

PRACTICE NOTES
Specific Cases, Techniques and Approaches

Body Talk: Some Thoughts On Anorexia

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In this paper, I will attempt to address questions about the dynamics of anorexia within family relationships, the ways in which anorexic thinking encapsulates itself in the mind, and how it can leave both the therapist and the family feeling 'starved out'. I will also address some organisational issues, in the ways the therapeutic agency can come to mirror the anorexic dilemma. How does the metaphor of 'growing' and 'growing up' join with the anorexic crisis? I will discuss the cases of both a boy and a girl with anorexia, in order to think about the dynamic differences in the 'becoming of a man' and the 'becoming of a woman'.

As I was writing this paper, I realised I wanted to use it as an opportunity to think about my own uncertainties about the dynamics of anorexia. I also wanted to try to understand a very particular sort of dread I feel when I anticipate seeing an anorexic patient. It is as though the anorexic person has a special way of defying the process of thinking. There is a certain sort of encapsulation of thinking in anorexia that can starve the therapeutic relationship. At times this type of thinking has felt like a wish to be treated respectfully, *as a body without a mind*. Along with this is something of narcissistic dread for myself, in seeing a person who literally has the difficulty of 'taking things in'.

It has been noted increasingly (e.g. Byng-Hall, 1995; Flaskas and Perlesz, 1996) that some systemic theory pays little attention to the importance of our own feelings as therapists. To take our feelings seriously can be essential to understanding both our relationship with our clients and what may be the unspoken aspects of their experience. One could argue that this failure on the part of systems theory has been, ironically, quite unsystemic. Alongside this, it seems there is a paradox in the understanding and treatment of anorexia. On the one hand, it is essential that the therapist appreciate the power of the intrapsychic dynamics of anorexia—what appears at times to be a 'life defying loyalty' to the condition. Yet access to the meaning of these dynamics is

often only gained through the 'outer world' of family relationships. Byng-Hall (1995) writes about how essential it is to understand the connection between inner mental representations and outer 'dramatisations' of the family scene in which anorexia occurs. Some systemic theory may have ignored the richness of that connection. This paper is about my experience of the links of which Byng-Hall speaks. It will be divided into three sections. In the first, there will be a discussion of some of the theoretical issues surrounding anorexia. The second will address some organisational issues in the treatment of anorexia. In the final section, there will be discussion of my work with both a boy and a young woman with anorexia, and some thoughts on the differences and similarities in their dynamics.

WHAT IS ANOREXIA ANYWAY?

Psychodynamically, what anorexia is seems hard to determine:

Is it an obsession? There often seems to be an obsessive compulsive aspect in the anorexic person's thinking and behaviour: there are thoughts that are engrossing and repetitive, connected to food and body image—the person has difficulty thinking about anything else. The compulsive aspect manifests itself in the repetitive and often ritualistic approach to starving oneself, e.g. only certain foods will be eaten, cut up in a certain manner. I once had contact with a girl who, after her eating was under control, started compulsively hand-washing, almost as though the message was, 'If I'm going to eat your dirty food, I'm going to wash my hands of it'.

Is it a type of hysterical conversion? An hysterical conversion is a defensive technique designed to prevent the

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emergence of emotional conflicts into consciousness (Freud, 1895: 187; Fairbairn, 1952). Its essential characteristic is that it is a substitution of a bodily state for a personal problem, although in the case of anorexia, there is perhaps a level of intention dissimilar from other hysterical conversions. It often seems that once the anorexic person is able to think about the meaning of eating, eating itself again becomes easier, *as though the mind has been retrieved from the body*.

It is a perversion? By this I mean not a perversion in the moral sense, but rather a perversion (turning aside, warping) of the developmental process. It is significant that anorexia is often connected to the upheaval of puberty, when issues of sexuality, identification and desire arise. From a psychoanalytic point of view, a perversion has the defensive function of avoiding or controlling anxieties about these issues. All interest, control and excitement is focused on eating and the mouth. This could be seen as a way of unconsciously avoiding other anxieties. The anorexia could also be seen as a regression to, but also a denial of, the desires of infancy, where the mouth was the primary area of connection with the world.

Is it a psychosis? The body image distortion that the anorexic person suffers has the convincing quality of a discrete delusion. Lacan, the French psychoanalyst, describes (1966) a state in psychosis of refusal to recognise one's own desires and wishes. Certainly the inability to recognise 'hungry feelings' seems to come at a price of being severely cut off emotionally.

Anorexia seems to be a sort of kaleidoscope of all these states—obsession, hysterical conversion symptom, perversion, psychosis—with different aspects being highlighted at different times. However, at the core of the anorexic position, it feels as though there is something that is very difficult to reach. I wonder if, at this core, there is a breakdown of symbolic thought (somewhat similar to what occurs in schizophrenia). Basically, for the anorexic, food has ceased to *represent* nourishment that the parents *provide* and has *become* the parents. Hughes (1985: 18) writes 'we consider one of the reasons the anorexic adolescent girl must not eat, must not have the body of a woman, is not only out of fear of becoming like her mother, but of fear of becoming her mother'. In the context of this terror, I suspect that many young people who are helped to eat again are not 'cured' of anorexia, but just learn to manage it. In my experience, many people who have survived anorexia will speak of being haunted by the lure of anorexic thinking and its accompanying sense of control at times in their lives when they feel vulnerable.

For Lacan, the 'mirror stage' of infant development occurs at about six months: in this stage, the baby deals with his/her experience of being fragmented by fixing upon his/her mirror image (Lacan, 1977: 1). The image is substituted for the experience of the self: the real is replaced by the ideal, and this, according to Lacan, is the birth of alienation. I've been struck by the way this theory fits with the body image disturbance of the anor-

exic person—in the search for an ideal image, they lose the reality. The real mirror cannot reassure them that they are not fat. In the light of Lacan's concept, anorexia is a manifestation of an early disturbance that lies 'beyond the glass', as it were. I wonder if part of the disturbance in working with anorexic people is that we all live with not being able to see ourselves completely. That is, our body image is an *image* of the body, not the body itself. Our sense of the body is affected by our anxieties, assumptions, anticipations, pleasures and fantasies. I would argue that by virtue of having a consciousness, we all suffer from some body image distortion.

Most of my work with anorexic patients has been with younger adolescents, who have been hospitalised after becoming medically compromised—that is, they have become physically vulnerable due to starvation. I feel I have had quite limited success in individual work, and have been more effective in family therapy with anorexic patients and their families. Christopher Dare writes (1993: 4):

Family Therapy has been shown to be strikingly effective for early onset (that is, soon after puberty) anorexia nervosa. Follow-up studies, five years later, show that efficacious treatment in adolescence has long term benefits for this group.

Both Hilde Bruch (1982) and Selvini Palazzoli (1974) found the individual psychotherapy was ineffective. Equally, however, there is an active interest in anorexia in the current individual psychotherapy literature. The case studies in this literature suggest that although anorexia is difficult to treat, work is possible. Perhaps therapy has been hindered partly by the difficulty in formulating the anorexic crisis.

Family work is useful in addressing the crisis of control that the anorexic person presents to the family. However, from the theoretical point of view, there has at times been an over-simplification, as though the issue of control were the only crisis. The advantage of family work is that it allows the possibility of understanding the process of projective identification in the family—when shared family anxieties are projected into the patient and then acted upon. For example, in the literature there is a suggestion that anorexia can be a projection of fear of weight originating in the anorexic's same sex parent (Bruch, 1978: 27; Wilson, 1983). Perhaps the advantage of family work is that one is dealing with a phenomenon that often feels unreachable in individual work. I am reminded of Wilfred Bion's comment that thoughts look for a mind to think them (Bion, 1962: 110-119; Aschbach and Schermer, 1987: 99). Bion's statement could be extended to: 'sometimes anorexia feels like a thought trying to find a mouth to say it'.

Why is anorexia a largely female condition? How does the anorexic crisis connect to the psychological making of a woman? Why is the girl's separation from mother more complicated in adolescence? Does it indicate that the girl's inner world is more important to her and therefore a sense of *feeding* her inner world would

have particular significance? How does the notion of woman being the 'other', 'the looked upon' in this culture connect to body image crisis, in anorexia? Perhaps it also joins with cultural complications about the expression of female desire. How much does anorexia connect with an historical aesthetic tradition about the denial of wants? This cultural background has been vividly discussed by Orbach (1978) and Kayrooz (1994).

ORGANISATIONAL ISSUES AROUND ANOREXIA

I will now discuss some organisational issues connected to the treatment of anorexia. There are important questions to be asked about what sort of parallel process happens in the hospital staff group dealing with anorexic patients—that is, in which ways does the organisation mirror the conflicts of the anorexic? Does the staff group collude with the anorexic's invitation to treat the her/him as 'a body without a mind'? Is it possible to get caught up in the almost psychotic belief that 'we are what we eat, and that is all we are'? If so, there is the danger of the patient being treated as a container of calories, on the road to a destination called 'target weight'. Having said that, equally it would be dangerous to lose sight of the physical crisis that anorexia can create. To do so may be colluding with the disbelief in the finality of death that the anorexic person often presents. It is as though the control can outlive the being. Sometimes the anorexic experiences the fantasy of viewing his/her own funeral, watching omnipotently, whilst relatives and staff grieve and regret their actions.

The therapeutic team often have to deal with feeling controlled and starved out by anorexic patients. It is important that this be paid attention to and contained within the organisation. I mean 'contained' in the *Kleinian* sense, that such feelings are thought about within the staff group as a way of potentially understanding the patient's experience. Without this containment, the projected feelings in the group are at risk of being acted upon, and the 'starving' staff can feel induced to sadistic action. Although the nasogastric tube has its place in emergency re-feeding, I wonder if, at times, it could unconsciously be used as an attack on the anorexic's closed mouth. Equally, sometimes anorexic patients can become reluctant to give up the tube. Perhaps the tube colludes with a belief that one does not need to eat, chew and swallow to live, that one can live magically.

CASE STUDIES

I will now discuss some work with an eleven year old boy, and with a fifteen year old girl. For them both, anorexia could readily be conceptualised as an attempt to stall puberty, sexuality and separation. However, I would like to try and think about the differences in the dynamics between the girl and the boy. The following case examples are my understanding of how the young person's internal images of their parents complicate their own sense of growing up. The anorexia dramatises

this struggle. Of course, systemically this dramatisation meets with the parents' own desires and anxieties about being good parents who can nourish their children. A powerful battlefield is created from intrapsychic forces.

The Case of Cindy

Cindy was a fifteen year old girl who was admitted to hospital in a state of malnourishment. She had previously seen a psychiatry registrar at another hospital. Her father said that Cindy disliked this man intensely. This marked a pattern I came to know well: Cindy's strong negative feelings would be voiced by her father. Cindy would remain silent. The shut mouth would remain more powerful than the speaking one. Cindy was in hospital for three months. Due to staffing pressures, I saw Cindy individually, twice weekly, during her hospitalisation, and saw the family weekly. After her discharge from hospital, Cindy chose to come to individual appointments. Intermittently I continued to see the family for over eighteen months. For the first three months I had the consultation of the Family Therapy team, using the one-way mirror for the family work. I would describe my family work as psychodynamically informed, although I use techniques from other schools of family therapy.

Individual sessions with Cindy were difficult. She resented being in hospital and the way in which it interfered with her fatal dietary plan to be 28kgs. She was frequently silent for long periods of time in the sessions. Sometimes the quality of the silence would change from controlling to sad. I found myself depending on my countertransference, commenting on her feelings of being controlled, stuck and abandoned. Cindy gave me vivid experiences of these states—in the sense that my interpretations were often rejected, so that *I* felt stuck and abandoned as a result of her rejection of my words. In the last ten minutes of the session, Cindy would usually cry silently. She would respond to comments about feeling abandoned by her parents to the hospital, but feeling hatred of the control that both the hospital and her parents had in her life. Gradually she started to acknowledge fears of her own, for instance, a fear that if she started eating she would not stop. Interestingly, mother was a caterer by trade and was somewhat overweight. Mother reported being unable to enjoy Cindy as a baby, being somewhat revolted by the physical and sensuous needs of a baby. It felt as though Cindy's difficulties remained at this preverbal level, where the sense of being 'catered for' with everything contrasted with the strong sense of never having enough.

Mother had longstanding depression. She assured me on our first meeting that she had considered suicide every day for years. From time to time she had had referrals from her GP to a psychiatrist. She described graphically how she would place the referral letter on the mantelpiece, haunted by the opportunity, but unable to use it. Father stressed how similar his wife and daughter were in their 'moodiness'. Within the whole family there seemed a level of relief that they had

at last arrived to see some sort of 'shrink'. Family sessions were frequently marked by a level of tension and silence between mother and Cindy. Father would try comforting Cindy, and the younger sister, Cathy, would try desperately to provide comic relief. However, three significant issues emerged which affected the parents' relationship with Cindy.

- Mother had had a child prior to marriage, whom she had been forced by her own mother to give up for adoption. She remained totally preoccupied with this absent daughter. On some level, *Cindy had never seen herself in her mother's eyes*. Perhaps this connected with the unconscious choice of the illness—that is, that Cindy was having increasing impact and presence, through her own diminishing. At one stage, Cindy sent me a message: I was not to think that the adopted child issue was the main problem. Perhaps this had the overdetermined meaning that I was not only not to 'lose sight of' Cindy as her mother had done, but also should pay extra attention to the issue that Cindy told me was of diminished importance.
- After some time, it appeared there was something unsayable for mother in the family sessions. I saw mother individually, and she disclosed that she had been sexually abused by her father when she was fifteen (Cindy's age). It was as if for herself she considered fifteen an unpassable year. Mother felt filled with shame on this disclosure and could barely stand to see me. However, it freed her to comment on her overprotectiveness of Cindy and lack of trust in her husband.
- Father, perhaps in response to his own and his wife's anxieties, would tend to be very critical of Cindy. He would lecture Cindy on her selfishness in being ill. This may have been a defence against the anxieties of a close father-daughter relationship. The disagreements in this sense, served as a distance regulator.

Cindy was caught between enormous dependency needs and anxieties about sexuality and individuation. Perhaps the use of silence by Cindy and her mother reflected anxieties about aggression that could be unleashed by speaking. I wondered if Cindy felt she could bite her mother's head off, and equally, feared she would become her mother.

Freud (1932) and Klein (1945) comment that a female's psychosexual development must undergo more complicated changes at adolescence than a male's. The girl is faced with both identifying with her mother as a woman, and simultaneously separating from her. This was Cindy's dilemma. In some ways Cindy could not separate, as she felt she had never 'had' her mother. As mother was helped by the therapeutic work, she began to set appropriate limits with Cindy. Mother also became significantly less depressed. Cindy became more vocal and more adolescent. After Cindy's discharge, I continued to see the family on an outpatient basis.

Cindy has managed to control her 'anorexic thinking' to the point she is able to work and function. Although all the difficulties have not disappeared, the work has helped identify and lessen some shared anxieties in the family.

The Case of Andrew

I saw Andrew, aged eleven, as an outpatient in a hospital setting over a three month period. For Andrew, the anorexia represented a crisis in the development of his identity. His rapid weight loss followed being teased at school for being a 'goody goody'. To Andrew it appeared that the unconscious meaning of 'goody goody' was 'soft and girlish'. Andrew was the middle of three children. His elder sister, Dale, was named after their father. She was extroverted and assertive. It felt to me as though in the mind of her family, she had symbolically inherited the father's phallus (Chodorow, 1978: 123). Andrew himself would speak of feeling unacknowledged by his father, and concurrently he resented his sister's confidence. The youngest child was a two year old whom Andrew mothered. Father was a somewhat quick tempered man who was disturbed by his son's psychological difficulties, feeling that Andrew had a 'feminine' illness. Mother was a depressed woman who missed their homeland, Ireland. The family had unsuccessfully migrated to Australia, and were planning to return home. Both parents had ambivalent relationships with their own parents, reflected in a difficulty both in leaving home and in successfully returning.

I was initially involved as the family therapist. However, after one month, the person doing individual work with Andrew left. I was left 'holding the baby'. Looking back, I think that both the family and I resented this. On one occasion, I almost forgot a session and arrived very late. The family did not complain, but gave me the feeling this was an expectable part of the service. The family were reluctant about the sessions, which were frequently dominated by mother's feeling of loneliness and her complaint about the unfriendliness of Australians. Several times mother asked me directly whether I thought Australians were more unfriendly than the Irish. It always felt as if this was to check whether her loneliness was about being unlikeable. I sensed that the parents felt that little would come of this 'Australian' therapy. Andrew, by contrast, always seemed keen to attend. I decided to start seeing him individually.

As Andrew's anorexic symptoms fairly rapidly disappeared, it emerged that he was struggling to work out what sort of man he would become. He appeared to me to be struggling with whether to identify with his mother or his father, and feared the consequences of either identification. He expressed a wish to be the sort of man who cared for his wife, although was anxious that this would be 'too soft'. Perhaps there was also an understandable wish to do a better job than his father. Sadly his mother withdrew him from treatment at a time Andrew was most fully expressing these concerns. In view of the family difficulties with attachment, the with-

drawal at that time may not have been an accident. However, the therapy did provide Andrew with a space which enabled him to think about his own growing up.

Although Andrew had the dilemma of his identification, I wondered if, as Andrew had more experience of his own masculinity, this would in some way decrease what Bion (1967) refers to as his 'nameless dread' of becoming his 'internal mother'. In this way, his position was perhaps freer than Cindy's. However, Andrew was also struggling with how to identify with his father, whom he perceived as an aggressive man. From this point of view, his anxiety was that to be masculine was to be aggressive. Connected to this was a sense of abandonment by his depressed mother. At one stage, Andrew expressed the feeling that the older he got, the lonelier he became. Andrew was dealing with the dilemma that to become a man, he would need to give up his mother as his object of identification. Perhaps that also left him with the anxiety of who would then 'mother' his mother?

CONCLUSION

In the course of writing this paper, I have been struck by the paradoxical nature of the anorexic position, in that it involves both a regression, and a rejection of regression and dependency. I was reminded of the many times in sessions I had felt starved out, my ideas 'spat back at me' or 'flushed away'. There seems to be an attempt in anorexia to stall the notion of time and development, as though the anorexia is an attempt to say no to a perceived future. With the two young people discussed, some of their anxiety was about becoming their internal parents. One could argue that it was only by working with their *real* parent that this was relieved. I think the anorexic's anxiety can be of terrifying, psychotic proportions. In parallel to this, at times the therapeutic team can feel driven mad by the anorexic dilemma. There can be the impulse to aggressively force-feed the patients, or alternatively, to starve the starving patients of their sense of self—that is, to treat them as *a body without a mind*.

Freud (1923) recognised the ego as 'first and foremost a body ego'—in other words, our first experiences of ourselves come through the body experiences. Anorexia could be seen as an attempt to regain and control this primitive experience of self. Perhaps on this level,

it is an extremely literal attempt at self-definition. It is the outer dramatisation of this struggle, the struggle for self, that needs to be facilitated in the arena of the young person's relationships.

Acknowledgments

I wish to thank Mrs Valli Shaio Kohon, child psychotherapist, and the editors, for their helpful comments.

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*The fine delight that fathers thought; the strong
Spur, live and lancing like the blowpipe flame ...*

G. M. Hopkins (1889). To R. B.

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