air. . .I do not remember that I did ever in all my practice see one, that was conversant with the Living so much wasted with the greatest degree of a Consumption (like a Skeleton only clad with Skin) yet there was no Fever, but on the contrary a coldness of the whole Body. . .only her Appetite was diminished, and her Digestion uneasie, with Fainting Fits, which did frequently return upon her. (pp. 211-212)

This happened almost 300 years ago. Morton called the disturbance "phthisis nervosa" to indicate a consumption of mental origin and to distinguish it from tuberculosis. Like a modern anorectic

the young lady refused the good doctor's help and died three months later. The cause of death was on the surface of events due to self-starvation. Why this occurred no one was quite prepared to say. Reports began coming in from other English physicians and from France and Germany reporting on the same syndrome with many different reasons suggested as to the cause. Up until 1914, however, the diagnosis was in the range of psychiatric disorders as they were classified at the time incident to the publication. Gull of England (1868) gave the diagnosis of an hysterical disorder; Lasegue of France (1874) also diagnosed hysteria; Janet (1903) called it psychasthenia, Gee (1908) melancholy; and Dubois (1913) schizophrenia. Then in 1914 Morris Simmonds, a German pathologist, published a report of a pituitary deficiency in an emaciated woman who had died following pregnancy and delivery. For the next 20 years, following Simmonds' publication, the focus of research and treatment shifted from the psychological to the physical. Cases of malnutrition were attributed to some endocrine disturbance, "resulting in increasing vagueness concerning what was included in the anorexia nervosa concept." (Bruch, 1973, p. 214)

In the 1930's it was clinically demonstrated that a psychological anorexia nervosa syndrome exists separate from Simmonds' disease. For one thing, the concentration camps of the 1930's furnished evidence that "psychosocial stress can alter hormone patterns and secretions," (Sours, 1980, p. 210). Also supporting a psychological basis for anorexia is the fact that when and if normal weight has been restored, the endocrine deficiencies disappear and the menses return. If there would be some hormonal deficiency prior to the onset of the

psychological anorexia, it has been difficult to determine because the self-starving young female does not come to the attention of her physician until the biologic functioning has already been altered by the self-starvation. Psychological functioning of the patient and her family are also adversely effected by the anorexia for which psychoanalytic theory and treatment offered a scientific approach to investigating pre-anorectic functioning of the starving female.

Psychoanalytic theory gained greater interest and acceptance starting in the 1930's. The increased interest in psychoanalytic developmental theory coincided in time with the demonstration that "psychosexual trauma could lead to amenorrhea" (Sours, 1980, p. 210), as could psychophysiological causes. From this merging of ideas there emerged a psychosomatic approach into the understanding of the precursors of anorexia although the psychosomatic validity for diagnosis has never been very clear. It has not been proven that the somatic changes subsequent to the anorexia reflect inherent weaknesses of the endocrine or digestive systems. Out of all of the confusion of the past 100 years what has remained constant are the phenomenological descriptions of the anorectic (Table 3). The clinical research challenge has been to determine the psychodynamic link or links between the somatic changes and the developmental regressions that occur.

Freud's libido theory in the beginning of psychoanalysis and the later anxiety theory provided a "dynamic circular concept of relationship between mind and body" (Grinker, 1973, p. 26). Anxiety

was "considered as a signal which detonated repressive and often regressive forces that shunted expression of psychological drives from higher level verbal or behavioral paths into old infantile patterns" (p. 27). From these psychosomatic concepts, hypotheses for psychosomatic disorders could develop.

Helmut Thomä, a psychoanalyst at Heidelberg University Psychiatric Hospital, published a clinical survey of 30 cases of anorexia nervosa in 1967. The German edition appeared in 1961 and the actual collection of data occurred during the preceding nine years, from early 1950 through 1959. In the foreword to the English language edition he states that the "symptomatology of anorexia nervosa is, in the truest sense of the word, psychosomatic" (p. 1). Yet in describing the pre-anorectic height and weight of his sample he states in italics "anorexia nervosa patients have normal physical constitutions before illness. There is not one shred of evidence for constitutional hypogonadism" (p. 42). Of the 30 cases referred, 29 were female and one male. All 30 were examined but only 19 accepted the inpatient treatment. Five of the treatment cases are presented in great detail including psychogenetic reconstructions of early histories. Three case histories are given in an abridged form and the remaining treatment cases are used anecdotally. He omitted "any discussion of childhood development and the special role of the mother . . . and no accurate picture of their family relationships was recorded" (p. 263). It is perhaps for this reason, from his lack of information,

that he does not subscribe to a disturbance in the mother-child unit as the source or at least contributory to the anorexia. At the same time, he is quite clear that he believed there was unanimous agreement among therapists, including himself, that "patients must be removed from their home environment" (p. 263).

One of the primary aims of Thomä's published work is to demonstrate the superiority of psychoanalysis over other approaches in gaining an understanding of anorexia (Thomä, 1967). He points out the limitations or total ineffectiveness of leucotomies, tube feeding, existential analysis, pituitary implantations, electroshock, insulin shock, and various drug therapies. In this sense it is very important for focusing attention on the need for continued research into a psychogenetic understanding of anorexia which he felt could be provided from psychoanalysis. Thomä viewed his anorectic cases in a psychoanalytic framework of drive regression in the face of the unbearable instinctual anxiety of adolescence. In seeking a psychogenetic reconstruction he states that "an oral ambivalence is the basis of the symptomatology" (p. 255), and then cautions against making any specific statements about the infantile form of the ambivalence since the observations are made on patients' regressive state.

Concerning regression to oral ambivalence, he explains the anorectic's subsequent behavior as stemming from the conflicts of this infantile stage whereby the nourishment object equals mother.

He explains an intense desire to fuse with mother and an intense desire to spit her out. At the primitive level to which the anorectic has regressed, prior to the primary narcissism of three months, according to Thomä's theoretical formulations which are based on classical Freudian theory, the sense of separateness from the mother does not yet exist. His theoretical conclusion is therefore that anorectics are defending against the loss of ego boundaries between the ego and the object. Case illustrations support the highly ambivalent relationship of the patient to her mother, including the fear of identification with the mother which ultimately hinders both physical and emotional development. He ascribes several possible symbolic meanings to food from his psychoanalytic work with the anorectics. Besides the fact that food represents mother it also represents dependence on mother, both of which the anorectic on a conscious level wants to avoid. In general Thomä postulates that a variety of anxieties "are concentrated in the fear of eating" (p. 260), including the fear of oral impregnation.

Thomä's emphasis on psychoanalytic theory sometimes leaves the reader questioning whether his psychoanalytic work with the young female patients is interpreted in a selective way because of his dedication to advancing the principles of psychoanalysis. His chapter on "Psychogenesis and Psychosomatics" (Thomä, 1967) contains more theoretical references than case references to support the

theories. He himself expressed disappointment that the regression which occurs cannot be better explained. "We have certainly not yet grasped the full psychodynamic significance of the particular form taken by regression in anorexia nervosa, nor of the changes in the ego" (p. 282). He does, however, give us clues as to why it is so difficult to penetrate the subjective world of the anorectic. The defenses used by the anorectic in the regressive state -- denial, projection, avoidance, negativism -- make it very difficult to establish the kind of transference that will shed some light on the symbolic significance of the self-starvation. Although the evidence pointed to some disturbance in the mother-child unit, there was insufficient evidence for Thomä to pursue it beyond the oral ambivalence of the anorectic. The fact that Mahler's work on separation and individuation had not been published until Thomä had completed his formulations also hindered exploring the psychodynamics between mother and child beyond the oral ambivalence of infancy.

Other psychoanalytic investigations of anorexia added disturbed object relationships as an important dynamic factor in the behavior of the anorectic patient. This placed more emphasis on the mother-child unit and other important family relationships. From Melitta Sperling's (1978) experience with the non-verbal infant and the non-cooperative adolescent, she began working psychoanalytically with the mothers. It should be noted, however, that in all cases there was some combination of therapy for mother and child. Her case study findings from her work with the mothers of infants with severe eating disturbances was that the mother had highly ambivalent feelings

toward the infant and in some cases she found an unconscious rejection of the child by the mother. Her presentation of the psychodynamics of the anorectic cases emphasized this ambivalent relationship as had Thomä. In addition, Sperling pointed out that pre-oedipal conflicts due to impairment in the early mother-child relationship leads to a vulnerability for oral and anal fixation.

The psychodynamics as perceived by Sperling (1978) in the course of providing psychoanalytic treatment for an anorectic adolescent or her mother or both (in one case) extend into the network of important people in the patient's life, both family and friends. She mentioned the father's important role within the oedipal context. In her observations she found that the anorectic's change in overt behavior to her parents around the time of the onset of the anorexia reflected a change from a positive oedipal to a negative oedipal constellation. The daughter no longer competed with the mother for the attention of the father but now became rivalrous with the father for the affection of the mother "with a possessive-controlling, homosexual attitude toward her" (p. 147). Sperling associates this change following a real or fantasized rejection or disappointment by the father.

Sperling views the dynamics in anorexia nervosa as very complex. She delineates oedipal and pre-oedipal conflicts around sexual identity, sexuality and instinctual pleasures in general. A distinction is not made between gender identity and female sexuality as Stoller would differentiate them. Sperling did not consider that the core identity could remain female but at an infantile sexual

level. Perhaps more diverse reasons for the suppression or denial of sexuality are not presented is that Stoller's work post-dates Sperling's actual clinical experience. In any case, he is not referenced in her bibliography.

Regarding the symbolization of the food refusal, Sperling's psychotherapeutic experience with the young anorectic provided multiple unconscious meanings. The unconscious meaning of food for the anorectic was, in her cases, a symbol of the life-controlling, omnipotent mother. Control over food intake also equals control over sexual impulses "since these patients deal with their sexual impulses by displacement from the genital to the oral level" (p. 163). In general Sperling found that "food and eating become equated with forbidden sexual objects and sexual activities" (p. 166). The amenorrhea and digestive disturbances are considered "expressions of infantile oral impregnation and birth fantasies" (p. 167). This latter viewpoint has also been noted by other psychoanalytic investigators: Lorand (1943); Masserman (1941); Sylvester (1945).

Issues of separation and individuation are not considered in the framework of Mahler's theories and in fact Mahler is not referenced in the section of the book on anorexia. Sperling did note the importance of the anorectic's separation from the mother and the anorectic's unconscious rejection of an identification with the mother's female role, but this was not discussed in the context of the impoverishment of the ego to effect a self and object constancy. Nevertheless her observations of the pathological

mother-daughter tie provide important data for further investigation along these lines. The psychogenetic base for the anorectic's conflict with the mother is attributed to the daughter's "deep rooted feeling of being rejected by the mother" (p. 164) which, according to Sperling, is partly a projection of the anorectic's rage at the mother and partly based on reality.

Concerning the nosology of anorexia nervosa, Sperling (1978) considers the disorder a specific neurotic syndrome in females who have "remained fixated at earlier levels of development" (p. 171). The defenses she associates with this syndrome are mainly "denial, repression, reversal of affect, reaction formation, overcompensation, displacement, and projection" (p. 162). Actual diagnostic classification was considered within a wide variety of character disorders ranging from borderline to hysterical. The author would like to point out that Sperling's contributions to the etiology, nosology and psychodynamic understanding of anorexia was obtained through the case study method in which she ardently believed: "Theories may come and go, but the case history is the fundamental truth" (Preface xi). The case material for the book was drawn from the treatment of 20 children with various psychosomatic disorders, together with their mothers. How many of these are anorectic cases is not stated. Four cases are presented as illustrations of the observations she has made on anorexia.

Hilde Bruch published her famous book Eating Disorders,

Obesity, Anorexia Nervosa, and the Person Within in 1973. The material was based on studies extending over nearly 40 years. Through the years she became widely known for her success in establishing therapeutic contact with these patients and their families. As a result many physicians referred their most difficult patients to her for consultation or extended psychotherapy. It is perhaps because she was consulted in so many desperate cases that diagnostically she places anorexia closer to schizophrenia than other investigators.

The material presented in the book covers her observations of 70 anorectic patients, 51 with the primary syndrome and 19 exhibiting atypical pictures. Of the 51 with a diagnosis of "primary anorexia nervosa," 45 were female and six were male. The author's discussion of her work will focus on her studies of the 45 female anorectics with a diagnosis of primary anorexia nervosa. It is interesting to note that up until a decade ago anorexia nervosa was considered a rare malady where even the specialists like Bruch treated only a few cases a year.

Bruch was trained in Harry Stack Sullivan's interpersonal theory of psychiatry. In this theoretical framework there is special emphasis on the infant's interaction with his or her environment. Infantile transactions are considered the precursors to later interpersonal relationships, one's view of one's self and of others. Out of the process of emitted and elicited behavior on the part of the infant and child with the caretakers there evolves a human structure known as the self-system which copes with life in

its own unique way according to its own unique experiences and its own constitutional inheritance. The outcome of the self-system is very dependent on the mother's empathy and tenderness in meeting the child's needs, especially in the preverbal stage. In the interpersonal system, very detailed personal histories are obtained to try to determine what went wrong at each era of the patient's life. The psychological language used in describing the developmental history differs from that of the libidinal theory of development in that the interpersonal theory is more pragmatic and is more concerned with observable and operational kinds of data. The two systems are compatible in many areas in spite of semantic differences, and in spite of Sullivan's more empirical approach to understanding human behavior. "We learn nothing about the human being except as we observe and experience him in an interpersonal field" (Witenberg, 1974, p. 852).

The theory of the evolution of a self-system with dynamisms (defenses in libido theory) and learned patterns of interrelating to protect the self from the anxieties of unmet need tensions is basic to Bruch's (1973) formulation of the psychogenesis of anorexia. Her approach within this matrix is multi-dimensional and expands into other scientific areas. One dimension is the neurophysiology of the anorectic's "error in cognitive awareness of the body self, the accuracy in recognizing stimuli coming from without or within, the sense of control over one's own bodily functions" (p. 89). Bruch conceives of these deficiencies in entero-exteroceptive awareness to derive out of the mother's inappropriate responses to clues

coming from the infant, with the eating function being but one example of the misperception of the child's needs. Entwined with the neurophysical interactions are the neuropsychological affects and attitudes which the mother or caretaker imparts to the infant regarding bodily functions and body image. Out of these complicated interactions between mother and child Bruch believes that engrams of experience are codified in the brain which lay the foundations for the child's ability or failure to perceive his bodily experiences and body image correctly. Bruch further states that the "learning process is not restricted to infancy but is continued throughout childhood" (p. 56).

The ability to experience one's body sensations correctly, according to what is actually happening to the child rather than according to what the mother misperceives is happening to the child, is in Bruch's (1973) conceptualization the basic impediment to the development of self-awareness and self-effectiveness.

> If confirmation and reinforcement of his own initially rather undifferentiated needs and impulses have been absent, or have been contradictory or inaccurate, then a child will grow up perplexed when trying to differentiate between disturbances in his biological field and emotional and interpersonal experiences, and he will be apt to misinterpret deformities in his self-body concept as externally induced. Thus he will become an individual deficient in his sense of separateness, with "diffuse ego boundaries," and will feel helpless under the influence of external forces (p. 56).

From the above reasoning Bruch has formulated the pathogenesis of severe eating disorders, both in obesity and in anorexia, as developmentally on a level with schizophrenia. This implies developmental failure in the symbiotic phase with an insufficient

differentiation from the "not-me" other. As a result, Bruch postulates that the child does not feel self-directed and is "prevented from developing a clearly differentiated body schema and sense of competence" (p. 62). A psychodynamic formulation which emphasizes the young anorectic's ego deficiencies growing out of a theory of faulty interaction between mother and child from birth onward provided Bruch a psychotherapeutic framework which was well-suited to attaining therapeutic contact with the severely regressed anorectic. The focus on the patient's feelings of helplessness and ineffectiveness in object relations and on the defects in initiative and "active self-experiences" (p. 57) has been the direction that psychoanalytic psychotherapy has been evolving for treating the borderline and narcissistic personalities. Heinz Kohut's theory of self psychology for the narcissistic personality parallels some of Bruch's thinking in that Kohut too departs from the instinctual line of development and describes the basic fault to evolve out of the parents' less than desirable responses to the child's evolving self. Kohut's theory further postulates that instinctual difficulties will gradually disappear as the patient develops a more cohesive self. As far as the anorectic is concerned, Bruch certainly agrees that there is a deficit in self in the sense of personal identity. At the time of writing her basic book, Eating Disorders, she saw herself in agreement with psychoanalytic theory on the fundamental issue, "that personality develops out of the dynamic interaction and experiences of the child with the people in his environment" (p. 62).

Regarding separation and individuation, Bruch is very explicit that the anorectic has not achieved a "clearly differentiated body schema and sense of competence" (p. 62); that the child has failed to "develop a self-directed identity" (Bruch, 1977, p. 4). This is said in many different ways throughout her many publications, with the word "autonomy" frequently used to refer to the anorectic's collection of deficiencies in self-directedness. It is out of the psychogenetic formulation of the lack of separateness of the anorectic from the mother that Bruch explains the resultant panic when the anorectic is faced with a new situation including separation. Not having achieved an adequate self-system, Bruch (1973) states that the anorectic is unprepared to deal with the changes of adolescence. Bruch explains the facade of adequate functioning in latency as being achieved through "robot-like submission to the environmental demands" (p. 57). Why the facade of latency can cover so much psychopathology is explained on the basis of the new demands of adolescence overwhelming the somewhat symbiotic anorectic. The increased sexuality of adolescence and the need to make an advanced female identification are not overlooked in Bruch's thesis, but more emphasis is placed on what ego psychology would call ego deficits accumulated in the separation-individuation phase. Exactly where on the developmental continuum between symbiosis and object constancy the anorectic may be fixated is not addressed by Bruch. She does not work in this frame of reference, nor was it particularly available to her when she started her research into anorexia.

One of the advantages of understanding Mahler's paradigm of

developmental psychology is that it helps to locate deficits in ego development along a developmental continuum from symbiosis, fourth or fifth month of age, to consolidation of individuality and the beginnings of emotional object constancy, 30th or 36th months of age. Mahler's descriptive data of this period grew out of her observational research studies of mother-infant and mother-toddler pairs from 1959 to 1968 which included 38 children and 22 mothers. Mahler's (1968) interest in the human symbiosis grew out of her encounter with childhood psychosis in her clinical practice of child psychoanalysis. Early studies with psychotic children led her to the theory of "the symbiotic origin of infantile psychosis." It was from these failures in adaptation to reality that Mahler set up a parallel research project with non-psychotic infants to learn about the separation-individuation phase of development of non-psychotic children.

From the results of the research study of the mother-child pairs, Mahler and her research associates formulated four sub-phases of the separation-individuation phase. It should first be noted, however, that in Mahler's theory the forerunners of the separation-individuation phase are the normal autistic phase, approximately from birth to one month and the normal symbiotic phase from approximately one to five months of life. Mahler differentiated between infantile autism and childhood schizophrenia in her work prior to 1959 from her study of 16 psychotic children and the anamnestic data obtained about them. The autistic phase is characterized by the infant's lack of awareness of a mothering

agent (Mahler, 1975). Gradually, according to the theory, the infant slips into a dual unity with the mother in which his biological survival is maintained. This, according to Freudian theory lays the bedrock for the lifelong though diminishing emotional dependence on the mother which is a universal truth of human existence. The process whereby the infant emerges from this cocoon is what is called the separation-individuation phase of development.

Before delineating the subphases of this developmental period, it may be helpful to define some of the more important terms as Mahler (1975) has conceptualized them in her research reporting.

> First, we use the term separation or separateness to refer to the intrapsychic achievement of a sense of separateness from mother and, through that, from the world at large. (This very sense of separateness is what the psychotic child is unable to achieve.)
>
> Second, we use the term symbiosis (Mahler and Furer, 1966) similarly, to refer to an intrapsychic rather than a behavioral condition; it is thus an inferred state.
>
> Third, Mahler . . . has earlier referred to infantile autism and symbiotic psychosis as two extreme disturbances of identity. We use the term identity to refer to the earliest awareness of a sense of being, of entity -- a feeling that includes in part, we believe, a cathexis of the body with libidinal energy. It is not a sense of who I am but that I am; as such, this is the earliest step in the process of the unfolding of individuality.
>
> Separation and individuation are conceived of as two complementary developments; separation consists of the child's emergence from a symbiotic fusion with the mother (Mahler, 1952), and individuation consists of those achievements marking the child's assumption of his own individual characteristics. These are intertwined, but not identical, developmental processes; they may proceed divergently, with a developmental lag or precocity in one or the other (pp. 7-8).

Mahler admits that "the kind of inferences that can be drawn

from direct observation of the preverbal period is a most controversial one" (Mahler, 1975, p. 13). However, the categorization of the behavior by the participant-observers is less controversial because it refers primarily to the manifest behavior of the mother-infant pairs. Mahler's interpretation of this behavior, specific for each child but yet with a common chronology, is a blending of drive theory with object relations theory with a biological timetable and a sociological background. What Mahler contributed that was new is an awareness of the changing nature of the child's needs from the mother as the child progresses from symbiosis to the beginnings of object constancy and self constancy. The chronology of the progression was uniformly found to cover the following four subphases of development.

1. The differentiation subphase from 5 months on (with dawning awareness of separateness);
2. The major spurt in autonomy called the practicing subphase from 10 to 15 months (with attention directed to new motor achievements, seemingly to the near exclusion of mother at times);
3. The rapprochement subphase from 15 to 22 months (with renewed demand upon the mother, who is increasingly experienced as separate, and with continued growth of the autonomous ego apparatuses);
4. Progress toward the gradual attainment of libidinal object constancy (from 22 to 36 months) (p. 260).

The delineation of four specific subphases in the process of separation-individuation is the result of "repetitive, if not ubiquitous, age-specific clusterings of behavioral sequences and affective reactions found in our children between 5 and 36 months of age" (Mahler, 1971, p. 405). The research team in trying to

integrate the behavioral data to demonstrate emerging ego functions and psychic structuring, observed that following the practicing period, which has been described as the child's "love affair with the world," there followed what seemed like a return of the separation anxiety of the previous period and a loss of some of the independence from the mother that had been gained by locomotion. It seemed that now that the child had come to be more aware of his separate self, he has once again an increased need to seek closeness with the mother. It was because of this return to the mother, albeit at a higher level of ego functioning, for reaffirmation of her continued availability in the face of his growing independence that Mahler labeled this phase the rapprochement subphase.

This particular subphase is considered a critical crossroads in the separation-individuation process and as a possible precursor of borderline psychopathology and narcissistic personality disorders. It was observed during this subphase that the toddler was especially vulnerable to the mother's lack of availability either physical or emotional. The characteristic behavior of this subphase is the acting out of the toddler's ambivalent feelings toward the mother. The child alternates between seeking reunion with the "symbiotic" mother and then defending against re-engulfment by the symbiotic mother. These conflicting needs in the toddler call for more patience and understanding from the environment, especially the mother, than the environment may be able to give. The "separating" mother may not want the separation from the toddler or she may resent the continued dependence of the toddler. The toddler, from

his or her part, may be carrying residual deficits from previous stages or inadvertently be subjected to current traumas to the extent that the ego is overwhelmed with the new awareness of separateness from the mother. It forces him to "give up both the delusion of his own grandeur and his belief in the omnipotence of his parents. The result is heightened separation anxiety and disidentification from, as well as coercive dramatic fights with, mother," (Mahler, 1975, p. 229). Mahler's observation was that even the most normally endowed child, with the most optimally available mother, did not weather the rapprochement struggle without some developmental difficulty. However, in some children it was thought that the rapprochement crisis leads to such ambivalence that the object world is split into "good" and "bad" which later become organized "into neurotic symptoms of the naricissistic variety. In still other children, islands of developmental failures might lead to borderline symptomatology in latency and adolescence," (p. 229).

Mahler had hoped to link up the substantive findings of her observational research with borderline phenomena shown by child and adult patients in the psychoanalytic situation. However, she concluded that "there is no 'direct line' from the deductive use of borderline phenomena to one or another substantive finding of observational research," (Mahler, 1971, p. 415). However, there are other psychoanalytic writers who do single out specific failures in the separation-individuation phase, particularly the rapprochement

subphase as pathognomic for subsequent borderline psychopathology (Kohut, 1966; Tartakoff, 1966; Kernberg, 1967; Frijling-Schreuder, 1969; Masterson, 1972).

Louise J. Kaplan, Ph.D., who was a research associate of Mahler of the Separation-Individuation Follow-Up Study has written an illuminating article cautioning against "oversimplification and premature closure regarding the precise manner in which the symbiotic and separation-individuation subphases exert their influence on later personality organization" (Kaplan, 1980, p. 39). Kaplan agrees with Mahler's 1971 article in The Psychoanalytic Study of the Child that the clinician should not "deduce a direct relationship between the manifestations of borderline phenomena (in the treatment situation, my addition) and the observation of normal developmental sequences in childhood," (p. 40). Kaplan's reasoning for this is that subsequent to the first three years of life and later borderline and narcissistic disturbances of childhood, adolescence, and adulthood lie many cumulative layers of personality organization whose principles of transformation to the later psychopathology have yet to be specified. The author emphasized the importance of the oedipus complex "as the fourth psychological organizer," (p. 40) whereby the oedipus complex not only is shaped by the symbiotic and separation-individuation subphases but in its turn the oedipus complex restructures the outcome of these earlier developmental events through its own resolution and mode of dissolution.

Examples of the importance of the oedipus in organizing the

later personality development are given by Mahler and Kaplan in "Developmental Aspects in the Assessment of Narcissistic and So-Called Borderline Personalities" (1978). Two cases from the research project are presented with follow-up at latency and early adolescence to illustrate "what we mean when we speak of the broad spectrum of borderline phenomena" (p. 73). In these two case studies, more so than when they were originally presented in the research reports, more attention is paid to the interlocking strands of narcissism and psychosexual development with the object relations of the separation-individuation process. The purpose of these case presentations is to demonstrate the complexity of evaluating developmental progression or of assigning developmental failures to any one particular sub-phase or cause. The authors reaffirm their findings within the psychoanalytic view of development by stating that "Consideration of the traditional hierarchic psychosexual stages is implicit in the separation-individuation sub-phase theory" (p. 72). In brief, the authors have attempted to place their separation-individuation theory into a broader perspective so that clinicians working with borderlines and narcissistic personality disorders will not be lulled into ascribing the psychogenesis of these disorders strictly to the rapprochement sub-phase of development. In the author's opinion, if that has a place here in the review of the literature, I heartily agree with these two researcher-clinicians that the term "rapprochement" has become overworked, much like the term "oedipal" was overworked in psychoanalytic literature before the advent of ego psychology.

The use of either of these two terms in describing a phase of human development is sometimes a gross oversimplification of an extremely complex developmental process. This is not to diminish the importance of Mahler's research in providing a more specific understanding of pre-oedipal developmental inadequacies and the fact that they may manifest themselves in borderline mechanisms and narcissistic vulnerabilities in later life. The main points the authors wish to make here are: (a) it is an oversimplification to relate failures in one subphase of the separation-individuation process with a corresponding specific form of narcissistic or borderline personality organization; (b) the dominance of one subphase distortion must not obscure the fact that there are always corrective or pathogenic influences from the other subphases to be considered; (c) the fate of the oedipus complex and the developmental crises of adolescence are influenced by previous developmental deficiencies or accomplishments and in turn influence the ultimate outcome of personality structure. Not to be overlooked as one of the determinants in the later functioning of the child is the "individual's constitutional endowment" (Mahler, 1975, p. 108).

Mahler's research has served as a model to organize pre-genital data so that there is a better understanding of pre-oedipal inadequacies and their possible effects on later functioning. There do remain, however, important themes of this period to be more fully explored. In her concluding remarks to her research project, she points the way to future research on the third year of life to consider the following themes:

> self-constancy and object constancy, the sense of identity, the internalization process and the nature and outcome of internalized conflicts involving libidinal and aggressive drives, other aspects of ego development and learning (such as the shift from the primary to the secondary process as well as the shift from the pleasure principle to the reality principle), the nature of the child's play and fantasy, and the child's interaction with his peers . . . (Mahler, 1975, pp. 270-271)

These subjects have relevance to some of the unanswered developmental questions of the anorectic female in adolescence: the fate of the drives, vulnerabilities in ego development that can remain dormant in latency, the contributions of later developmental crises to self and object constancy, inhibitions to the girl's ability to identify with her mother and the positive components of female sexual identity along developmental lines.

Peter Blos has delineated a second individuation process in adolescence. First published in The Psychoanalytic Study of the Child in 1967, it was reprinted in other publications in 1975 and in 1979. Blos points out that it would be a mistake to consider a parallel process to the first individuation taking place as actually it is a reverse process. Whereas separation-individuation in early childhood is accomplished by gaining a relative independence from external objects through internalizations of infantile parental imagoes, ideals, inhibitions, and authority, adolescents must gain independence from the very internal objects that were erected during the oedipal and pre-oedipal periods of childhood. They must give up these internal objects by transforming them into the adult ego-ideal, a structure which allows them to establish a new level of actual relationship with husband or wife, child, parents, and adult peers. In other words, adolescent individuation requires emotional disengagement from internalized infantile objects.

During the separation-individuation phase of early childhood, the child gained a measure of independence from the mother through internalizing her ministrations and emotional supplies to provide a a regulator of psychophysiological homeostatis in the absence of the mother. During the process of emotional disengagement from the internalized infantile objects, structural changes take place in a complex process between the adolescent, his new mental and physical capacities, his primary objects, internal and external, and the social environment at large. The accustomed ego dependencies of early childhood and latency are repudiated, weakening the ego in the face of intensification of the drives. The oedipal superego loses some of its rigidity and power while the ego ideal acquires more prominence and influence. "The second individuation, therefore, connotes those ego changes that are the accompaniment and the consequence of the adolescent disengagement from infantile objects" (Blos, 1967, p. 168).

Blos points out that the struggles in achieving a satisfactory second individuation are reflected in the acting out, in learning disorders, in lack of purpose, in procrastination, in moodiness and negativism, in somatic problems including anorexia that frequently are symptomatic signs of a failure in the disengagement from infantile objects. Probably all the reasons for these failure, either transient or permanent, have not yet been articulated. It is now generally agreed that inadequacies from previous developmental tasks would foreshadow some unusual difficulties with adolescence.

Blos, in On Adolescence, A Psychoanalytic Interpretation (1962) discusses the importance of the ego of the latency period being sufficiently developed to face the developmental tasks of adolescence. "Otherwise, as in the case of an abortive latency period, a prelatency ego must cope with pubertal drives" (p. 173). He then defines the essential ego achievements of the latency period:

> 1) an increase in cathexis of inner objects (object- and self-representations) with resultant automatization of certain ego functions; 2) an increasing resistivity of ego functions to regression (secondary autonomy) with a consequent expansion of the nonconflictual sphere of the ego; 3) the formation of a self-critical ego which increasingly complements the functions of the super-ego, so that the regulation of self-esteem has reached a degree of independence from the environment; 4) reduction of the expressive use of the whole body and increase in the capacity for verbal expression in isolation from motor activity (Kris, 1939); 5) mastery of the environment through the learning of skills and the use of secondary process thinking as a means to reduce tension. (pp. 173-174)

In this outline of ego readiness for puberty there is an assumed balance between ego progression and drive progression so that the former can deal with the latter to avoid regression and maintain the basic function of the ego -- "the maintenance of psychic cohesion and reality contact" (p. 172). This does not mean that a well developed latency ego will prevent regression, as a return to the love-hate relationships of infancy and early childhood is necessary in order for the adolescent to free himself from their original power and function in a more realistic world. It is when the regression is to a seriously defective ego of early childhood that a developmental impasse occurs and results in either a temporary or

permanent psychotic illness. Lesser early ego damage also becomes manifest at adolescence when the psychic structure is observed to be inadequate to the task of the adolescent individuation process. In the symptomatology that ensues it is difficult to predict whether behavior that appears deviant in adolescence will be abandoned once it has served its purpose in individuating from the family or whether the behavior will become an ingrained character trait.

According to Blos (1962), an important indicator in determining how the young person is mastering the adolescent turmoil is to find an emerging sense of reality gradually replacing the magical thinking and the omnipotence of early childhood, the ego ideal becoming less grandiose and more in keeping with actual abilities and possible goals. At the same time, he finds that the parents are also viewed more realistically and the ambivalently held infantile objects can now have some realistic acceptance as whole objects. In brief, how well the ego finally can introduce reality and adjust to it, is in the final analysis a good prognosticator that important psychic changes have taken place in a positive direction.

In latency the ego's task is also to turn to reality and deal with the world of education and peer relationships. There is an important difference however in the area of sexuality. Whereas the adolescent struggles to rechannel his sexual drive, the latency child in what we call civilized society struggles to repress his sexuality and develop some workable defenses against it that are not over-inhibiting of total functioning. There is some general

agreement that reaction formation and sublimation in conjunction with repression are the paramount defense mechanisms of latency. What is not so widely discussed is the place of fantasy and regression as defense and dynamic of latency.

Charles Sarnoff, child psychiatrist, has written an article (1971) on "structure of latency" exploring the role of the symbolizing function of the ego in latency to show the connection between instinct and fantasy according to Freudian thought:

> In adolescence and beyond, fantasy detracts from the solution of emotional problems through relationship with the real world and object seeking. Only in the creative artist is it seen as acceptable in the form of sublimation. In latency, fantasy gives vent to the drives and permits the child to live in peace with the parental figures. (p. 403)

Sarnoff further describes the role of fantasy in those cases where the child may be over-stimulated by the environment and has unresolved pregenital conflicts, the sexual drive which is maintained during latency may then be acted out rather than discharged through fantasy. Learning inhibitions are a further manifestation of unresolved oedipal and pre-oedipal difficulties with regression to anal-sadistic drives characteristic of the borderline child.

To complete the transition from latency to puberty, the literature postulates a gradual transition to reality of the sexual drive. Berta Bornstein (1951) was the first to describe two stages of latency, the first period from five and one-half to eight, and the second from eight until about 10 years. According to Bornstein, the common element to both periods "is the strictness of the superego

in its evaluation of incestuous wishes -- a strictness which finds expression in the child's struggle against masturbation" (p. 280). Sarnoff and Bornstein do not agree that the sexual drive diminishes during latency. Sarnoff quotes clinical examples to demonstrate that the sexual drive is maintained throughout latency. The fact that the ego matures and the strictness of the superego diminishes in the second period of latency gives an appearance, according to Sarnoff, of a diminished sexual drive, but the actual fact is that the ego is better able to deal with the incestuous wishes.

It is during the second phase of latency that reality testing improves and fantasy formation becomes less tenable. By 11 or 12 in the normal development of latency according to Sarnoff, with the maturing cognition and better mastery of castration anxieties, and an improved cathexis of reality through school and sports and the increased availability of the outside world as a source of objects, reality testing improves and "the structure of latency" weakens. The significance of this movement in relation to the drives is that fantasy alone, either in play or in thought, no longer can be the primary outlet for the discharge of the drives. "The stage is set for the turmoil of adolescence" (Sarnoff, 1971, p. 412) where the demands of the world must now be faced and resolved.

This excursion into what is considered a normal progression from the post-oedipal period to adolescence does not shed any more light on the latency of the anorectic which leads to an avoidance of sexuality in adolescence. Although Sarnoff has written

extensively on latency and has provided a more detailed review of this period than usual, many facets still remain to be explored. One that may have important relevance to the etiology of anorexia is the role of identification in determining the ability of the female adolescent to progress beyond the compliant, cuddly latency girl.

Concerning the psychodynamics of the family as a whole, as a system, the two clinicians who have placed the most emphasis on this aspect are the two who favor family therapy as a principal modality of treatment. They are Mara Selvini Palazzoli, psychiatrist formerly of the Milan Centre of Family Studies and currently with a family clinic in Palo Alto, and Salvador Minuchin, psychiatrist widely known for his family approach to the psychosomatic disorders of childhood. Dr. Minuchin is director of the Philadelphia Child Guidance Clinic and Professor of Child Psychiatry and Pediatrics, University of Pennsylvania School of Medicine. Both Palazzoli and Minuchin have conducted research studies on the psychotherapy of families of anorectics. The research is not of a strict experimental method but more in a case study method of family therapy.

Palazzoli published her study of 12 families in Self Starvation (1974). The book sums up "experiences and reflections gathered during some 20 years' work on the fascinating problem of anorexia nervosa . . ." (Preface, p. xiii). The final section devoted to family therapy reflects only the three years' work prior to 1974 when Palazzoli changed from exploring intrapsychic dynamics to family treatment. Her preliminary findings of characteristic

behavior patterns corroborate, in the main, the impressions of other psychotherapists who work with families of anorectics. The families as observed by Palazzoli have many characteristics of the anal level of development. They are rigid, resistant to change, argumentative, and moralistic. Communications between and among family members are rejected or contradicted so that differences do not become resolved. The families prefer to keep their socialization within their own boundaries. Friendships are not incorporated into the family and two-person alliances outside the family are discouraged as disloyal. Both parents view themselves as sacrificers in the cause of duty, respectability and marital stability. The fathers convey their dissatisfactions subtly through silence and withdrawal; the mothers by defensiveness and the threat of abandonment. In general the parents are deeply disillusioned about the marriage but present themselves as an exemplary couple to the outside world.

The research methodology leading to these findings in family interaction was based on the psychotherapeutic study of 12 families interviewed by one male and one female therapist. The interviews were recorded and monitored by other members of the team. The theoretical model for organizing the data was J. Haley's "pragmatic axioms of human communication" (p. 204). The details of the methodology were not given.

Sociological observations of the 12 families were given in Chapter 27, pp. 242-252. The major characteristic noted was that these Italian families were attempting to preserve agricultural-patriarchal values in an urban-industrial setting. In this particular ethos the family is conceived as the unit for survival and there is a tendency to stick

together "like a brood of ducklings" (p. 242). Ten of the wives withdrew from all outside activity after marriage even though two were university graduates and some of the others held diplomas. The fathers stated that a "real" wife must dedicate all her time to her husband, children and the well-being of the family. The two wives who worked outside the home were criticized by their husbands, children and extended families. The wives reacted in a variety of ways to their socially-imposed roles. Some responded with total dedication reflected in intolerance and perfectionisms; some hid their secret resentment in martyrdom, hiding their anger and depression in physical complaints and inefficiency; and some reluctantly adapted and denied that their chores were intolerable although they were fearful about their performance. Palazzoli sees these families as caught in the mores of a changing culture. The fathers, unsure of themselves and afraid of independent women, chose women attached or submissive to her own parents and with many shortcomings in the areas of "adaptability, imagination, intelligence" (p. 244). The mothers in these marriages were considered to have a low opinion of themselves so that they sought their higher social status and valid identity in the traditional role of wife and mother.

Minuchin's studies of families of anorectics are part of his general interest in treating the psychosomatic disturbances of childhood and more particularly viewing the family unit as the unit of therapy. His thesis is that there is not a diabetic type of family or an asthma type or an anorectic type but that there is a type of family whose organization supports somatic symptoms as an expression of emotional distress and that the symptom bearer, in a dysfunctional kind of way, is the reliever of such stress (Rosman, Minuchin, et al., 1977). Minuchin and his colleagues

identified four characteristics of family functioning in the psychosomatic family. They are enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. A fifth characteristic was added to move from a linear model to an open system or circular model. The fifth factor is the child's "involvement in parental conflict in such a way so as to detour, avoid or suppress it" (p. 343).

The conclusions are based on a study of 53 cases ranging in age from 9 to 21, with 11 percent of the group male patients. There is no formal research design for the study. The population is drawn from referrals from a children's hospital. Diagnosis of anorexia nervosa was a pediatric assessment of the pathogenic signs of the disorder. There were 16 different family therapists who treated the families employing diverse modalities including couple therapy, individual psychotherapy, behavioral techniques and other methods as well as conjoint sessions. The theoretical framework for the therapeutic approach is structural family therapy using a blend of "elements of ecology and ethology," (Aponte and Hoffman, 1977, p. 572). The family theorists that are acknowledged as contributing to the conceptualization of the treatment are Lidz who emphasizes generational and sex boundaries, their maintenance and violation, Wynne who presents the concept of pseudomutuality and amorphousness in role definition, Bowen who focuses on the undifferentiated ego mass of the family, as well as with more recently developed tactical procedures such as benevolent manipulation, exaggeration of the symptom, relabeling, prescribing the symptom, etc.

The four characteristics which were found to be the model of the families with diabetic, asthmatic or anorectic children have already

been stated -- enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. These factors have been discussed in more detail in the book entitled Psychosomatic Families, Anorexia Nervosa in Context by Salvador Minuchin, Bernice L. Rosman, and Lester Baker (1978). Below are brief statements to define these concepts within the meaning of Minuchin's work.

Enmeshment -- In enmeshed families the individual gets lost in the system. Excessive togetherness and sharing bring about a lack of privacy. Family members intrude on each others' thoughts and feelings. Family members have poorly differentiated perceptions of each other and, usually of themselves.

Overprotectiveness -- The parents' overprotectiveness retards the children's development of autonomy, competence, and interests or activities outside the safety of the family.

Rigidity -- Rigid families are heavily committed to maintaining the status quo. They typically represent themselves as normal and untroubled and deny any need for change. Almost any outside event may overload their dysfunctional coping mechanisms, precipitating illness.

Lack of Conflict Resolution -- Family members quickly mobilize to maintain a manageable threshold of conflict. They achieve this control through position shifts or distractive maneuvers that diffuse issues. Some families avoid or deny conflict. Often one spouse is an avoider. The avoider manages to detour confrontation or may simply leave the house.

In concluding the section on the review of the relevant literature, it is apparent that the case study method has been favored as a method of clinical research on anorexia nervosa. The psychotherapists who

have been cited have contributed the accepted psychodynamic insights on the disorder to date. However, in all fairness to the field of scientific inquiry, only Mahler's study meets the criteria for a research study. Of course Mahler was not attempting to ferret out the etiology of an adolescent disorder but rather to build developmental theory through participant and non-participant observation. This approach has not been possible with anorexia for the rather obvious reason that the symptoms of anorexia are not compelling until adolescence and by then any specific precursors are apt to be lost to observation. This probably accounts for the fact that the empirical research on anorexia is limited to those aspects of the disorder that are quantifiable. In the physiological field, changes in the endocrine system have been measured and remeasured; in the area of statistical follow-up, outcomes have been counted and discounted; in testing the accepted phenomenology of anorexia through empirical studies, there has been some statistical confirmation in Michael Strober's* studies conducted at UCLA Neuropsychiatric Institute. However, up to now none of these studies have provided any additional insight into the etiology or treatment of anorexia nervosa in young females. Only the case studies of very talented and experienced clinicians have provided a beginning understanding of the complex and varied determinants of this disorder.

The clinical reports on anorexia which have been reviewed did not define research variables in advance for study. Nevertheless, out of the data available and pursued some common themes in the development

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*These studies were not yet in publication at the time of writing this proposal. Titles are listed in "References."

and functioning of the anorectic emerged. The ambivalence in the relationship with the mother was usually in some way a part of the psychodynamics as was the avoidance of a more mature female sexuality and the inability to effect an individuation from the mother. These themes also appeared in the review of the prototype case referred to in the section on Research Design and Methodology, and have been incorporated as variables to be investigated. The investigation of the apparently benign latency is an original focus provided by the investigator derived from the historical data of the prototype case.

CHAPTER III

Research Design and Methodology

Design

The research design is a retrospective study of six anorectic cases to trace through early experiences which may account for the onset of the eating disorder after an apparently stable latency. This comes under the general heading of a naturalistic design whereby subjects' responses are recorded as they exist or happen to unfold without manipulative interventions or intentional modifications. The specific research method of investigation is a combination of ex post facto (retrospective investigation of past history) and case study. Case study involves an intensive analysis of single individuals, their life histories, current feelings, thoughts, and behaviors, and the complex network of relationships among them. The raw data consists of the diagnostic assessment compiled during the diagnostic phase of treatment and the treatment notes. The diagnostic assessment contains medical, educational, social, psychological and developmental histories for each subject and her family in ascending chronological order up to the age of the treatment in process or treatment termination. The mother was usually the main source of information but there are also contributions from the anorectic patient, other family members, and the school and family physicians when they were responsive to the request for information.

The data on each subject is maintained in a separate file under a

disguised name for the research. The data on each subject was studied in an effort to identify psychological issues and faulty adaptive patterns which are unique to each subject's development. Insights gained from psychotherapy and any new historical data gained in the ongoing psychotherapeutic work were integrated with the information obtained during the diagnostic assessment phase. Data from psychotherapy sessions subject to symbolic interpretation were reported as footnotes to keep them separate from factual reporting of events and feelings.

The underlying assumption of the retrospective method in the research of psychopathology is that developmental continuity is the bedrock of most psychopathological theories (Millon and Diesenhaus, 1972). By a retrospective investigation of past histories an attempt is made to deduce the distinctive events of their past which may have produced the problem in question. However, causal interpretations need to be regarded with some suspicion and any hypotheses generated from the data subject to further research. On the positive side of the case study method, including ex post facto data, is that it affords opportunity for the researcher to

> draw upon the full range of his observational and intellectual powers to speculate and probe new ideas, to move flexibly and unimpeded in his explorations of the highly interwoven and qualitative character of natural pathologic functioning. Unconstrained by the demands and rigors of more formal procedures of inquiry, he may uncover new directions and subtleties that can rarely be generated in more tightly controlled studies. These new speculative notions may then, in turn, be investigated through more refined, objective, and systematic procedures. (Millon and Diesenhaus, 1972, p. 56)

Theoretical Framework

Retrospective research studies carry an assumption of developmental continuity (Millon and Diesenhaus, 1972) such that early life experiences

comprise an "antecedent chain of events that give rise to and shape the character of later emotional impairments" (p. 54). The developmental crisis that occurs at the interface of the anorexia and adolescence is considered in this research to derive from failures in some prior developmental phases. This viewpoint is compatible with psychoanalytic theory which postulates a deterministic view of development. John Sours (1980), a well-known psychoanalyst and a leading contributor to the study of anorexia nervosa states:

> Anorexia nervosa, it is clear, is a developmental and psychosomatic syndrome (Nemiah, 1972), which is associated with certain psychopathologies and characterological styles (p. 223).

This viewpoint differs somewhat from the developmental theory of Hilde Bruch (1973) which puts more emphasis on biological development and interpersonal actions.

> My emphasis on early feeding experiences as a pacesetter for infant-mother interaction does not imply an effort to revive the old psychoanalytic hypothesis that the gratification of oral drives foreshadows in a deterministic way later personality traits and emotional health or sickness (p. 64).

The differences between the two developmental theories in understanding psychological forerunners of anorexia was discussed in more detail in the review of the literature. However, because Bruch has been such an outstanding presence in the study of anorexia, it is important to note that her interpersonal theory is compatible with the concept of developmental continuity even though it does not encompass all the principles of psychoanalysis nor utilize the language of psychoanalysis in all instances. This semantic detour has been made to show that though a psychoanalytic framework has been chosen for the

research, the author is mindful of Bruch's contributions to the psychogenetic understanding of anorexia nervosa (Bruch, 1977) and will not exclude them.

To sum up, the research data were examined along developmental lines within a psychoanalytic framework in which the etiology of anorexia nervosa was explored using six treatment cases of the author. The focus was on the mother-child interaction and the functioning of the pre-anorectic as manifested in the historical data and in the psychoanalytically oriented psychotherapy. Margaret Mahler's description of the mother-child dynamics that take place from birth to three years of age was the background for delineating the separation-individuation process for each case. Peter Blos's theory of the second individuation process was used to provide the background for understanding the vicissitudes of the individuation process of adolescence.

Variables to be Investigated

It was necessary to identify those variables which appear to be the most relevant to the research questions. The method for doing this was to take one of the six cases and use it as a prototype for searching out factors that have a crucial bearing on developmental issues and adaptation. The case chosen for this purpose is designated the Valerie K case. Valerie's case was selected mainly because the background information on Valerie and her family is the most complete. Also the subject has been in therapy the longest of the subjects, three years, which provided the researcher the opportunity to observe the subject's functioning over a longer period of time, from age 12 years and 10 months to 15 years and 10 months.

Six factors appeared to be the most significant in the Valerie K case in relation to the research questions. These factors were then examined in the other five cases in a focused, systematic manner and were retained as the variables for all six cases. A seventh factor also emerged as an important variable for all the cases and was added. The final list of variables to be studied was:

1. The mother's laissez-faire attitude* toward this child from the time of conception.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty.

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic.

4. The confused attitude of the girl toward her developing sexuality.

5. The mother's negative view of aspects of her feminine role.

6. The well-functioning facade of the family before the girl becomes anorectic.

7. Unexpected events associated with the birth of the child.

The factors listed above are the research variables which were investigated for all six cases. In order to do the case reviews in a systematic and clearly defined manner, the variables were broken down into smaller components. These components provided operational boundaries for the investigation of the six variables. The following statements define the variables as they were found to exist in the six

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*For purposes of this research, "laissez-faire attitude" means a range of non-assertive attitudes from avoiding conflict with the child to avoiding the child.

cases:

1. The mother's laissez-faire attitude toward this child from the time of conception.

    a. Avoidance of important issues of the pregnancy.

    b. Relinquishment to others of many caretaking activities during early development.

    c. Avoidance of being involved and dealing with conflict about discipline unless the child's behavior precipitated a crisis.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty.

    a. Greater activity in the infant care.

    b. Doing special favors for this child.

    c. Terminating the close involvement in late latency.

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic.

    a. The importance of the peer relationships.

    b. The importance of the sibling relationships.

4. The confused attitude of the girl toward her developing sexuality.

5. The mother's negative view of aspects of her feminine role.

    a. Locked into domesticity through duty.

    b. Husband emotionally detached from her.

6. The well-functioning facade of the family before the girl becomes anorectic.

    a. The high achievement of father and children.

    b. The mother's visible support of the achievers suggesting a high degree of togetherness to the outside world.

7. Unexpected events associated with the birth of the child.

Although Valerie's was the prototype case, the author maintained flexibility in the final choice of variables to select those that were most common to all six cases.

Sampling

The sampling frame used for this research was a small group of accidental (volunteer) subjects -- clients who were referred and who elected psychotherapy. Selection of the six cases was from the total number of 12 female anorectics referred to the author in the past three years. Those selected were the first six that met the following criteria.

1. A diagnosis of primary anorexia nervosa according to the "Diagnostic Criteria for Use in Psychiatric Research" (Feighner, et al., 1972) plus the phenomenological criteria outlined by Hilde Bruch (1973) which includes Feighner's criteria but is more descriptive. Both sets of criteria encompass DSM-III. See Appendix I, Table 3, for all three definitions of the diagnosis.

2. The subjects are female.

3. The subjects remained in treatment at least three months.

4. The subjects had not reached their eighteenth birthday at the time of referral.

The researcher was the clinician who interviewed patient, families, and significant others, when available, for the initial assessment data required during the diagnostic phase of treatment. The researcher is aware that this may have introduced some consistent bias in the focus and interpretation of the diagnostic interviews. This possible bias was at least somewhat mitigated by reports from the school and from the family doctor as well as by collaborative meetings with other professionals

involved with the case. The fact that the therapeutic approach was multi-dimensional, involving a family therapist, an individual therapist, and a pediatrician or internist to monitor the physical health of the patient tended to correct for individual biases and countertransferences. For five of the cases the "team" conferred on a regular basis, the conferences diminishing as the patient improved. On the other case, collaborative conferences were held over the telephone because of geographical distance. The collaborating members of the team helped to introduce other perspectives in understanding the ongoing material from treatment as well as the diagnostic information.

Confidentiality

In order to facilitate following the discussions and references to each case, some identifying data for each case have been collected in Table 2 of the Appendix. Each case is basically identified by a fictitious name which has been assigned for the purposes of this research. To further protect the confidentiality, geographical locations have been omitted as have physical descriptions of subjects or family members. Since the study will only use selected variables, the total identity of any one family is not revealed. The fact that the six research cases were not active at the initiation of the research study removed the contaminating effect of the research on the ongoing psychotherapy.

CHAPTER IV

Presentation of the Research Data

This chapter presents the research data for each subject. Preceding the data is a brief overview of the history, family situation, and therapy contact for each girl to provide a more unified view of each subject.

Valerie was referred at age 12 years 10 months following several prior therapeutic attempts. She weighed 64 pounds at a height of 4 feet 9 inches. Her eating problem started two years previously coincident with the death of her uncle and the loss of two girlfriends who lived in the neighborhood. Valerie started by removing ice cream, her favorite food, from her diet. With each subsequent disappointment or loss Valerie removed another sweet or carbohydrate from her diet. Although the two girlfriends were replaced with two other girlfriends, the replacements also departed from the neighborhood as did a favorite teacher. By this time Valerie had become very whiney and irritable and had restricted her diet mostly to protein products she could prepare herself, such as bacon or hot dogs. When the family took a cruise the summer she was 12 years old, the mother decided to leave her with relatives because the mother thought Valerie's problems would spoil the family's vacation. When the family returned Valerie had practically stopped eating and was exercising after every meal. Two months later she was hospitalized on a psychiatric unit for three months. She was discharged home as her sister was preparing to go away to college. Self-starvation was resumed and outpatient psychotherapy was strenuously resisted. At that point the mother contacted Hilde Bruch who made the referral that became part of this project. Outpatient psychotherapy was instituted three times a week for Valerie, once a week for the parents, and family sessions monthly. Psychotherapy continued for 41 months. The self-starvation gradually* disappeared; menarche was established at age 14 years 10 months. The family consisted of father, age 47, physicist; mother, age 45, college graduate and homemaker; sister, age 19, college student living away from home; and brother, age 17, high school student.

1. The mother's laissez-faire attitude toward this child from the time of conception

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*Adequate nutrition was insured during this time by the prescription of a food supplement by the pediatrician on the team.

a. Avoidance of important issues of the pregnancy

Valerie was conceived when her siblings were ages four and six. Now that both children were in school, Valerie's mother wanted another child so she would not be expected to go to work. During the pregnancy, the mother gained only two pounds and after delivery she wieghed eight pounds less than at the beginning of the pregnancy.

The mother experienced the delivery as two to three weeks premature. The evidence is that delivery was past due since Valerie was born with blisters over her body, a usual indication of an infant past term.

b. Relinquishment to others of many caretaking activities during early development

The father got up for the night feeding or if the baby cried during the first few months. The brother, aged five, climbed into Valerie's crib in the morning if she were crying to soothe her until a parent arose to take care of her. The sister, aged seven, walked Valerie in her carriage most every day. Valerie screamed at the approach of female strangers and the sister was left with the responsibility for comforting and calming her.

Both the brother and sister included Valerie in their play activities with other children until she was around five or six. Valerie was "the little doll" of the neighborhood, and her older brother and sister spoke for her and protected her.

c. Avoidance of being involved in dealing with conflict about discipline unless the child's behavior precipitated a crisis

The mother had expressed a desire to be more permissive

with Valerie than she had been with the two older children. However, when this attitude did not succeed in achieving desirable results the mother could be very punitive. One example is when Valerie at age three refused to eat anything for lunch but cookies, the mother claims to have withheld food from her for several days.

When Valerie first attended nursery school at age three, she cried so much the mother gave in and stayed with her at the nursery school. Yet at age 12 as Valerie became more irritable and whiney following a continual loss of her best friends, the mother left Valerie behind when the family took a cruise because she did not want to be annoyed by the child's mood. Valerie had already been curtailing caloric intake but it was at this point that she practically stopped eating.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty

a. Greater activity in infant care for this child

The father got up for the night feeding or if the baby cried during the first few months.

b. Doing special favors for this child

He built her a doll house that was the envy of the neighborhood.

c. Terminating the close involvement in late latency

The father stated that he did not know how to treat girls once they started to grow up. Although he no longer held her on his lap, he did continue to use the endearments of pre-latency such as "honey" and "sweets."

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic.

a. The importance of peer relationships.

At age 10, two of her very good friends in the neighborhood moved away. These were two sisters that Valerie played with all the time. When they moved away, she became very irritable and stopped eating ice cream. She found two new friends to replace these girls in a few months but soon they moved away too. After that, she eliminated more sweets from her diet.

During the course of psychotherapy, as Valerie improved, she made close friends with three younger girls in the neighborhood. They ranged in age from 11½ to 13 when she was 14. The mother observed that in their presence Valerie was spontaneous, lively, and assertive. When in the classroom or at home without these younger friends, Valerie was described as "excessively shy" by her teachers and as "angry" and "non-communicative" by her family.

b. The importance of sibling relationships.

Valerie's older sister went away to college a few weeks after Valerie was discharged from the hospital* for her anorexia. When the sister departed, Valerie regressed, stopped eating and refused psychotherapy. It was after this trauma that Valerie was

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*This was prior to the referral of which this research is a part.

referred to this investigator.* The early close ties with both her older siblings have already been described in 1b.

4. The confused attitude of the girl toward her developing sexuality

Valerie told her mother that she did not want children; that she considered menstruation disgusting. She also refused mother's offer to buy her a training bra. However, she accepted enrollment in a modeling school and spent a great deal of time on her appearance. She denied any interest in boys and would not attend the school dances. At age 13 when her peers showed a growing interest in boys, Valerie turned to younger friends who were one to three years younger than she was. Her menses started when she was 14 but she did not tell her mother right away and wished to avoid wearing any protection.

5. The mother's negative view of aspects of her feminine role

a. Locked into domesticity through duty

The mother was very particular about cleanliness and orderliness. The children helped her very little as she was too hard to please. She did not feel justified to hire anyone so that she did most of the work herself and felt over-burdened and used. If the

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*A sequence in play therapy with Valerie in the second year of treatment suggested she wished her sister was her twin. In her play with the doll house and the dolls, Valerie was finding increasing pleasure in presenting herself as a twin. One day in the play, she became quite rebellious in her interaction with the mother figure around wearing or not wearing a sweater to school. Her verbalizations became lively and spontaneous, quite unlike her usual reticence to communicate in psychotherapy. She told the therapist that she wished she had a twin because then the two of them "could stand up to mother." In her play acting in which she did not give herself a twin, she presented very compliant behavior to mother.

children left a mess anywhere, they could become the object of her outrage. One day Valerie let the dogs into the kitchen after the mother had just washed the floor. The mother is reported to have yelled and screamed at Valerie so severely that Valerie could not sleep until she had written her mother a note of apology and love which she handed to her mother at three o'clock in the morning.

b. Husband emotionally detached from her

The mother complained that she could not easily engage her husband in a verbal exchange either on conflictual matters or just for a sharing of feelings. He was a very self-contained person and the wife claimed that she never knew when she had reached him. When angry, she would yell and scream at him in an attempt to obtain a response. During one of these outbursts when Valerie was eight, the mother threw a chair against the wall, broke the chair, and made a hole in the wall in an attempt to attain her husband's attention. She said it was a fruitless attempt and she never repeated the throwing behavior although the yelling and screaming continued.

The father was not generally available to any family members except for concrete services such as transportation or help with homework. Otherwise, he watched a lot of television or was engaged in his projects from work. The children got into the habit of discussing problems and events with their mother almost exclusively.

Both parents claimed their sex life was satisfactory, but neither parent wished to discuss it.

6. The well-functioning facade of the family before the girl becomes anorectic

a. The high achievement of father and children

The father had a master's degree in a scientific field and one year toward his Ph.D. from a prestigious university. He held a well-paying, responsible position and was trusted to represent his firm all over the country. If any new technology became important to the company, the father was usually the employee who was given special training.

The older sister was an A and B student in high school; she was elected to class offices; and was popular with students and teachers. She was never a behavior problem at home or school.

The older brother was a straight A student with very little effort. He excelled in water sports and was given a paid teaching position by the school during the summer before he was a senior.

Valerie had been an average student until age 10 when she lost two close friends in the neighborhood and began curtailing caloric intake. At that time she became an A and B student and her behavior became practically perfect. If a teacher wanted to quiet a student, she would seat the student next to Valerie who appeared to be incorruptible.

b. <u>The mother's visible support of the achievers, suggesting a high degree of togetherness to the outside world</u>

Although the mother was a college graduate with a degree in elementary education, she did not seek a career outside the home but devoted herself almost entirely to supporting the activities of husband, children and community. She was active in her children's projects and was a leader in adult affairs of the community. She involved her husband in her activities and he passively cooperated.

7. Unexpected events associated with the birth of the child

a. Valerie was born with blisters over her body necessitating her being in isolation for 24 hours after birth. She weighed about a pound less than her other two siblings.

b. A few weeks after birth Valerie developed two hemangiomas which sealed themselves off at one year. By age 13 they had almost disappeared.

c. Valerie was highly irritable with strangers in early infancy, especially women.

Cathy was referred by the family doctor at age 11 years 3 months because of a continued weight loss dating from her brother's five brain surgeries which occurred 18 months previously. Cathy lost 10 pounds at that time and although she was in a rapid growth spurt did not regain the weight, remaining at 82 pounds at a height of 5 feet 3 inches. Several other medical emergencies, losses or changes occurred subsequent to the brother's operations. Six months before the referral the mother fell and broke her hip, the paternal grandfather died of cancer, and Cathy's twin sister broke her arm. A neighborhood boy who had been Cathy's "boyfriend" rejected the relationship in this same time span. This was also a period when the twin was seeking some distance from Cathy, was showing anger to the entire family, and had been referred for psychological help. Cathy received twice a week outpatient psychotherapy with monthly sessions for the family and weekly sessions for the mother. The psychotherapy continued for 17 months. The self-starvation disappeared within the first three months of treatment; the other somatic symptoms diminished but did not disappear. Menarche began at 12 years 6 months of age in the fifteenth month of treatment. The family consisted of father, age 37, college graduate and a vice-president of a bank; mother, age 37, high school graduate and a homemaker; brother, age 13, student in junior high school; and a twin sister, student in junior high school.

1. The mother's laissez-faire attitude toward this child from the time of conception

a. Avoidance of important issues of the pregnancy

The mother was unaware that she was carrying twins until the delivery. Also the father only wanted one child which the couple

already had. Conception of the twins is alleged to have taken place after a dance at which the husband was noticeably attentive to other women. The mother claims to have come home drunk and angry and had intercourse without protection, resulting in the pregnancy.

b. Relinquishment to others of many caretaking activities during early development

The mother did not transfer her caretaking activities because there were no available helpers. The two grandmothers said they were too ill to help out and the husband was traveling most of the time. The family lived in a rural area, miles from the nearest neighbor, and also moved about every six months so that there was no social support system either. The mother remembers being overwhelmed and depressed with breast-feeding two infants plus another child in diapers. Cathy's regression in the therapeutic sessions suggested that she at least perceived herself as having unfulfilled longings for more of mother's attention as an infant.*

c. Avoidance of being involved in dealing with conflict about discipline unless the child's behavior precipitated a crisis

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*For the first month and a half the mother nursed the twins simultaneously, one at each breast. In the third week of therapy Cathy entered the psychotherapy session with a carton of milk in one hand and a carton of juice in the other. As she sipped alternately from them, her expression was very content. She did this for a month at the beginning of each session.

She also acted out being a baby in a crib. She would lie on her back on the floor and engage me in retrieving the nerf ball for her. When I recaptured it and I tossed it back to her she would chortle with delight. After five or 10 mintues of this interaction she would return to the present reality and apologize for making me work so hard. This went on for several weeks. By the time she gave up this regressive behavior, the symptoms of anorexia were no longer a serious problem.

The mother was not very effective in setting limits or obtaining a response to her authority from any of her children except Cathy. With Cathy she was able to get a sympathetic response by tears and self-pity. Cathy would then become compliant and relieve her mother's frustration. As a reward she became mother's favorite. The twin was more often the object of both parents' anger.*

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty

a. Greater activity in infant care for this child

There was no evidence in the record that the father gave infant care to any of the children.

b. Doing special favors for this child

The father favored Cathy's compliance but his only known reward was not to shout and yell at her.

c. Terminating the close involvement in late latency

There is no evidence that the relationship changed.

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic

a. The importance of the peer relationships

Cathy became anorectic when she was almost 10 years old. Besides her twin sister she had few friends up to that time. The summer she became anorectic a neighborhood boy who had been friendly to her stopped paying attention to her.

b. The dependency of the sibling relationships

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*The twinship provided a handy vehicle for the splitting of the mother's and father's ambivalence.

The twins had their own secret language until the age of three or four. The twinship remained close in the primary grades. Besides the twinship itself which fostered closeness, they clung to each other to present a united front against the teasing they received because of a genetic anomaly about the eyes. The brother had two different colored eyes. The school children called him a "Martian" which carried over to the twins who had a wide spacing of the eyes. Cathy, when she first came to psychotherapy, had designed a logo for their T-shirts reading "Twin Power." However, Cathy's twin showed more desire for some freedom from the twinship than Cathy.*

5. The mother's negative view of aspects of her feminine role

a. Locked into domesticity through duty

The mother did not enjoy housekeeping chores but did find gratification in creating decorative items for the home through sewing. It was not unusual for dirty dishes to be in the sink and beds unmade when the father came home from work. The sewing in process was often strewn about the living room. The untidy home was a constant source of friction between the mother and the fastidious, orderly father. The girls sided with the mother against the father so that he ranted and raved against all three of them when the house was upset.

The mother did not enjoy cooking either. Although she was very involved in knowing about vitamins and minerals, the family would

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*Cathy remained more submissive and somatized with headaches and diarrhea. (It should be noted that as Cathy began recovering, the twin started losing weight and she was assigned an individual psychotherapist too.)

often have the same thing for dinner several nights in succession.

The mother suffered from dysmenorrhea and the entire family knew when she was suffering from her period. She claimed that her husband was unsympathetic and wanting sex even at these times. She resented his sexual advances in general and "submitted" in order to "appease" him.

b. Husband emotionally detached from her

The mother experienced the father as very domineering. Up until Cathy's anorexia her greatest defense against his dominance was passive resistance, but through the course of psychotherapy she became a little more assertive. The father showed the most sensitivity toward his son who evidenced kinesthetic and cognitive handicaps as a result of the brain surgeries.

6. The well-functioning facade of the family before the girl becomes anorectic

a. The high achievement of father and children

The father was a college graduate and in six years had worked his way up to a vice presidency of a bank. The son, until his surgery, was a good average student, played in the school band and was outstanding on citizenship ratings. The semester she became anorectic the teacher wrote on her report card that it was a "joy to have her around."

b. The mother's visible support of the achievers, suggesting a high degree of togetherness to the outside world

The mother had one year of college when she married, but did not return to school. Instead, she became very active in self-help

groups such as Overeaters Anonymous and Alcoholics Anonymous although she was neither obese nor alcoholic. The family's social life centered about these group meetings or visits to the grandparents. The father enjoyed the outdoors and planned backpacking trips for summertime vacations. The mother supported the father's trips and took a leadership role in the self-help groups. The family was isolated from other families except for participating in self-help organizations. Cathy's twin described the family as "operating off one brain." The mother drove the three children to their many appointments, including school.

7. Unexpected events associated with the birth of the child

The conception was a surprise to the father. The birth of twins was a surprise to both parents.

Cathy was born with a hemangioma on her cheek which cleared up when she was around three.

Both twins had mild facial characteristics of an unusual genetic syndrome (Waardenburg Syndrome).

Wilma was referred by a family friend at age 10 years 3 months when the psychotherapy Wilma was receiving in the small mid-western town of their residence was ineffective. Wilma had lost 30 pounds in the preceding five months, going from 106 pounds to 76 pounds at a height of 5 feet 1 inch. The weight loss started as dieting to lose a few pounds but did not stop, becoming critical when the parents took a three-week vacation without Wilma. Her best and only girlfriend had moved away so she was left with adult friends of the parents. When the parents returned from their vacation Wilma had practically stopped eating, was depressed, did not want to go to school, and was confused by the "voices" who admonished her not to eat even when she was hungry. The mother became frightened at the continuing regression and made plans for the three of them, mother, father, and daughter, to move in with friends in California temporarily while they sought help for Wilma in a more metropolitan area. Wilma received outpatient psychotherapy

twice a week individually and once a week with her parents. The brother attended two family sessions. Treatment continued for three months and then the parents decided to return home and resume with the former psychotherapist who was now obtaining consultation from a state facility. The parents phoned a few months later to say that Wilma was eating better and was happier. The family consisted of father, age 48, who owned his own retail business; mother, age 45, who worked part-time in the father's store; and a brother, age 20, who worked in California. Father, mother and son were high school graduates.

1. The mother's laissez-faire attitude toward this child from the time of conception

a. Avoidance of important issues of the pregnancy

Pregnancy came as a big surprise, see item 7.

b. Relinquishment to others of many caretaking activities during early development

Wilma was born in the sixteenth year of a close marriage and the mother did not want the birth to interfere with her established routine any more than absolutely necessary. She returned to her part-time bookkeeping job when Wilma was three months old, leaving her with a baby sitter two days a week until the age of two. At age two she was put in nursery school for two full days a week until the age of three and one-half. At three and one-half the mother made arrangements to trade off baby sitting with a friend several days a week and this was in effect until Wilma started kindergarten.

When Wilma was 15 months old the family resumed their three-week "adult" vacations on which they took the brother but left her with another family. When they returned after the first one, the baby sitter had toilet-trained Wilma. Throughout her life the parents left her with others while they vacationed. Her anorectic illness had begun prior to their last vacation, but the parents did not notice it

until the brother pointed it out upon their return.*

c. Avoidance of being involved in dealing with conflict about discipline unless the child's behavior precipitated a crisis

There was no evidence in the record that Wilma rebelled against any authority of the parents until the conflict regarding eating. From all accounts, prior to the anorexia she had been a most obedient and compliant little girl. Her struggle between the anorexia and pleasing her parents was concretely expressed by an inner voice that interferred with her desire to eat and warned her not to do it. Sometimes the voice came from her head and sometimes from her stomach. The mother became too upset to deal with the conflict and wanted to go on an "adult" vacation. The father alternated between humoring his daughter with bribes or by threatening her with some kind of abandonment as the mother did.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty

a. Greater activity in infant care for this child

The father was very pleased with the birth of the second child and particularly pleased that it was a girl. He got up for the night feedings in place of the mother. Occasionally he gave daytime bottle feedings. He took Wilma into the shower with him when she was one to three years of age. He would hold her in his arms and "let the water pour over them."

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*The mother was more concerned with Wilma's precocious breast development at age 9 years 10 months and "warned" her of the impending menses.

b. Doing special favors for this child

The record did not show any evidence of this.

c. Terminating the close involvement in late latency

Wilma's physiological latency was coming to an end when she was nine and one-half years old. His relationship to Wilma was not known to have changed except that on her part she was becoming afraid of his anger.

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic

a. The importance of the peer relationships

Late latency for Wilma was around eight or nine. Her best girlfriend moved away the summer that she was nine. She had started to "diet" the preceding spring but the weight loss accelerated with the departure of her best friend and her parents' vacation. She lost 30 pounds in five months.

b. The importance of the sibling relationships

Neither Wilma nor her parents described a close relationship between the two siblings, although the brother revealed a "silent" identification with his sister in a surprise family session. Refer to 5b below.

4. The confused attitude of the girl toward her developing sexuality

Wilma had an early pubertal maturation with noticeable breast development by age nine and one-half. She was also very tall for her age and felt very self-conscious about her growth, both at school and with neighborhood children. Her dieting reduced the breast

development and delayed menarche. The mother had "warned" her to expect her menses soon and described them in very negative terms.

5. The mother's negative view of her feminine role

a. Locked into domesticity through duty

Wilma's mother was sexually inhibited in her marriage until the death of her mother in the eleventh year of the marriage. She went into a depression until her husband told her to "snap out of it" or he would divorce her. A few months later she became pregnant with Wilma. She resented the pregnancy but tried to fulfill her obligations to the child. The mother's menses began at age 11 and she viewed it as something negative and presented it that way to Wilma.

b. Husband emotionally detached from her

The parents appeared satisfied with their relationship once they had a better sex life. The emotional detachment appeared in relation to the children. Neither parent had been aware of their children's unhappiness in growing up. In a family meeting the son brought out his agony at being unusually tall for his age. The mother remembered the school had recommended psychological help for him when he was in grammar school but they had not followed through. It was actually the son who pointed out to the parents that Wilma was becoming alarmingly thin.

6. The well-functioning facade of the family before the girl becomes anorectic.

a. The high achievement of father and children

Though the father was only a high school graduate, he founded a successful business on his own. The brother was an average

student in school but did well in athletics; he was no discipline problem. Wilma was an A-B student; and was no discipline problem. Although Wilma did not have many friends, she got along very well with adults.

b. The mother's visible support of the achievers, suggesting a high degree of togetherness to the outside world

This was an intact marriage of 26 years in which the parents lived as a childless couple much of the time. The mother was a willing helpmate in her husband's business, but there is no evidence for any special support of the children's activities. It was not until Wilma became anorectic that family planning was centered around a child's needs.

7. Unexpected events associated with the birth of the child

Wilma was born 11 years after her brother. The mother never expected to conceive a second child because the father had fertility problems which the doctor said would increase with age. The mother had not wanted a second child but did not think it necessary to use any birth control methods.

Frances was referred by her pediatrician at age 13 years 6 months after a weight loss of 20 pounds in six months, going from 94 pounds to 74 pounds. She was also irritable, negativistic, and becoming a loner at school. Several losses occurred at the time Frances started reducing her caloric intake: the death of the maternal grandfather and the loss of her two best girlfriends because their parents divorced and they moved out of the neighborhood. Her older brother's beginning his first steady relationship with a girlfriend was also a loss in her personal relationships at this time. Frances received individual outpatient psychotherapy twice a week and family therapy with her parents and her brother once a week. When, after four months, she was eating more normally and weighed 88 pounds, the mother terminated everyone's psychotherapy. Menarche had not yet appeared. The family consisted of father, age 42, college graduate and vice president of marketing for a large manufacturing company; mother, age 41, college graduate and homemaker; and a brother, age 15, high school student.

1. The mother's laissez-faire attitude toward this child from the time of conception

a. Avoidance of important issues of the pregnancy

The mother did not report anything special about the conception or pregnancy except that she was "afraid not to get pregnant." It took four years to conceive the first child.

b. Relinquishment to others of many caretaking activities during early development

Frances' only sibling, a brother, was 18 months old when she was born. For the first seven weeks, Frances' mother had the help of her mother and her grandmother who came and lived with them. After they left the father took over Frances' care when he came home from work. He diapered, fed, and bathed her.

Toilet training occurred while Frances was visiting the maternal grandmother. Frances' mother claimed that Frances did it herself; she did not remember the age. The mother also did not remember at what age Frances began talking.

c. Avoidance of being involved in dealing with conflict about discipline unless the child's behavior precipitated a crisis

The brother was encouraged to grow up but Frances was not. Whereas the 15-year-old brother was permitted to take overnight trips with his 17-year-old girlfriend, Frances did not yet attend boy-girl parties. She spent a lot of time in her mother's company, was very compliant, and was rewarded with clothes of her mother's choosing. When after a few months of psychotherapy Frances became more assertive, it precipitated a major crisis between them. Frances took the initiative in preparing her own food and the mother criticized what

she had prepared for herself. The girl became so enraged that she took a kitchen knife and threatened to kill her mother. The brother intervened and "rescued" the mother who was reported to be completely immobilized by Frances' behavior. The father who had not been home returned and restored the equilibrium of the family by his support of Frances.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty

a. Greater activity in infant care for this child

He diapered, fed, and bathed her as an infant.

b. Doing special favors for this child

He woke her up for school in the morning; drove her to school if she was late; helped her with school projects. She had a collection of 25 dolls he had brought her from his travels.

c. Terminating the close involvement in late latency

The father began spending more time with his son once the boy became active in sports. Dad became coach of his son's baseball team and then also had more in common with Frances' brother. He stated that it was easier for him to understand teenage boys than teenage girls.

3. The importance of peers and/or silbings in the support system of the late latency and early adolescence of the pre-anorectic

a. The importance of the peer relationships

Around six months before the onset of the anorexia, the parents of her two closest girlfriends from latency began divorce proceedings. Frances started "dieting" around the time the girls moved out of the area and she was soon anorectic. She tried to make new

friends but seemed to lack confidence to sustain the new relationships. She very easily felt rejected and retreated from new relationships. Instead, she started looking more toward her brother to help with her social life.

b. The dependency of the sibling relationships

The brother was very outgoing, had a good sense of humor and had many friends including a steady girlfriend. When Frances would not be invited to a special event she would ask to go with him and his girlfriend. He often good-naturedly included her.

4. The confused attitude of the girl toward her developing sexuality

Frances was very interested in being attractive to boys but she was shy and insecure with peers of both sexes. The mother terminated psychotherapy before Frances' menarche and encouraged her to become involved in the track and baseball teams. Frances complied although she was not a very good athlete. Although Frances was almost 14 years old the mother showed no concern about her sexual development. The mother viewed her own menses as an undesirable attribute of womanhood.

5. The mother's negative view of aspects of her feminine role

a. Locked into domesticity through duty

The mother was very well organized and her home was clean and well run. Her feelings about housekeeping chores were not revealed in the record.

b. Husband emotionally detached from her

The mother felt that her husband did not really listen

to her, but would try to turn the argument into a joke and tease her rather than give her serious attention. He would, in her opinion, make fun of her feelings rather than relate to them.

6. The well-functioning facade of the family before the girl becomes anorectic

a. The high achievement of father and children

The father, a college graduate, was a vice president of marketing in a large manufacturing company. The son was an A student, good in athletics, and popular with both boys and girls. Frances was an A-B student, with a lot of studying, and was elected to offices on the student council, Neither child was a discipline problem in school. The father was an athletic coach in his leisure time and excelled in athletics himself.

b. The mother's visible support of the achievers, suggesting a high degree of togetherness to the outside world.

The mother was a college graduate but never worked outside the home. She was active in PTA and in the women's auxiliaries that supported her son's athletic teams. She was easily available to drive groups of young people to sporting events or to school events. Though not athletic herself when Frances joined a softball team, she agreed to be a manager.

7. Unexpected events associated with the birth of the child

a. The conception, nine months after the birth of the first child, was unexpected inasmuch as it took four years for the mother to conceive the first time.

b. Projectile vomiting at three months of age.

Betty was referred by the family doctor at age 14 years 10 months, three months after her weight loss became noticeable. In six months she had lost 30 pounds, going from 113 pounds to 83 pounds at a height of 5 feet 4-3/4 inches. Menarche had appeared at age 12 but disappeared during the weight loss. Mood was depressed and negativistic. Six months preceding the weight loss the mother had stopped preparing evening meals and started devoting more time to her decorating business. The father had taken a separate residence two and one-half years previously but had retained a close relationship with wife and children with some hope of reconciliation. When the mother became impatient with this arrangement she began spending more time in building up her business and was less available to her daughters than usual. At the same time Betty's twin was establishing friendships separate from Betty. Betty received individual psychotherapy twice a week and the parents had conjoint therapy once a week. Betty made a rapid weight gain and after four months insisted on discontinuing psychotherapy.* Menses reappeared a few months after termination. The family consisted of father, age 40, two years of college, owner and president of his own manufacturing company; mother, age 39, college graduate and interior decorator; and Betty's twin sister, high school student.

1. The mother's laissez-faire attitude toward this child from the time of conception

a. Avoidance of important issues of the pregnancy

Mother conceived in the second month of the marriage. Although the parents had planned not to have children for several years, no birth control method was used.

The mother was not prepared for a twin birth even though twins ran in her family. She claims that the obstetrician only heard one heartbeat before delivery. This may have been due to the fact that the mother delivered two months prematurely.

b. Relinquishment to others of many caretaking activities during early development

The mother received a great deal of assistance with the

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*Betty started with a different therapist two years later because of a drinking problem.

babies during the first year and a half. The maternal grandmother came and stayed for months at a time. During the first year, the father took care of the night feeding and also helped with bathing and diapering. The mother's younger sister, who was a twin herself, also came to help out. With so many people assisting, it was difficult to identify who was the primary person involved in weaning from the bottle and in toilet training.

c. Avoidance of being involved in dealing with conflict about discipline unless the child's behavior precipitated a crisis

Betty's mother viewed herself as having been a model child without any effort on her parents' part. She had been a cheerleader, class president, very popular and had no recollection of ever giving her mother any problems. She expected the same behavior from her twin daughters and was very upset when they rebelled or challenged her. In infancy, Betty was the difficult baby, rocking her crib so hard that she demolished it by the age of four. The mother had no idea why the child was so distressed nor did she have a recollection of trying to soothe her.

In latency, the twin became very aggressive and combative with her peers while Betty became cooperative. In early adolescence, the twin became less aggressive but Betty became very rebellious and anorectic. However, both twins gave their mother a hard time and she alternately punished them by denying them clothes of indulged them with expensive ski trips and trips to Europe. The father left the home when the twins were 12½, leaving the mother to cope with the rebellion by herself.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty.

a. Greater activity in infant care for this child

There is no evidence that he favored one twin over the other in infancy. He took care of both of them. Refer to 1b.

b. Doing special favors for this child.

Until the onset of the anorexia, Betty was the more docile twin and the father was more approving of her.

c. Terminating the close involvement in late latency.

The father left the home when the twins were 12½ and established a separate residence. He continued to date the mother, however, and did not file for divorce. Two years later when Betty became anorectic he offered to return to the home if that would solve her problem, but the mother discouraged him. Both twins expressed the thought that the parents would be reunited after they, the twins, were out of the home.*

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic.

a. The importance of the peer relationships

Up until adolescence, Betty's closest and sometimes only friend was her twin and the friends of the twin.

b. The importance of the sibling relationships.

The girls were very close until late latency when the twin began pulling away from the twinship and establishing some

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*This prophecy has turned out to be true. When the twins were 18 and away at school, the father asked to return to the home permanently and the mother was very agreeable to the offer.

friendships and activities she did not share with Betty. Sometimes Betty would make her twin's friends her friends but she was not able to make friends without her twin sister until after treatment for the anorexia.

4. The confused attitude of the girl toward her developing sexuality

Betty who was 15 at referral was very interested in dating, but her two acknowledged boyfriends were not very available for physical closeness. One was in jail for drunk driving and the other was a paraplegic. Betty attended many coed parties and often came home drunk. Whether there was sexual activity during the parties was not determined. Her mother offered to help provide contraception for her but she refused because she said it was not necessary. Her menses started several months after treatment termination.

5. The mother's negative view of aspects of her feminine role.

a. Locked into domesticity through duty.

The mother did not like domestic chores and she let them slide with the result that the house was seldom tidy. The twins contributed little help except under duress. When the father left the home, housekeeping became more chaotic. The mother started a decorating business, stopped preparing meals, and socialized a great deal, neglecting the home even more.

b. Husband emotionally detached from her.

The father had a strong reaction against anyone controlling him and early in the marriage a control struggle ensued between husband and wife. He seldom came home on time for dinner with the family,

would not call in advance and resented being told about it. When his wife or daughters exacted a promise from him, he might or might not fulfill it. The father appeared insensitive to the mother's need for his emotional support in raising the twin girls and was very critical of her attempts to set limits and enforce them. He did not try to do this, stating that when people (his daughters) are "irrational" he cannot relate to them.

The parents appeared to communicate best in their sexual life. Although the father was not a man to express his feelings verbally and the mother gave in to impulsive outbursts of frustration, in bed they were very mutually satisfying partners and remained sexual partners throughout the separation of six years and eventual reconciliation.

6. The well-functioning facade of the family before the girl becomes anorectic.

a. The high achievement of father and children.

Although the father only had two years of college, while still under 40 years of age he founded a highly successful business manufacturing a precision scientific instrument. The family lived in a prestigious neighborhood and even after the father left the home he maintained his wife and daughters at the same high economic level. The girls were above average students and excelled in skiing and cross-country running.

b. The mother's visible support of the achievers, suggesting a high degree of togetherness to the outside world

The mother transported the twins to all their special

events. She accompanied the father on his business trips, both domestic and abroad. Even during the separation they were a "together" family. They celebrated all birthdays and holidays together and there was mutual support between the parents during a crisis to any family member such as death or illness.

7. Unexpected events associated with the birth of the child

   a. Betty was born a twin.

   b. The twins were two months premature.

   c. Betty had to remain in the hospital four weeks after her mother was discharged and her twin had to remain three weeks.

Brenda was referred at age 14 years 8 months by an adult psychiatrist whom the step-mother had consulted. Brenda had lost 23 pounds in the preceding six months going from 115 pounds to 92 pounds at a height of 5 feet 4 inches. Menses had stopped and her usual sunny disposition had become depressed and irritable. The weight loss started soon after the family moved to another state and Brenda had to make all new friends. Also at the time of the move her oldest brother with whom she had a close, trusting relationship left home to live in Europe. The weight loss became critical four months after the move when Brenda returned home from a month's visit with her biologic mother. She had practically stopped eating and menses had ceased. Brenda received individual outpatient psychotherapy twice a week plus once a week with her parents and occasional family sessions. After two months Brenda was hospitalized at her parents' request. She was discharged back to outpatient after two and one-half months and continued in outpatient for seven months. The parents discontinued the therapy when Brenda started rebelling against the strict religious code of the family. Though no longer depressed, her weight was still at the tenth percentile for her height and the menses had not yet returned. There was evidence that she was maintaining the appearance of an improved diet and yet not gaining weight through shifting over to bulimic symptoms. The family consisted of father, age 46, college graduate and vice-president of a manufacturing firm; step-mother, age 44, high school graduate and homemaker; sister, age 21, college student living away from home; brother, age 19, living in Europe; step-sister, age 19, college student living away from home; brother, age 17, high school student; step-brother, age 17, high school student; and brother, age 11, grammar school student. The biologic mother, age 44, high school graduate, lived in another state and supported herself as a bookkeeper. She shared her home with a long-standing lesbian lover. The father married the present step-mother when Brenda was eight years old.

1. The mother's laissez-faire attitude toward this child from the time of conception

a. Avoidance of important issues of the pregnancy

This was the mother's fourth pregnancy in eight years. Her attitude about this pregnancy is not known as the mother left the father and the five children when Brenda was seven years old.

b. Relinquishment to others of many caretaking activities during early development

The step-mother who knew Brenda since birth through the church claimed that Brenda always looked like a little "waif" in church, not "shiney and sparkling clean."

When the mother left the family, she took only one child with her, the youngest, a boy of five. Brenda, the second youngest, was left to the care of her older sister, age 12, and the "ladies of the church" who took turns looking after the children. The father was away a great deal on business.

c. Avoidance of being involved in dealing with conflict about discipline unless the child's behavior precipitated a crisis

Brenda's early relationship to her biologic mother is not known. The step-mother married the father when Brenda was eight and had no known disciplinary problems with her until adolescence. At that point, Brenda started to express positive feelings for the mother who had left the family and also was becoming less compliant with parental demands. The step-mother felt very threatened by this and withdrew her approval and emotional support from Brenda, calling upon the father to be the disciplinarian. She threatened to leave the marriage if the

father could not control Brenda.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty.

a. Greater activity in infant care for this child

There is no evidence that the father was involved very much in the infant care of any of his children.

b. Doing special favors for this child

Brenda was a pretty little girl and looked a lot like the father. There is no evidence that he did special favors for her, but there is evidence that her sunny disposition and good behavior won her approval from both father and step-mother until adolescence.

c. Terminating the close involvement in late latency

The father was closer to his sons than to his daughters, but he was quite indulgent of Brenda as the youngest female child until she began challenging her step-mother's authority in late latency. That put the father in the middle between the two women and he became increasingly annoyed at Brenda's behavior.*

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic

a. The importance of peer relationships

Brenda's family moved to another state when she was in junior high school. She was thus forcibly separated from a close-knit group of girlfriends she had known for five years and was frightened to attend a new school without them. She began being very

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*At a family psychotherapy meeting he told Brenda he would rather see her die of starvation than lie (to her step-mother) about her eating habits.

perfectionistic about her school work. Although always a good student, now she was not even satisfied with an A but wanted all A+'s. This was the beginning of her starting to lose weight.

b. The importance of the sibling relationships

Brenda's closest sibling tie was to the oldest brother. He was the person in the family that she enjoyed talking with the most because he would listen without criticism and help her with problems and make her feel better. Unfortunately for Brenda this brother left home a month after the family made the big move out of the state. He had been the only one in the family who would discuss the biologic mother with her so she was now without any allies in dealing with her confusion over this "first mother" as she called her.

4. The confused attitude of the girl toward her developing sexuality

Brenda had a lively interest in boys and enjoyed their being attracted to her. She was popular at church dances and other church functions but not yet allowed to go on single dates. She said she did not want any runny-nosed brats running around her house and did not enjoy baby sitting. Her menses stopped at age 15 when she became anorectic and they had not returned a year later when the parents terminated the psychotherapy. At that time she was only at the fifteenth percentile for normal weight for her height and was secretly and gradually becoming bulimic to maintain her low weight and still eat with the family.

Brenda acquired a close girlfriend near the end of psychotherapy who was very athletic and very outspoken. She drove around in an

expensive sport car with Brenda a frequent passenger. Brenda enjoyed the attention from her friend who treated her at times like a date. The girlfriend was evidently quite strong because sometimes she would pick Brenda up and carry her. Whether this was transient acting out of an identification with the lesbian mother or something more permanent was not determined.

5. The mother's negative view of aspects of her feminine role

a. Locked into domesticity through duty.

The biologic mother had five children in 10 years and her husband who travelled a lot did not share household responsibilities. This was a very patriarchal family wherein the father expected the mother to devote most of her time to the children, the home, and the church. The biologic mother rebelled against this when Brenda was around six and the marriage broke up a year later after the mother began living with her lesbian lover. In a letter to Brenda while Brenda was hospitalized, the mother stated she felt "trapped" by the marriage and the children.

The step-mother accepted the father's patriarchal rule in principle and enjoyed the security and protection her husband provided. Sometimes she felt her husband was patronizing of her or did not listen to her complaints, but there were no apparent major problems until Brenda began challenging her step-mother's authority. If the father gave the step-mother less than his total support, she felt rejected and threatened to leave the family. It was very difficult for her to deal with the unhappy, rebellious Brenda partly because she had always been such a dutiful daughter and wife herself.

b. Husband emotionally detached from her

The husband travelled three to four days of every week. When he was home he enjoyed his church duties and the athletic activities of his male children. His first wife wrote in a letter to Brenda that she felt "the church was No. 1, the job No. 2, you kids No. 3, and I was No. 4." The second wife could raise her level of priority by threatening to leave and then the father would listen.

6. The well-functioning facade of the family before the girl becomes anorectic

a. The high achievement of father and children

The father was a college graduate and held a responsible management position in a large manufacturing company. He also held high office in the church. All of his five children and his two step-children were good students although Brenda was the one who excelled with her A's and A+'s. All of the children were well-liked by their peers and were not a discipline problem in school. Brenda was elected to class office after she had been at the new school only six months. In addition, the boys were good at sports and all the children were active in the church youth groups.

b. The mother's visible support of the achievers, suggesting a high degree of togetherness to the outside world

The step-mother worked part-time early in the marriage while the father made his slow but steady progression up the corporate ladder. After a few years she quit her job and devoted herself entirely to the home, to the children's projects and to church projects designated specifically for women. The family went to church together

and took many vacations together until the children were in their teens.

7. Unexpected events associated with the birth of the child.

There are no known unexpected events around Brenda's birth.

CHAPTER V

Summary of Research Findings

This section presents a summary of the data extracted from the records of six completed treatment cases of anorexia nervosa in young females. To help maintain the focus of the research project, the subjects of the two research questions are restated. One question concerns a search for some separation-individuation issues that may contribute to the etiology of anorexia nervosa in young females and the other question endeavors to explore possible kinds of behavior in latency which may obscure separation-individuation problems in the pre-anorectic girl. For both questions, the phenomenon of separtation-individuation provides the developmental umbrella under which the questions are being examined. According to the research plan, seven variables with 12 subheadings have been selected for data collection. Results of that effort have been listed in Chapter 4. What now follows is a summary of the results for each variable.

1. The mother's laissez-faire attitude toward this child from the time of conception

a. Avoidance of important issues of the pregnancy

The evidence here is that all of the mothers had some reluctance to be pregnant at that particular time. For one mother and father it was too soon in a new marriage; for two mothers it was too close to the previous birth; and for Wilma's mother it was a rude disruption of 10 years of married life with only one child. Valerie's

mother "endured" the pregnancy as a lesser evil than working. Brenda's mother was not available for comment, but in a letter to Brenda while Brenda was hospitalized stated she had felt "trapped" by the marriage and the children. From the available data in all the histories, it certainly does appear that some negative feelings about this particular birth became attached to the child from the beginning. Active rejection was not so apparent as letting things slide as much as possible. It is for this reason that I call it a laissez-faire attitude. Although it is a kind of rejection, the term is intended to describe a particular kind of rejection which is very subtle in its passive aspects.

b. Relinquishment to others of many caretaking activities during early development.

In four of the cases (Valerie, Frances, Betty, Wilma), the mother had a great deal of help either from within the family or from baby sitters. In these four cases the father played a very active role in night feedings or night soothings with two of the fathers also bathing and diapering. Cathy's father rather ignored both the twin daughters and their mother, leaving the mother depressed and leaving the twins to console one another. Therefore, in five of the cases the mothers were not the constant and available caretakers. It seems that if available, the mothers used other family members to care for the child as much as possible. This does not necessarily constitute rejection of the child, but indicates a certain lack of interest or investment of energy during the early development of the child by the mothers and not entirely compensated for by care from the fathers.

c. Avoidance of being involved and dealing with conflict about discipline unless the child's behavior precipitated a crisis.

It was difficult to frame the precise words to describe the interactions between mother and daughter over discipline and limit setting that appeared in the records of the history and psychotherapy. What emerged as a common factor in five of the cases was a certain unwillingness or inability of the mother to set behavior limits until the misbehavior annoyed her sufficiently. Limits were not necessarily set to teach self-discipline but to relieve the mother's frustration. It was the point at which the girl's behavior got on the mother's nerves that the mother took action. If the girl then resisted the mother's authority, a crisis would ensue in which either the mother gave in or the child gave in. I am indebted to Hilde Bruch for some further insight into this mother-child interaction. In a personal discussion with her, she pointed out how it is difficult for these mothers to negotiate a compromise solution, but that they must see everything in black or white,* either their way or the child's way. The mothers managed the discipline better with their other children because the rigidity of their authority was more consistent and predictable from the start. With their other children the mothers applied firm limits early on rather than waiting until they ran out of patience. This indicates a very subtle difference between the mothers' interaction with the anorectics-to-be and their siblings. The siblings often thought the anorectic girls-to-be (Valerie, Cathy,

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*All the mothers had some compulsive personality traits, with associated depression.

Brenda) "got away with murder" while the girls themselves thought their mothers unreasonable.

In summary for this variable, the mothers appeared to have had too little energy or too little patience to be involved on a reasonably empathic and consistent level with the anorectics-to-be when they were infants and toddlers. A certain intensity of involvement seemed to have been lacking between infant and mother to develop the optimal attunement required to establish "a sense of well being" (Mahler, 1975, p. 204) or a firm foundation for a "true self" (Winnicott, 1965, p. 148). Chapter 6 covers this in more detail.

2. The father's manifestations of positive feelings for the girl from birth to the advent of puberty

a. Greater activity in infant care for this child

In three of the cases (Wilma, Frances and Valerie) the fathers were very enthusiastic about the birth of the female children in this study. Wilma and Frances were the first girls in the family and the data shows that the fathers enjoyed being active in the feeding, diapering and bathing. In the case of Valerie, both parents saw her as resembling the father's mother in appearance and in disposition. The father's special attentiveness to Valerie is associated with this similarity to his mother about whom his wife felt very negatively.* In the case of Betty, the father certainly shared in the infant care of her and her twin, but it is not known what this meant to him. The interaction between Cathy's father and the twins appeared to be more

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*Except to Valerie's father this grandmother had the reputation within the family of being cold and distant.

negative than positive in contrast to the other four cases. About Brenda, there can be no certainty since early developmental data was not available from the biologic mother.

b. Doing special favors for this child

What emerged from this is not so much that the fathers did special favors for the subjects (Valerie and Frances) but that they favored them because of their compliance and submissiveness. There was a consensus on this in one way or another for all six cases. The fathers* enjoyed the non-aggressive non-demanding little girls.

c. Terminating the close involvement in late latency

In four of the six cases (Valerie, Wilma, Frances and Betty) where a warm, close relationship with the father was described during latency, it was terminated once the female child started to show signs of pubertal development. The remaining two subjects, Brenda and Cathy, had never had, according to the record, a very close relationship with the father prior to the onset of puberty. For these two girls the close male relationship within the family had been with someone else. For Cathy it had been with her brother but he changed from his repeated brain surgeries when Cathy reached late latency. Brenda's closest relationship was with her older brother who left home in Brenda's late latency. For all six girls, therefore, a diminished close relationship with a male family member occurred around the end of latency.

3. The importance of peers and/or siblings in the support system of the late latency and early adolescence of the pre-anorectic

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*The fathers also evidenced compulsive traits with emphasis on logical thinking rather than feeling.

a. The importance of the peer relationships

For all four of the non-twin cases there was a loss of a best girlfriend prior to the onset of the anorexia either because the girlfriend moved away or because the family of the anorectic-to-be moved away. In the case of the two twins the closest peer relationship was the twin relationship, making the twinship doubly important. The fact that all these important relationships terminated within six months prior to the onset of the anorexia, or diminished in the twin cases, raises the question of the significance of these relationships at this time in the lives of the subject. A simple solution for the losses would have been to replace them. As young latency girls there was no evidence that any of them had had difficulty in making new friends.

Actually as five* of the subjects began to recover from the anorexia they each did make some kind of replacement for the lost friend(s). Valerie found younger friends, Brenda attracted peers by her outstanding achievements, Cathy and Betty tagged along with their twins' friends, and Frances tagged along with her brother and his girlfriend. Except possibly for Brenda, these replacement solutions were more appropriate for a younger age and are regressive in that the girls did not make new peer relationships but remained with siblings or younger friends. This suggests two important issues that were associated with the loss of the girlfriends. One is an understanding of what ego functions the girlfriend (or twin) performed for the pre-anorectic, and the other is the basis for the anorectic's inability at this time of her life to make and retain new relationships.

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*Because Wilma moved out of state, her progress could not be followed in any detail.

b. The importance of the sibling relationships

Besides the loss of close girlfriends there was for each subject except Wilma* a close sibling relationship that was diminished six months prior to the onset of the anorexia. Valerie's only sister went away to college, Brenda's favorite brother went abroad for two years, and Frances' brother and only sibling began going steady for the first time. For both twinships the non-anorectic twin was attempting to be more independent of her sister. Also in the two families with the twins there was no available sibling replacement. Betty had no other sibling but the twin, and although Cathy did have an older brother, he had been physically and intellectually impaired by hydrocephalus. To summarize, close sibling relationships were becoming less available at a time when "best" girlfriends were being lost.

The significance of the losses will be discussed in the next section from the developmental point of view with focus on separation and individuation at nodal development phases. Parts of the discussion on the peer relationship will parallel the significance of the sibling relationship in that siblings can function as a transition from the infantile tie to the parents to non-incestuous and less dependent relationships outside the home.

Included in a consideration of the significance of the losses developmentally is the quality of the object relationships of the pre-anorectic. The fact that there are two twins out of an accidental sample of six cases leads one to consider whether the

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*Wilma's brother and only sibling left home a year before Wilma became anorectic.

anorectic-to-be tends to want or perhaps need a kind of twinship relationship with peers and siblings.* A twinship can provide an almost constant availability of an alter ego which is known to make the process of individuation more difficult and more prolonged.

4. The confused attitude of the girl toward her developing sexuality

The data in the records on the sexual attitudes of the girls prior to puberty is very sparse.** It is therefore difficult to draw any conclusions about how the pre-anorectic girls in this study were dealing with their female identity prior to adolescence. They may or may not have played with dolls in a warm, nurturing way. The fact is that there are more references to playing school and to action games than to playing house, but this does not mean that they were tomboys. Except for Cathy, the ordinary tomboy behavior representing the expected bisexual identification common to latency girls (Kaplan, 1974) was not evident.

It is in the time span between late latency and early adolescence that references to their female sexuality start to appear. All of the girls began to show a greater interest in their appearance. However, at the same time Valerie and Frances avoided coed activities. Valerie

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*Valerie demonstrated in her play therapy that she was more spontaneous and assertive when she imagined that her sister was her twin.

**None of the mothers provided information on the recognition of early sex differences and only Cathy's mother claimed knowledge of masturbatory activity. Valerie, Cathy, Frances and Wilma were noted as having received information on procreation from their mothers during early latency, but no responses were noted.

made friends with girls younger than herself and Frances just did not have friends. Brenda enjoyed attracting the boys at the church dances but she was also attracted to a female girlfriend and stated that she did not want children.

Only two of the girls (Cathy and Betty who were the twins in the research project) expressed a desire to have children; they were also less negative about menstruation. It was not coincidental that their mothers showed the least inhibition to discuss sexual aspects of their marriages. After Cathy passed through a tomboy stage and achieved menarche at age 12½, she showed a more positive interest in boys. Betty who was 15 had wanted to be popular with boys for a year. She went to many boy-girl parties but she defended against a close physical relationship with the opposite sex by choosing first a boy who was in jail for drunk driving and then a paraplegic in a wheelchair.

As a range of behaviors for early adolescent girls, their ambivalence about having menses and becoming mothers does not seem so far from the norm of other young girls. The behavior that distinguished the group was the self-starvation that reduced the breasts and body curves and interrupted or postponed menarche. The somatic expression of their repressed sexuality signalled a greater unconscious need to stave off sexual maturation than one would expect to find in an ordinary ambivalent attitude toward growing up.

5. The mother's negative view of aspects of her feminine role.

a. Locked into domesticity through duty

Three of the mothers were portrayed as being extremely compulsive, organized and orderly about their housekeeping and three

were portrayed as being pretty lackadaisical about it. Only one mother, Wilma's, worked outside the home throughout the marriage. Since she only worked part-time for the father, one could summarize that none of the mothers strayed very far from the hearth. The fact that four of the six mothers had a college degree and the other two had taken some college courses would indicate that they were intellectually able to function in a sphere outside the home. Nevertheless, the major focus for all six mothers was their family life and whatever activities that encompassed at the time. Although there were many complaints that husbands did not pay attention to them and that they were overburdened with household duties, for some reason they did not break this pattern and remained in a rather patriarchal family structure. Betty's mother did start her own business, but this did not occur until after the father had left the home. The other five mothers at the time of the study found their outside interests in the activities of the children, and for Valerie's mother, also within the community. In addition, Cathy's mother became a non-paid volunteer in several self-help groups, but no one except Betty's mother sought a paid career outside the home and, as stated, this was after the father left the home and Betty was in late latency.

An explanation for the mothers not seeking an outside career could be that the families were financially comfortable and did not need a second income. However, this was not given as the reason for remaining close to family and family activities. None of the families could be considered very wealthy in that sacrifices had to be made to send children to college and to take summer vacations. Cathy's

mother admitted that she was afraid to compete in the commercial world. Valerie's mother who had been a school teacher before marriage said that she would not return to the classroom because children no longer respected authority. Only Betty's mother had sufficient initiative and drive to compete within her area of training, interior design, in the competitive, commercial world. The other mothers appeared unsure of themselves and fearful of failure in paid employement outside the home.

b. Husband emotionally detached* from her

All of the mothers complained of some lack of emotional understanding from their husbands. Even Wilma's mother who appeared to be an equal or dominant partner complained that her husband made unilateral decisions without considering her feelings. From the data of the other five families, this was a common complaint. The mothers also complained that the husbands were not usually available to discuss the emotional hurts and frustrations that arise in parenting children and maintaining emotional security for all members.

Regarding sexual compatibility and satisfaction, this was an area difficult for most of the parents to discuss except for Betty's and Cathy's mothers. Betty's mother admitted that her sexual relationship with her husband always remained very good even when there were unsolved problems in many other areas. It was perhaps this non-verbal communication that they could share and which they maintained during the separation of five years that brought them back

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*As a group the fathers evidenced compulsive personality traits with emphasis on logical thinking rather than feeling.

together after the twins left home. Cathy's mother experienced her sexual interaction with her husband often as sadistic and uncaring, but at least she could talk about it. The other four couples very blandly spoke of a satisfactory sex life, but did not wish to discuss it.

6. The well-functioning facade of the family before the girl becomes anorectic

a. The high achievement of father and children.

This was the variable on which there was the greatest agreement for the six families. All of the fathers either held above-average jobs in stable, well-known industries or were the founders and presidents of a manufacturing company themselves. All but two of the fathers had graduated from college. The exceptions were the fathers of Betty and Wilma. Both of these men, however, had taken college courses in fields of their interest, founded their own company, and were financially successful. All of the children were average or above average in school with the anorectic girls being seekers for perfection and perhaps to be considered over-achievers. None of the children were known disciplinary problems in school or in the neighborhood. In particular, the anorectic girls were exemplary students in school with high grades and behavioral conduct consistently in the outstanding range. The anorectic girls were also good in certain sports such as swimming and track, and the siblings were usually outstanding in the same sports plus some team sports which the anorectic avoided. Brenda and Frances held class offices as did the siblings of Valerie, Brenda and Frances.

b. The mother's visible support of the achievers, suggesting

a high degree of togetherness to the outside world.

As already noted in the preceding section, the mother primarily devoted her time to the interests of her husband and her children. Both parents were active support members of Little League and swim teams and water polo teams or of whatever teams the children were players. The mothers usually spent more time in baking, selling, raising money and transporting the children while the fathers spent more time coaching and managing. Sometimes entire families came to the meets.

Vacations were usually taken as a family. When a family member was excluded from the vacation it was the subject child (Wilma and Valerie). Cathy's family relationships were the ones most limited to relationships within the family. Cathy's sister stated that the family "acted as if they had one brain." This appeared to be less true for the other families but togetherness was a theme for all six families to some degree including Betty's family where the parents were separated. The other families were intact.

7. Unexpected events associated with the birth of the child

The birth of each child (except Brenda whose very early history was not available) contained some kind of unexpected event, either immediately after conception or within the first three months of the infancy. The data present a collection of physiological difficulties or physical anomalies or a genetic syndrome or, in two cases, the surprise of a twin birth. One set of twins was premature and two conceptions were not thought possible. Between the five subjects there were 12 different events that could be viewed negatively if one were

the mother or the father of the infant. In this conglomerate of unexpected events it would be dangerous to generalize the consequences to all the parents, particularly the mothers. However, it is probably safe to say that these events put additional stressors on the family equilibrium over and above the natural disturbance that occurs by the entrance of a new member into the family. The fact that five of these children presented more difficulties than one would anticipate with the birth of a new child might conceivably cause some initial negative attitude toward the child and provide a basis for a lasting ambivalence. The evidence of using other caretakers as much as possible and the laissez-faire attitude on discipline would at least partially support an early ambivalence of the mothers for the anorectics-to-be.

Besides the physical anomalies there were other stressful circumstances at birth. Three conceptions occurred while there was still an infant in the home. In the case of Frances it meant two caesareans for her mother in 18 months. Wilma being conceived 11 years after her sibling put the parents in the position of changing their life style radically to accommodate an infant. Whereas none of the children were ever abused and they were given the material advantages commensurate with the family's income level, the girls' histories impressed as their being tacked on to the family and never really integrated. Wilma became a young adult in an adult family almost from the beginning. Valerie became the "little doll" of the family and was called "Buffie" after a well-known television character. About Cathy, it is not known when if ever her father forgave the mother for "tricking" him into having two more children when he did not want any more. Betty's

parents who were both very ambitious did not consciously want to start a family for several years but the mother became pregnant the third month of the marriage. Even for Brenda, about whose early life we knew so little, we can surmise that since the marriage was already floundering and the mother later left for a lesbian life that the fourth pregnancy in eight years was not enthusiastically received. Her correspondence to Brenda indicated how "trapped" she felt.

Besides whatever anxieties and ambivalence the mothers may have had and may have transmitted to the child about the birth, there is also the impact that the physical anomalies had on the infants themselves regardless of the mother's reaction to them. One set of twins was premature and had to remain in the hospital four to five weeks after mother was discharged; the other set of twins inherited a genetic defect that caused them to be stared at. Valerie had a large hemangioma on her abdomen and a smaller one on her chest, and Cathy had one on her cheek. The protruding blood vessels could have been a deterrent to close body contact with the infants, thus transmitting to the girls something negative about their bodies. For the twins, Betty and Cathy, the twin that suffered the greater trauma at the birth is the twin who became anorectic. Betty remained a week longer in the hospital and Cathy had the hemangioma. Betty was also the head-banger during infancy evidently finding it more difficult to adjust to her environment than her twin. It is possible that a combination of the constitutional factors and the environmental climate into which these children were born all contributed to making them vulnerable for some kind of regression in later life. If indeed these factors prevented

an optimal cathexis of the mother during the symbiotic phase, then one can reason that the succeeding separation-individuation phase would have difficulty at least in the areas of identity, body image, and self concept.

CHAPTER VI

Discussion

The outpatient treatment records of six young females diagnosed as having primary anorexia nervosa have been reviewed in relation to 14 variables to explore their possible contribution to the etiology of anorexia. Ten of the variables focused on the anorectics' important relationships (1a, 1b, 1c, 2a, 2b, 2c, 3a, 3b, 6a, and 6b); three provided data on attitudes toward femininity and/or sexuality of mother and daughter (4, 5a, and 5b); and one listed unexpected reality events of birth and early infancy (7). Precipitating events are contained in an overview paragraph for each subject in Chapter 4. A summary of the data for each variable was given in Chapter 5. In this chapter the data summaries will be discussed in conjunction with some of the pertinent theoretical literature. There will be an emphasis on separation and individuation issues consistent with the focus of the research project. Relevance of the data to the two research questions will be given at the end of the chapter under the section entitled "Response to Research Questions." Suggestions for future investigations will conclude the chapter.

The discussion is organized around key concepts that emerged in analyzing the research data. In that way research variables that pertain to more than one concept can be viewed from different perspectives. The important concepts and the related variables are listed below. Each item in the concept column will be a separate heading.

Key Concept	Related Variables*
Significance of Object Loss as a Precepitant to the Anorexia	3a, 3b, overview paragraph on each case
Attitudes of the Mothers Toward the Pre-Anorectic Girls	1a, 1b, 1c, 5a, 5b, 6a, 7
Failure in Feminine Identification	4, 5a, 5b
Orality and Regression	1c, 3a, 3b, 6a, 7
Relationship with the Father and Oedipal Outcome	2a, 2b, 2c, 4
Family Structure and Relationships	5a, 5b, 6a, 6b
The Second Individuation	All variables contribute

Theory

The first separation-individuation phase according to Mahler (1963, 1968, 1971, 1972, 1975) occurs from the fourth or fifth month to the 30th or 36th month (Mahler, 1972, p. 333). Within this time span many important ego functions unfold and begin to integrate with the developing personality in a dynamic interplay between mother and child and the rest of the environment. The degree to which the child becomes an autonomous, self-regulating person with a sense of his or her identity and with a fair degree of libidinal object constancy depends on the degree to which the child has individuated from the mother. There is a second individuation phase according to Blos (1962, 1967, 1979) which takes place in adolescence and provides a second opportunity to individuate from the mother. The process whereby the two individuations take place is quite different. In the infantile individuation, self and

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*Refer to page 49 for a description of the variables.

object representations are internalized through interaction with the caretaking person, the mother (Blos, 1979). In the second individuation process the adolescent proceeds in the direction of disengagement from the internalized objects of early childhood arriving eventually at more realistic and more mature relationships with his or her parents and with others. The parents are no longer idealized and other ego ideals are found.

Significance of Object Loss as a Precipitant to the Anorexia

The innumerable developmental processes involved on the way to object constancy* in the first separation-individuation phase afford many opportunities for deficiencies to occur. Some may be very subtle, some may be repaired along the way to maturity, and some may not be visible until a later date when the child is put under stress. This appeared to be the case for the six subjects in this study. The pre-anorectics, after infancy,** were considered no problem until the eating disturbances which surfaced toward the end of latency*** or in early adolescence. The stress factor that can be identified at the onset of the eating problem was the conflux of physical maturation with object losses or diminished close relationships.

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*Libidinal object constancy "has to be regarded as the last stage in the development of a mature object relationship" (Mahler, 1975, p. 110). The progress is from a need satisfying relationship to a mutual give and take relationship.

**Frances had projectile vomiting at three months; Betty was a head banger in the first year; and Valerie was highly irritable to strangers early in the first year.

***Although Wilma was only nine and one-half years old at onset of the anorexia she was beginning puberty. Valerie may be an exception to this since her eating problems began at 10 years of age.

Object loss or some other disappointment has been noted by other investigators as one of the precipitants of primary anorexia (Blitzer, et al., 1961; Nemiah, 1950). Melitta Sperling (1978) reporting on her psychoanalytic work with a 13 year old anorectic girl also found that the loss of a close girlfriend preceded the onset of the illness. Sperling concluded that the traumatic results of the object loss were due to the fact that the patient had attempted to separate herself from her mother by transferring her dependency relationship to the friend and had failed. In other words the significance of the loss of the close girlfriend was that it represented a developmental failure in separation through the loss of a transference object.

The closeness of a female peer appears to be a part of normal development for girls working out separation-individuation from their mothers (Anni Bergman, 1980). Favorite siblings or other relatives often serve in this role too as transitional relationships on the way to less dependence on the parents. An indication that something pathological was involved with the pre-anorectic females in the study was the severe regression that followed the losses. A more likely response would have been to find new friends.

Because of what appeared to be an over-reaction to the departure of close girlfriends or siblings, the nature of the relationships was examined for a clue to their importance. In four out of the six cases the relationships were more childlike than one would expect for girls entering puberty. Two of the girls were twins seeking to preserve the shared identity and mutual dependency of the twinship and another girl, Valerie, wished that her sister was her twin and then turned to younger

friends after her sister went away to college. Frances, after her two closest girlfriends left the neighborhood, could not maintain the replacement friendships she tried to make and therefore ended up trailing after her brother and his girlfriend. Wilma, the youngest of the subjects, was so embarrassed by her precocious bodily development that she wanted to stay home and hide. Only Brenda appeared to be able to make a peer replacement for the friendships that were lost when the family moved from a different state. However, her object choice betrayed continuing problems with individuation from her biologic mother. The replacement best friend was a rather masculine female who excelled in athletics and drove around in an expensive sport car. She took Brenda to and from school and sometimes picked her up and carried her to the car. The strong hint of a homosexual attachment could have been a transitory trying out of the biological mother's lesbian identity or some more permanent identification with her, but in either case Brenda's behavior indicated difficulty with her own female identity. The fact that she was also drifting into bulimia was an added indicator of a continued regressive tie to her mother. In summary, all of the girls evidenced some kind of serious difficulty with object relations at the point where their lost friendships or diminished sibling* relationships coincided with their increasing drive maturation.

In determining the significance of the lost relationships the

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*The siblings of the twins were moving toward more independence; Valerie's older sister and Brenda's favorite brother had moved out of the home; Frances' brother had his first steady girlfriend.

function that the relationships performed was also examined. In early latency while friendships were available and usable, and there is no record that they were not, the pre-anorectic girls looked quite normal compared to their peers. Their compliant natures won them approval at home and at school and their scholastic achievements were above average. The latency calm of which Sarnoff (1971) writes was achieved at least superficially. Displacements to new objects, sometimes with the use of siblings as transitional relationships were occurring. Except for the over-use of some obsessional defenses such as reaction formation and perfectionism, all appeared to be going well. It was the loss of the alleged displacement objects during the increase in pubertal maturation that revealed the fragility of the new tie and the regressive pull still existent in the old object ties to the parents. A more complete decathexis of the parents which should have gradually been progressing throughout latency was apparently missing. Anny Katan (1951) has described a particular kind of displacement which needs to occur to provide the developmental thrust into adult sexual life. In this process incestuous fantasies and wishes become irreversibly directed away from the parents, are eventually repressed and abandoned and thereby deprive the old objects of their significance in the sexual life of the maturing adolescent. Because Katan considers the process irreversible she has called it object "removal" rather than object "displacement." An important precursor to a reasonably successful attainment of the "removal" of the old objects is a reasonably resolved oedipal conflict. For the girls in this study there is no firm evidence that they had proceeded beyond the

phallic-oedipal level.* The implications are that their relationships were more at the need-satisfying, supportive levels than at the more advanced, triangular level of their pubertal peers. The regressive aspects of the ties will be discussed again in relation to the second individuation phase.

Attitudes of the Mothers Toward the Pre-Anorectic Girls

The data of three of the research factors indicated that from infancy the mother was often quite negative in her attitudes toward the pre-anorectic girl. The three research items are: (1) the mother's laissez-faire attitude; (2) the mother's negative view of aspects of her feminine role; and (3) the unexpected events associated with the conception or early infancy in the life of the child (variable 7). Variable 7 is included in this section because of its contribution to the mother's negative attitude toward the child. All of the mothers except Brenda's** are known to have shown some reluctance to be pregnant at that time. The occurrence of unexpected events*** could have exacerbated any negative feelings about the birth because they introduced additional stressors.

From birth the records show a lack of an intense, exclusive relationship in the mother-child unit. Fathers, siblings, other family

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*Sours (1980) and Sperling (1978) also concluded that their anorectic patients were at the phallic-oedipal level.

**Brenda's very early history is not known although in a letter to Brenda the mother described feeling "trapped" by home and children.

***The unexpected events included a premature birth, two twin births, hemangiomas in two cases, a conspicuous genetic syndrome in one case and two unexpected conceptions.

members and baby sitters became important caretakers of all the pre-anorectic babies except Brenda and Cathy.* It was as if others rushed in to fill a void left by the mothers. Limit setting became very inconsistent, sometimes being very punitive and sometimes very lax, depending more on the mother's need to control what was important to her at the moment than the long-term benefit to the child. It is a combination of these factors that the author has called the laissez-faire attitude of the mother. Although there is at times rejection in this attitude, the phrase is primarily meant to convey something less aggressive and more subtle. Hilde Bruch (1973) describes the mother's attitude similarly to the author's impressions:

> The early histories often fail to give evidence of gross neglect, and the commonly used terms like rejection or lack of proper love, do not help us understand the problem. The details one usually learns are quite subtle; the important aspect is whether the response to the child's need was appropriate, or was superimposed according to what the mother felt he needed, often mistakenly (p. 51).

Bruch's conclusions (1973) are that children who develop severe eating disorders have had inappropriate or mechanical responses to their needs and grow up with "robot-like submission to the environmental demands" (p. 57). They grow up with gross defects in initiative and with an inability to identify bodily experiences. Winnicott's (1965) concept of the True and False Self also derives out of an examination of the part played by the mother in her ability to sense her infant's needs. According to his theory the "good-enough mother" (p. 145) fosters the True Self by her good-enough adaptation to the infant through a

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*Cathy's mother was depressed after the birth of the twins and being left alone to care for them and a son only 18 months old.

complicated series of interactions, conscious and unconscious. In the mutual cueing that takes place between mother and child, if the mother is not able to follow the baby's signals sufficiently then the baby begins to make more accommodations to the mother than the mother does to the baby. The child becomes compliant instead of spontaneous and a False Self is built to deal with the environment and also to protect the True Self. Although compliance plays a role in adjusting to some of the requirements of civilized life, Winnicott makes the point that when compliance becomes a dominant part of one's behavior one is handicapped in recognizing and dealing with one's true feelings. The views of Bruch and Winnicott in regard to the importance of the mothering role in the mother-child unit are compatible with Mahler's. Mahler describes the mother as the catalyst of the individuation process. She uses the term "communicative matching" (1963, p. 321, taken from Pine and Furer, 1963) to capture the pre-verbal subtleties that constitute the mother's emotional acceptance of the child.

The subjects of the study fulfill the descriptive prophecies of Winnicott and Bruch for children whose early needs were too often out of synchrony with the mothers' perception of their needs. Their behavior in latency was unusually compliant in school and in play. Grades in citizenship were outstanding and academic grades were better than average. These attributes were maintained throughout latency and in fact academic strivings became more prominent the closer the pre-anorectics moved toward adolescence. With their compliant natures went a happy, Pollyanna affect which contributed a shallowness to their personality and made them appear somewhat false.* I believe

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*Brenda, when she started to improve, became aware of this in herself and began to identify her "fake" behavior.

that their fakery, or reaction formation approach to life, is what makes it so difficult to engage the anorectic girl in a therapeutic relationship.

The details of how the mothers may have misinterpreted the child's early needs could not be documented directly from the available records. It was found from the data however that there was a lack of intensity and exclusivity in the care of the subjects in the early years and that there was throughout latency an inconsistent involvement in limit setting and discipline. Within the inconsistencies there were examples of rejection and indifference to feelings as when the parents of Wilma and Valerie excluded them from family vacations even after they were anorectic and without friends. There were also examples in which the pre-anorectic child, within the permissiveness of the laissez-faire attitude, was indulged more than her siblings regarding household responsibilities. Other investigators who had similar findings of inconsistency (Sperling, 1978 and Thomä, 1967) called attention to the extreme ambivalence in the mother-daughter relationship. The author does not disagree with the idea of ambivalence in the relationship but prefers the term laissez-faire because it also contains a quality of indifference or deliberate abstention.

Failure in Feminine Identification

One of Mahler's cardinal hypotheses (1963) is that the development and maintenance of the "sense of identity" (p. 309) cannot occur without the first step in the separation-individuation process, namely, differentiation. Mahler's use of the term "sense of identity" grew out of her studies of symbiotic and infantile psychoses. The

sense of identity in that context means a well differentiated sense of the self and the non-self, of the me and the not-me, of what is internal and what is external. There is no evidence to conclude that the sense of being a separate entity was not achieved by the six subjects in the project. What is more of an issue is the level of identification that took place in the individuation from the mother. Because the anorectic subjects retreated from their budding sexuality, the imcompleteness of the sexual identification with their mothers is of particular importance.

Identification is largely an unconscious process whereby a person incorporates within himself a mental picture of an object and then thinks, feels, and acts as he conceives the object to think, feel, and act (Hinsie and Campbell, 1977). For girls the identification with their mothers forms a basis for their feminine gender identity. This needs to be differentiated from "core gender identity" (Stoller, 1979, p. 40).* All of the girls in the project showed evidence of having achieved a feminine core gender identity. They all dressed very attractively and spent a great deal of time on their grooming. However, except for Brenda and Betty, the two oldest girls in the group,** they were avoiding boy-girl activities at the point of referral. Only Cathy showed tomboy activities and competitiveness with boys as part of the

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*"Core gender identity is the sense we have of our sex, of maleness in males and of femaleness in females. . .It is a part of, but not identical with, what I have called gender identity, a broader concept standing for the mixture of masculinity and femininity found in every person. ('Male' and 'female' refer to sex, or biologic state, 'masculinity' and 'femininity' to gender identity, a conviction about one's self and one's role)."

**Betty was 14 years 10 months and Brenda 14 years 8 months at referral.

bisexual identification of latency. All of the girls showed a preoccupation with their appareance, but there was no record of adult female role play in latency such as playing house or playing with dolls. The nature of their female identification appeared to be at a very superficial level. Their apparent disinterest in the procreative female role raises the question of whether they had identified with their mothers as part of the oedipal process and, in fact, whether they had sufficiently completed an oedipal phase of development. Only two of the subjects, Betty and Cathy, the twins, expressed a desire to have children and that may have been more from a desire to repeat the twinship than from an identification with their mothers. Core gender identity does not carry with it "implications of role or object relations; it is, I suppose, a part of what is loosely called 'narcissism'" (Stoller, pp. 40, 41).

The negative views which the mothers had concerning their own feminine role would provide at least a partial understanding of why the anorectic subjects did not identify with the reproductive and nurturing functions of their mothers. In many subtle ways the mother communicates to her daughter how she experiences herself as a woman (Anni Bergman, 1980). Lichtenstein believes that the mother imprints upon the infant an "identity theme" (1961, p. 208) which creates an irreversible destiny for the child. In this way the child is made to be the instrument for the fulfillment of the mother's unconscious needs. Although there are data that the mothers in the study were discontent with aspects of their female role, the evidence in the records is not strong enough to link this discontent with the subjects' panic reaction to their budding sexuality. The mothers' more negative

attitudes toward their femininity and sexuality may have been well hidden and well defended within their unconscious. Only two of the mothers (Betty's and Cathy's) would discuss the sexual part of their marriage; the others only responded with a word or two. What was repressed may well have been more revealing than what was expressed.

Orality and Regression

Anorexia nervosa always involves a serious eating disturbance and this can lead to erroneous assumptions about the psychopathology resulting from the oral phase. One misconception is that the anorectic experienced some early trauma around food. This is not necessarily true. Early feeding disturbances are not found in all the histories of anorectics; in fact, they may not be greater for anorectics than for the general population. No one has ever reported on it. The records of the six cases in this project showed that only two of the children evidenced early feeding problems and they were of short duration. Valerie's occurred at age two and was more of an anal struggle with her mother than an oral problem. The feeding problems in any case may merely be the vehicle for expressing a mother-child conflict rather than being a basic conflict over food. Sandler and Dare (1970) have pointed out that conflicts from the oral phase may have little to do with eating. There are many other psychological processes that occur during the first year of life besides the satisfactions gained via the mouth. Many of the ego developments that take place during the separation-individuation phase occur simultaneously with portions of the oral phase.

Another area in which misconceptions can arise in viewing the regression of the anorectic is in assigning the developmental level of

the fixation. The oral character of the symptom may lead one to conclude that all anorectics are primarily fixated in the oral phase. Reports from two psychoanalysts (Sperling, 1978 and Sours, 1980) who have treated the anorectic female concluded that they are pregenitally fixated along a continuum from psychoses to psychoneurotic character disorders with most of them at the phallic-oedipal level. The extent of the fixation as well as the point of the fixation varies from case to case. The earlier the fixation the worse the prognosis. The six anorectic subjects in this study exhibited many anal characteristics (negativism, stubbornness, and compulsivity) as well as oral. Phallic narcissistic attributes were also present in their academic achievements and competitiveness and in their careful attention to their attractive appearance. Their highest level of functioning was found at the phallic-oedipal level.

There are several reasons for concluding that the six anorectic subjects remained at the pre-oedipal level. One that has already been mentioned is the level of their object relationships which appeared to be at the twinship, dyadic level. Another reason is the apparent absence of an autonomous superego structure which could regulate the drives, including hunger, more realistically and more constructively. Had there been more internal structuralization from the oedipal resolution, the "undefended regression" (A. Freud, 1971, p. 169) that the anorectic experienced would not have occurred. A better identification with the mother and a stronger superego could have provided a more solid defense against the regressive pull to pregenitality.

The unconscious choice of a somatic path to express conflicts over

dependency and over the sexual drive adds to the evidence for a disturbance in the early mother-child relationship. According to Winnicott (1975) somatization as a defense against anxiety indicates that the harmonious integration of psyche and soma was greatly interferred with at an early age. The interference is attributed to the mother's lack of empathy for the child's needs. Whereas this does not of itself decree an oral fixation it does produce a regressive tendency to dependency through somatic problems. The strength of the regression depends on many factors including subsequent life experience.

Relationship with the Father and Oedipal Outcome

The data obtained on the subjects' mixed feelings about their budding sexuality raises the question as to whether sufficient feminine identification had taken place for an oedipal relationship with the father to have occurred. Although four of the fathers were very attentive in the early years and continued a special involvement until the beginning of the pubertal maturation of the four girls, these early attachments may have been experienced as substitutes for the laissez-faire mothers. According to Edgcumbe and Burgner (1975) a reported early attachment to the father can be part of a "search for a substitute for the disappointing pre-oedipal mother, rather than a turn toward an oedipal father" (p. 168). Using a similar line of reasoning, the desire of the two twins to have a child may be an expression of their wish to recreate the twinship relation through a mother-child relation rather than an expression of an oedipal fantasy with the father. Without knowledge of the sexual fantasies of the subjects and without evidence of their struggling with the conflicts of a triangular* relationship,

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*Although it was not part of the research data there was evidence that Brenda, Frances, Betty and Cathy were experiencing an oedipal struggle with their parents during the course of therapy.

it is difficult to know to what degree they had progressed beyond the dyadic level of relationships by the end of latency. The fixity of the pregenital regression strongly indicates however that the oedipal terrain had only been lightly trod, if at all.

An important outcome of the oedipal struggle is the continuing structuralization of an "autonomous superego" (Tyson and Tyson, 1983). The term means that the child has growing independence from external objects, from the drives, and from pressures caused by early archaic introjects."* One of the outstanding personality traits of the pre-anorectic girls during latency was compliance with parental and school authority. Whereas this is a step in the structure of superego development (Tyson and Tyson, p. 15) it is not at a level to provide individuated functioning from the parents and family. Compliance continues to bind the child to the infantile ties that interfere with the second individuation that is to occur in adolescence. The pre-anorectic girl remains relatively dependent on external objects and unintegrated archaic introjects for control of her instinctual drives and regulation of her self-esteem.

Family Structure and Relationships

The family structure and relationships as recorded fit the stereotypes of the families of anorectics described by Palazzoli (1974) and Minuchin (1978) from their treatment experiences with these families. The families in this study were middleclass or upper middleclass, very achievement oriented and with the father appearing

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*Tyson and Tyson attribute this concept to Hartmann and Lowenstein, 1962 and Jacobson, 1964.

as the dominant figure and the mother as the devalued, submissive wife. However, even in this patriarchal stereotype, it was clear that the wife had a great deal of power in the family. The children usually reported to the father through her. Her own feelings of duty and obligation and self-righteousness governed the children and intimidated the father. In spite of the apparent patriarchal set-up of these families, the fathers wanted to avoid a direct confrontation with the mothers so that the children did not have an ally when in conflict with an angry mother. The children either had to confront the mother's anger themselves, be deceptive, or comply with the demands. Mostly they complied.

The fact that the six families fit fairly well into the stereotype that other authors have described is a bit questionable. One would wonder whether or not these same dynamics could exist in a working class or lower class family that had identified with middleclass values. What would be the logical reason for the fact that most anorectics occur in middle or upper middleclass families? The answer to that is certainly not understood, but it would not be surprising that a search of all the anorectic cases in Western civilization would reveal that striving families at any economic level would be vulnerable to this kind of disorder provided that some particular dynamic factors between mother and daughter would obtain.

Whether or not the stereotype description of the family of the anorectic is limited to middle or upperclass is probably not as important as how this particular kind of high-achieving family produces a female child who is so vulnerable to regression in early adolescence. There is certainly not enough information in this research project to

define this in all of its many ramifications. However, there is enough information to suggest that these families foster a great deal of togetherness but very little true intimacy. The family script is more directed to the world and is less tuned to handle the feelings of the individual members. In the incident described between Frances and her mother over mother's being more concerned that Frances eat what the mother wants rather than caring that Frances was eating is a good example of the danger to a family member who would challenge the mother's ideas. The enmeshment that is attributed to these families does not imply true closeness and intimacy but rather a lack of differentiation of individual needs. Cathy's twin described the undifferentiated family ego very well. "This family acts like it only has one brain."

The Second Individuation

Blos (1967, 1979) in describing the second individuation process of adolescence points out that regression is a precondition for progression. However the regression experienced by the six subjects in the study was pathognomic for adolescence in that it did not serve as a defensive bridge to adulthood. There was no swing between progression and regression which is the usual course of events as the adolescent reworks the infantile ties to the parents to a more mature level. It is a severe test of the adolescent ego to return temporarily to pre-genital phases of development and not be re-engulfed by pre-oedipal strivings. If there remain ego deficiencies from the passage through the first separation-individuation phase, adolescence is a stress point that will bring them out of hiding.

The degree of early ego inadequacy often does not become

> apparent until adolescence, when regression fails to serve progressive development, precludes the second individuation and closes the door to drive and ego maturation. (Blos, 1979, p. 157)

The process for disengaging from the mother is considered more complex for girls even under ordinary circumstances. The girl not only needs to differentiate herself from the pregenital mother but she must also identify with positive aspects of the reality mother to build a feminine ego ideal. Girlfriends, older sisters, or teachers are often chosen to provide parts of the ego ideal as well as to serve as displacement objects for the close and dependent tie to the mother. The fact that displacements of this kind were not available to, or perhaps not useable by, the pre-anorectic girls in the study created more closeness to their mothers at a time when they needed more distance. A not uncommon solution to the regressive pull to the mother is a delinquent flight into heterosexuality. Instead the six anorectic subjects starved themselves, halted the sexual development of their bodies, and avoided sexual involvement with life.

Why the anorectic girl remains in a state of regression has been attributed to her desire to remain a little girl and not grow up; that she is afraid to grow up and mature sexually. Why she is so reluctant remains a 300 year old mystery. The data obtained on the mother-child unit in this project suggest that the veiled hostility of the laissez-faire mother interferred in some way with the pre-anorectic girl's being able to identify with the mothering figure. The early self and other representations may have been too noxious to be integrated within the ego and superego structures. Wilma expressed this very concretely when the "voice" of conscience spoke to her from

her stomach and told her not to eat even though she was hungry. The mother, or parental introject of the mother, was not very digestible.

The lack of an integrated superego was not conspicuous prior to the anorexia. The compliant nature of the pre-anorectics' behavior could cover up their lack of psychic structuralization during latency. However, once they entered puberty, their reliance on outside sources of control put them either at the mercy of their drives or at the mercy of their mothers to provide the controls. Perhaps the self-starvation is an attempt to escape both fates. Had the fathers been more responsive to the pre-anorectics' femininity and been more emotionally available to them, the subjects would have had an alternative source of support for the second individuation. Without the active participation of the fathers the True Self was in danger of being extinguished by the continued appeasement of the mother. Rather than suffer the psychological death of her basic identity, the anorectic girls seemed to prefer a physical death by self-starvation. At least they could feel that they were finally in control.

Response to Research Questions

Research Question No. 1: What are some separation-individuation issues that contribute to the etiology of primary anorexia nervosa in young females?

The data suggested that the subjects were not particularly wanted or welcomed by the mothers at the time of their conception and birth. Many of the early caretaking activities were given to other family members or a babysitter with the possible implication to the young infant that she was not a wanted or welcomed addition to the family at this time. The laissez-faire mothers did not appear to provide the

"communicative matching" that Mahler (1963, p. 321) describes as necessary for the unfolding of the child's autonomy and the organization of the unintegrated ego. This observation is similar to Winnicott's (1965) concept of the "good-enough mother's" (p. 145) ability to sense her infant's needs. In Winnicott's framework the not quite good-enough mother fosters compliance as a way of relating to their environment rather than with spontaneity and a sense of omnipotence. The over-compliant way of relating is considered the development of a False Self in order to protect the True Self from annihilation. In other words, these children do not experience their own feelings but react to what is expected of them; they accommodate to the mother's needs in order to be loved and approved. The compliant nature of their object relationship with the mother precludes the child's experiencing her own inner needs and demands. This tends to make the child more dependent on the mother than herself and interfered with the growing sense of autonomy and sense of self necessary to individuating from the mother.

Identification with the mother appeared to occur only at a superficial, narcissistic level of attractive femininity. Fantasy play denoting interest in procreation and nurturance of small children was conspicuously lacking. The attainment of object constancy, or being on the way to object constancy, which is considered one of the important hallmarks of success for the separation-individuation phase was not certain for any of the pre-anorectic girls. Although by first grade none of the subjects manifested separation anxiety in the absence of their mother, this is not the same as maintaining a libidinal tie to the mother in spite of disappointments. What appear to be stable relationships can often be maintained with need-fulfilling objects by

splitting off negative feelings to someone else. After the onset of the anorexia and the regression in object relationships occurred, it appeared that the mothers received the negative side of the highly ambivalent relationships from the rapprochement sub-phase of the separation-individuation process.

These possible deficiencies in identification, autonomy, and object constancy did not greatly interfere with latency, but upon the threshold of adolescence when the instinctual demands became more urgent, the pre-anorectic girls may have become overwhelmed by their feelings that their bodies were getting out of control because they felt unable to regulate their own drives. Had they experienced an oedipal relationship with their fathers they would have had a more secure feminine identification and a more autonomous superego.

Research Question No. 2: What behavior in latency may obscure separation-individuation problems in the pre-anorectic girl?

The scholastic achievement and the approval of teachers and peers which the pre-anorectic girls attained would ordinarily lull parents into feeling very content about the development of the girls who were to become anorectic. Weaknesses were well disguised until there were pubertal signs of maturation. At that time while their peers turned themselves to boy-girl concerns and showed increasing individuation from parental standards and values, the anorectic girls-to-be remained at the level of the calm and compliant latency girls. While they continue with the action games of latency, their peers were proceeding to notice boys and to start testing parental limits. When their bodily changes could no longer be ignored they began the self-starvation that led to the developmental impasse of adolescence with the regression in

object relationships that has already been described in the twinship relationships.

Another behavioral clue that the pre-anorectic girls may have experienced more anxiety in latency than was apparent was the strength of their obsessional defenses. As the pre-anorectic girls proceeded chronologically through latency toward puberty, they became more and more perfectionistic in their academic work. The closer they came to puberty the harder they worked for outstanding grades and recognition. Reaction formation had been a very important defense that went with their compliant attitudes and smiling affect. The more they advanced through latency chronologically, the less appropriate was their Pollyanna behavior in contrast with their peers. Gradually, as the gap widened, they were alienated from their peers. Although they maintained the outward dress of a pre-adolescent they avoided the freer behavior of the pre-adolescent, retarded the maturation of their bodies through self-starvation, and denied interest in boy-girl relationships.

Directions for Future Work

It is clear that an analysis of six treatment cases restrospectively from closed records cannot possibly speak for the general population of young anorectic females. However, some of the commonalities among the cases appear to have a sufficiently firm base to warrant their further examination and future research. Several areas in the cases studied could benefit from having more data and more examination. The oedipal period and the development of the superego would have had a critical bearing on the outcome of the separation-individuation from the mother, but the quality of the relationship with the father was not well documented. The role of the father generally has received little

attention in the literature on separation and individuation and warrants more investigation. Another area which can provide more understanding of the vicissitudes of the girl's identification with her mother would be the development of the female siblings in the same family. This may shed more light on how the pre-anorectic daughter became so vulnerable to the mother's caretaking in the early years. Was it really lack of communicative matching and rejection or did the pre-anorectic girls bring with them some constitutional factors that made them incompatible with the mothers' character structure? There is much that remains to be learned.

APPENDIX

Table 1

Losses* Experienced Prior** to the Onset of the Anorexia

Valerie K, 12 years and 10 months:

Two sisters, her best girlfriends, moved away during a divorce.
Family took a Caribbean cruise and left her with a relative.
Her only sister went out of state to college.
Her mother removed her from a public school and placed her in a private school.

Betty L, 14 years and 10 months:

Father took up a separate residence; divorce possible.
Her twin sister breaking the bond and making separate friends.
Betty forced to accompany mother and twin sister on a vacation without the father.

Wilma D, 10 years and 3 months:

Parents took a vacation and left her with a relative.
Her best girlfriend moved away.
Older brother, only sibling, moved to another state.

Brenda K, 14 years and 8 months:

Oldest and favorite brother took a position overseas.
Family moved to a different state which introduced new school, new friends, new house, new church.
Visited biological mother and the mother's lesbian lover for a month. Loses the support of her step-mother, her older sister and her father because she does not condemn her mother.

Cathy L, 11 years and 3 months:

Older and only brother undergoes five brain surgeries. This absorbed most of the parents' energy.
The twin sister becomes depressed and withdrawn from Cathy too.

Frances K, 13 years and 6 months:

Death of the maternal grandfather resulting in mother's depression and withdrawal.
Loss of best girlfriend due to divorce of girlfriend's parents.
Older brother and only sibling takes a steady girlfriend for the first time.

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Laura B, 18 years and 3 months:

Best girlfriend of four years found another best girlfriend.
Left home to attend junior college.

Barbara K, 30 years and 8 months

Older sister goes away to college, "Like my right arm being cut off." Barbara was 20 at the time.
Older and only brother married the girl he made pregnant.
Vomiting also started at this time, age 20.

Rita R, 20 years and 7 months:

Enrolled in local college and joined sorority. Lived partly at home and partly at the sorority.
Best girlfriend in the sorority graduated and left.
Broker up with her first steady boyfriend.

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*The losses pertain to losses of important people either physically or emotionally or both or to a dilution of an intense relationship or to a change in a highly cathected environment such as home or school.

**These losses occurred up to six months prior to the onset of the anorexia.

N.B.: The ages given after each subject are the ages at which the first treatment meeting took place. The first treatment session took place usually within two years of onset except for Barbara who was ill 10 years before referral.

Only the first six subjects meet the criteria for inclusion in the sample population of young anorectics. The last three were included in this table for emphasis on the prevalence of separation issues. The nine cases comprise the total number of primary anorexia nervosa cases referred to the researcher April, 1979 - April, 1982.

Table 2

Identifying Data

Name	Age First Interview	Age at Onset	Months in Treatment*	Intact Family Yes	Intact Family No	Sibling Order	Number and Gender of Siblings
Valerie K	12 yrs-10	12 yrs-3	41 (+)	x		Last of three	Sister, 19 Brother, 17
Betty L	14 yrs-10	14 yrs-7	4		x	One of twins	Twin sister
Wilma D	10 yrs-3	10 yrs-1	3 (+)	x		Last of two	Brother, 19
Brenda K	14 yrs-8	14 yrs-3	12		x	Fourth of five	Sister, 21 Brother, 19 Brother, 17 Brother, 11 Step-sister, 19 Step-brother, 17
Cathy L	11 yrs-3	10 yrs-3	17 (+)	x		Twins are second of three	Brother, 13 Twin sister
Frances K	13 yrs-6	13 yrs	4	x		Last of two	Brother, 15

*Treatment months refer only to treatment following intake conducted by researcher. Those subjects also receiving treatment prior to that intake are identified with a (+). An exclusive medical approach is not included.

Table 3

Diagnostic Criteria for Primary Anorexia Nervosa

According to DSM III, 1980	According to H. Bruch, 1973*	According to J. P. Feighner, et al., 1972
Intense fear of becoming obese, which does not diminish as weight loss progresses.	A disturbance of delusional proportions in the body image and body concept. The gruesome emaciation is defended as normal and right (p. 251).	Age of onset prior to 25.
Disturbance of body image, e.g., claiming to "feel fat" even when emaciated.	A disturbance in the accuracy of the perception or cognitive interpretation of stimuli arising in the body, with failure to recognize signs of nutritional need as the most pronounced deficiency (p. 252).	Anorexia with accompanying weight loss of at least 25 percent or original body weight.
Weight loss of at least 25 percent 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 percent.	Curtailment of the caloric intake (p. 252).	A distorted, implacable attitude towards eating, food, or weight that overrides hunger, admonitions, reassurance and threats: e.g., (1) Denial of illness with a failure to recognize nutritional needs; (2) apparent enjoyment in losing weight with overt manifestation that food refusal is a pleasurable indulgence; (3) a desired body image of extreme thinness with overt evidence that it is rewarding to the patient to achieve and maintain this state; and (4) unusual hoarding or handling of food.
Refusal to maintain body weight over a minimal normal weight for age and height.	Hyperactivity and denial of fatigue (p. 253).	No known medical illness that could account for the anorexia and weight loss.
Amenorrhea (in females).	A paralyzing sense of ineffectiveness. This is camouflaged by enormous negativism and stubborn defiance, making personal contact with them very difficult (p. 254).	No other known psychiatric disorder with particular reference to primary affective disorders, schizophrenia, obsessive-compulsive and phobic neurosis. (The assumption is made that even though it may appear phobic or obsessional, food refusal alone is not sufficient to qualify for obsessive-compulsive or phobic disease.)
	Episodes of bulimia in about 25 percent of the cases of primary anorexia nervosa (p. 253).	At least two of the following manifestations: (1) Amenorrhea; (2) Lanugo; (3) Bradycardia
	The main issue is a struggle	

According to DSM III, 1980	According to H. Bruch, 1973*	According to J. P. Feighner, et al., 1972
	for control, for a sense of identity, competence and effectiveness (p. 251).	(persistent resting pulse of 60 or less); (4) Periods of overactivity; (5) Episodes of bulimia; (6) Vomiting (may be self-induced).

*From Eating Disorders, New York: Basic Books.

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