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**TOWARDS A MORE SPECIFIC MODEL
OF ANORECTIC PATHOGENESIS:
PARENTAL SELFOBJECT USE OF THE PRE-ANORECTIC CHILD**

Christina Frederick

Doctoral Dissertation Presented to
the School of Graduate Studies
of the University of Ottawa

May 1995



Christina Frederick, Ottawa, Canada 1995



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ABSTRACT

Decades of research on the anorectic's family relationships have contributed a certain measure of depth and precision to our current understanding of this syndrome's pathogenesis. Yet none of the existing etiological formulations is specific as regards the predisposition to anorexia nervosa in that they also apply to other psychopathological conditions. Furthermore, many of these models do not address the precipitation and maintenance phases of the disorder, preferring to remain narrowly focused on premorbid personality factors. As well, existing etiological conjectures do not adequately explain several phenomena regularly encountered among anorectics, such as their relentless quest for perfection and their unusually intense autonomy strivings.

In line with this problematic, the current work outlines a modal etiological pattern that is specific to core-group restrictive anorectics and that addresses the precipitation and maintenance phases of the disorder as well as predisposition. It also offers an explanation for their assiduous quest for perfection and their inordinately strong autonomy strivings. It does so by focusing on a hitherto largely overlooked aspect of relationships in the anorectic family, namely the particular ways in which the pre-anorectic child is called upon to compensate for parental emotional deficits. It is conjectured that the predisposition to anorexia nervosa arises in the context of her simultaneous function as a self-denying, merged selfobject to her mother and as an omnipotent, idealized selfobject to either or both parents.

Such selfobject use of the pre-anorectic child is argued to leave her with a heightened sensitivity to environmental rejection experiences because of her inordinate dependence on external validation combined with the habit and expectation of being seen as "special". In addition, she finds herself with a uniquely polarized false-self system, particularly strong autonomy strivings, and a highly restricted repertoire of behaviours deemed acceptable, all of which eventuate in a particular proneness to shame and self-rejection. Moreover, this particular conjunction of family relationships and resulting cognitive and emotional distortions is seen to readily distinguish the anorectic from other psychodiagnostic groups with whom she shares certain clinical characteristics.

It is the above combination of premorbid personality characteristics that is conjectured to place her at special risk for anorexia in the face of the normal developmental and environmental stresses of adolescence. More precisely, these personality factors place her at such risk, firstly, by compromising her ongoing self-esteem regulation either by sharply restricting the conditions under which she is able to maintain a relative sense of emotional well-being or by introducing an inherent tension or instability into her false-self

system. Secondly, the adaptive mechanisms learned within the postulated selfobject relationships help to determine the coping strategies that she chooses in adolescence. That is, the anorectic's self-perfecting in the form of slimming is seen to exemplify an "adult" version of an earlier strategy for the avoidance of shame and self-rejection.

As this strategy, however, essentially represents the misapplication of a local solution to a global problem, in contradistinction to the situation of the non-anorectic dieter, it ultimately fails. This, together with the family systemic factors so often cited in the literature and the strongly polarized, countervailing tendencies within her false-self system, are argued to eventuate in a series of intrapersonal and interpersonal vicious escalations that conspire to entrench her ever further in her symptoms.

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I. INTRODUCTION

Problematic

Most researchers in the field of anorexia nervosa agree that the nature of the anorectic's relationship to one or both of her parents represents a necessary, if not sufficient, factor in the pathogenesis of her illness. In fact, several decades of investigation have spawned a variety of etiological conjectures regarding the anorectic's relationships to her parents. Many of these formulations have contributed some measure of depth and precision to our current understanding of this syndrome's pathogenesis.

Nevertheless, none of these explanations is specific as regards the predisposition to anorexia nervosa in that they also apply to other psychopathological conditions. Moreover, many of these formulations do not address the precipitation and maintenance phases of the illness, preferring to remain narrowly focused on the premorbid personality factors believed to arise out of the anorectic's relationship to her parents. In addition, existing etiological models do not adequately explain several phenomena regularly encountered among anorectics, such as their assiduous quest for perfection and their inordinately strong autonomy strivings.

Brief Overview of the Current Work

In line with these considerations, the current work aims to highlight a modal etiological pattern that is specific to anorectics and that addresses not only the predisposition to this illness, but also its precipitation and maintenance. As well, it seeks to explain these patients' unrelenting pursuit of perfection and their unusually intense autonomy strivings.

It will do so by examining a hitherto largely overlooked aspect of relationships in the anorectic family, namely the pre-anorectic child's function as a parental "selfobject", whereby the child is induced to behave in such a way as to meet the parent's defensive requirements. Goodsitt (1983, 1985), a self psychologist, points to this aspect of the pre-anorectic child's family relationships in his etiological formulation of anorexia. This approach appears particularly promising in that, unlike the largely deficit models of pathogenic parenting, such as that of Bruch (1973), it not only accounts for what is lacking in the anorectic's emotional development, but also helps to explain how certain of the cognitive and emotional distortions that these patients tend to manifest may have arisen. Unfortunately, Goodsitt never takes the logical next step of outlining the precise ways in which the pre-anorectic child is called upon to meet parental selfobject needs. As well as meeting the three above-mentioned objectives, the current work aims to help fill

this particular gap in the self-psychological literature on anorexia nervosa: it will be conjectured that the predisposition to anorexia arises in the context of her simultaneous function as a self-denying, "merged selfobject" to her mother and as an omnipotent, "idealized selfobject" to either or both parents.

Such selfobject use of the pre-anorectic child will be argued to leave her with a heightened sensitivity to environmental rejection experiences because of her inordinate dependence on external validation combined with the habit and expectation of being seen as "special". As well, she finds herself with a uniquely polarized self-definition, particularly strong autonomy strivings, and a highly restricted repertoire of behaviours deemed acceptable, all of which eventuate in a particular proneness to shame and self-rejection. It is these characteristics, it will be argued, that ultimately predispose her to the onset of anorexia in the face of the normal developmental and environmental stresses of adolescence. Moreover, these characteristics will be conjectured to play a role in the ongoing maintenance of the anorectic syndrome.

The above hypotheses are situated within a neo-psychoanalytic perspective, informed principally by self-psychological (Kohut, 1971, 1977) and object relations (Kernberg, 1975; Laing, 1971; Mahler, 1968; Mahler, Pine, & Bergman, 1975; Winnicott, 1965) constructs.

General Structure of the Current Work

The present work consists of ten chapters beyond this introduction. The chapter immediately following this one describes the (Popperian) epistemological and methodological framework within which the thesis is situated. It also discusses the utility of etiological theorizing and the problem of heterogeneity among anorectic patients. Next, a brief overview of the anorectic syndrome is offered, including a brief history of the illness, incidence, diagnostic criteria, differential diagnosis, sub-groupings of anorectic patients, clinical characteristics of "core-group" anorectics, and prognosis. This is followed by a critical review of existing etiological theories, including the biological, psychodynamic, family systemic, cognitive-behavioural, sociocultural, and existential-phenomenological models. The succeeding chapter consists of a more in-depth discussion of the problematic that underlies the present work and that arises out of the critical review in the previous chapter.

Next, as an aid to the reader, Chapter VI. presents a schematic outline of the thesis' principal arguments, as regards the predisposition to, the precipitation of, and the maintenance of the anorectic syndrome. This is followed by the current work's central

chapter which describes the conjectured construction of the anorectic predisposition in terms of the particular ways in which the pre-anorectic child is utilized to fulfill parental selfobject needs. First, the role of selfobjects in psychological development in general is reviewed from a Kohutian perspective, followed by a brief outline of how this notion can be seen to apply to the situation of the pre-anorectic child as described in the anorexia literature. The concept of the parental selfobject use of a child in general is then operationalized, both in terms of parental and child behaviours. The cognitive and emotional distortions eventuated in a child by such selfobject use is discussed next. This is followed by a consideration of the pre-anorectic child's function as a merged selfobject, together with the corresponding operationalization of parent-child interactions and resulting distortions in the child's personality. As this is still not specific to the anorectic, the notion of the pre-anorectic child's additional function as an idealized selfobject is presented, based on the presumed etiologies of traits which the anorectic shares with narcissistic personalities. This is again followed by the corresponding operationalization and discussion of personality dynamics eventuated in the child. Finally, the combined effect of the pre-anorectic child's simultaneous function as a merged and idealized selfobject is outlined; these personality dynamics are then contrasted with those of other psychodiagnostic groups who share some of the anorectic's clinical characteristics.

The next chapter moves on to a consideration of the developmental, environmental, and family systemic precipitants of anorexia. The anorectic's ways of coping with adolescent stressors, from a failed prodromal withdrawal through the application of a more "adult" version of the earlier coping mechanism described in the previous chapter, are then outlined. This is followed in the next chapter by a discussion of various aspects of the maintenance phase of the illness, including the anorectic's misapplication of a local solution to a global problem, the family systemic factors so often cited in the literature, and certain intrapersonal and interpersonal vicious escalations that arise at least partly out of the combined effects of her simultaneous function as a merged and idealized parental selfobject.

Next, Chapter X. outlines various implications of the current etiological model for both the individual and family treatment of anorexia nervosa. Finally, the conclusion discusses some of the present work's limitations, as well as certain epistemological considerations regarding future research.

II. EPISTEMOLOGICAL AND METHODOLOGICAL ISSUES

The conjectural nature of the thesis is situated within a critical rationalist epistemological discourse (Popper, 1968, 1972), as outlined below.

Critical Rationalist Epistemology

Most researchers in cognitive science now view the human individual as actively constructing his knowledge of the world, rather than as passively receiving a ready-made version of his environment. The implications of this position for the status of that which we call knowledge is clear--there is no way to assess the *objective* truth of knowledge, if the object of that knowledge can only be accessed through a further (constructive) act of knowing (von Glasersfeld, 1985; Mahoney, 1988). Rather, the best that we can hope for is to be able to construct theories that are *consistent* with already accepted constructions of reality, be they theoretical or empirical.

This epistemological stance is generally referred to as constructivism and its more philosophical (as opposed to social science) variants take two main forms, generally referred to as "moderate" or "radical" (Mahoney, 1988). Moderate constructivism admits of a pre-given reality, which cannot, however be directly known, as described above. According to radical constructivism, on the other hand, all is construction and nothing is pre-given (except it would appear, the totally constructed nature of reality!).

Popper's (1968, 1972) critical rationalism is a particular epistemology and methodology that is congruent with the tenets of moderate constructivism. For example, according to both moderate constructivist and Popperian reasoning, empirical observations do not offer some sort of privileged access to empirical reality, but rather are constructs or conjectures about that reality. Thus, both moderate constructivism and critical rationalism strive not for theories that correspond to reality, which cannot be known, but rather for theories that are *consistent* with empirical reality, that is, with perceptual constructs of reality.

According to Popper's (1968) central epistemological notion, a theory can never be *verified* or shown to be true, for one cannot possibly know whether an as yet unmanifest particular instance will not at some point contradict one's theory (Hume, 1964). Hence, a theory can only be *refuted* or shown to be false by finding an inconsistency between its predictions and empirical observations. Again, these empirical observations are not believed to correspond to empirical reality, but rather to be constructs or conjectures about that reality.

To Popper (1968, 1972), a good scientific theory is one which is refutable at the empirical level in that it is able to make predictions about observable empirical events. Once again, these "events" are seen as constructs rather than as real-world happenings. Thus, critical rationalism strives for consistency between the empirical world and the conceptual realm of theory-building through the search for inconsistencies between two levels of constructs--the empirical and the theoretical. When such an inconsistency is found, it is the rational or theoretical conjecture, rather than the empirical one, that is assumed to be flawed, and the theory stands refuted.¹

A further criterion of a good theory is that it must be internally consistent at the rational level. That is, in addition to empirical falsification, the Popperian researcher uses critical reasoning to find logical inconsistencies in his argumentation. This criterion also applies to metaphysical speculation, such as Popper's (1968, 1972) theory of knowledge itself, which of necessity derives its rigour from logical consistency alone. Thus, while both scientific and metaphysical theories aim for logical consistency in their argumentation, only scientific theories explicitly form a bridge to the empirical level of reality through the process of refutation (Popper, 1972).

In accordance with the foregoing criteria, the present work aims at a scientific theory that is both internally consistent at the rational level and refutable at the empirical level.²

The Method of Critical Rationalism

What then, is the actual methodology of critical rationalism? Following an identification of the problem to be studied, the researcher sets about the task of speculation. In terms of the logical operations involved, such speculation generally takes the form of "inductive" reasoning, that is, of inferring general or universal statements from particular instances, as in all scientific reasoning. As we have already seen, there is no logical necessity to such "induction", for a particular phenomenon that contradicts the universal statement may arise at any time (Hume, 1964; Popper, 1968).

As for the cognitive processes inherent in such speculation, they appear to involve the

¹ It is also important to remember that critical rationalism does not object to a theory's being based on assumptions that are irrefutable, as long as the theory itself is presented in a refutable form. Indeed, all theories, including those based on so-called data-driven research, are ultimately based on irrefutable assumptions. That is, there is really no incontrovertible ground upon which to base human knowledge. This does not, however, prevent theories from being refuted, that is, from being shown to be inconsistent with existing empirical constructions.

² This attempt at refutability is only intended to apply to that portion of the thesis that represents a more or less original contribution to the anorexia literature, namely the etiological model of the predispositional phase of the illness.

thinker's entertaining a number of alternative viewpoints or possible resolutions of the problem in question. These varying perspectives are then usually examined and either rejected or tentatively accepted for their "intuitive" appeal. (This latter process presumably already includes a search for inconsistencies, even if only implicit; for example, when a more intuitively oriented individual does not feel an idea to "resonate" with him, it is probably because this idea clashes or is inconsistent with his existing reality constructions).

The theory is further examined critically through more formal attempts at logical counterargumentation, which generally involve a search for contradictions within the theory itself or vis-à-vis existing theories (usually those already accepted by the thinker). The theory is also assessed in terms of whether it does in fact explain or resolve the problem posed at the outset. The theory is then modified accordingly (or discarded outright).

Finally, the researcher formulates his theory in a refutable fashion, that is, from the theory he deduces at least one prediction or hypothesis³ as to what empirical observations one can expect to make.⁴ Thus, he opens his theory to falsification, through the possibility of finding an inconsistency between the rational and empirical levels of knowledge. That is, a theory is considered falsified or refuted when the predictive hypotheses logically derived from it are not confirmed. Another way of conceptualizing this aspect of Popperian epistemology is that a theory is a general statement from which one logically derives particular statements or predictions. These predictive hypotheses about particulars are empirically tested and if not confirmed, signify the refutation of the theory's general statement(s).

For instance, in physics, the special theory of relativity is rendered refutable by logically derived hypotheses, such as those which predict that certain stars will be visible at given points in time and space. If such a prediction about the location of a star at a given time were not confirmed, Einstein's theory would be considered to have been refuted. On the other hand, if such a predictive hypothesis were confirmed, the theory would be considered to not have been refuted. (In Popperian epistemology, the confirmation of such a *predictive hypothesis* does not signify the confirmation or verification of the *theory*. For future predictions also logically deriving from the theory may not, in fact, be

³ While the terms "theory" and "hypothesis" have a specific meaning in Popperian epistemology, such terms as "model", "conjecture", "speculation", "notion", or "formulation" do not, and they can be used interchangeably in reference to either a theory or a predictive hypothesis.

⁴ Such a logical deduction may or may not proceed in several steps, whereby one hypothesis deriving from the theory is used to deduce a further hypothesis. It may occur that only the final hypothesis of the series takes the form of a prediction.

verified because of some flaw in the theory not accessed by the previously confirmed predictive hypothesis.)

Finally, when a theory is refuted, it is not discarded outright. Instead, it is first re-examined to see what problems may be inherent in all or part of it. It is then modified accordingly, and one or more newly derived predictive hypotheses are again tested empirically. Refutation is thus best viewed as fuel for further speculation and refinement of a theory, rather than as its wholesale demise.

Some Theoretical and Practical Rationales for Etiological Theorizing

One way to generate a broader range of explanations about a given phenomenon is to examine that phenomenon from a variety of perspectives. For example, to examine a given physical object from a number of spatial perspectives gives rise to a greater diversity of conjectures about that object than does doing so from a single standpoint--as a case in point, to observe the moon not only with the naked eye, but also with a telescope, as well as to observe a portion thereof under a microscope, gives rise to a greater variety of theoretical constructs about it than to observe it with the naked eye alone, a procedure that long did little to refute the popular notion that the moon was made of green cheese. At a more psychological level of discourse, to interview the members of a family on their differing lived experiences of each other and of a given situation, as in phenomenological family research (Emmrys, 1992), gives rise to richer understandings of that family situation than do more unidimensional family research methods such as those of Minuchin (1974) and Selvini Palazzoli (Selvini Palazzoli, Cirillo, Selvini, & Sorrentino, 1989; Selvini Palazzoli & Viaro, 1988). Moreover, in both these examples, it can be seen that such diverse observational perspectives impose a certain rigour on one's theorizing in that not only must any viable conjecture take these differing observations into account, but the various conjectures that arise out of these observations must also be consistent amongst each other.

Similarly, conjectures about the genesis of a given psychopathology are invaluable to the development of theories about that disorder's ongoing characteristics and probable future course. For such an expansion of the temporal dimension of a given disorder through etiological theorizing gives rise to a host of complementary explanations. That is, to study a given syndrome only in the present moment is to exclude potential constructions of that syndrome's nature that may be derived from conjectures about its cause and past course. Moreover, the predictive power of psychopathological theorizing is enhanced by etiological constructions. For, if one has no conjectures about the cause and past course of a given disorder, it is difficult at best to predict much of anything about its future manifestations.

At the level of practice, the improvement of the psychotherapeutic treatments for a given syndrome, while often seeming to proceed by trial and error, is in fact usually informed by a hypothesis or prediction about what will occur as a result of a given intervention. And such predictive hypothesizing about which treatment conditions may help to alleviate a given disorder is usually at least partially based upon conjectures about the circumstances under which that symptom picture typically arises, that is, upon etiological theories.

For instance, a self psychologist, believing his patient's personality disorder to be rooted in a lack of adequate mirroring in childhood, will likely predict that providing this experience for her within the treatment setting will allow her to develop a healthier self-structure. Moreover, etiological hypotheses can be used to enhance therapeutic efficacy not only at the level of process, but also at the level of content. For instance, theories of pathogenesis may help the cognitively-oriented therapist in his conjectures about his client's explicit and implicit belief systems. And the psychoanalyst may be interested in etiological hypotheses in order to inform not only his historical reconstructions, but also his ongoing transference interpretations.

Similarly, the family processes that are believed to have contributed to the predisposition to a certain syndrome in one of the children may still be ongoing, perhaps in combination with more recent factors, and can be directly addressed in conjoint sessions. In anorectic families, such processes very likely are indeed still ongoing--because the pervasiveness of developmental deficits in both the typical anorectic patient and her parents points to moderately severe character pathology, it is probable that the parents' emotional needs have not changed and that the anorectic child continues to be subject to pressures similar to those experienced in childhood.

Finally, in the area of prevention, the arguments for etiological theorizing are even more compelling, for such hypotheses can obviously be utilized to forestall future pathological developments by changing the conditions under which they are believed to arise. Thus, etiological hypothesizing can be seen to be of considerable importance to the enterprise of clinical psychology, both theoretically and practically.

The Problem of Heterogeneity Among Anorectic Patients

Anorexia nervosa has long been perceived as heterogeneous in its manifestation, in terms of both personality organization and family structure (Crisp, 1980; Sours, 1980). Some theorists have suggested that there may exist a spectrum of anorectic syndromes, as well as some subclinical varieties, and that anorexia is perhaps best seen as a symptom that

represents a final common pathway for a number of psychopathological processes (Garfinkel & Garner, 1982; Yager, 1982). Indeed, anorectic symptoms have been observed in individuals ranging from fairly well-functioning neurotics to severely disturbed schizophrenics (Bruch, 1973; Sours, 1979, 1980).

The fact remains, however, that there are striking similarities among many of the anorectics described in the literature, even across differing theoretical orientations or cultural settings. This is the so-called "core group" (Evans, 1982; Sours, 1980; Story, 1976) of female restrictive anorectics who have been described at length by such leading theorists as Bruch (1973, 1988), Selvini Palazzoli (Selvini Palazzoli, 1974; Selvini Palazzoli & Viaro, 1988), Minuchin (Minuchin, Rosman, & Baker, 1978), and Crisp (1980). It is to this core group of "classical" anorectics and their families that the present work will limit itself, both for the sake of clarity and due to the relative abundance of both empirical and clinical observational data on this type of anorectic patient.⁵

This is not to say, however, that even these so-called classical cases and their families exist in any sort of pure form. The problem of accounting for individual differences that plagues all nomothetic research in psychology is clearly operative here. Thus, the etiological hypothesis to be offered is intended not to apply universally to core-group anorectics, but rather to represent a *modal* pattern among them.

⁵ This core group of anorectic patients is described in greater detail in Chapter III, "Overview of the Syndrome".

III. OVERVIEW OF THE SYNDROME

History of the Illness

Richard Morton's 1694 report is believed to be the first clinical description of anorexia nervosa. Associating it with tuberculosis and other wasting diseases, he referred to a state of "nervous consumption" characterized by decreased appetite, amenorrhea, food aversion, emaciation, and hyperactivity (Foreyt & McGavin, 1989; Gordon, 1990). The delineation of anorexia nervosa as a distinct, psychological syndrome did not occur until almost two hundred years later when Lasègue (1873) in France and Gull (1874) in England coined the terms "anorexie hystérique" and "anorexia nervosa" respectively. As the condition was found to also exist in some men, the former term was soon replaced by "anorexie mentale" in France. Since that time, anorexia nervosa has been widely reported in the psychiatric, endocrine, and gynecological literature, often under different names and with different interpretations given to the various components, but with little variation in the overall clinical picture (Edelstein, 1989; Foreyt & McGavin, 1989; Gordon, 1990).

Then in 1914, the research on this syndrome was thrown in a whole new direction when Simmonds reported the presence of pathological lesions in the pituitary gland of a severely cachectic patient (Bruch, 1973; Garfinkel & Garner, 1982). After the publication of these findings, the search for an underlying endocrine disturbance persisted for some twenty-five years. Finally, in the 1930's and 1940's, the major focus of the research returned to the psychological aspects of anorexia nervosa (Selvini Palazzoli, 1974; Vandereycken & Meermann, 1984), as outlined in the next chapter of the present work.

Incidence

Anorexia occurs predominantly in females (85% to 95% of all reported cases), with a mean age at onset of 17 years (with some data suggesting bimodal peaks at ages 13-14 and 17-18 years) (Garfinkel & Garner, 1982; Halmi, Casper, Eckert, Goldberg, & Davis, 1979; Harris & Phelps, 1987). The onset of this disorder is rare in females over the age of 40 years. Epidemiological studies among females in late adolescence and early adulthood have found rates of 0.5% to 1.0% for presentations that meet the full DSM-III-R criteria for Anorexia Nervosa (American Psychiatric Association, 1994; Halmi et al., 1979; Harris & Phelps, 1987). For women of all ages, conservative estimates suggest that 1 out of every 250 develops the condition (American Psychiatric Association, 1994; Edelstein, 1989; Harris & Phelps, 1987). More commonly encountered are subclinical presentations of this disorder. There are few statistics concerning the prevalence of this disorder in males.

Although precise data are not available, due to methodological problems such as inconsistent diagnostic criteria and inadequate record-keeping, the incidence of anorexia nervosa appears to have increased over recent decades. It is not clear, however, to what degree this increase simply reflects an increase in public and professional awareness of the disorder (Gordon, 1990; Harris & Phelps, 1987).

Diagnostic Criteria

The central characteristic of anorexia nervosa is the pursuit of thinness beyond the point of consensual attractiveness, social desirability, and normal health concerns. Even when extremely emaciated, anorectic patients deny their thinness and claim that they are "too fat" (Bruch, 1973; Chediak, 1977; Garfinkel & Garner, 1982).⁶

The most widely accepted diagnostic criteria for anorexia nervosa are those of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association (1994, pp. 544-545):

"A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight and shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person

⁶ A number of other features usually associated with this syndrome are outlined later in this chapter, under "Clinical Characteristics".

has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)⁷"

Differential Diagnosis (Bulimia Nervosa)

The DSM-IV offers the following diagnostic criteria for bulimia nervosa (American Psychiatric Association, 1994, pp. 549-550):

"A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- 1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
- 2) a sense of a lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa."

Anorexia nervosa can thus be distinguished from bulimia nervosa in that bulimics present with normal (and in some cases mildly excessive) body weight and regular menses. Furthermore, while the most salient feature of anorexia nervosa is the drive for thinness, the central characteristic of bulimia nervosa is the excessive ingestion of food followed by compensatory purging behaviours. (Thus, in the DSM-IV, binge-eating and purging occur both as a *symptom* of one of the two variants of anorexia nervosa and as a *syndrome* in itself.)

In addition, while bulimics share some aspects of anorectics' concerns, such as the fear of weight gain and the great influence of body shape and weight on self-evaluation, they can

⁷ The binge-eating/purging type of anorexia is often referred to as "bulimic anorexia". It represents not only a subtype of anorexia nervosa, but also, in chronic, long-standing cases of restricting-type anorexia nervosa, a breakdown of the usual overcontrolled stance (Garfinkel & Garner, 1982).

be readily distinguished from anorectics along several individual and family dimensions (Ravenscroft, 1988; Schwartz, 1988). For example, in contrast to most anorectics' denial of their problems, bulimics are usually distressed by their symptoms and often seek professional assistance. Moreover, they are generally socially outgoing and engage in heterosexual relationships, whereas anorectics are often isolated and asexual. As well, bulimics frequently have a history of other impulsive behaviours, for example, substance abuse, overspending, or repeated suicide attempts (Herzog & Copeland, 1985; Ravenscroft, 1988), while anorectics are generally overcontrolled. And unlike anorectics, bulimics have often been observed to respond to pharmacotherapy (Schwartz, 1988; Swift, Andrews, & Barklage, 1986).

Similarly, bulimic families are readily distinguishable from their conflict-avoidant anorectic counterparts in that they frequently manifest overt conflict, hostile attacks on the symptomatic daughter, substance abuse, and other forms of acting out (Ravenscroft, 1988; Vandereycken & Meermann, 1984).

Anorexia nervosa can also be differentiated from the dieting and food fads of many teenage girls, for these young women take no pleasure in dieting, derive little sense of superiority from the fact that they lose weight, and do not have the willpower of the typical anorectic (Gordon, 1990; Sours, 1980; Vandereycken & Meermann, 1984).

Subtypes of Anorexia Nervosa

As noted above, the DSM-IV (American Psychiatric Association, 1994) recognizes two forms of anorexia nervosa-- the restricting and the binge-eating/purging types. However valid this distinction may be, it is nevertheless an oversimplification of the heterogeneity intrinsic to anorexic patients (Strober, 1986). Indeed, the restricting form of anorexia can be further subdivided into several different types (Bruch, 1977; Martin, 1983; Sours, 1979, 1980).

As noted in the last chapter, this heterogeneity among restrictive anorectics has fueled speculation as to whether anorexia nervosa represents a discrete syndrome or merely a final common symptomatic pathway for a number of varying psychiatric conditions (Garfinkel & Garner, 1982; Hsu, 1980; Vandereycken & Meermann, 1984; Yager, 1982). A number of researchers (Bruch, 1973, 1977; Evans, 1982; Selvini Palazzoli, 1974; Sours, 1979, 1980) agree, however, that both of the above appear to be true. That is, there does seem to exist a true anorexia nervosa syndrome which represents a separate nosological entity, as well as several atypical forms.

Physiologically, the clinical characteristics of all forms of anorexia nervosa appear deceptively similar--severe weight loss is associated with various signs of malnutrition, such as amenorrhea, bradycardia, electrolyte imbalance, and the presence of lanugo (an overgrowth of fine body hair) (Chediak, 1977; Crisp, Hsu, Harding, & Hartshorn, 1980; Foreyt & McGavin, 1989). Primary anorexia nervosa can, however, be differentiated from atypical variants in that it is characterized by the pursuit of thinness, a buoyant feeling of omnipotence, an intense interest in food, and extreme hyperactivity, whereas in the atypical forms, loss of appetite, fatigue, and indolence are more often found (Bruch, 1973; Sours, 1979).

In terms of frequency of cases, there are believed to be two major groups and several atypical groups of restrictive anorectics (Bruch, 1973, 1977; Evans, 1982; Garfinkel & Garner, 1982; Martin, 1983; Sours, 1979, 1980). These clinical observations are at least partly corroborated by empirical research that has pointed to the existence of two bimodal peaks as regards age of onset (13 to 14 years and 17 to 18 years) (Garfinkel & Garner, 1982; Halmi et al., 1979; Harris & Phelps, 1987; Herzog and Copeland, 1985; Martin, 1983).

The largest group is represented by the stereotypical restrictive anorectic patient so often described in the literature, with onset in mid-to-late adolescence, who presents with an almost unvarying cluster of cognitive, body-image, and self-esteem problems that clearly distinguish her from all other groups of anorectics (Bruch, 1973, 1977; Sours, 1979; Story, 1976). This type of anorectic patient presents with body-image disturbance, a relentless pursuit of perfection as thinness, a sense of grandiose omnipotence in the face of her successful weight loss, hyperactivity, and a strong denial of any problems. As a child she has generally been passive, compliant, accommodating, and overachieving--in short, a "model child" (Bruch, 1973; Garfinkel & Garner, 1982; Hogan, 1985; Selvini Palazzoli, 1974). Her core psychological issues are believed to be a severe identity disturbance and sense of ineffectiveness (Bruch, 1973; Goodsitt, 1983, 1985). These are the patients who have been so often described by the major researchers in the field, such as Bruch (1973), Crisp (1980), Minuchin (Minuchin et al., 1978), and Selvini Palazzoli (1974), and who belong to what has been referred to as the "core group" of anorectics (Bruch, 1973; Sours, 1980). It is to this group of anorectic patients that the current work is intended to apply.

The second largest group is represented by those anorectics with onset in early adolescence and who are believed to be less compromised in their emotional development than the core-group patients (Bruch, 1973; Evans, 1982; Sours, 1979, 1980). While they have also grown up in enmeshed families, these individuals are perceived to have been

able to muster at least some passive defiance of their controlling mothers and to therefore be better equipped to handle the maturational challenges of adolescence. It appears that they feel threatened principally by the intensified sexual impulses of puberty which give rise in them to a generalized fear of loss of impulse control (Bruch, 1973; Sours, 1980). They may then begin a diet in order to prove to themselves that they are in fact in control of their impulses. While this type of anorectic patient seeks control and autonomy as does the core-group patient, she does not present with nearly as extreme an identity disturbance or body-image distortion. Moreover, she does not pursue thinness as a form of perfection, nor does she experience a grandiose sense of omnipotence due to her weight loss (Bruch, 1973; Sours, 1980). This group of anorectics often remits spontaneously or with minimal treatment.⁸

In addition to these two most statistically frequent types of restricting anorectics, there are the relatively rare male anorectics, usually prepubertal or early adolescent boys who have been overweight in childhood, and who now present with a variety of neurotic and more severe conflicts (Bruch, 1973, 1977; Selvini Palazzoli, 1974; Sours, 1979, 1980).

Bruch (1973, 1977) also identifies forms of "pseudo-anorexia-nervosa", wherein neurotic or schizophrenic conflicts eventuate in a symbolic refusal to eat. In these groups of patients, there are highly varying symptom clusters. In addition, weight loss is merely incidental to other psychiatric conditions, is often the subject of complaints, and/or is valued only secondarily for its coercive effect. The typical pursuit of perfection as thinness, the sense of omnipotence, autonomy strivings, and hyperactivity are not present in these cases. For example, in histrionic patients the rejection of food may follow a frightening sexual experience. And in schizophrenic patients, the whole eating function may be misinterpreted, leading to a delusional fear of swallowing. Pseudo-anorectic patients are generally apathetic and indolent; some are indifferent as to whether they gain or lose weight.

As well, Sours (1979) points to chronic alcoholics who chain-smoke and restrict food intake in order to avoid weight gain as a further subtype of anorexia nervosa. Finally, researchers have described subclinical varieties, such as late adolescent or young adult women who diet vigorously in order to maintain a fashion-model slimness and yet show few or none of the other behaviours of the typical anorectic (Orbach, 1986; Sours, 1979). For instance, such individuals show no avoidance of sexuality, and may in fact be hypersexual. Another subclinical variety is represented by the socially active and professionally ambitious young woman who lives an intense social and sexual life in

⁸ As many of these individuals may never find it necessary to present for treatment, one is tempted to speculate that this type of anorexia nervosa may actually be more common than the core-group variety.

order to avoid hunger, eating, and loss of impulse control (Sours, 1979).

Clinical Characteristics of Core-Group Anorectics

As noted above, it is to these anorectics so often described in the literature that the present work is intended to apply.

Anorexia nervosa is a multi-faceted phenomenon, but there is broad consensus that the central feature of the disorder is weight loss resulting from a restriction of food intake not due to loss of appetite (Chediak, 1977; Crisp, 1980; Garfinkel & Garner, 1982; Vandereycken & Meermann, 1984). Further symptoms, such as amenorrhea, bradycardia, electrolyte imbalance, the presence of lanugo, an obsessive preoccupation with food, and the hoarding of foodstuffs are believed to be secondary to the extreme weight loss, as they also occur in other starving individuals (Chediak, 1977; Crisp, 1980; Edelstein, 1989). However, other symptoms, such as hyperactivity, body image disturbance, and certain hormonal changes, are not present in other cachexic individuals and hence are not believed to be related to starvation (Edelstein, 1989; Garfinkel & Garner, 1982). Indeed, the typical anorectic is remarkable for her absence of fatigue given the hyperactivity that she manifests.

From a more psychological perspective, core-group anorexia is marked by a dread of becoming fat and by a relentless, omnipotent struggle for thinness, above all other considerations in life (Bruch, 1973; Crisp, 1980; Edelstein, 1989; Selvini Palazzoli, 1974; Story, 1976). The anorectic controls her food intake ruthlessly and exercises fanatically, setting her standards ever higher and carrying her pursuit of thinness to greater extremes of perfection. No matter how much weight she loses, she is never satisfied because she is never thin enough (Bruch, 1973; Orbach, 1986; Rumney, 1983). Besides being intent on perfection in the form thinness, anorectics have been observed to be highly ambitious, competitive, and driven individuals who seek "sublime perfection, purity, and a sense of 'specialness'" in life in general (Sours, 1980, p. 4). They have been described as "routinely and stubbornly obsessed with questions of purity and human perfectibility" (Story, 1976, p. 178) and as under the sway of an elated "remaking" version of "rebirth" fantasies (Hogan, 1985). Indeed, many anorectics seem to feel that life is not worth living unless one is perfectly thin, and perfect in everything else as well (Goodsitt, 1985; Rumney, 1983). Their self-perfecting activities are generally accompanied by an elated grandiosity, by fantasies of omnipotence, and by a sense of superiority (Bruch, 1973; Goodsitt, 1985; Hogan, 1985).

Core-group anorectics are generally reported to have been obedient, compliant, overachieving model children (Bruch, 1973; Garfinkel & Garner, 1982; Hogan, 1985;

Selvini Palazzoli, 1974). A few months prior to the manifest onset of the anorexia, they may suddenly become obstinate, stubborn, and greatly concerned with autonomy and control (Minuchin et al., 1978; Selvini Palazzoli, 1974; Stierlin & Weber, 1989). This is generally accompanied by a paralyzing sense of ineffectiveness which pervades all thinking and activities (Bruch, 1973, 1977; Orbach, 1986). In addition, the anorectic demonstrates a confused perception and cognitive interpretation of bodily stimuli, with an inaccurate hunger awareness as the most pronounced deficiency (Bruch, 1973, 1977; Crisp, 1980; Goodsitt, 1983, 1985).

Finally, the core-group anorectic tends to deny her problems (Orbach, 1986; Selvini Palazzoli, 1974; Sours, 1980). For example, she generally denies feeling any sadness, while manifestly oscillating between depression and euphoria. She is believed by many researchers to suffer from alexithymia, the inability to experience her emotions (Bruch, 1973; Goodsitt, 1983, 1985; Hogan, 1985; Sours, 1980). Toward others she is often cold, distant, mistrustful, and somewhat aggressive (Hogan, 1985; Selvini Palazzoli, 1974). As well, she has been observed to be extremely sensitive to rejection (Bernabé, 1976; Minuchin et al., 1978).

Phases of the Illness

Three principal phases have been identified in the course of anorexia nervosa (Casper & Davis, 1977; Garfinkel & Garner, 1982). In the prodromal phase, which occurs months or even years before weight loss, patients appear to experience a lowering of self-esteem and an increased self-consciousness about their physical appearance in reaction to traumatic events in their lives. This emotional disequilibrium eventually leads to the decision to restrict food intake (Beumont, Booth, Abraham, Griffiths, & Turner, 1983; Casper & Davis, 1977).

The second or precipitation phase marks the beginning of anorexia nervosa proper, with the development of anorectic attitudes and behaviours, including a strong resistance to eating, a fear of becoming fat, and pride in the ability to lose weight (Casper & Davis, 1977; Garfinkel & Garner, 1982).

By the third or maintenance phase, starvation effects overshadow the anorectic symptoms. Patients are forced to acknowledge the severity of their condition and to reluctantly allow themselves to be treated (Beumont et al., 1983; Casper & Davis, 1977; Garfinkel & Garner, 1982).

Prognosis

The course and outcome of anorexia nervosa show a great variability. Some individuals with anorexia nervosa recover completely after a single episode, some of them spontaneously (Garfinkel & Garner, 1982; Theander, 1985; Torem, 1991). Other individuals have recurrent episodes followed by periods of remission associated with symptom relief and improvement in daily functioning (American Psychiatric Association, 1994; Hsu, 1980; Theander, 1985). About 40% of treated patients recover fully, 30% show a partial improvement, and 20% develop a chronic and unremitting form of the disorder (American Psychiatric Association, 1994; Hsu, 1980; Steinhausen & Glanville, 1983; Szmukler & Russell, 1986; Torem, 1991). The mortality rate for anorexia nervosa has been reported to be between 7% and 15%, with death most commonly resulting from starvation, suicide, or electrolyte imbalance (Crisp, Kalucy, Lacey, & Harding, 1977; Herzog & Copeland, 1985; Hsu, 1980; Thompson & Gans, 1985; Toner, Garfinkel & Garner, 1986; Torem, 1991). Suicide has been reported in 2% to 5% of chronic cases (Crisp et al., 1977; Herzog & Copeland, 1985; Thompson & Gans, 1985; Toner et al., 1986).

IV. CRITICAL REVIEW OF EXISTING ETIOLOGICAL MODELS

Introduction

The past several decades of research on anorexia nervosa have seen a proliferation of causal explanations of differing theoretical orientations that invoke biological, individual, interpersonal, or sociocultural factors, or some interplay of these forces. These varying etiological models have contributed a certain measure of depth and precision to our current understanding of this syndrome's pathogenesis. Nevertheless, these conceptualizations suffer from a number of epistemological, methodological, and theoretical difficulties and oversights.

The following section will outline and evaluate the leading etiological theories of anorexia nervosa. As the biological and classical psychoanalytic models have been called into question by the consensus of opinion in the field (Bruch, 1973; Garfinkel & Garner, 1982; Hsu, 1983; Vandereycken & Meermann, 1984), they will only be reviewed cursorily. In addition, three unpublished dissertations written at the University of Ottawa will be reviewed. Understandably, as these are the work of students, they will be seen to present more difficulties than the work of the more experienced researchers.

Biological Models

Within the biological perspective, the notion of endocrine dysfunction as a primary, innate cause of anorexia nervosa has evolved from the pituitary insufficiency theories of the early part of this century (Nemiah, 1950) to the "primary hypothalamic dysfunction theory" (Garfinkel, Brown, Stancer, & Moldofsky, 1975; Hsu, 1983; Leibowitz, 1983; Moore, 1981) of the past two decades. The presence of amenorrhea in anorectics even before significant weight loss has occurred and the persistence of amenorrhea and hypothalamic dysfunction in recovered anorectics, as well as the vital role of the hypothalamus in appetite regulation, have been offered as the principal evidences for this formulation (Hsu, 1983).

This theory comprises two possible models: Firstly, a pre-extant defect of the hypothalamus may be activated by the developmental and environmental stresses of puberty and adolescence, leading to amenorrhea and appetite disturbance (Garfinkel et al., 1975; Hsu, 1983; Leibowitz, 1983). Secondly, higher cortical structures may alter hypothalamic function during such times of stress, giving rise to amenorrhea, appetite deregulation, and hyperactivity (Moore, 1981; Vandereycken & Meermann, 1984).

While such a theory appears both relevant and plausible, existing data do not convincingly demonstrate whether the observed hypothalamic dysfunction is a cause of anorexia nervosa or merely its result (Garfinkel & Garner, 1982; Harper, 1983; Vandereycken & Meerman, 1984). Because many of the physiological correlates of anorexia appear in other forms of severe emaciation, more methodologically sophisticated endocrinological and neurological research in this area is indicated in order to pinpoint the exact role of such biological factors in this syndrome.

Other biological conceptualizations of anorectic pathogenesis have pointed to the heritability of the disorder (Hudson, Pope, Jonas, & Yurgelun-Todd, 1983), with up to a 1:3 concordance for anorexia in monozygotic twins reported in various studies (Vandereycken & Pierloot, 1981). Unfortunately, none of these genetic studies observed twins reared apart and important environmental variables cannot be ruled out.

In summary then, the principal biological causal explanations of anorexia remain unsubstantiated (Edelstein, 1989; Garfinkel & Garner, 1982; Harper, 1983) and await more carefully elaborated research designs for an eventual attempt at empirical testing.

Psychodynamic Models

Classical Psychoanalytic Models

With the eclipse of the pituitary insufficiency models of anorexia nervosa in the early 1940's, classical psychoanalytic formulations prevailed as virtually the only explanations of the syndrome for almost two decades. These conceptualizations understood anorexia primarily as a defense against oral ambivalence, oral aggression, regressive instinctual drives, and/or oral impregnation fantasies (Jessner & Abse, 1960; Moulton, 1942; Sylvester, 1945; Thomä, 1967; Waller, Kaufman, & Deutsch, 1940). That is, the act of eating is viewed as the symbolic equivalent of these varying drives and fantasies. The restriction of eating behaviours is then seen to represent a defensive denial of these urges and desires deemed unacceptable by the patient.

While such concepts generally demonstrate a high level of internal consistency, their originators rarely, if ever, aim at empiricability. And even if one accepts such notions *a priori*, as do most psychodynamic approaches to at least some degree, the intrapsychic preoccupations invoked can be seen to apply to a significant extent to individuals in a large number of psychodiagnostic categories. Furthermore, by remaining narrowly focused on predisposition, these formulations do not adequately address the precipitation or maintenance of the anorectic symptom. As well, they usually point to only one or two

etiological factors, thereby overlooking a host of other potentially salient intrapsychic and environmental factors. For example, Emmrys (1992), writing within a phenomenological family approach, criticizes the psychoanalytic theorists for their strong emphasis on intrapsychic, early childhood experiences to the virtual exclusion of here-and-now lived interpersonal experiences. Finally, these conceptualizations are unable to explain many of the personality characteristics, such as the approval-seeking, compliance, lack of responsiveness to her own needs (Garner & Garfinkel, 1982), sense of omnipotence, pursuit of perfection, body image disturbance, alexithymia (Bruch, 1973), and extreme sensitivity to rejection (Bernabé, 1976; Minuchin et al., 1978) observed in the typical anorectic patient.

Due largely to such shortcomings of the early psychoanalytic model of anorexia, more recent psychodynamic theories have emphasized ego functioning and early object relations rather than drive-defense issues.

Bruch

Influenced by ego psychology and by her clinical observations of more than two decades, Bruch (1962, 1966, 1973) elaborated the first etiological model of anorexia nervosa that focused on the pervasive developmental deficits in perception and cognition usually seen in these patients. She points especially to a distortion of body image of delusional proportions, to a disturbance in the perception and cognitive interpretation of bodily stimuli such as hunger or satiety, and to an overwhelming sense of ineffectiveness that affects all areas of the patient's life. Moreover, in Piagetian developmental terms (Piaget, 1966), Bruch sees the anorectic as functioning cognitively at the level of concrete operations.

Bruch (1973) attributes these personality deficits to significant problems in the child's early interactions with the parents, particularly the mother. Like Piaget, Bruch distinguishes between behaviour initiated within the individual and that which represents a response to environmental stimuli. She further posits that for healthy development, a balance is necessary between accurate environmental response to child-initiated cues and environmental stimulation acting upon the child. In the case of the pre-anorectic child, the latter is believed to outweigh the former, with the mother not only failing to respond affirmingly to behavioural and emotional expressions arising within the child, but also intrusively controlling the child so as to gratify her own emotional needs. Indeed, Bruch has described the typical anorectic mother as having difficulty conceiving her child to have feelings and needs that differ from her own. Thus, rather than learning to recognize her own inner states, the pre-anorectic learns to respond almost exclusively to environmentally initiated cues, with resulting deficiencies in her sense of personal initiative and self-

experience (Bruch, 1973).

While Bruch views the mother-child dyadic relationship as central in the etiology of anorexia nervosa, she does not overlook the contribution of larger familial factors. For example, she frequently observed both parents to routinely ignore their child's verbalizations and emotional needs, while at the same time proclaiming themselves to be inordinately sacrificing, giving parents with an exceptionally happy family. Similarly, Bruch (1973) believes the usual reports of marital harmony and contentment on the part of anorectic parents to camouflage deep underlying disappointments and resentments within the marriage. Finally, she describes these families as showing rigid attitudes and high expectations, with an emphasis on external appearances, obedience, and conformity.

According to Bruch (1973, 1978), a child who grows up in such a family does not feel that she is living her own life, but rather that she is the property of her parents and at the mercy of external influences. She is thus unprepared for the advent of adolescence with its developmental and societal demands for separation and individuation. Feeling that her own body is all that she can ever hope to control, the anorectic symptom is precipitated in the patient's misguided pursuit of autonomy and personal effectiveness through the control of her body.

The contributions of Bruch in the area of anorexia research have clearly been impressive. Not only do her formulations offer a viable alternative to the earlier drive-defense etiological model of the disorder (Garfinkel & Garner, 1982), but she was also the first theorist in the field to highlight and to attempt to explain the various perceptual and conceptual disturbances typically shown by the anorectic patient (Chediak, 1977). Moreover, Bruch's theoretical conjectures can be said to be among the most comprehensive to date in their thoroughgoing examination of a large number of this syndrome's characteristics. In addition, while she cannot be said to offer a systemic etiological hypothesis, she did go beyond an exclusive focus on the mother-child dyad in her albeit brief descriptions of the anorectic family's belief systems and behavioural patterns as a whole. Finally, several of Bruch's concepts, such as that of the anorectic's misperception of interoceptive stimuli, have been empirically tested (Garfinkel, Moldofsky, & Garner, 1979; Garfinkel, Moldofsky, Garner, Stancer, & Coscina, 1978; Halmi, Goldberg, & Cunningham, 1977; Modarressi & Kenny, 1977) without having been refuted to date.

Nevertheless, Bruch does not strive for refutability and most of her conceptualizations remain untested. Moreover, while her formulations may account for many of the syndrome's characteristics overlooked by the earlier psychoanalytic writers, they are

unable to explain such features as the pursuit of thinness as an end in itself, the strength of her autonomy strivings, or the persistence of body image distortions in a specific direction (Goodsitt, 1985). In addition, her notion of the anorectic's developmental arrest at Piaget's concrete operational level has been disputed by others in the field (Joubert, 1992; Warah, 1990).

Finally, the central etiological factor proposed, that of a non-responsive, controlling, intrusive maternal figure, may apply to a variety of other moderately severe personality disorders, such as some types of severely depressed individuals, self-defeating personalities, dependent personalities, or borderline patients. (In Bruch's defense, it can, however, be said that she elaborates the presumed effect of such parenting on the young child's perceptual and conceptual development in more detail than do most theorists who invoke this pathogenic factor.)

Selvini Palazzoli

In a similar conceptualization influenced by Fairbairn's version of Kleinian object relations theory, Selvini Palazzoli (1974) also leaves behind the early psychoanalytic focus on orality in favour of an elaboration of the anorectic's sense of helplessness and ineffectiveness in the face of an overly controlling maternal figure. Unable to affirm herself or openly express aggression due to her mother's inability to tolerate her daughter's separateness, the pre-anorectic incorporates the negatively perceived and seemingly all-powerful maternal image or "object" in an attempt to control it. The pre-anorectic child thus comes to identify her own body as a representation of the mother whom she so fears and from whom she desperately wishes to separate. Self-starvation is then seen as a rejection of the maternal object and as a rejection of the associated feminine physical characteristics in general.

Such a formulation is to be particularly credited for offering an explanation for the anorectic's intense focus on her body. Moreover, Selvini Palazzoli's focus on the child's crucial early relationship with her primary caretaker is an improvement over the earlier psychoanalytic etiological theories that see the individual as directed by impersonal internal forces and agencies seemingly disconnected from the surrounding environment.

Nevertheless, Selvini Palazzoli's early etiological formulations are heir to many of the epistemological and other shortcomings that plague most object relations theories. More so than Bruch's ego-psychological formulations, Selvini Palazzoli's early writings abound in reified psychodynamic structural concepts, such as "internalized part-objects", that thus do retain at least one of the difficulties of the classical models. In addition, as she has made no effort to operationalize such intrapsychic processes as the internalization of

parental part-objects, the accuracy of such conceptualizations cannot be readily tested empirically (Hsu, 1983; Joubert, 1992).

Indeed, one of the main shortcomings of Selvini Palazzoli's early writings is this strong emphasis on intrapsychic phenomena, to the exclusion of explicit interpersonal perceptions and communications. Similarly, her narrow and causally linear focus on the mother-daughter dyad may underestimate the influence of other family relationships (Emmrys, 1992), such as the father-daughter relation or the parents' marital dynamics, not to mention that of such other potentially salient factors as innate developmental tendencies or the larger social milieu. And by underscoring predisposition in the form of past events, she tends to overlook the probable importance of more recent precipitating and perpetuating factors in the course of anorexia nervosa.

Partly because she barely mentions such other possible factors, Selvini Palazzoli ends up with a rather non-specific hypothesis, for such a mother-daughter relationship has also been proposed as a central etiological factor in a variety of other moderately severe personality disorders--thus, it is not clear why these other types of individuals might not also attempt to control a negative maternal introject through self-starvation. Lastly, her formulations do not explain the alexithymia, pursuit of perfection, sense of omnipotence, extreme sensitivity to rejection, or persistence of certain types of perceptual and conceptual disturbances believed to characterize the typical anorectic patient.

Masterson

Following Mahler's developmental theories, Masterson (1972, 1977, 1978) has also proposed an object relations model of anorectic pathogenesis. Viewing anorexia nervosa as a borderline disorder, he focuses primarily on the anorectic's developmental arrest in the separation-individuation phase (Mahler et al., 1975) and the resulting disturbances in her representations of self and object.

According to Masterson, the pre-anorectic's mother is unable to tolerate her daughter's age-appropriate attempts to separate and become autonomous and hence responds to them by withdrawing emotionally, thus reinforcing her daughter's dependency and compliance throughout childhood. However, the developmental and societal press for separation and autonomy in adolescence reactivates this early conflict and the pre-anorectic is again confronted with her fears of the withdrawal of her mother's affection and of "abandonment depression". The pathological part of the anorectic's ego is believed to deny the reality of any separation from her mother and to unconsciously fantasize about a symbiotic reunion with her mother. The anorectic symptom is then used to act out these

fantasies in the form of a regressive behaviour that eventually leads to greater dependency.

To its credit, Masterson's formulation can be said to be developmental, rather than static or merely structural, in its examination of the re-activation of the separation-individuation crisis in adolescence prior to symptom precipitation. Moreover, it offers a clearer and more detailed explanation of the maternal reinforcement of the pre-anorectic child's clinging dependency and compliance than do other theorists in the field.

Nevertheless, many of the same criticisms that were levelled at Selvini Palazzoli's (1974) object relations model also apply to Masterson's etiological hypotheses regarding anorexia nervosa. For example, he has made no attempt to operationalize his notion of "withdrawing or rewarding object relations units" for empirical testing. And as in the early Selvini Palazzoli, his narrow focus on the mother-child dyad in a causally linear fashion may exclude other important familial or larger environmental factors.

As well, with his overriding emphasis on the separation-individuation phase of development, Masterson overlooks the significant impact of earlier developmental stages. Indeed, there is little reason to assume that a mother who is unable to place her child's emotional needs before her own during the separation-individuation phase would have been able to do so in earlier developmental phases--it may simply be that during developmental phases where the child is not yet ambulatory, the lack of a mother's attunement to her child's emotional needs is less obvious to the observer, as the mother is in essence playing to a captive audience. More recent mother-infant observational studies (Stern, 1985; Stern, Barnett, & Spieker, 1983) have pointed to a number of such subtle possible disjunctions in the mother-child relationship, occurring as early as the symbiotic stage and believed to have a significant effect on the child's later emotional development.

Furthermore, Masterson does not clearly account for the refusal of food as the particular regressive behaviour of choice in the anorectic patient. Indeed, the typical anorectic's pursuit of thinness, self-perfecting tendencies, alexithymia, and body image distortion are left largely unexplained by this model. The place of the anorectic patient within the borderline category is never fully clarified either--for while there is still much conceptual confusion in the literature as to this category, the above four characteristics in fact sharply distinguish the anorectic from the classical borderline patient, even as described by Masterson (1972, 1978) himself. That is, even though Masterson defines the borderline syndrome more in terms of clinging dependency than of the impulsivity, moodiness, rage reactions, propensity to psychotic decompensation, etc. highlighted by other theorists (Kernberg, 1975), it is nevertheless unlikely that most anorectics belong in his borderline category. Conversely, he does not explain why only some borderline patients become anorectic, rather than bulimic, obese, or not eating-disordered at all.⁹

Sours

Writing from an object relations perspective, Sours (1979, 1980) is virtually alone among the psychodynamic theorists in explicitly addressing the heterogeneity of the anorectic syndrome. Indeed, his major contribution to the field has been his careful differentiation, among non-psychotic female restrictive anorectics, of a more severely disturbed "core group" as described by Bruch (1973) and Selvini Palazzoli (1974) from a smaller group of patients presenting with neurotic, Oedipal conflicts (Evans, 1982).

Sours' (1980) etiological hypotheses regarding the so-called core group of anorectics echo Bruch's (1973), Selvini Palazzoli's (1974), and Masterson's (1972, 1977, 1978) descriptions of a controlling, emotionally needy mother who reinforces her child's dependency and submission. Such a mother uses her child as a "part object", not allowing her daughter any real individuality of her own and preventing her from successfully traversing the separation-individuation phase of early childhood. Thus, when the pre-anorectic child reaches the second individuation phase in adolescence, she is still unable to separate from her mother due to her lack of ego development, and food refusal, generally beginning during late adolescence, becomes a symbolic, albeit maladaptive, attempt at disidentification from her mother.

In the case of the less seriously disturbed type of anorectic, on the other hand, the child's ego development has been less compromised. Here, the child has been able to muster at least some passive defiance of her mother and the onset of symptoms in early adolescence is generally related to a developmental reactivation of Oedipal wishes in puberty, rather than to a struggle to separate from the mother (Sours, 1980).

It is to Sours' credit that he also points to the potential salience of both innate factors within the child and the contribution of other family members in the construction of the anorectic predisposition (Sours, 1980). Nevertheless, his formulation is subject to many of the same shortcomings seen in the other object relations models of anorexia, such as presentation in a form not aiming at empirical testability, a relative lack of etiological

⁷ A possible heuristic solution to this rather complex nosological issue may be found in viewing the type of anorexia described by Masterson as representing a unique sub-category of his brand of borderline disorder, much as the type of narcissistic personality disorder described by Kernberg (1975) can be seen to be a sub-type of Kernberg's borderline personality disorder. However, as already suggested, what Masterson describes as anorexia nervosa seems to be heavily weighted in the direction of such descriptors as the same "clinging dependency" that he has always highlighted in his borderline patients in general, to the exclusion of numerous other centrally important characteristics observed by many other clinicians in the field, such as perfectionism, the need for control, and alexithymia. One is then tempted to speculate to what degree Masterson's rather Procrustean assignment of anorectic patients to his particular version of the borderline category vitiates much of his discussion of anorexia nervosa in the first place!

specificity, and the inability to explain certain clinical characteristics believed to be present in the typical anorectic patient.

Goodsitt

As already mentioned, Bruch (1973) describes core-group anorectic patients as displaying body image distortions, a deep sense of ineffectiveness, and severe deficiencies in their awareness of inner feelings and sensations. She views these disturbances in body image and interoceptive experience as due to defects in the ego or self organization. Utilizing a self-psychological conceptual framework, Goodsitt (1977, 1983, 1985) offers a more detailed description and etiological explanation of these self-regulatory deficits.

From a self-psychological perspective, healthy self-regulatory functions include the capacity to provide one's own sense of cohesiveness and security, tension regulation, and self-esteem regulation (Kohut, 1971, 1977). These functions are initially provided by an external source, such as a parent, who acts as a "selfobject" for the child by empathically mirroring or confirming the child's feelings and actions. Kohut (1971) defines "selfobject" as a symbiotic object that is cognitively perceived as external to the self, but emotionally experienced as part of the self. Such a selfobject is not seen to have his or her own needs or attributes, but rather is seen by the other to exist only to fulfill this other's needs. In addition, a selfobject is seen to have only those qualities that the other ascribes to him or her.) If adequate parenting of this type occurs, the above-mentioned self-regulatory functions are internalized and become part of the child's mental structure.

According to Goodsitt (1983, 1985), this process does not occur during the early childhood development of the future anorectic. Instead of providing empathic mirroring, her parents tend to ignore, minimize, or smother her emotional expressions. She thus learns that it is more important to not be a burden to others than to contact and express her own inner experience.

As a result, the pre-anorectic child is unable to recognize her own physical, cognitive, and affective experiences and integrate them into an organized self-structure. Because of this lack of internal self-regulation she feels inadequate, ineffective, and out of control. Her actions are not self-initiated, but rather only reactions or responses to others. She relies upon outside sources for her self-esteem and in order to tell herself what to do or how to feel. Indeed, without such external support and structure, she may feel fragmented or incomplete. Not surprisingly, as she relies upon others so greatly for her well-being and self-cohesion, she comes to see herself as excessively influenced by others (Goodsitt 1977, 1983, 1985).

Later in life, the anorectic syndrome serves as a sort of substitute self-organization. Much anorectic behaviour is motivated by a pressing need to eliminate tensions that exist because the anorectic is unaware of her needs and desires and therefore cannot fulfill them. Thus, many actions of the anorectic are merely reactions to her deficits in self-regulation, rather than expressions of spontaneous initiative or personal goals and values. Similarly, food rituals and hyperactivity are used to avoid recognizing unpleasant feelings or cognitions.

And while anorexia nervosa is thus a disorder of the self, it is also very much a disorder of separation-individuation. For since anorectics are deficient in self-regulatory structure, they are ill equipped to separate. According to Goodsitt (1969, 1985), anorectics have a symbiotic character disorder and reveal impaired self-object differentiation and object constancy. Hence, they require a symbiotic relationship to feel complete and to avoid psychosis, emotional annihilation, and separation anxiety.

Another factor that greatly impedes the separation-individuation process is the need of one or both of the parents for a symbiotic relationship with their daughter. In fact, if their daughter improves, the parents are vulnerable to depression and other forms of emotional decompensation due to the symbiotic loss of their daughter. Given this situation, the anorectic has often dedicated herself to maintaining the parent's well-being or emotional equilibrium. She is devoted to being a selfobject to the parent rather than being a self with needs and wishes of her own. Thus, while the anorectic does indeed have strong symbiotic needs herself, she tends to suppress these longings.

Goodsitt (1985) has referred to this fear of burdening others and pervasive sense of discomfort for simply existing as "self-guilt". It is as if the anorectic feels guilty for occupying space, for having any desires of her own at all. Her life is directed towards serving others and any pleasure that she may experience for herself is seen as selfish. Even eating, which Goodsitt interprets as giving to the self, comes to seem an unjustifiable self-indulgence. Similarly, the anorectic experiences guilt for wanting to grow up and have a separate identity, thereby abandoning her parents.

Goodsitt's formulation is most notable for its comprehensive description and etiological explanation of the self-regulatory deficits only outlined by other theorists such as Bruch (1973). Moreover, his notion of the parents' use of the pre-anorectic child as a selfobject provides a useful conceptual framework for clarifying both intrapsychic phenomena and interpersonal transactions in the anorectic's early childhood. As well, his conjectures are able to satisfactorily explain many of the behaviours and personality features of the typical anorectic. For instance, his notion of self-guilt elucidates the anorectic's characteristic self-effacement more thoroughly and more convincingly than do most other theories in this area.

Nevertheless, many of Goodsitt's terms are never precisely defined, and he cannot be said to strive for refutability. Furthermore, his etiological explanations are not contextualized within the family system or sociocultural milieu. (These elements could, however, be readily integrated with his theory as it stands.) As well, Goodsitt's etiological hypotheses are not specific to anorexia, for they do not explain how the described personality deficits or separation-individuation difficulties lead to the particular choice of symptom. And while it may explain much in the typical anorectic patient's behaviour, his conceptualization does not explain her pursuit of perfection and sense of omnipotence since many individuals who experience such non-confirmatory parenting do not present with such narcissistic features, but rather with depressive or other disorders. Finally, Goodsitt offers a much less detailed explanation of the precipitation and maintenance phases of the syndrome than do other theorists in the field.

Family Systems Models

Although such psychodynamic theorists as Bruch (1973, 1978, 1988) and Sours (1980) have looked beyond the mother-daughter dyad to highlight certain characteristics of the typical anorectic family as a whole, their formulations cannot be said to be systemic, for in these models the locus of pathology is still seen to be in the individual within whom a number of familial and societal influences have converged in a fairly linear fashion.

From a systems perspective, on the other hand, a child's behaviour is determined by the degree and type of interdependent interactions with its parents, any given action in a behavioural sequence being seen as both the effect of a preceding transaction and as the cause of a succeeding one. These causal sequences are seen as circular, rather than linear, and as proceeding in such a way as to maintain the system's overall homeostasis.

In families characterized by certain types of transaction and communication patterns, pathological symptoms may come to play a crucial role in the system's self-regulatory mechanisms. That is, an individual family member's symptom may be used to maintain the system's equilibrium and to avoid open conflict, particularly between the parents. In this process, the symptomatic behaviour both reinforces, and is reinforced by, the behaviour of other family members. Thus, from a systemic perspective, the individual's symptoms represent both a cause and an effect, and are not solely his own symptoms but that of the entire family system.

Selvini Palazzoli

Initially influenced by the strategic family systems theories of the Mental Research

Institute in Palo Alto (Bateson, Jackson, Haley, & Weakland, 1956), Selvini Palazzoli (1974) and her group had, by the early 1970's, begun to develop a systemic etiological model of anorexia nervosa to replace her earlier object relations approach. While Selvini Palazzoli's version of family systems theory eventually departed significantly from that of the Palo Alto group, she continued to share their strong focus on family communication patterns.

In her clinical observation of anorectic families, Selvini Palazzoli (1974) has found that they are characterized by a spirit of self-sacrifice, a rejection of each other's communications without conflict resolution, and a deep underlying marital disillusionment camouflaged by a façade of harmony. She also notes a particular reluctance on the part of the parents to assume either a leadership role or the responsibility for things that go wrong--consequently, one finds a great deal of blame-shifting, with even mothers who blame themselves for their daughter's anorexia attributing their behaviour to their great sense of self-sacrifice and devotion. Finally, and most centrally in this formulation of Selvini Palazzoli's, while overt coalitions between a parent and child are not deemed acceptable, the symptomatic child functions as a secret ally to both the father and mother, a situation referred to as "three-way matrimony".

Based on her clinical observations of 142 families with an anorectic member, Selvini Palazzoli's etiological model has evolved into a description of rule-governed "family games" or complex family interactional processes in which the anorectic herself is seen as an active participant and which eventually culminate in anorectic symptomatology (Selvini Palazzoli & Viaro, 1988): Since early childhood, the future anorectic has been over-involved in the parents' underlying marital disillusionment through an intense covert alliance with one of her parents. Regardless of whether she has been more involved with her mother or her father as a child, in adolescence she becomes involved in a particularly intense relationship with her father, due either to a heightening of the already existing seductive bond between them or to their mutual displeasure with the mother. In the next stage of this game, the daughter begins to diet in an attempt either to disidentify herself from her mother and thus gain autonomy or to defiantly challenge the mother. Unfortunately, her father does not wholeheartedly support her in this new venture, despite his continuing alignment with her against the mother, and the daughter feels let down by what she perceives as her father's "*volte-face*". Now despairing, and resentful of both parents, she reduces her food intake even further. In the final stage of the "*imbroglio*" or family game, not only is the anorectic's strategy reinforced and maintained by the power and control it confers upon her, but the entire family now covertly supports the anorectic symptom.

Selvini Palazzoli's (Selvini Palazzoli, 1974; Selvini Palazzoli & Viaro, 1988) family systems model represents a compelling alternative to her earlier object relations theory that focussed almost exclusively on intrapsychic processes relating to the mother-daughter dyad. Moreover, as they involve more readily observable behaviours in the form of family communication patterns, these formulations are more easily operationalizable for an eventual attempt at empirical refutation. Indeed, the finding that parents of anorectics reported more anxiety and depression when their child was improving than when she first entered the hospital has been interpreted as already furnishing empirical support for the notion that the anorectic's symptoms may be protective to one or both of her parents (Crisp, Harding, & McGuinness, 1974). She has also modified her strong earlier emphasis on predisposition by more carefully examining the precipitation and maintenance of the symptom (Selvini Palazzoli & Viaro, 1988). Indeed, her painstaking elaboration of the perceived steps of the anorectic family's "game" (Selvini Palazzoli & Viaro, 1988) represents one of the most detailed descriptions of symptom precipitation in the entire literature.

Nevertheless, a number of shortcomings plague Selvini Palazzoli's (Selvini Palazzoli, 1974; Selvini Palazzoli & Viaro, 1988) systemic etiological model. For instance, from a traditional empirical (Garfinkel & Garner, 1982; Kog, Pierloot, & Vandereycken, 1983; Vandereycken & Meerman, 1984) viewpoint, her theories have been faulted for being based on clinical observation, rather than on controlled scientific studies, and for offering no description of the methods utilized for data analysis and validation. This does not, however, present a problem from the critical rationalist position, as long as this clinical observation is meant to serve simply as fuel for speculation rather than as a formal attempt at empirical refutation (Popper, 1968, 1972). From a traditional, data-driven research perspective, her results are also seen to contain significant observer rating bias as the "observers" were also the clinicians treating the families (Yager, 1982). Again, this is not problematic from the standpoint of constructivist epistemology which maintains that all observation is informed by the pre-extant theories and reality constructions of the observer in any case. What critical rationalism would, however, object to in such a model is that, while it can probably be operationalized more readily than Selvini Palazzoli's earlier formulation, as already mentioned, there has in fact been no known effort to do so.

Selvini Palazzoli (Selvini Palazzoli, 1974; Selvini Palazzoli & Viaro, 1988) has also been criticized for not specifically explaining the occurrence of anorexia as opposed to another breakdown syndrome (Hsu, 1983; Vandereycken & Meerman, 1984; Yager, 1982). Indeed, these communication patterns may be operative in a number of other disorders (Garfinkel & Garner, 1982). In point of fact, Selvini Palazzoli utilized no control groups of either normal or other pathological families, but rather focused her research efforts virtually exclusively on the observation of anorectic and psychotic families. Conversely,

the family interactions she outlines may represent a modal rather than a universal pattern, as these processes may occur in many anorectic families, but not in all (Garfinkel & Garner, 1982).

Moreover, falling heir to a problem that plagues most family systems theories (Mook, 1989; Nichols, 1987), Selvini Palazzoli (Selvini Palazzoli & Viaro, 1988) accords the system an ontological status supraordinate to that of the individual, thereby unduly minimizing the free will and intentionality of its individual members (Emmrys, 1992). For example, she does not address the explicit or implicit factors in the anorectic's own personality that may contribute to her symptoms. And in what can perhaps be seen as an over-correction of her previous position, she appears to underestimate the importance of predisposition by placing too exclusive an emphasis on the recent and current family communication patterns which may be perpetuating factors, but not necessarily predisposing ones (Garfinkel & Garner, 1982).

Furthermore, Selvini Palazzoli (Selvini Palazzoli, 1974; Selvini Palazzoli & Viaro, 1988) never explains how these family communication patterns translate into such features as the alexithymia, striving for perfection as thinness, sense of omnipotence, strong autonomy strivings, and perceptual or conceptual disturbances typically observed in anorectic patients (Yager, 1982). This may be due to her model's rather unidimensional focus on family transactions, with only scant attention given such factors as sociocultural imperatives and developmental pressures. Finally, in the sixth (maintenance) stage of her etiological model, Selvini Palazzoli (Selvini Palazzoli & Viaro, 1988) provides no explanation of the nature of the secondary gain offered by the anorectic's symptoms to the other family members.

Minuchin

Like Selvini Palazzoli, Minuchin (Minuchin et al., 1978), in an independent formulation, considers the family a rule-governed system. However, unlike Selvini Palazzoli who focussed only on anorectic and psychotic families, Minuchin (Minuchin, 1974; Minuchin et al., 1978) has offered a structural definition of the functional or "normal" family, which he views as promoting its children's individuation and autonomy while at the same time providing security and protection. Psychopathology is then seen to arise in those family systems that deviate from this normative family structure, in terms of their boundaries, roles, alliances, and conflict resolution strategies.

Minuchin (Minuchin et al., 1978) has outlined a number of structural features believed to characterize the anorectic family, as well as other psychosomatic families such as those

having an asthmatic or diabetic child.

Firstly, the anorectic family is seen to suffer from enmeshment, an intense, overinvolved, overly close form of family interactional style in which boundaries between family members, and often with the parents' families of origin, are poorly delineated. Family members tend to intrude on each others' thoughts and feelings and to have poorly differentiated perceptions of themselves and of each other. In such an enmeshed family system, a child often learns to seek competence and achievement not for herself, but rather for the external approval it wins.

Such families also tend to be overprotective and hypervigilantly preoccupied with their children's behaviour and bodily functioning. This over-control of the child is masked by much concern and talk of parental self-sacrifice, so that the child understandably finds it difficult to protest and to develop a degree of autonomy. In addition, the child may in turn be encouraged to become self-sacrificing and protective of one or both of the parents.

Another feature of anorectic families is their rigidity and inability to successfully adapt their family interactions to external or internal stressors and changes. For example, they often find it extremely difficult to allow the separation and individuation of their children through the normal developmental stages. Instead, they usually attempt to maintain the status quo, thus precipitating illness in one of its members.

A low threshold for conflict and a lack of conflict resolution is considered to be another feature of psychosomatic families. Harmony is so highly valued that disagreement and personal initiative tend to be construed as acts of betrayal, making negotiation of conflict difficult at best. Thus, conflicts are often submerged in the spirit of loyalty and self-denial that pervades these families.

In addition to these structural family characteristics, Minuchin (Minuchin et al., 1978) also points to a physiological vulnerability on the part of the child and to the child's involvement in parental conflict as necessary etiological factors. The child may help his parents to avoid marital conflict in three ways: She may be encouraged to side with one parent against the other in a sort of stable coalition. Or she may be "triangulated" or induced to side with one or the other parent in a shifting pattern that depends on the circumstances. Thirdly, the parents may simply suppress or "detour" their conflicts by focusing instead on the child who is then viewed as the only family problem. It is the effectiveness of the child's symptom in containing the marital conflict and thus keeping the family intact that contributes to the development and maintenance of the symptom as an integral part of the family system.

Indeed, it is by explaining the role of the anorectic symptom within the family context that Minuchin (Minuchin et al., 1978) has most contributed to the research on anorectic pathogenesis. In fact, the hypothesis that the anorectic's symptoms may be protective to one or both of her parents is believed to have empirical support in the findings by Crisp et al. (1974) that the parents of anorectics reported more anxiety and depression when their child was gaining weight again than when she first presented for treatment. Moreover, in contrast to Selvini Palazzoli, Minuchin (1974) has offered conceptualizations of normal families as well as of those presenting with pathological symptoms.

Unfortunately, many of the same epistemological problems inherent in Selvini Palazzoli's (Selvini Palazzoli & Viaro, 1988) systemic conceptualizations are also to be found in Minuchin's formulations. Like those of Selvini Palazzoli, Minuchin's findings have been criticized as being too anecdotal and impressionistic (Garfinkel & Garner, 1982; Kog et al., 1983; Vandereycken & Meerman, 1984), as offering no description of the methodology employed (Emmrys, 1992), and as being overly biased in that the observers were also the clinical treatment team (Yager, 1982). However, from a theory-driven, critical rationalist viewpoint, these issues are not as problematic as is the fact that Minuchin has made no effort to operationalize his model for empirical refutation. Indeed, such concepts as enmeshment, overprotectiveness, rigidity, and lack of conflict resolution have proven to be difficult to define operationally (Kog, Vertommen, & Vandereycken, 1987; Wood & Moshe, 1983) and would need to be more carefully delineated before any attempt at refutation were made.

Moreover, the family structural features highlighted by Minuchin (1978) are postulated to apply to psychosomatic families in general (Hsu, 1983; Vandereycken & Meerman, 1984; Yager, 1982), and they probably need to interact with other factors in order to give rise to anorexia nervosa (Garfinkel & Garner, 1982). In an even more trenchant critique, Yager (1982) observes that Minuchin depicts anorectic families in the same terms used to describe families with an autistic child. On the other hand, while these characteristics may occur in many anorectic families, they do not appear in all (Garfinkel & Garner, 1982; Yager, 1982). Indeed, like most theorists in the field, Minuchin never addresses the issue of the heterogeneity of the syndrome, for example, by attempting to outline various possible sub-types of anorexia nervosa.

Furthermore, while Minuchin does discuss the predisposition and precipitation phases of the syndrome, the factors that he highlights may in fact be perpetuating factors rather than predisposing or precipitating ones (Garfinkel & Garner, 1982). In addition, Minuchin's theory has been criticized as being correlational rather than etiological. That is, the family characteristics that he describes may be the result of the anorexia, rather than its cause

(Hsu, 1983; Vandereycken & Meerman, 1984; Yager, 1982).

Finally, as do most systemic theorists, Minuchin tends to minimize the personal agency of the family's individual members (Mook, 1985; Nichols, 1987). For example, writing from a phenomenological standpoint, Emmrys (1992) has faulted Minuchin for failing to describe such patterns as enmeshment in such a way as to "reveal the rich tapestry of intentions and aspirations which help create it" (p. 46). Similarly, Minuchin's model barely addresses other potentially important factors such as the anorectic child's intrapsychic processes, her involvement in dyadic subsystems (Vandereycken, Kog, & Vanderlinden, 1989), or sociocultural and developmental influences. It also fails to explain how the family's postulated structural features give rise to the anorectic's characteristic alexithymia, strong desire for autonomy, pursuit of perfection as thinness, or body image distortion (Yager, 1982).

Cognitive-Behavioural Models

While not cognitive-behavioural in their metapsychological allegiance, Bruch's (1973, 1978) etiological formulations of anorexia nervosa were among the first to highlight the anorectic's significant cognitive distortions. As already mentioned, Bruch (1962, 1973) viewed the typical anorectic patient as functioning, in Piagetian (1966) terms, at the level of concrete operations, a stage of cognitive development partly characterized by egocentric and magical thinking.

Garner and Associates

Similar distortions and misconceptions in the cognitive functioning of the anorectic have more recently been studied by a number of cognitive-behavioural theorists, principally by Garner and his associates (Garner, 1986; Garner & Bemis, 1982, 1985; Garner, Garfinkel, & Bemis, 1982). Their etiological model primarily addresses the maintenance phase of the syndrome through an empirical analysis of the most commonly found errors in reasoning of anorectic patients, as well as of the irrational belief systems that are believed to motivate their self-starvation.

Based on Beck's (1976) classification of logical errors in the cognition of depressed and phobic patients, these researchers have identified a number of errors in reasoning frequently encountered in anorectics and that comprise the following (Garner, 1986; Garner & Bemis, 1982, 1985; Garner et al., 1982).

Dichotomous reasoning, or thinking in absolute, all-or-none terms, is applied both to the anorectic's weight preoccupations and to other areas of her life, especially those involving

achievement and self-evaluation. For example, a one-pound weight gain may be seen as tantamount to incipient obesity. Similarly, even slight deviations from a rigid routine of diet, exercise, or homework are perceived as a total loss of control. Yet while the anorectic may evaluate herself according to such extreme standards, she is nevertheless able to perceive others realistically.

Overgeneralization refers to deriving a rule from one single event and applying it to other dissimilar situations. Overgeneralization is often seen in an anorectic's beliefs about thinness. For instance, she may assume that because someone she knows who is thin is also competent, that thinness will lead to competence. Similarly, she may conclude that because she was unhappy at a normal weight, that weight gain will cause her to be unhappy again. Or she may apply overgeneralization to her evaluation of herself, for example, by deciding that she is a total failure because she has failed in one area.

In magnification, the patient tends to overestimate the significance of undesirable consequent events. For instance, isolated lapses in willpower are interpreted as the precursors to a permanent loss of self-control. And not unlike those suffering from depression, anorectic patients tend to magnify poor performances and to minimize their achievements when evaluating themselves.

Selective abstraction involves focusing on isolated details while ignoring contradictory or more salient evidence. For example, an anorectic patient often believes that thinness is the only standard by which one should measure self-worth, or that fatness is a clear indication of incompetence and lack of self-control, despite any evidences to the contrary.

The errors of personalization and self-reference involve the egocentric interpretation of impersonal events or the overinterpretation of events relating to the self. For example, the anorectic often thinks that casual acquaintances or strangers would notice if she gained so much as a pound. She may also be extremely sensitive to disapproval from others in areas of her life unrelated to weight control.

Finally, superstitious thinking involves a belief in a cause-effect relationship of events that are usually considered non-contingent. It may include magical thinking and is often related to the strict adherence to food or exercise rituals. For example, an anorectic patient may suffer great anxiety after deviating from an exercise ritual, believing that some sort of unnamed punishment may ensue.

These errors in reasoning are postulated to be at least partially responsible for the underlying assumptions and beliefs that have been identified in most anorectic patients

(Garner, 1986; Garner & Bemis, 1982, 1985; Garner et al., 1982). Many of these assumptions may be central to the patient's personal identity, while at the same time being implicit or not readily verbalizable by her. For instance, one's worth as an individual is often seen as being determined by one's body shape and/or weight. Self-denial may be thought to be the hallmark of virtue. Family members are often perceived to be infallible. Often, feelings of hunger or sexual desire are seen as signs of weakness to be eradicated and complete self-control is thus believed to be essential. Finally, the assumption is often made by anorexics that it is necessary to have absolute certainty before making a decision.

Those irrational beliefs specifically related to weight, weight loss, self-denial, and self-control are held to play a crucial role in the maintenance phase of the syndrome. For as the anorectic's former environmental reinforcement contingencies are replaced almost exclusively by the positively reinforcing sense of control that losing weight comes to represent, these ideas seem to take on a functionally autonomous life of their own. In addition, the anorectic is negatively reinforced in her weight loss by the fear of becoming fat that she develops during this stage of her illness. Indeed, since the anorectic never does reach her ideal weight, it is not thinness, but weight loss and its accompanying sense of self-control that is seen to be the central reinforcer for the anorectic (Garner & Bemis, 1982).

As well, Garner and his associates have contributed significantly to the description of the perceptual disturbances also believed to motivate the anorectic's relentless dieting. Following Bruch's (1962, 1973, 1978) early lead, they have conducted a number of empirical studies examining anorectic patients' distortions of body image, as well as their perception and cognitive interpretation of bodily stimuli such as hunger or satiety (Garfinkel, Moldofsky & Garner, 1979; Garfinkel, Moldofsky, Garner, Stancer, & Coscina, 1978; Garner & Garfinkel, 1981; Garner, Garfinkel & Moldofsky, 1978; Garner, Garfinkel, Stancer & Moldofsky, 1976). This research suggests that anorexics tend to overestimate their body size (Garner et al., 1976) and that their perception of bodily stimuli is more determined by external than internal cues (Garfinkel et al., 1979; Garfinkel et al., 1978).

To their credit, Garner and his associates demonstrate a concern with the empirical validity of their formulations by going beyond the anecdotal research of most of their predecessors. In fact, their controlled studies have resulted in the most thorough description to date of the anorectic's cognitive distortions. No less importantly, more than any other researchers in the field, they have attempted to highlight the centrality of irrational belief systems in anorectic behaviour. And while most of their formulations focus primarily on the perpetuating factors in anorexia, Garfinkel and Garner's (1982)

multidimensional model does outline the disorder's earlier phases to some extent and is, in fact, one of the few models to explicitate the difference between the predisposition, precipitation, and maintenance phases of the syndrome.

Nevertheless, certain aspects of the cognitive-behavioural model of anorexia nervosa have been the target of a number of critiques (Eminrys, 1992; Hsu, 1983; Joubert, 1992; Vandereycken & Meermann, 1984). For example, the errors in reasoning outlined by Garner and his associates are not specific to restrictive anorectics, but may apply to many bulimic, depressed, and/or personality-disordered patients. Their description of these cognitive errors can also be said to lack precision in that there is a significant overlap between some of the different categories of cognitive errors. In addition, Garner and his associates do not explain how these errors in reasoning lead to the specific irrational beliefs that contribute to the precipitation and maintenance of the anorectic symptom, rather than to some other symptom. They also fail to clarify why only some of her irrational beliefs, and not others, are operative during the maintenance phase of the illness. For instance, if family members are often seen to be infallible, why are they not believed if they assert that the anorectic has become too thin, rather than overweight as she herself believes?

Writing from a phenomenological standpoint, Emmrys (1992) questions the notion of "belief systems referred to as cognitive sets [that] are described as quasi-autonomous mental facticities which "cause" behavioural changes in the subjects" (p. 59). Indeed, while the decontextualized obsession with and fealty to such cognitive sets does appear to be one of the principal hallmarks of such disorders as anorexia nervosa, these cognitive sets are not maintained independently of familial factors. In point of fact, even the more multidimensional formulations of Garner and Garfinkel (1982) barely outline the family interactional patterns involved in anorexia. Perhaps in future research, Garner and his associates might follow White's (1983) lead in studying the belief systems of the entire family. Such an undertaking seems particularly relevant to the study of the cognitive sets operative in anorexia given such frequently encountered phenomena as the initial family-wide denial of the anorectic's severe emaciation.

Moreover, Garner and his associates do not mention the potentially significant impact of such emotions as rage or hatred, that are generally less conscious in patients as alexithymic as the typical restrictive anorectic. For while Garner and his group's theories do not deny the existence of unconscious cognitions and emotions, their concern for empirical validity has led them to focus their attention on more readily observable explicit feelings and beliefs. Instead of relying so heavily on self-report instruments, they might attempt to develop research methodologies adequate to the task of exploring anorectic patients' more implicit cognitive and emotional experiences.

Finally, although Garner and his associates have made significant contributions to the field with their numerous empirical investigations of the anorectic's perceptual disturbances, these studies contain methodological difficulties relating to the experimental method, to the composition of both their patient and control groups, and to the time of measurement during the illness and its treatment (Vandereycken & Meermann, 1984).

Joubert

Situated within a Piagetian framework, Joubert's (1992) unpublished dissertation proposes a cognitive model of anorectic pathogenesis that attributes the predisposition to anorexia both to an innate propensity to accommodation and to unusually strong environmental pressure to accommodate. Such a high degree of accommodation gives rise to a pathological self-schema (self-schema here being defined in the Piagetian sense of a set of control procedures) whereby the individual only has access to a limited repertoire of control procedures. At a further level of specificity, the anorectic self-schema is defined as a set of control procedures relating to the body only, a situation believed to result from a combination of over-accommodation combined with sociofamilial encouragement of bodily control.

Unlike Bruch (1973), Joubert does not believe that the typical anorectic functions at the level of concrete operations. That is, according to Joubert, it is not only while the anorectic is literally engaging in control procedures that she has a sense of being in control. Rather, the anorectic has reached the stage of formal operations as defined by Piaget (1966), but only in an atrophied form. The anorectic is thus seen as having acquired a "formal self" or "subject permanence", which Joubert defines as having an ongoing sense of being a subject who has control in her environment, regardless of whether or not she is actually engaged in a control procedure at that given point in time. As already mentioned, in the anorectic this ongoing sense of being a subject who assimilates or has control in the environment is limited to the sense of having control over one's own body.

In the syndrome's precipitation phase at adolescence, the pre-anorectic finds herself subject to the same environmental and developmental pressures for more assimilation faced by most adolescents (for example, in the form of more autonomous educational achievements and of career choices). But the pre-anorectic, having an atrophied formal self, can only accede to this pressure to assimilate through the exercise of bodily control, mainly in the form of diet and exercise since thinness is valued socioculturally.

To her credit, Joubert's application of Piagetian theory to the genesis of self-schemata and to the notion of a limited repertoire of control procedures can be seen to offer an extremely useful conceptual framework for explaining certain aspects of the anorectic's behaviour. Moreover, her hypothesis that the anorectic, instead of being developmentally arrested at Piaget's (1966) concrete operational stage (Bruch, 1973), may have attained an atrophied version of formal operations is an original contribution to the literature in this field.¹⁰

In addition, her theory is presented in a clear, precise, and more or less refutable form. (The precision with which she defines her terms is due in part to her adoption of a Piagetian conceptual framework, most of which is itself articulated with a high degree of clarity and exactness.) Finally, with its nested configuration of a cognitive schema, a self-schema, a pathogenic self-schema, and an anorectic self-schema, her model can be said to have a particular appeal syntactically and aesthetically.

Joubert's formulation can nevertheless be seen to present several problems. For example, she does not present a sufficiently explicitated or convincing argument for her notion that subject permanence begins at the formal operational stage, rather than during the sensori-motor developmental phase, as is widely believed. Nevertheless, her further hypothesis that the anorectic has subject permanence in the sense of having an ongoing sense of being a subject that has control in her environment, independently of the concrete experience of being engaged in an actual control procedure at that given point in time, is an original and intriguing notion. However, the conjecture that the anorectic has attained this form of subject permanence does not seem to be consistent with the anorectic's apparent need to concretely act out bodily control procedures. For one is tempted to argue that if she had these control procedures as a formal self-image, she would not need to repeatedly act them out in order to maintain such a sense of control. Indeed, Joubert never reconciles her own theory with Bruch's (1970, 1973) widely accepted observation that the anorectic feels herself to be fundamentally out of control of her behaviours, needs, impulses, and especially her body. Thus, the anorectic may not, in fact, have attained subject permanence as she claims.

And while Joubert offers a powerful conceptual framework, indirectly buttressed by an empirical case study, as an explanation for the anorectic's limited repertoire of control procedures, her model is unable to explain why it is bodily control specifically that the anorectic chooses, beyond repeating the notion frequently encountered in the literature that control of the body is encouraged by her family and by society. At the same time, she

¹⁰ At least one empirical study (Kowalski, 1986) has pointed in the same direction with its finding that the anorectic is capable of abstract reasoning but with a reduced capacity for certain more advanced forms of abstract thought. However, these results are presented with a far lesser degree of theoretical elaboration than that displayed by Joubert's formulation.

fails to mention the somewhat different hypothesis, also accepted in the field, that the body is all that the anorectic feels that she is allowed to control by her family (Bruch, 1973; Selvini Palazzoli, 1974). Moreover, control of the emotions, which is also valued by society and the typical anorectic family, is never addressed.

Finally, Joubert's theory does not sufficiently incorporate (or convincingly argue against) many of the stressors believed to be operative during the syndrome's precipitation phase by the consensus of opinion in the field. Despite the fact that she appears to favour multifactorial models, she ultimately focusses rather narrowly on the modern pressure for greater autonomy in adolescence as presenting an insuperable challenge to an individual so accommodating. Indeed, she barely mentions the anorectic's presumed struggles with the environmental rejection experiences and developmentally determined resurgence of repressed emotions that are pointed to by many researchers. Similarly, scant attention is paid to systemic issues such as family-wide separation anxiety or other relevant features of the anorectic's presumed family relationships. Her omission of these factors does not violate the tenets of her Popperian epistemological framework, but if these elements are in fact an essential aspect of anorectic pathogenesis, then her theory is more likely to be refuted through an empirical test.

Sociocultural Models

Sociocultural factors in the pathogenesis of anorexia have also been mentioned by many of the theorists in the field (Bruch, 1973; Garfinkel & Garner, 1982; Gordon, 1990; Orbach, 1986; Selvini Palazzoli, 1974). The incidence of the syndrome appears to be on the rise (Foreyt & McGavin, 1989; Gordon, 1990), which is not surprising given the ever-increasing media emphasis on the thinness ideal for women. What is more, this ideal of slimness is closely associated with the overall ethic of self-control that pervades our society. While some early research showed that women in the higher social classes or in certain occupations such as dance, modelling, or athletics were more vulnerable to such value systems (Druss & Silverman, 1979; Garner & Garfinkel, 1980), more recent studies have shown that anorectics are now to be found in many segments of the population in the industrialized world (Gordon, 1990; Orbach, 1986).

Some authors have also pointed to the contradictory role of the female in modern Western society (Bruch, 1985; Orbach, 1985, 1986; Selvini-Palazzoli, 1974) in the precipitation of anorectic symptoms. For while women are still generally expected to fulfill the more passive, traditionally feminine roles of wife and mother, they are now expected to succeed in the relatively more masculine, competitive career world as well. What is more, the pre-anorectic child is believed to also be subject to particular pressures from her family to both conform to their model of a submissive, compliant daughter and then to succeed in a

number of more independent activities when she reaches adolescence. Hence, the anorectic ends up trying to prove herself in a willful but highly conformist manner by becoming quite successful at slimming her body.

From the feminist perspective (Boskind-Lodahl, 1976; Orbach, 1985, 1986), the problem lies even deeper than this, and essentially arises out of the entire societal vision of femininity. Indeed, according to this viewpoint, the anorectic is trying not to efface her femininity, as some theorists (Crisp, 1980) believe (apparently mainly in reference to the younger, non-core-group anorectics (Sours, 1980)), but rather struggling desperately to be accepted and respected as a woman in a society with unrealistic standards. And to this end, they use the weapon so often used against women historically, their bodies (Orbach, 1985).

Such sociocultural perspectives clearly constitute necessary elements in any comprehensive model of the etiology of anorexia. Nevertheless, on their own they are far from sufficient for explaining the appearance of this syndrome in given individuals, for all women subject to media exhortations to thinness obviously do not develop an eating disorder. Rather, such societally validated definitions of perfection and self-mastery appear to interact with far deeper individual and familial emotional disturbances in those afflicted with this disorder (Bruch, 1985).

Existential-Phenomenological Models

Binswanger

The well-known case of "Ellen West" (Binswanger, 1958a) has influenced a number of theorists in the field of anorexia research, most notably Bruch (1973) and Selvini Palazzoli (1974). Unfortunately, it is far from clear that Ellen West was in fact an anorectic. Firstly, Binswanger himself categorized her as a schizophrenic, a diagnosis that was at least partially an artifact of the nosological practices of his era. (Those disorders now seen as being situated between neurosis and psychosis in terms of their severity and usually referred to as personality disorders were then viewed as either neurotic or psychotic manifestations.) More recently, Bruch (1973) and Selvini Palazzoli (1974) have contended that she would have been diagnosed as an anorectic had she lived in our time period. Yet in the light of even more recent refinements in the diagnosis of eating disorders, Ellen West's clinical picture appears more congruent with that of *bulimia nervosa* (Garfinkel & Garner, 1982): an emotional lability so extreme as to be reminiscent of bipolar disorder (rather than the alexithymia of most restrictive anorexics), overt suicidal ideation, a preoccupation with romantic infatuations and involvements, a

headstrong and aggressive childhood disposition, not to mention repeated episodes of binging and purging.

Yet despite the fact that Ellen West would likely be diagnosed as bulimic by many clinicians today, Binswanger's (1958a) case study has provided us with a wealth of original insights into certain issues related to the typical anorectic's emotional struggles, such as the limitless quest for thinness. And while it is not Binswanger's purpose to offer an etiological theory, his existential and temporal analysis of Ellen West's lived experience offers a number of conjectures that may prove useful to the construction of new etiological hypotheses.

Based largely on clinical observations and on the copious, rather poetic writings that she left behind, Binswanger's description of Ellen West's lived experience offers little information about her childhood, except that as a nine-month-old infant she refused milk and that as a small child she willfully resisted her parents' authority over her. Apparently she sucked her thumb and preferred boys' clothing and dress until the time of her first falling in love at the age of 16. Aside from the fact that they were wealthy, Jewish, and twice interfered with her marriage plans, even less is known about her parents. Even as a married woman, Ellen West appeared quite involved with them, and one is tempted to assume that they still maintained a certain control over her.

Ellen West first noticed that she had great difficulty being away from her parents while travelling with friends after her graduation from high school. After breaking an engagement at her father's behest at the age of 19, she noticed the first beginnings of the fear of becoming fat that was to rule her life from then on. At the same time, her desire for food increased greatly and she began to binge, purge, and exercise to exhaustion, as well as to restrict her food intake at other times. She also suffered from anxiety, depression, and deep-seated feelings of worthlessness and self-loathing. Despite a number of cultural and intellectual interests, several intensely experienced infatuations, and her marriage at age 28 to her cousin, her desire both for food and to remain slim remained the overriding obsession of both her waking and dreaming life. Railing against her fate of being heavy and strong when she would have preferred to be delicate and thin, Ellen West fantasized about an ethereal world without restrictions and directed much of her aggression towards the body that she saw as an intolerable prison. Finally, at the age of 31, she became increasingly depressed and preoccupied with suicidal thoughts, and after a brief hospitalization for this depression, she took her own life with a lethal dose of poison.

Such a cursory overview of the case of Ellen West does not come close to doing justice to the richness and depth of detail offered both by the writings of the patient herself and by

Binswanger's existential analysis of her case. In this analysis, Binswanger points not to predetermined mechanical processes as in classical psychoanalytic thinking, but rather to her lived experience and to the freedom and responsibility inherent in her relationship to the world. Although he does not speculate on the causes of such a stance, Binswanger emphasizes from the outset her rejection of all three aspects of the individual's lifeworld as outlined by Heidegger (in Binswanger, 1958a)--the *Eigenwelt* of one's own personal and inner space, the *Mitwelt* of human otherness, and the *Umwelt* of non-human otherness and of the physical body. This apparent rejection of the world, from early childhood on (unlike the typical anorectic), strongly restricted her existential possibilities and gave rise to an ongoing feeling of emptiness.

Ellen West railed not only against the world and against her own being but also seemed to want to stop time itself through her refusal to accept the ground of her existence. In Binswanger's temporal analysis of Ellen West's lived experience, her sought-after ethereal world represents the future. But because it was disconnected from either the past or from the ground of her existence, this was an atemporal, unrealizable future of limitless and hence empty possibilities. She thus existed in an eternal present, cut off both from her past and from her future. Indeed, the more she attempted to escape her ground through a flight to the ethereal, the more she became trapped within the atemporality, immobility, and decay of the "tomb world". Without an ontological connection between past, present, and future, her existence became inauthentic, absurd, empty, without meaning or form, and her only escape remained suicide.

With its richly textured descriptions and generally high level of categorical nuance, Binswanger's analysis can only be described as masterful. Its wealth of insights into numerous facets of Ellen West's existence shows evidence of both breadth and depth. Many of his hypotheses have a strong intuitive appeal, as for example, his description of the rupture of her three temporal modes and of the inauthenticity and emptiness of her future. Moreover, his emphasis on Ellen West's freedom and responsibility in the manner in which she chose to live represents an intriguing alternative to the more deterministic formulations generally encountered in this field. His application of Heideggerian categories and concepts to a psychological case study is also a highly original stance. These spatial and temporal categories seem all the more pertinent in that they represent what is probably most basic in human existence.

Binswanger's case study of Ellen West does, nonetheless, present a number of difficulties. His study has been criticized for not offering a more explicit description of its methodology (Emmrys, 1992). Moreover, Binswanger's actual methods are not always consistent with the few methodological and/or epistemological arguments that he does put

forward. For example, despite his stated predilection for Husserl's phenomenological method (Binswanger, 1958b) and his rather epistemologically naïve claim to "adhere strictly to the facts of the life-history" (Binswanger, 1958a, p. 269), he seems to accept Heideggerian categorizations of human spatio-temporal experience in an unquestioning, *a priori* fashion (Bernabé, 1976). Thus, while Heidegger's far-reaching insights can be seen to contribute great depth and richness to the psychology of Binswanger and others, Binswanger's claim of avoiding "theoretical prejudgment" (Binswanger, 1958a, p. 321) strikes one as overstated. Similarly, although he decries same in psychoanalytic writing, he often has recourse to rather elaborate speculation on certain "symbols" in the experiences of Ellen West.

From an inductionist perspective, Binswanger's formulation can also be seen to be plagued by the central epistemological problem of all single-case studies, for what he gains in depth through such an especially intense focus, he may lose in generalizability. However, in Binswanger's defense, one might point out that such in-depth speculation about a single individual's experience may more often give rise to new and different conjectures than those emerging within the broader focus of the usual nomothetic research.

It was never Binswanger's purpose to offer an etiological hypothesis, but rather an existential analysis of Ellen's lived experience. Nevertheless, one might argue that the meaning of a phenomenon is at least partially to be found in its genesis and in its past. Similarly, just as Binswanger's analysis is not fully contextualized temporally, he offers virtually no information on her family relationships (Emmrys, 1992)--and this despite his stated emphasis on situating Ellen West's experience in the context of her lived world.

Possibly because of this latter omission, his account at times appears rather pejorative in regard to Ellen West's rejection of her early environment, when in fact this may have been the best adaptive mechanism available to her at the time. That is, he assumes that the environment had much that was useful to offer her, which may not have been the case. One is tempted to speculate that she may have suffered an even greater lack of emotional development had she not taken such self-protective measures. Indeed, this rejection of her environment may actually have been, at least initially, a genuinely self-affirming gesture on Ellen West's part, much as the daughter in Emmrys' (1992) single-case family study appeared to want to construct a more authentic life for herself.

Finally, it has already been mentioned that Binswanger's formulation is not necessarily generalizable to other patients who might be assigned to the same diagnostic category as Ellen West (probably bulimia nervosa, according to current taxonomies). At the same

time, much of it is not specific to this category of patients either, in that various forms of psychopathology involve some rejection of one's *Mitwelt*, *Eigenwelt*, and *Umwelt*, as well as a resistance to the facticity or givens of one's life. Moreover, in his assignment of human corporality to the *Umwelt* of impersonal space, Binswanger appears to replicate the anorectic stance that views the body as a thing outside the self.

Warah

In an unpublished dissertation addressing the anorectic's cognitive processes, Warah (1990) offers an explanation of the anorectic's "cognitive polarization", from an existential standpoint. Her metatheoretical framework consists largely of an argument against the "rationalist onto/epistemology that insists on the supremacy of logic in being and knowing and that attributes mental illness to a disturbance of logical thought" (p.122). Through a "metatheoretical" analysis of the concept of the boundary inherent in the logical principle of identity (that is, "What is, is"), Warah points to the inability of this principle to account for the "emergence" of being and of knowledge. In her view, this emergence simultaneously involves both categorical continuity and discontinuity and cannot exist in the absence of ambiguity. She also points to the primordial importance of "*dépassement*" or a going beyond one's current perspective as a vital element in the cognitive processing of information. Such a *dépassement* is not to be construed as some sort of logical procedure--rather, it represents an essentially alogical process rooted in human corporality.

Using this conceptual framework as a point of departure, Warah describes and analyzes various manifestations of the anorectic's "cognitive polarization", a term that refers not only to the dichotomous reasoning observed by numerous researchers in the field, but also and above all to her inability or unwillingness to place limits on her actions. That is, she sees the anorectic's polarization as an overall way of being that involves the whole individual and not just her thought processes.

In what she considers the key concept in her formulation, Warah views this cognitive polarization as the hallmark of an overly rational form of thinking, instead of the result of irrationality or erroneous reasoning, as is generally believed. Indeed, since the anorectic appears to know how she ought to behave but does not translate this knowledge into action, her problem is hypothesized to involve not her reasoning, but rather her actions and her lived experience.

Warah supports this notion by pointing to the empirical research that has found that the anorectic is capable of abstract thought and that she suffers from no global cognitive deficit (Kowalski, 1986). And while she mentions at least three studies (Bourke, Taylor,

& Crisp in Warah, 1990; Fox in Warah, 1990; Kowalski, 1986) suggesting that the anorectic does have a specific difficulty with the coordination and integration of several abstract concepts, a skill believed to represent a more advanced stage of formal operational reasoning, Warah contends that the anorectic's cognitive deficit is not one of abstract reasoning ability. Rather, it is postulated to lie in her limited ability to go beyond (*dépasser*) the identity postulate or to elaborate "existential syntheses" (p. 112). This incapacity to go beyond the principle of identity is hypothesized to involve an alogical dimension of knowing and to be situated not at the level of logic or reason (secondary process), but instead at a more primordial level of pre-logical, corporeal experiencing (primary process). Unable or unwilling to open herself to her "sources of creativity" (p. 112), the anorectic suffers from a sort of "hyperlogic" of limited temporal scope that allows her to order her world and protects her from a more severe decompensation.

For Warah, the anorectic's cognitive polarization is most evident in her dietary restriction and sharp delimitation of her bodily contours. These behaviours are seen to represent a categorical rejection of otherness and a near-absolute self-affirmation through the drawing of extremely rigid self-other boundaries. Such a spatial delimitation reflects the anorectic's literal application of the logical principle of identity out of a need to reduce all ambiguity in her lived experience. In addition, the anorectic's physical hyperactivity serves to temporalize and "dynamize" her hyperspatial and static way of being and thus constitutes a defense against a sense of emptiness and discontinuity.

Warah's formulation is notable for its comprehensiveness, for she rarely fails to situate her ideas vis-à-vis the related empirical and theoretical literature in the field. In addition, she reinterprets the accepted research in a highly intuitive and original manner. For instance, her description of the anorectic's extreme delimitation of her bodily contours as a form of hyperspatialization that reduces ambiguity and substitutes for a lack of temporal continuity has a strong intuitive appeal.

Even where her ideas appear to resemble those of other theorists in the field, she often succeeds in developing a useful new elaboration of the concept in question. For example, while her hypothesis that the anorectic experiences difficulty with *dépassement* is adumbrated by Binswanger (1958), Warah's closer examination of the cognitive propensities underlying such a difficulty represents a powerful conjecture that potentially explains much in the anorectic's way of being. Similarly, her notion of the anorectic's resistance to primary process thinking resembles Edelstein's (1989) observation that adaptive regression is both feared and highly disturbed in the anorectic; as well, others in the field have pointed in a similar direction, albeit through less fully elaborated formulations (Sours, 1980; Stierlin & Weber, 1989; Woodman, 1980, 1982).

Nevertheless, Warah's linking of this fear to the anorectic's thought processes can be seen as a significant contribution to this line of speculation.

Finally, Warah also recognizes where her argument is not specific to anorexia (for example, in her description of the anorectic's difficulties with *dépassement*) and then goes on to present a more specific corollary to her central argument with her discussion of the anorectic's hyperspatialization of her body.

Nevertheless, her description of her own epistemology often seems inconsistent, both with the actual methods she utilizes and with some of her theoretical convictions. For example, she claims to deduce her hypotheses from her metatheoretical framework, yet in fact quite frequently has recourse to speculation, a procedure fully legitimate from a Popperian standpoint but apparently not within her own epistemological perspective.¹¹ Moreover, given the vigour with which she decries rational argumentation, it is surprising to see her espouse such a logic-based epistemology in the first place.

Furthermore, a number of Warah's concepts seem to be compromised by a lack of nuance, unexplained assumptions, and/or certain oversights. For instance, in her criticism of Western logic, she focuses rather narrowly on the identity principle, appearing to suggest thereby that this is about all that Western logic has to offer. Similarly, in arguing for the logical principle of identity's inability to account for the emergence of new being or new knowledge, she does not address the potential salience of other basic logical postulates in such emergence. For example, she barely touches on the principle of non-contradiction which is highly relevant to her notion of *dépassement* and which has been re-emphasized through the critical rationalist tradition's notion of refutation (Popper, 1968, 1972). In fact, the problem may lie less in the identity postulate than in the inability of traditional logic to account for the passage from one logical postulate to another, or to provide the thinker with precise rules for the application of these postulates. Indeed, this passage from one logical postulate to another may be what Warah refers to as the "alogical" process involved in *dépassement*.

Furthermore, Warah never specifies whether this process is alogical by virtue of not adhering to the rules of traditional deductive logic or by virtue of not being determined by a set of governing rules at all. If she means the former, she is quite probably correct in designating such processes as alogical. As a matter of fact, even such "rationalists" as Popper (1968, 1972) would readily agree that certain thought processes (for example, theoretical speculation) involve non-deductive processes. On the other hand, if Warah means "alogical" to refer to that which is not rule-governed, she neither identifies this as

¹¹ Just because one is not arguing from a particular to a general, and therefore not engaged in inductive reasoning, does not mean that one is using deduction.

the rather broad assumption that it is nor offers any sort of argument for this construal. Indeed, certain processes may appear alogical and "ambiguous" simply because we have not as yet constructed a satisfactory theory of their rule-governed regularities or inherent causal order.¹²

Similarly, Warah never convincingly demonstrates that the alogical element in *dépassement* is indeed a primary-process-like, pre-logical, and corporeal process, as she contends, rather than some more advanced form of intuition or some other as yet little explored aspect of non-logical abstract thought. For as a matter of fact, normal children also tend to experience difficulty with *dépassement* at an early age, which suggests that more than primary process cognition is involved here.

This possible inaccuracy in Warah's theory may be at least partly due to her equation of pre-logical, primary process thinking with the "alogical dimension of being and knowing", which she describes as consisting of the individual's sources of creativity, comprising images and fantasies, fundamental assumptions about the nature of reality, and basic survival mechanisms, and as including the unconscious, the subconscious, and the irrational (p. 60). Such a move is similar to the "pre/trans fallacy" described by the transpersonal psychologist Wilber (1980), whereby various non-rational states of early infancy and certain superficially similar, yet more advanced, self-actualized states of consciousness are collapsed into one category. For as in the pre/trans fallacy, Warah does not differentiate between the more primitive, pre-logical sensori-motor cognition of early childhood and other more developed, alogical, intuitive, and creative forms of cognition. Of course, these areas of human functioning remain relatively unexplored and such concepts as intuition or creativity are far from being either precisely delineated or empirically substantiated. Nevertheless, one would perhaps be wise to tentatively approach these areas with a greater degree of precision and categorical nuance. (In defense of Warah's theory, one might surmise that it is simply heir to the lack of nuance in the classical psychoanalytic categorization of similar processes (Freud, 1973).)

Another problem lies in Warah's interpretation of the empirical research that has found that the anorectic expresses a normal viewpoint as regards the preference for an open and flexible lifestyle and for a moderately thin figure and yet is unable to translate her attitudes into action. Warah concludes from this that the anorectic's behaviour is due neither to a lack of information nor to distorted thoughts. Rather, she posits that what is involved is the anorectic's relationship to her actions ("*l'acte*") and lived experience. Warah emphasises this point by stating that she thus conceives the problem of anorexia as one of action ("*l'acte*") and not of thought, appearing thereby to sever thinking from action and

¹² Of course, such a theory may or may not include our present forms of logic; in addition, it may necessitate the creation of a new logic.

experience.

Yet, as most orientations in psychology would acknowledge, action and lived experience necessarily involve thought processes. Indeed, one is tempted to argue that Warah herself would probably agree with such a statement given her apparent predilection for such holistic thinkers as Bergson and Bohm (in Warah, 1990). Such a stance also seems incongruent with her allegiance to the existentialist perspective that sees meaning as motivating human action. (In fact, a strong case could probably be made for the primacy of thought and belief systems in the motivation of human behaviour (Mahoney, 1979). Indeed, even autonomic physiological processes are now believed to be open to significant influence by an individual's thought processes (Weiten, 1986).) Perhaps partly because of this problem, Warah never convincingly differentiates her concept of cognitive polarization from the dichotomous or all-or-none reasoning so often described in the literature, beyond simply stating that cognitive polarization involves not just thought processes but also an entire way of being.

Finally, Warah states that the anorectic family is characterized by an overall atmosphere of confusion and ambiguity, a notion that is inconsistent with the observations of several other clinicians in the field (Bruch, 1988; Stierlin & Weber, 1989). For example, Stierlin and Weber (1989) have identified particularly hard-edged reality constructions and overly rigid and sharply delineated role definitions in the typical anorectic family. Indeed, Stierlin and Weber (1989) point to the same hyperrationality and intolerance of ambiguity in the anorectic family that Warah ascribes to the individual anorectic patient. Thus, Warah may perhaps have been more precise by simply reiterating Minuchin's (Minuchin et al., 1978) observation that the boundaries between family members (but not their assigned roles) tend to be ambiguous in the anorectic family.

Emmrys

Emmrys' (1992) unpublished dissertation presents a phenomenological case study of the family life of an individual anorectic patient. Inspired by Giorgi's "Duquesne method" (Giorgi, 1985 in Emmrys, 1992), his modified methodology consists of a combination of family and individual interviews followed by a detailed textual analysis. As well, he not only argues vigorously for the epistemological value of such phenomenological research methods for the study of family life, but also engages in an extensive, rather polemic dialogue with numerous other formulations in the anorexia research.

Emmrys sees his subject family (consisting of a father, mother, and two teenagers) as having a clear, well-articulated authority structure and a traditional distribution of family

responsibilities. He also finds the family members to especially value interpersonal closeness and to lead lives that centre very much on the home and on their relationships to each other. The family relationships that are perceived to be most important by the family members themselves are the cross-generational ones. The mother and daughter, in particular, have a special, egalitarian, best-friend sort of relationship that Emmrys describes as uncharacteristically intense for the North American cultural context. In fact, the anorectic daughter appears to occupy a special role in her family in that she is seen by the other family members to be the one most intimately involved with all the others. For example, the father appears to be more overtly invested in his relationship with his daughter than in that with his wife. The son, however, disputes the other family members' view of his own relationship with his sister as being satisfying and close by pointing to a certain amount of rivalry and conflict in their relationship.

According to Emmrys, his study also reveals that the parents tend to ignore any communications that contradict their perception of the family as a unified, harmonious unit. Similarly, individual family members are found to be overly clearly defined by each other in a process that he refers to as "objectification". Such an objectifying relationship is not a true opening to the other, but rather an imposition that acts as an obstacle to an authentic face-to-face or "We-encounter". For example, the son is perceived by the father to be just like himself, a definition of the son's life that Emmrys views as having more to do with the father's past than the son's. Nevertheless, these objectifications of each other are seen as providing the family with a sense of meaning, permanence, and predictability.

For Emmrys, the onset of the daughter's anorexia coincided with "a crisis of authenticity" whereby her former life and its significance to her were radically reappraised and found to be inauthentic and unsatisfying. Following an initial period of social withdrawal, both from other family members and from others in the community, the daughter embarked upon a weight-loss and exercise programme, purportedly in order to develop a healthier body. Emmrys views this project as "a personal initiative motivated by a deep need to create an authentic sense of self... [and by] the pleasure of fulfilling self-originated intentions" (p. 265), rather than as a response to environmental incentives or pressures. And since the familial domain had previously been the primary medium within which the daughter had imbued her experiences with meaning, moving away from this arena necessitated the creation of a whole new world for herself, a task which she began by addressing her body. Thus, the anorectic behaviours occurring during the early phase of her illness are seen not as a struggle for autonomy within a controlling family milieu, as in many theories of anorectic pathogenesis, but rather as the manifestation of a freely chosen search for a new, more authentic mode of existence.

With the onset of symptoms, a three-way conflict involving the daughter and her parents developed. The parents became overprotective and their lives increasingly centred on their daughter's behaviours. However, these behaviours and conflicts were seen as transitory and situation-specific since they were not perceived to be present during the pre-symptomatic period which was characterized more by intense dyadic relationships. And while the daughter's eventual hospitalization helped to resolve the family conflicts and re-established normal eating patterns, it left the crucial issue of the desire for authenticity on the part of the daughter unaddressed.

Finally, Emmrys compares and contrasts his conclusions with those of other theorists in the field, finding the latter to not be confirmed by his own phenomenological analysis in many respects (with the exception of Binswanger's (1958a) case of Ellen West). For example, he does not see his own results as substantiating the behavioural view that the anorectic daughter was reinforced by the family or larger environment for her symptomatic behaviour. Similarly, he finds no evidence of a familial belief system that values self-denial, self-control, or that sees hunger, fatigue, and sexual impulses as unacceptable signs of weakness, as reported by some cognitively-oriented studies in the field. And while some of Minuchin's (Minuchin et al., 1978) systemic observations closely match his own results, Emmrys does not find in his own subject family anything to suggest the lack of an authority structure pointed to by Minuchin. Finally, Emmrys does not see his data as corroborating the image of a controlling mother and submissive daughter often found in the psychodynamic theories of anorexia nervosa.

Emmrys is to be particularly credited for his development of a comprehensive methodology for the exploration of family life. Indeed, following on the work of Mook (1985, 1986, 1987, 1989), his is one of the first systematic adaptations of the Duquesne method of phenomenological research (Giorgi, 1985 in Emmrys, 1992) to the study of the intersubjective reality of the family. Furthermore, his use of both individual and family interviews, in the manner of Laing and Esterson (1972), probably gives rise to a number of different individual perspectives more successfully than would the usual family interviews. Moreover, the perspectives of these other family members evoke a far more complex, more richly textured world of intersubjective meanings than that generally found in the literature on anorectic families.

Moreover, aside from certain epistemological claims, Emmrys' arguments appear to be internally consistent throughout his work. In addition, his notion of a crisis of authenticity that coincides with the onset of anorectic behaviours is an important and original contribution to the literature on this syndrome, particularly in that it represents a useful correction to the pathologizing stance of most theories in this area. This formulation is especially valuable in as much as this crisis is contextualized within the

relational domain of the family. Furthermore, his comparison and contrast of the results of his study with the views of other researchers in the field proves to be not only thorough, but also stimulating and at times entertainingly polemic. Finally, Emmrys' formulation is notable for its courageous recursive critique of its own methodology and for the precise suggestions it offers for the eventual improvement of this methodology.

Nevertheless, Emmrys' study is not without a certain number of epistemological and other problems. For instance, in adapting Giorgi's research method (Giorgi, 1985 in Emmrys, 1992) which derives from Husserlian phenomenology, Emmrys assumes that he can bracket his own bias such that the phenomenon in question reveals itself without any prestructuring by his theoretical orientation or even without any inference on his part. From a constructivist perspective, such "bias" is unavoidable in any form of empirical research, whether phenomenological or not, as any interpretation of data necessarily involves theorizing or a certain construction of reality. Indeed, the so-called data itself cannot be "observed" without construction on the part of the "observer" (von Glasersfeld, 1985).¹³

Emmrys does not appear to recognize his own contribution as ultimately being theoretical in nature, preferring to see it as somehow grounded in atheoretically observed data. Yet, from a constructivist perspective, whenever Emmrys goes even slightly beyond his subjects' stated perceptions by articulating the implicit meanings that he perceives in their statements, instead of just repeating *verbatim* what they have said, he is in fact making an interpretive leap, however minute it may be. (The epistemological question here almost becomes one of how large an interpretive leap is to be considered legitimate within one's given research methodology.)

Regardless of the ultimate legitimacy of Emmrys' claim to be able to avoid "bias" and inference, it appears that at least in this particular work he does not do so. For just as Binswanger (1958a) has been critiqued for his apparent *a priori* adoption of certain Heideggerian concepts (Bernabé, 1976) in his analysis of the case of Ellen West, so Emmrys' findings seem to be influenced by his existential-phenomenological orientation to highlight such notions as authenticity, project, and objectification. That is, of all the myriad phenomena occurring in his subject family, the results of his study centre on those most congruent with his own theoretical leanings. Of course, there is nothing wrong with these concepts *per se*, and indeed in Emmrys' study they prove conducive to original, thought-provoking theorizing. Yet they do not represent the sort of pure, atheoretical category that Emmrys might wish. Similarly, one also wonders about the "bias" that may

¹³ From a *radical* constructivist perspective, whereby all is construction and there is no pre-given reality at all, the notion of bias itself no longer makes sense.

have been introduced into his study by the types of questions he asked his subjects, even if these were open-ended, or by the type of subject responses that he chose to question in greater detail. Again, from a constructivist perspective, there is nothing inherently objectionable about such "bias", it is simply that Emmrys does not appear to be consistent with his own epistemological assertions.

Moreover, while the single-case study approach offers the researcher such advantages as the luxury of extremely detailed analysis, it is not without one major epistemological problem, from an inductionist perspective--it is not necessarily generalizable. Indeed, Emmrys himself views his subject family as not representative of the clinical population in question, being less dysfunctional than the typical anorectic family. And yet despite this acknowledgment, he uses his study's results to directly argue for the invalidity of other theoretical formulations that pertain to anorectic families in general.

Also, while Emmrys' central concept of a crisis of authenticity may be highly relevant to the experience of many anorectics, he unfortunately fails to convincingly explicate the similarities and differences between authenticity and the autonomy so often mentioned in the anorexia literature. In fact, he often describes authenticity as what most theorists would refer to as autonomy (the extent to which one acquiesces to others' attempts at control), despite the fact that authenticity in an existentialist sense connotes far more than this.

Furthermore, in his critiques of other theories of anorexia, Emmrys at times oversimplifies or even exaggerates the formulations in question in order to make them more vulnerable to attack. This tactic is apparent, for example, in his attributing to the psychoanalytic perspective concepts such as an "oppressor-oppressed dynamic" (p. 270) in the mother-daughter dyad or a complete lack of autonomy in the pre-anorectic child. At the same time, he perceives others' arguments, and not just his versions of them, as being "simplifications, overgeneralizations, or even misinterpretations" (p. 300).

Similarly, he at times unnecessarily sees his own interpretations of the anorectic's experience as excluding those of other theorists in the field. For instance, he sees the anorectic's project not as "simply a response to a long-tolerated maternal oppression.... [but rather] a positive and creative step toward redefining the terms of her involvement in the world" (p. 270), without offering any reason for his apparent assumption that these two concepts cannot comfortably co-exist.

Conclusion

The foregoing critique of the various etiological models of anorexia nervosa is not meant

to imply that they are not, for the most part, valuable tools for the understanding and treatment of this disorder. Indeed, a number of these formulations evince considerable depth, scope, and intuitive appeal. As well, almost all of these theories demonstrate a high degree of internal logical consistency. With the possible exception of the biological models which tend to exclude psychological factors in their etiological explanations and which have largely been refuted in any case, most of these theories are also congruent with each other (Harper, 1983).

From a Popperian perspective, the principal epistemological shortcoming of most of these etiological models is that their originators have made no attempt to offer them in a form conducive to empirical refutation. Nevertheless, this is not to say that they could not be so operationalized given an eventual clearer definition of concepts. Equally importantly, this does not necessarily mean that these theories are not accurate. As has been seen, many of the formulations reviewed have also been criticized by some researchers for being based on clinical observation rather than on controlled studies. This does not, however, present a problem from the critical rationalist position which does not stipulate what constitutes the best stimulus or procedure for speculation and theory construction.

Further, most of the etiological literature appears to assume that anorectic patients are a homogeneous group, which is probably not the case (Sours, 1980). Thus, from an inductionist perspective, many of these theories would be seen as overgeneralizations. From a Popperian standpoint, these theories are more likely to be refuted due to the presence of non-core-group patients in a given sample. And even if these theories had been intended to apply to the more homogeneous, so-called core-group of restrictive anorectics (Bruch, 1973; Sours, 1980), they would still likely represent generalizations from an inductionist viewpoint. Of course, this is a problem inherent in all nomothetic research, and these formulations are best seen as representing modal rather than universal patterns (Garfinkel & Garner, 1982; Vandereycken et al., 1989; Vandereycken & Meerman, 1984).

On the other hand, the etiological models reviewed are not specific as regards the predisposition to anorexia in that their explanations apply to other diagnostic groups. (Two exceptions to this are the formulations of Warah (1990) and Emmrys (1992). Unlike most of the other models reviewed, however, these do not claim to be etiological explanations in that they seek to describe the anorectic's personality characteristics and family relationships respectively, rather than to speculate as to the processes whereby either of these arose.)

In addition, by remaining narrowly focused on predisposition, most of these models do

not adequately address the precipitation or maintenance of anorectic symptomatology. Moreover, most of the models reviewed highlight only one or two pathogenic factors, thereby overlooking a panoply of other potentially pertinent intrapsychic and environmental factors. As a case in point, a number of the theories reviewed, especially the psychodynamic ones, have been faulted for their intense focus on the mother-child dyad.¹⁴ Furthermore, most of these etiological models do not adequately explain a number of the personality characteristics consistently observed in anorectic patients.

Again, the foregoing criticisms of the principal etiological models of anorexia nervosa should not be construed to mean that these theories are necessarily inaccurate or not of heuristic utility, either in clinical practice or in the construction of further hypotheses in this area. Rather, these critiques are simply intended to highlight those areas still needing greater epistemological or theoretical refinement.

¹⁴ Nevertheless, it is equally important not to underestimate the centrality of this relationship, during the first one to two years of life, to the construction of the human personality (Stern, 1985).

V. PROBLEMATIC

The Role of Family Relationships in Anorexia Nervosa: The Lack of Specificity in Existing Etiological Theories

Most psychologists subscribe to the notion that personality arises through the interaction of innate and environmental factors. Among the environmental factors, a young child's relationship with his parents is one of the most often cited determinants of the child's later personality characteristics, including the predisposition to certain psychological disorders. While these dimensions of child development have been most closely examined by a variety of neo-psychoanalytic traditions (Fordham, 1976; Mahler et al., 1975; Stern, 1985), other approaches, such as the cognitive-behavioural (Guidano & Liotti, 1983; Guidano, 1991) or the humanistic-experiential (Mahrer, 1978), have also recognized the salience of such very early patterns of reciprocity. Indeed, most of the notions involved are not in contradiction with even radical behaviourism in that many of the parent-child transactions in question can be described as reinforcement contingencies.

As has already been mentioned, the family relational matrix is generally acknowledged to play a central role in the development of the anorectic predisposition, not only by systemic theorists (Minuchin et al., 1978; Selvini Palazzoli, 1974; Selvini Palazzoli & Viaro, 1988; Stierlin & Weber, 1989), but also by many others of varying orientations (Bruch, 1973, 1978; Crisp, 1980; Garfinkel & Garner, 1982; Sours, 1980). Indeed, the literature abounds both with descriptions of these families during the symptomatic phase and with speculations as to the nature of the pre-anorectic child's relationship with her parents. Yet, as mentioned earlier, these formulations suffer from a lack of specificity in that the characteristics usually mentioned could also be applied to families manifesting a variety of other pathologies.

For example, the families of bulimics are also believed to be achievement-oriented, concerned with outward appearances, and in some cases, diet- and weight-conscious (Garfinkel & Garner, 1982; Schwartz, 1988; Sours, 1980); the families of other psychosomatic patients are perceived as enmeshed, rigid, conflict-avoidant, controlling, and overprotective (Minuchin et al., 1978); the families of schizophrenics are seen to be enmeshed and to disqualify each others' communications (Laing & Esterson, 1972; Selvini Palazzoli et al., 1989; Singer & Wynne, 1965).

As for conjectures about the genesis of the anorectic predisposition in early childhood, most theories point to a chronic deficit in the parental holding environment, a sort of global empathic failure on the part of the child's primary caretakers, combined with a

constriction of the child's autonomy by overcontrolling maternal behaviour (Bruch, 1973, 1988; Crisp, 1980; Garfinkel & Garner, 1982). While such theories are most certainly plausible, such a level of descriptive nuance does little to differentiate anorexia from many other moderately severe personality disorders, such as self-defeating personalities, or from some depressed patients. And if existing etiological models have not yet been able to differentiate anorectic pathogenesis from that of certain other disorders, then there must be at least one causal factor involved that has not been identified to date.

Of course, this is not to say that existing family theories may not be *necessary* components of an eventual comprehensive etiological model of anorexia nervosa, for most researchers in the field agree that the final symptomatic outcome is multiply determined (Garfinkel & Garner, 1982). Rather, existing theories about the genesis of the anorectic predisposition are not *sufficient* because of their lack of specificity. Thus, the present work is not intended to refute these existing theories, but rather to enhance them by rendering them more specific.

One may well ask why it is that a more specific theory is preferable, given that the more general a theory is, the greater the number of particular instances to which it can be applied. Indeed, the construction of general or unifying explanations of seemingly diverse phenomena is the essential goal of all science. Nevertheless, this utility is greatly diminished if a theory is so general that it is not able to make predictions with accuracy and precision, and is hence irrefutable.

The atomic theories of matter offer a case in point: The early assertion by Democritus that matter consisted of atoms was so general as to be of little predictive value--for example, this theory had no way of explaining the obvious differences between lead and gold. But the theories of modern physics, which postulate specific types of atomic structures corresponding to specific types of matter, are not only able to explain the differences between such materials as lead and gold, but are also able to predict the outcome of various operations upon those differing types of matter.

Similarly, one might state that psychopathology arises under conditions where the parents' emotional needs take precedence over the child's--but this theory, too, is so general as to be of little use in predicting the type of symptoms or defensive structures that will arise in a given individual or family. Even to say that the severity of a child's psychopathology is positively correlated with the degree to which the parents' emotional needs take precedence over the child's is still of limited utility in this regard. But if one also examines the specific type of parental needs and how they manifest in the family system, then one can begin to predict the symptomatic form that the child's

psychopathology will take.

Thus, every theory should aim to be as general as possible while still being specific enough to offer a high level of accurate and precise predictive power or empirical refutability. Of course, ultimately there is no complete specificity possible outside of the individual case, but one can strive for more specificity while remaining within a certain diagnostic category, in this instance, that of the core-group restrictive anorectic.

The challenge, then, is to construct a refutable etiological theory that is specific to core-group restrictive anorectics and that does not contradict other theoretical or empirical constructs accepted in the field (unless these latter can be refuted by the present arguments). As already noted, the etiological model to be outlined in the following chapters is not intended to apply universally to this core group of anorectics, but rather to represent a modal pattern among them.

The Lack of Comprehensiveness of Existing Etiological Theories

It can also be said that the more behavioural manifestations of a given psychopathological syndrome an etiological theory is able to explain, the more powerful a conjecture it represents. Thus, the present thesis also aims to account for several phenomena, regularly encountered among core-group anorectics, that have not been adequately explained to date: Existing theories are not able to account for the typical anorectic's apparently unremitting pursuit of perfection beyond observing that her parents greatly stressed achievement, thereby overlooking the fact that most individuals with such parents do not develop such seemingly limitless quests for perfection. Current formulations are also unable to explain the anorectic's unusually intense autonomy strivings--simply viewing these strivings as developmentally determined, attempted corrections of parent-child enmeshment does not explain why most individuals who have experienced such relationships do not, in fact, develop such a strong preoccupation with autonomy. Similarly, the research in the field accounts neither for the anorectic's sense of omnipotence and superiority nor for her proneness to feelings of rejection.

Finally, as already mentioned, many existing etiological theories do not adequately address the precipitation and maintenance phases of the anorectic syndrome and can thus be said to also be lacking in comprehensiveness in this regard.

VI. OUTLINE OF THESIS' PRINCIPAL ARGUMENTS

As an aid to the reader, the principal arguments to be presented in the following three chapters are first outlined more briefly in this chapter:

The Construction of the Anorectic Predisposition in Familial Context

Goodsitt (1985) has argued that the anorectic was used as a parental selfobject, which is congruent with the descriptions in the literature (Bruch, 1973; Crisp, 1980; Selvini Palazzoli, 1974; Sours, 1980; Stierlin & Weber, 1989) of the anorectic's family relationships. However, this etiological formulation is not specific to anorectics, but rather applies in many personality disorders.

One solution to this problem consists of applying Kohut's (Kohut & Wolf, 1978) conjectures about the different types of selfobject relationships that adults may seek to existing descriptions of the anorectic's family relationships: the anorectic appears to have been used in a "merged" selfobject relationship with her mother, giving rise to a self-effacing adaptive mechanism. This is more specific, but it is still not specific to anorectics, as individuals with self-effacing tendencies who are assigned to other diagnostic categories, such as bulimics, self-defeating or masochistic personalities, and some depressed or borderline patients (Kernberg, 1975; Masterson, 1972), may also have experienced such parenting. Moreover, it does not explain her characteristically omnipotent, seemingly limitless quest for perfection (Bruch, 1973; Garfinkel & Garner, 1982; Hogan, 1985; Sours, 1980). In fact, this trait of the typical anorectic can be used to differentiate her from other self-effacing diagnostic groups.

Perhaps there is a clue as to how this feature arose in the anorectic in accepted theories of how such a characteristic arises in other clinical populations: the only other diagnostic group presenting with such a trait is the narcissistic personality who is believed to have been excessively idealized as a child (Kernberg, 1975; Robbins, 1982). Extrapolating from this research, it is proposed that the anorectic was not only used as a merged selfobject by her mother, but also as an "idealized" selfobject by either or both parents.

The conjecture that the anorectic was both idealized and used in a merger-hungry relationship does not contradict any of the foregoing assumptions or theories. For example, Kohut's (Kohut & Wolf, 1978) merger-hungry selfobject relationships may or may not take an idealized form. Moreover, this argument is not inconsistent with other phenomena observed in the anorectic syndrome. In addition, it is able to account not only for the anorectic's characteristically assiduous quest for perfection, but also, as will be seen, for her inordinately strong autonomy strivings, neither of which has been

adequately explained by existing etiological formulations. Finally, this etiological model appears to not be applicable to any other diagnostic group. (The increasing degrees of specificity of this etiological model are outlined schematically in Figure 1 below.)

FIGURE 1

Increasing Levels of Specificity of Etiological Model

Parental selfobject
(predisposed to
personality disorders)

Merged
parental selfobject
(predisposed
to self-effacing
personality disorders)

Idealized
merged
parental selfobject
(predisposed
to anorexia
only
(amongst recognized
diagnostic groups))

It is further proposed that the pre-anorectic child's *simultaneous* function as a merged and as an idealized selfobject compounds the emotional and cognitive distortions that are pursuant upon her function as either one of these. Specifically, the *combination* of these cognitive and emotional distortions give rise to the following personality factors, specific to anorectics among current psychodiagnostic categories, that predispose her to anorexia in the face of the developmental and environmental stresses of adolescence. These personality factors compromise her on-going self-esteem regulation either by further

limiting the conditions under which she is able to maintain a relative sense of emotional well-being (as in #1 and #4 below), or by introducing an inherent tension or instability into her self-system (as in #2 and #3 below).

1) The pre-anorectic evinces a heightened sensitivity to environmental rejection experiences because of her strong dependence on external validation (arising through having been used as a merged selfobject) combined with the habit and expectation of being seen as "special" (arising through having been used as an idealized selfobject), as compared to individuals who have been used only as merged selfobjects (and do not expect to be seen as special) *or* as idealized selfobjects (and are far less dependent on external validation). In fact, the pre-anorectic may literally feel as if she has ceased to exist when she is not validated by the environment for her specialness and perfection. From an early age, she has utilized the strategy of striving to become perfect in such a way as to gain environmental approval in order to forestall possible rejection experiences and their accompanying shame.

2) The pre-anorectic child also manifests a uniquely polarized self-definition consisting of both debased and exalted self-images (for example, worthlessness vs. specialness) that results in a heightened proneness to shame, self-rejection, and self-hatred (due to the discrepancy between the two self-images) and in a concomitant desire to create a more perfect self.

3) Similarly, the pre-anorectic child is uniquely polarized between strong feelings of helplessness, separation guilt, and separation anxiety (arising through having been used as a merged selfobject) and feelings of omnipotence and a strong desire to self-actualize (arising through having been used as an idealized selfobject). Because of the discrepancy between these feeling states, she again finds herself ashamed, as well as subject to the especially strong strivings for autonomy and control so often highlighted in the literature, unlike individuals who have been used only as merged selfobjects (and are relatively content to not separate and individuate from significant others) *or* as idealized selfobjects (and already feel autonomous and in control).

4) The range of behaviours and emotions deemed acceptable by the pre-anorectic child (that is, those that were acceptable to the parents) is even more restricted than that of individuals who were used only as merged selfobjects *or* idealized selfobjects. As such, she is all the more vulnerable to experiencing shame and self-rejection in the face of normal adolescent emotions and needs.

The Precipitation of Anorectic Symptoms

With the onset of adolescence, the pre-anorectic faces a variety of external stressors (especially environmental rejection experiences and other losses) (Bruch, 1973; Garfinkel & Garner, 1982; Selvini Palazzoli, 1974) and internal stressors (the developmentally determined resurgence of previously repressed rage, sadness, sexual impulses, and autonomy strivings) (Crisp, 1980; Sours, 1980), many of which readily evoke both shame and self-rejection in her, for the reasons outlined in #1 through #4 above. (For example, as she moves out into a larger and more demanding social world at adolescence, she is, like most individuals, subject to a greater number of rejection experiences than when she was a child. Such experiences are, however, far more problematic for the pre-anorectic than for other individuals due to her strong dependence on external validation combined with the expectation of being seen as special, as outlined in #1 above. That is, unless she is actively affirmed as somehow special by the environment, she may feel as if she has literally ceased to exist.)

This emotional distress is amplified within the family system, as the idealizing parent(s) experience(s) disappointment, loss, and/or narcissistic rage at the child's increasing failure to live up to their idealized projections, and therefore withdraw(s) from the child emotionally or overtly or covertly reject(s) the child. (In some case, one or both parents may withdraw from the child during adolescence, for one or more of a number of other reasons, in the sort of *volte-face* described by Selvini Palazzoli (Selvini Palazzoli & Viaro, 1988).) This in turn leads to greater shame and self-rejection within the child, as she begins to feel abandoned by the parent(s) who once idealized her, which in turn leads to greater negative affect on the part of the parent(s). Thus begins a vicious escalation which must eventually be resolved through the introduction into the system of a symptom that will satisfy the now intensified needs of all parties involved.

The pre-anorectic child has learned that she can forestall environmental rejection experiences and their accompanying shame and self-rejection, that she can regain control of herself and her environment, by striving to appear perfect in the eyes of the other (because of her function as an ideal selfobject) while radically effacing her own needs (because of her function as a merged selfobject). The pursuit of perfection *qua* a societally validated slimness through dietary restriction adequately fulfills both these tendencies within her and hence serves as a coping strategy suited to her specific predisposition. Excessive slimming is thus simply a more "adult" version of an earlier adaptive mechanism.

As has already been emphasized in much of the anorexia research (Bruch, 1973; Garfinkel & Garner, 1982; Selvini Palazzoli, 1974), the normal developmental thrust

towards further separation and individuation from the parents at adolescence is also highly problematic for the anorectic-to-be. For as she has functioned as a merged selfobject to at least one of her parents, she experiences both internal and family-systemic pressures against this separation. The existing research has not, however, been able to account for the fact that many other individuals subject to such parental pressures against separation (for example, bulimics, self-defeating personalities, and some borderline or depressive individuals) do not present with autonomy strivings as strong as those of the typical anorectic. The hypothesis of her simultaneous use as a parental idealized selfobject may offer this explanation, for serving as a parental ideal selfobject likely fosters in the pre-anorectic child a sense of omnipotence and a particularly strong drive to self-actualize. As noted earlier, it is the discrepancy or tension between these feelings and her separation guilt and anxiety that lead to her inordinately strong need for greater autonomy and control.

Here too, one can surmise the beginnings of both intrapersonal and systemic vicious escalations, as the anorectic's separation attempts lead to ever greater separation guilt and anxiety within her and to ever greater anxiety and clinging in her parent(s). And here again, dietary restriction proves a suitable adaptive mechanism, for it symbolically confers the illusion of autonomy (Bruch, 1973; Garfinkel & Garner, 1982; Joubert, 1992; Sours, 1980), thereby lessening the shame of her not truly being able to separate from her parents, a shame that is intensified by the internalization of parental idealizing attributions of omnipotence and self-actualization.

The Maintenance of Anorectic Symptoms

Any theory that seeks to explain the maintenance phase of the anorectic syndrome must be able to account for the anorectic's inability to stop dieting when she reaches a moderate weight, while other women who undertake diets are able to stop. The non-anorectic woman likely stops dieting when she reaches a moderate slimness because she has now eliminated the "*local*" shame or dissatisfaction of not being at what she considers a desirable weight (or before that if she finds food restriction more aversive than not being at her desired weight).

The anorectic, however, is unable to stop dieting because she is doing so for reasons that go well beyond that of the non-anorectic dieter: instead of attempting to eliminate the merely local shame or dissatisfaction of feeling overweight, she is trying to undo the far more "*global*" shame arising out of the rejection experiences and other stresses of adolescence. To the extent that the anorectic's explicit focus on the local shame of still being "overweight" allows her to avoid experiencing the more global nature of her

shame, she is highly motivated to continue dieting. Moreover, as the elimination of local shame through weight loss does not truly eliminate the more pervasive, at least partly unconscious, global shame, she feels the need to perfect herself further. And yet, since her strategy did initially appear to alleviate some of her shame, it seems to her that by continuing to diet she will be able to eliminate even more shame.

Unfortunately, the anorectic's attempted solution to adolescent rejection experiences and to her global shame only serves to increase her internal conflicts. For the more that she struggles to self-perfect and self-actualize in compliance with parental idealizing injunctions, the more the opposing parental injunction that she remain a merged selfobject demands that she self-efface. Once again the anorectic symptom of continued weight loss appears to neatly fulfill both these injunctions and thus offers the anorectic some degree of adaptation to her situation. And in seeking relief from her situation through her symptom, she comes to need this symptom all the more, thus giving rise to a vicious escalation.

Furthermore, continued weight loss serves an important function systemically, for her illness allows her to remain dependent upon her parents, which prevents parental separation anxiety, shame, decompensation, and/or rejection of the anorectic for trying to separate, as the research has so often emphasized (Bruch, 1973; Garfinkel & Garner, 1982; Minuchin et al., 1978; Sours, 1980). Thus, the anorectic herself is at less risk of decompensation, for she experiences less feelings of rejection by her family, less separation anxiety of her own, and less shame or guilt for trying to separate in the first place, at the same time that she is afforded the illusion of autonomy that, as has been seen, is so important to her because of earlier parental idealizing attributions.

Finally, while the anorectic's coping strategy initially reduces shame and other negative affect (as did her childhood version of the same strategy), it eventually exacerbates them as her weight continues to drop to even lower levels, and she finds herself caught in a further vicious escalation. For as her cachexia becomes pronounced, she begins to experience additional distress in the form of critical comments from family and friends and in the form of secondary effects of starvation, including the weakening of her emotional defenses. Again, as her attempted solution was initially successful in alleviating her emotional distress and as she feels that she has no other solutions open to her (Bruch, 1973; Joubert, 1992), she continues to utilize this adaptive mechanism for the reduction of her distress, with the result that she experiences even more distress and needs all the more desperately to continue to diet.

VII. THE CONSTRUCTION OF THE ANORECTIC PREDISPOSITION IN FAMILIAL CONTEXT

The Role of Selfobjects in Psychological Development

A number of researchers (Bowlby, 1969; Kernberg, 1975; Stern, 1985; Winnicott, 1965) have pointed to the centrality of parental empathic failure in the genesis of emotional dysfunction, particularly in regard to the personality disorders. This empathic failure has generally been described as a chronic lack of parental attunement and responsiveness to the child's spontaneous emotional needs, often beginning in earliest infancy.

In line with this strong emphasis on parental empathic connectedness, Kohut's self psychology has offered even more elaborate speculations on the specific role of the parent-child relationship in the development of the child's self (Kohut, 1977). He argues that the self develops out of both innate factors and through the interaction with the child's "selfobjects". Kohut defines a selfobject as an object (that is, another individual) who is cognitively perceived as external to the self, but is emotionally experienced as a part of the self, in the same manner as Winnicott's "transitional object" (Winnicott, 1965) or Mahler's "symbiotic object" (Mahler et al., 1975). A person functioning as a selfobject for another is not perceived as a separate and independent individual with his or her own characteristics, needs, and wishes. Rather, one relates to a selfobject as one does to a part of oneself, such as one's arm. Since selfobjects are experienced as part of the self, the expected control over them is closer to the control that a normal adult expects to have over his own body and mind than to the control that he or she expects to have over others. Thus, when parents serve as adequate selfobjects to the young infant, they are accommodating to the child's spontaneous emotional needs, rather than expecting the child to accommodate to their emotional needs and wishes.

Functionally, a selfobject is used to stabilize and complete the self, to positively affect the sense of self. For according to Kohut (1977), the very early self has no permanent structure or continuity in time and thus requires the empathic responsiveness of these selfobjects to initially perform functions of self-cohesion and self-regulation for it. Through internalizing and identifying with such an empathically attuned selfobject, the child gradually learns to self-soothe and develops self-love and a cohesive sense of self.

More specifically, Kohut (1977) asserts that two modes of relationship with one's selfobjects are necessary for the development of such a cohesive, emotionally healthy self. Firstly, in much the same way as described by other theorists (Bowlby, 1969; Stern, 1985; Winnicott, 1965), the infant needs to be "mirrored" or responded to in his age-appropriate needs and spontaneous gestures, through an empathic "holding" function

that is believed to usually be carried out by the mother. More precisely, a mirroring selfobject is one who responds to and confirms the child's innate sense of vigour and personal adequacy as manifested by verbal and non-verbal supportive and validating responses to the child's spontaneous gestures and accomplishments. Further, a mirroring selfobject is attuned to the affects and subjective experience of the infant and provides appropriate soothing, tension regulation, and containment of negative affect. Such attunement to the child's emotional experience takes the form of accurate decoding of the child's verbal and non-verbal signals followed by the appropriate responses. For example, an adequately mirroring selfobject would pick up a child in response to the child's apparent communication of the desire to be held, rather than in response to the parent's own need for physical contact with the child. A child in interaction with such an appropriately mirroring selfobject would feel itself to generally be in control of the parent serving as the selfobject, instead of vice versa.

Secondly, the very young child needs a relationship with an idealized selfobject, that is, with an individual to whom the child is allowed to look up as an image of calmness, steadfastness, infallibility, and omnipotence. Kohut (1977) believed that this function was usually fulfilled by the father. Specifically, a parent functioning as an idealized selfobject for the child, would behave in such a way as to accept the child's idealization, rather than acting embarrassed or in some other way discomfited with the child's rather unrealistic image of the parent. Further, this parent would not behave in such a way as to regularly disconfirm or shatter the child's image of him. For example, a parent who often appeared insecure, helpless, anxious, unreliable, emotionally labile, or "flawed" in some other way, due to substance abuse or emotional disturbance, would likely not serve as a suitable idealized selfobject for a young child.

The absence of one of these two types of selfobject experiences is believed to be compensated for by the presence of the other, and at worst, the child may later develop a neurotic disorder. However, the lack of both of these dimensions will in all likelihood result in an inadequate sense of self and ongoing difficulty with self-esteem regulation, such as that seen in many personality disorders. In order to compensate for this difficulty in autonomous self-esteem regulation, these individuals will continue to seek out selfobject relationships even in adulthood, often in their couple relationships (Kohut & Wolf, 1978).

Probably because he treated individual adults rather than families, Kohut never took the logical next step of addressing the compensatory selfobject relationships that these individuals may form with their children. (Family therapists have, of course, long theorized that children are often conscripted as "delegates" to externalize parental marital

or other conflicts (Boszormenyi-Nagy, 1973; Kerr & Bowen, 1988; Minuchin, 1974), used as substitute spouses in the context of disappointing marital relationships (Kerr & Bowen, 1988), or even "parentified" into caretakers of chronically needy parents (Boszormenyi-Nagy, 1973.)

The Pre-Anorectic Child as Parental Selfobject

Prior Research Findings

As has already been seen, in the area of anorexia research, Goodsitt (1983, 1985) has proposed that the pre-anorectic child is made to serve as a selfobject to a needy parent, being repeatedly induced to behave in such a way as to produce emotional well-being in the parent. This hypothesis seems congruent with the work of certain other theorists (Bruch 1973, 1988; Orbach, 1986; Selvini Palazzoli, 1974; Sours, 1980) who are united in their assertion that not only has the anorectic patient not had her own psychological needs met as a child, but also that she has learned to compliantly negate her own experience and expression of those needs for the sake of the parent's welfare. Minuchin (Minuchin et al., 1978) points in the same direction with his notions of "enmeshment" and of "cross-generational coalitions", wherein parents seek to have their emotional needs met through a particularly close relationship with one of their children. Similarly, Emmrys (1992) has commented on the "objectification" of children for parental purposes, a process whereby a child is defined in a particular way that may correspond more to the parent's defensive needs than to the spontaneous initiatives of the child.

This line of etiological reasoning seems especially promising in that unlike the principally deficit models of pathogenic parenting, such as that of Bruch (1973), they not only highlight what was lacking in the anorectic's early development, but also examine the constraints placed upon the pre-anorectic child's behaviour by her parents' emotional needs. Such theorizing may help to account for certain of her typical cognitive and emotional distortions and also offer a greater specificity of pathogenesis.

Moreover, there appears to be empirical support such notions regarding parental emotional use of the pre-anorectic child in the studies that have pointed to the emotional vulnerability of anorectic's parents (Crisp et al., 1980; Kalucy, Crisp, & Harding, 1977; Morgan & Russell, 1975). And while the research has not identified the clear prevalence of one particular type of psychopathology in the parents of anorectics (Yager, 1982), at least one study has suggested that one of their principal emotional difficulties appears to be the inability to cope successfully with object loss and the resulting deterioration in self-esteem (Biro, Boizou, Jeammet, Chabert, & Aubin, 1984). As Goodsitt (1985) points out, the parents of anorectics are vulnerable to depression and psychic decompensation

upon "losing" their child.

From a systemic perspective, the parents' defensive utilization of their children generally occurs against a backdrop of overt or covert marital disappointment. (In the case of the anorectic family, this marital disillusionment is believed to be covert, as the parents of anorectics generally present with a façade of marital harmony (Bruch, 1973; Selvini Palazzoli, 1974).) In general, the more unsuccessful the marriage and the more disturbed the parents, the more power parental anxiety has over the child and the more the child must behave in accord with parental emotional needs in order to maintain an attachment. That is, the child of such parents unconsciously tries to behave in accord with parental defensive requirements to the extent that it cannot tolerate parental anxiety or its own anxiety over the parent's withdrawal when it does not comply.

Such parental withdrawal from the child is believed by such authors as Scheff (1989) to be motivated by the parent's "narcissistic rage"--a combination of shame and rage, that is not necessarily overtly expressed (Kohut, 1977; Lewis, 1971; Terman, 1975)--that results whenever the child that has been selected as a parental selfobject fails to fulfill this function and "abandons" the parent. The consequences of this parental narcissistic or abandonment rage are relatively serious to the child, for until the child learns to decode and comply with the parent's emotional requirements, the child likely experiences successive, "process traumatic" ruptures in emotional connectedness with the parent. And if certain conceptualizations of the symbiotic stage of development are accurate (Mahler & Furur, 1968; Stern, 1985), in very early infancy the situation may be further complicated by the child's co-experiencing of the parent's emotional turmoil.

Behavioural Transactions in Parental Use of Child as Selfobject

Theories of parent selfobject use of children remain largely untested because they have rarely been operationalized into observable behaviours. Upon closer examination, the transactions comprising such parental selfobject use of the child can be seen to involve basic operant conditioning procedures, such as that found in all child rearing. That is, the child's behaviour is gradually shaped through various reinforcement contingencies, so that the parent may have the emotional experience that he or she seeks.¹⁵ (For example, as a young toddler, the pre-anorectic child is more likely to be reinforced for remaining in close physical proximity to her mother than for venturing forth to explore the environment (Masterson, 1977).) Such operations occur both on a moment-to-moment basis and

¹⁵ It should be noted that these processes are rarely, if ever, under the completely conscious control of the parents. Rather, they represent more or less automatic behaviours arising not only out of the parents' defensive needs of the moment, but also out of their prior learning experiences, such as their own parents' behaviour toward them when they themselves were young children.

during longer interactional sequences.

More specifically, a parent may utilize positive reinforcement whereby child behaviours that correspond to parental selfobject needs are rewarded with nurturance, protection, attention, approval, material objects, and so on. A parent may also engage in negative reinforcement wherein a given response on the part of the child leads to the removal of an aversive stimulus and this response is therefore strengthened. Thus, producing parentally desired behaviours comes to be utilized by the child to forestall aversive consequences such as emotional abandonment, being ignored by the parent, or having its needs and interests neglected by the parent. Such parental behaviours are especially painful to the young infant as it may experience emotional annihilation and literally feel itself to cease to exist under such circumstances (Winnicott, 1965). Alternatively, the child may be rejected in a more overt fashion, through an angry dismissal, a verbal or physical attack, blame, criticism, parental intrusion in the child's activities, or the imposition of restrictions on the child's behaviour. No less anguishing to the infant may be the aversive stimuli that take the form of decompensation, fragmentation, anxiety, sadness, underlying abandonment rage, and/or other negative affect on the part of the parent, even if these emotional states are not consciously recognized and/or expressed by the parent because of his or her particular defense mechanisms.

In addition to such basic operant reinforcement contingencies, the child may be subject to "objectifying" behaviour on the part of the parent. In objectification (Emmrys, 1992; Laing, 1971), the parent perceives the child to be a certain way and repeatedly defines and affirms the child to be this way, even if this is not congruent with the child's spontaneously arising self. This definition of the child may be communicated explicitly or implicitly, in both verbal and non-verbal behaviour. Such operations are, of course, to be sharply differentiated from simply telling a child to behave in a certain way, for in the case of objectification, he or she is simply affirmed to already *be* a certain way, regardless of the child's actual behaviour and inner experience.

Thus, the parent "superimposes on the child his or her own concept of the child's needs and thereby provides primarily distorting and impinging experiences, first in nonverbal, pre-symbolic communication, for example, in a feeding situation or a bathing situation, and then in verbal communication with direct mislabeling of the child's feeling states, such as that he must be hungry or cold or tired or happy or anxious or sad or bad, regardless of the child's own experience. This process is subsequently extended to include mislabeling the child's role and behaviour in the family, at school, in the neighbourhood, and in broader society (Sacksteder, 1989, p. 44)."

Furthermore, these objectifying attributions about the child may become so reified as to affect the meanings that are imputed even to child behaviours incongruent with these attributions. Especially in more dysfunctional families, these explicit or implicit attributions and fantasies about the child may involve unacknowledged or unactualized aspects of the parental personalities that are more comfortably projected onto, that is, perceived in, the child. All selfobject relationships involve a measure of such objectification of the other, in that the other is made over in fantasy, if not ultimately in actuality, into what one needs or wants the other to be, without much regard for his or her subjective experience (Stern, 1985).¹⁶

The Child's Responses to Parental Behaviours

If parental behaviours are unrelated to the child's state, needs, or spontaneous gestures, the child's activity, rather than being rooted in personal impulse, becomes merely an operantly conditioned reaction to the parent's behaviour. Thus, the child adapts its explicit behaviour to the needs of the parent in order to maintain an attachment to him or her, to avoid such painful affects as loss, helplessness, and/or rage, and to gain some measure of control over the parent's responses. Over time, the child becomes more and more compliant, to the point of developing a "false self" (Winnicott, 1965).¹⁷ While the child thereby avoids obvious problems in its relationship to the parent, there also is little real contact between such a child and its parent. The parent remains unaware of and unresponsive to the child's genuine needs and eventually the child, too, is unable to identify its own needs and wants and likely develops a personality disorder of some type.

Similarly, in those circumstances where the child is objectified or defined in accordance with parental selfobject needs, "whenever the child's personal experience differs from the parents' explanation of the feelings they suppose the child is having, thoughts and emotions that have already been produced are excluded, and the parents' redefinition of them is likely to be further processed... These situations can have considerable repercussions on emotional differentiation. On the one hand, they can contribute to the

¹⁶ In practice, operant conditioning of the child's responses cannot be as clearly distinguished from objectification of the child as they have been here for heuristic purposes, for the two processes not only overlap to a significant degree, but operant conditioning procedures may also be used to reinforce the child's acceptance of the parent's objectifying perceptions of him or her.

¹⁷ A "false self" can be defined as a set of beliefs about oneself, together with corresponding behaviours, that arise out of an over-accommodation to the environment rather than out of a more balanced interaction between one's innate, spontaneous self and an adequately responsive environment. Of course, from the standpoint of orientations that do not assume the existence of an innate self, such as the radical behaviourist, such notions as a "false" self make no sense. Moreover, the relative "falseness" or "trueness" of one's self is obviously a matter of degree in that all humans are shaped to one extent or another by the environment. Indeed, without environmental support, our innates selves can barely manifest in the first place (Winnicott, 1965).

exclusion of a whole range of emotional experience from the self-image so that it will be consistent with the image that the parents seem to accept more favorably; on the other hand, they create a feeling of unreliability concerning one's ability to recognize and define properly one's own internal states (Guidano & Liotti, 1983, p.39)."

The interpersonal behaviours of a child that is functioning as a parental selfobject can be operationalized using descriptive categories of observed behaviour, such as those utilized by Humphrey and Benjamin (1986) in their "structural analysis of social behaviour". For example, a child in such a position may take in and learn from the parent's cues as to how it should behave; it may defer, conform, yield, submit, give in, appease, apathetically comply, follow the rules, uncomprehendingly agree, cling, depend, withdraw, and/or become wary and fearful. In terms of the child's relationship to itself, its behaviours can be categorized with such descriptors as controlling and managing self, restraining and holding back self, doubting and putting self down, feeling guilty, blaming self, punishing self, rejecting or dismissing self, ignoring its own needs, neglecting its own potential, deceiving itself, having an undefined or unknown self, losing itself in fantasy and daydreaming, and/or drifting with the moment (Humphrey & Benjamin, 1986).

How Parental Selfobject Use of Child is Camouflaged in the Anorectic Family

For parental selfobject use of a child to function effectively as an adaptive mechanism for the parent, the true nature of the relationship must remain unconscious (Zinner & Shapiro, 1989). Indeed, the parental messages involved are often covert (Laing, 1971). In some cases, not only do there exist implicit injunctions against metacommenting on what is actually occurring, but parental use of the child is also further camouflaged by the presence of "pseudomutuality".

Pseudomutuality has been defined as an engagement limited to the level of appearances that simultaneously negates the more fundamental qualities of the other (Wynne, 1987). It can be seen as a predominant preoccupation with fitting together, maintaining an ongoing attachment, and protecting against the dissolution of the relationship, at the expense of the differentiation of the identities of the individuals involved. Operationally, it might take the form of repeated parental protestations of affection, caring, and concern for the child combined with neglect or active negation of the child's expressions of need. In contradistinction, "mutuality" involves a relationship in which the identity of each participant is recognized and positively valued (Wynne, 1987). "Non-mutuality", on the other hand, involves a role-limited complementarity without a strong investment in exploring what the relationship has to offer either person (Wynne, 1987), as is found in

disengaged families (Minuchin, 1974), for instance.

Based on the descriptions in the literature (Bruch, 1973; Guidano, 1991; Sours, 1980; Stierlin & Weber, 1989), pseudomutuality appears to be operative in the anorectic family. Guidano (1991) observes: "On the one hand, they portray themselves as parents completely devoted to the well-being and upbringing of their children; on the other, their parenting behavior is more concerned with obtaining confirmation of that image from others than with fulfilling their children's concrete need for emotional warmth and support..... (p. 45)." Thus, parental verbalizations are used more to regulate their own self-esteem than to communicate real information or genuine caring; they are often accompanied by an observable lack of concern with their daughter's needs and feelings (Bruch, 1973; Stierlin & Weber, 1989). Similarly, normal parental duties are often redefined as "self-sacrifice" (Bruch, 1973; Selvini Palazzoli, 1974; Stierlin & Weber, 1989).

More generally, the parents of anorectics appear to be invested in the maintenance, at least at a level of words and ideas, of a buoyantly optimistic, quasi-delusional interpersonal reality through the use of denial and reaction formation (Sours, 1980). For example, marital disillusionment is redefined as a harmonious, satisfying relationship (Selvini Palazzoli, 1974). The parents' strong nurturance needs and separation anxiety are roundly denied (Stierlin & Weber, 1989). Finally, family-wide repressed anger, hostility, and interpersonal ambivalence are cloaked in conflict avoidance and protestations of affection for one another (Bruch, 1973; Selvini Palazzoli, 1974; Stierlin & Weber, 1989).

Some Nuances

These formulations may seem to imply that such processes operate in a linear, unidirectional fashion, flowing from hell-bent-on-wholeness parents to their helpless offspring. In fact, it might be a useful corrective to study such processes at work between spouses or even siblings. Moreover, these sorts of "objectification" processes and selfobject relationships are intergenerational and the parents were likely subject to similar experiences in their own childhoods (Boszormenyi-Nagy, 1973; Kerr & Bowen, 1988). Finally, while the linguistic convention of describing one element in a complex process at a time may also appear to "linearize" such formulations, there is no intention here to imply that such processes do not involve myriad, systemic interactions with a host of other factors. For example, the adaptive use of a child as a parental selfobject generally occurs not only in the context of overt or unacknowledged marital failure, but also against a larger backdrop of past and present extended family relationships and of an even larger matrix of sociocultural and historical realities.

Furthermore, a child may derive a certain amount of gratification from its participation in this type of relationship. To be a selfobject for the parents, and to thus help determine its parents' emotional experience, is a role that holds a powerful and seductive appeal. In addition, a child's function as a parental selfobject may be determined not only by environmental reinforcement, but also partly by such innate factors as a particular sensitivity to interpersonal cues on the part of the child.

Moreover, all human interactions involve some objectification of the other in the sense that we never experience the other in the same way that he subjectively experiences himself, but rather perceive the other based at least partly on our own defensive requirements. Thus, objectification can be said to be a dimensional concept that is operative to varying extents in both "healthy" and "dysfunctional" families (Zinner & Shapiro, 1989). The degree to which a child's emotional development will be compromised appears to correspond to the degree to which the parents' emotional needs take precedence over those of the child. Similarly, the form that the child's later psychopathology will take corresponds to the content of the parental attributions toward that child.

The Pre-Anorectic Child as Merged Selfobject

Remaining Problematic

As has been argued, such selfobject relationships are very likely operative in many anorectic families, with their well-known separation anxieties and clinging control of the child (Bruch, 1973; Garfinkel & Garner, 1982; Minuchin et al., 1978; Selvini Palazzoli, 1974). In fact, Goodsitt (1983, 1985), a self psychologist, has explicitly pointed to the use of pre-anorectic children as a parental selfobjects. Nevertheless, the mere existence of such relationships does not differentiate anorectic families from many other psychodiagnostic groups in which the children are also used as parental selfobjects to varying degrees.

Because the child's ultimate adaptive mechanisms and symptom choices are strongly influenced by the type of parental needs that manifest in their objectifying definition of the child, that is, by the specific nature of the selfobject relationship in question¹⁸, it is important to identify what particular type of selfobject relationship is involved. That is, the specific way in which a child is objectified partly determines the constraints¹⁹ on its

¹⁸ Adaptive mechanisms are probably also partly determined by the child's innate capacities.

¹⁹ A constraint is here defined as that which prevents or distorts the natural, developmentally determined emergence of an innate potential.

behaviour and hence its potential adaptive mechanisms. The next sections of the thesis will, therefore, propose a unique configuration of selfobject relationships between anorectics and their parents that will be argued to apply to the core group anorectics and yet at the same time distinguish them from other diagnostic groups.

According to Kohut's last statement on this issue, there are various specific types²⁰ of selfobject needs that adults may seek to have met in their relationships, although, unlike Goodsitt (1983, 1985), he did not specify that children could be used for such purposes (Kohut & Wolf, 1978).

One may well ask why one would want to utilize such broad categories as Kohut's selfobject relationships (essentially only five types), when one could argue that there are as many types of selfobject relationships as there are close interpersonal relationships? What is being sought here is that optimal tradeoff between specificity and generality whereby the theoretical constructs proposed apply only to core-group restrictive anorectics amongst psychodiagnostic groups and yet to the majority of patients within this core group.²¹

The milder forms of these selfobject-seeking types outlined by Kohut (Kohut & Wolf, 1978), which may be found among neurotic or mildly to moderately character-disordered individuals, are mirror-hungry personalities who seek out confirming and admiring selfobjects to temporarily counteract their inner sense of worthlessness, ideal-hungry personalities who experience themselves as worthwhile only when they have a selfobject whom they can admire for their power, beauty, intelligence, etc., and alter-ego personalities who need a relationship with a selfobject who confirms the reality of the self by conforming to the self's attitudes and values.

The more severely disturbed forms, that are found among those with moderate to severe character disorders, include merger-hungry personalities who need to control their selfobjects as a substitute for inner self-cohesion. In fact, their interpersonal boundaries are so tenuous that they are often unable to discriminate their own thoughts, emotions, and motivations from those of their selfobject. As their selfobject is experienced as their own self, they are very intolerant of independent behaviours in this other and extremely sensitive to separations from him or her. This type of self-object relationship may take

²⁰ It should be noted that, as with virtually all diagnostic categorization, while a given individual will present with predominantly one of these modes, there may be aspects of the others present.

²¹ As is the case with all theories of predisposition, there may be individuals who have experienced such selfobject relationships in childhood, but who do not become symptomatic due to the presence or absence of other, as yet unexamined, innate factors and external (precipitating or mitigating) influences. In this sense, the present work's central etiological theory highlights *necessary* but not *sufficient* factors.

any one of the previously described three forms, or some combination of these three forms, depending upon the specific selfobject needs of the individual in question.

Among the more severely disturbed forms of selfobject needs, Kohut (Kohut & Wolf, 1978) also describes the contact-shunning personalities who avoid social contact and become isolated because of frighteningly intense, denied needs for others.

Prior Research Findings

Can we tell from accepted empirical data about the anorectic's early family relationships which of the above five types of selfobject relationship she may have experienced? This data describes the mother of the typical anorectic as highly controlling, non-responsive to her daughter's emotional needs and spontaneous initiatives, symbiotically close to her daughter, and fearful of separation from her. According to a number of researchers (Bruch, 1973; Crisp, 1980; Garfinkel & Garner, 1982; Goodsitt, 1983, 1985; Masterson, 1976; Selvini Palazzoli, 1974; Sours, 1980), the anorectic's mother typically has difficulty conceiving her child to have feelings and needs different from her own and in many ways views her child as an extension of herself.

This type of relationship corresponds to the specific type of selfobject relationship referred to as "merger-hungry" by Kohut (Kohut & Wolf, 1978)--the merger-hungry individual prefers to exist in a sort of emotional fusion with his selfobject, seeks near-absolute control over him or her, and feels highly threatened by any possibility of separation from him or her. Indeed, since the other is needed to function as part of the self, and is used to stabilize and complete the self through merger, that other cannot be perceived as separate and independent. This type of selfobject relationship can be said to resemble that of an infant to its mother, that is, the individual functioning as a selfobject serves as a sort of symbiotic mother to the merger-hungry individual.

According to the research (Bruch, 1973; Garfinkel & Garner, 1982; Sours, 1980; Stierlin & Weber, 1989), there appears to be much more variance in the types of relationship that the pre-anorectic child has with her father than with her mother. As such, it is probably not possible to make any general assertions as to the father's selfobject use of the pre-anorectic child. It is thus hypothesized that the pre-anorectic child has indeed functioned as a merged selfobject to her mother and may or may not have also served in such a capacity to her father. For the sake of simplicity, this section of the thesis will refer exclusively to the maternal figure in its discussion of the merged selfobject use of the pre-anorectic child.

Behavioural Transactions in Maternal Use of Child as Merged Selfobject

As the literature so often points out (Bruch, 1973; Goodsitt, 1983, 1985; Selvini Palazzoli, 1974), the mother of the pre-anorectic child over-controls her child's cognitive, emotional, and behavioural experience through selective reinforcement. The mother attributes to her child cognitions, emotions, and even behaviours that the child may not actually experience and that correspond rather to the mother's emotional moods and needs. Indeed, due to the fluidity of boundaries between herself and her child, the mother of the pre-anorectic child typically appears unable to discriminate her own thoughts, wishes, and intentions from those of her child. Thus, beginning in earliest infancy, her behaviours towards her child tend to be unrelated to the child's emotional state, needs, or spontaneous gestures.

Such maternal behaviours can be seen to represent an extreme form of the objectification described in the preceding section on the parental selfobject use of children in general. As discussed in that section, such objectification may be operationalized as the parent's repeated, explicit verbal affirmations that the child is a certain way and/or a more implicit definition of the child in this way through non-verbal behaviours.

Similarly, the mother of the pre-anorectic child is believed to positively reinforce clinging behaviour and to ignore or punish individuating behaviour (Masterson, 1977; Selvini Palazzoli, 1974). The child's autonomous feelings and thoughts are either not recognized or actively disconfirmed, as they imply the threat of separation or alienation which is highly anxiety-provoking to the mother. Any acts of self-assertion, not to mention the overt expression of anger, on the part of the child are seen as intolerable acts of aggression and hostility. In fact, passive, thing-like behaviour is viewed as normal and is rewarded.

Operationally, a merged selfobject relationship thus involves the same sort of operant reinforcement contingencies described in the section on the parental selfobject use of children in general. That is, varying child behaviours are positively reinforced, negatively reinforced, and/or punished. More specifically, one sees the same sort of parental behaviours also described in this earlier section. For example, the mother of the pre-anorectic child may reward child behaviours that correspond to her merger-hungry selfobject needs (for example, the child's passive compliance) with attention, approval, and/or material objects. She may also negatively reinforce a desired response on the part of the child through the removal of such aversive consequences as being ignored or neglected. In addition, she may punish certain child behaviours in a more overt fashion, through an angry dismissal, blame, criticism, intrusion in the child's activities, or the

imposition of restrictions on the child's behaviour. Finally, the mother of the pre-anorectic child may be subject to decompensation, fragmentation, anxiety, sadness, underlying abandonment rage, and/or other negative affect when her child's behaviour does not conform to her needs for merger; these emotional states on the mother's part then also serve to punish undesirable responses in the ongoing shaping of her child's behaviour.

The Child's Responses to Maternal Behaviours

The reader probably recalls that a merged selfobject relationships is one of the two more severely disturbed forms of selfobject relationships postulated by Kohut (Kohut & Wolf, 1978). As illustrated above, in this state of psychological fusion between two individuals, one person demands extreme accommodation to his or her emotional needs from the other. Children used in such a merged selfobject relationship, then, must accommodate to an extreme degree and behave in such a way as to reinforce parental attributions towards them or risk emotional abandonment and loss of ontological security on a moment-to-moment basis. From a more systemic perspective, because of the intense (denied) parental attachment and nurturance needs, the pre-anorectic child can be seen as also subject to particularly strong systemic pressures to accommodate to such a merger with her mother.

Given all that is at stake here, it is not surprising that the pre-anorectic child develops an extreme sensitivity to her mother's unspoken needs and feelings and becomes highly compliant (Bruch, 1973; Garfinkel & Garner, 1982; Masterson, 1977; Orbach, 1986; Selvini Palazzoli, 1974), adapting her behaviour to her mother's cues, rather than *vice versa* as in "good-enough" parenting (Winnicott, 1965).²² Thus, the pre-anorectic child's actions, rather than arising spontaneously from her own needs and wishes, become little more than operantly conditioned reactions to her mother's behaviours. Similarly, the mother's objectifying definition of her child contributes to the child's no longer recognizing or processing those feelings and thoughts that do not conform to the mother's image of her (Guidano & Liotti, 1983). Such a "false-self" development (Winnicott, 1965), prevents overt conflict between mother and child, but also leads to the exclusion of certain emotional and cognitive experiences from the child's self-image.

²² The well-known compliance of the pre-anorectic child may be due not only to extreme maternal and systemic pressures, but also to the interaction of the child's innate traits with the mother's personality. For example, the pre-anorectic child may be innately passive, making it relatively easy for her mother to establish a merger with her. In addition, certain authors have postulated altruistic motives on the part of even the very young child, hypothesizing that the child feels the desire to help the emotionally needy parent (Searles, 1979) or that it experiences guilt for any distress that it may cause the parent (Zahn-Waxler & Radke-Yarrow, 1983).

As described in the thesis's section on the parental selfobject use of children in general, one can operationalize the interpersonal behaviours of a child that is functioning as a merged selfobject with descriptive categories of observed behaviour, such as those of Humphrey and Benjamin (1986). For instance, a child in a merged selfobject relationship may defer, conform, yield, submit, give in, appease, apathetically comply, follow the rules, uncomprehendingly agree, cling, and/or depend. As seen previously, the relationship of such a child to itself, can be operationalized with such descriptors as controlling and managing self, restraining and holding back self, doubting and putting self down, feeling guilty, blaming self, punishing self, rejecting or dismissing self, ignoring its own needs, neglecting its own potential, deceiving self, having an undefined or unknown self, losing itself in fantasy and daydreaming, and/or drifting with the moment (Humphrey & Benjamin, 1986).

Corresponding Cognitive and Emotional Distortions in Child

The pre-anorectic child's function as a merged selfobject to her mother contributes to the development in her of certain personality traits or enduring belief systems.

1) One of the most salient of these, for the later precipitation of anorectic symptoms, is her overdependence on external frames of reference. This overreliance on environmental feedback manifests itself in three principal, interrelated ways.

Firstly, the pre-anorectic child is grossly deficient in the domain of subjectivity, that is, she has great difficulty in recognizing and trusting her own perceptions, feelings, or thoughts, as has been well documented in the literature (Bruch, 1973; Garfinkel & Garner, 1982; Goodsitt, 1983, 1985; Orbach, 1986; Swift & Wonderlich, 1988). As such, she tends to achieve self-recognition through her relationships with significant others (Minuchin, 1974; Minuchin et al., 1978). Thus, the pre-anorectic child has come to passively accept her parents' definition of her, to see herself in terms of parental attributions towards her. This carries over into her relationships with other individuals in that she rapidly and reflexively attempts to discern the other's expectations of her in any given situation and to immediately conform to these. That is, as she experiences herself largely through the other's reflection of her, she ends up needing the other's confirmation of her behaviour on an ongoing basis (Goodsitt, 1983, 1985; Minuchin et al., 1978).

Secondly, this difficulty in recognizing and trusting her own perceptions, feelings, or thoughts, is accompanied by an overall lack of autonomy. The literature is replete with descriptions of the pre-anorectic child as compliant, obedient, submissive, and passive (Bruch, 1973; Crisp, 1980; Garfinkel & Garner, 1982; Orbach, 1986). Rarely are there

any parental reports of tantrums, negativism, or aggression. In fact, it has been said of the pre-anorectic child that she is a "juvenile expert in parent-watching and pleasing" (Swift & Wonderlich, 1988, p. 146). As has been seen, the cost to the pre-anorectic child of not complying with the maternal need for merger is the loss of approval and basic attachment, and at an early age, the extreme emotional distress that accompanies these situations. Yet, complying with maternal requirements does not spare the child such negative emotional experience, either, for as Erikson (1968) has postulated, the price of failing to resolve the developmental crisis of autonomy is shame and self-doubt. Laing (1971) similarly points to the guilt that ensues upon this type of self-abandonment. Moreover, while the pre-anorectic child may be outwardly productive, she experiences little subjective pleasure or gratification through her activities because these are not autonomously, freely chosen behaviours.

Finally, the pre-anorectic child's difficulty in identifying her subjective experience and her poorly developed autonomy go hand in hand with pronounced self-effacing and self-denying tendencies. As she has little awareness of her own needs, it is not surprising that she should not allow her own wishes and needs to take precedence. In fact, "...she directs her attention to pleasing, accommodating, and being sensitive to others. The guiding rule for her life is to serve others by meeting their needs. She strives to become a selfobject and not a self (Goodsitt, 1985, p.79)."²³ It is as if the future anorectic has difficulty in justifying her existence, in feeling that she has a right to a life of her own (Selvini Palazzoli, 1974).

Indeed, Goodsitt (1985) has pointed to the pre-anorectic child's "self-guilt", a vague yet pervasive type of guilt experienced for wanting to have a separate identity or selfhood. Similarly, Friedman (1985) sees "unconscious survivor guilt", which is based on a belief that the pursuit of a normal developmental goal is harmful to one's parents or significant others, as a major factor in a wide range of "masochistic" psychopathology, including anorexia nervosa. Masterson (1972, 1977) also highlights the presence of such guilt in anorexia and views it as the cumulative result of innumerable experiences of maternal disapproval and withdrawal in response to individuating behaviours on the part of the child. It is the avoidance of this type of guilt, as well as of direct maternal sanctions, that motivates the pre-anorectic child's well-known self-effacement tendencies.

²³ It should be noted that such extreme self-effacement represents not a loss of all desire or concern for the self, but rather an adaptive mechanism within an extreme situation. For given that the pre-anorectic infant would lose her all-important primary attachment, at least temporarily, if she did not comply with maternal selfobject needs, the effacement of somewhat less essential needs may not seem an unreasonable compromise. Indeed, this is not masochism in the popular sense of the word, but rather a trade-off whereby the child has chosen the maximal benefit to herself given the circumstance in which she finds herself.

2) In addition to her overdependence on external frames of reference as manifest in the phenomena described above, the pre-anorectic child's function as a merged selfobject contributes to the formation of a self-image infused with feelings of shame, inadequacy, and inherent worthlessness. This self-concept arises out of the implicit rejection of the child's spontaneous being in the merged selfobject relationship. Indeed, as shame has been defined as the emotion that arises out of a failure to evoke the desired response from the environment (Lewis, 1971; Mollon, 1984) and as the child who functions as a merged selfobject receives little appropriate response to its verbal and non-verbal cues, it is not surprising that the pre-anorectic child should experience a high degree of shame. This shame and sense of inefficacy is compounded by her failure, as was seen above, to achieve a sense of individual autonomy.

3) The pre-anorectic child is also left with a restricted repertoire of behaviours, affects, and cognitions deemed acceptable, to the extent that the merger-hungry mother once found many of her daughter's spontaneous experiences to be non-acceptable. Hence, she is prone to self-rejection and shame in the face of many normal behaviours and feelings, even in the absence of others' negative evaluations of same. She thus suffers from a severe inhibition of spontaneous expressions of self (Goodsitt, 1983; Selvini Palazzoli, 1974; Stierlin & Weber, 1989).

Among the emotions deemed unacceptable, the future anorectic feels particularly threatened by anger, rage, and hostility (Goodsitt, 1983, 1985; Masterson, 1977; Orbach, 1986). In fact, she experiences massive, but denied, rage at the demand that she give up her self in order to maintain the attachment to her mother (Goodsitt, 1985). She is not, however, allowed to express this rage which leads to increased unexpressed rage, resentment, shame, frustration, helplessness, and powerlessness, which in turn leads to even greater rage in a vicious cycle of shame and rage that may finally become overt as her defenses break down in the maintenance phase of the anorectic syndrome (Scheff, 1989).

The Pre-Anorectic Child as Idealized Selfobject

Remaining Problematic

The postulation of a merged selfobject type of mother-daughter relationship, which is found throughout the literature on anorexia nervosa (Bruch, 1973; Goodsitt, 1983; Masterson, 1977; Minuchin et al., 1978; Orbach, 1986; Selvini Palazzoli, 1974), is both necessary and sufficient to explain the anorectic's characteristic self-effacement and excessive compliance. Yet this is still not specific to anorexia, as there are other diagnostic groups presenting with self-effacement or excessive accommodation to the

environment, for example, many "masochistic" or self-defeating personalities, many dependent personalities, some borderline personalities, and some depressed individuals (Giovacchini, 1984). Moreover, it does not explain her apparently contradictory omnipotent, limitless pursuit of perfection and specialness in the form of thinness^{24,25} (Bruch, 1973; Hogan, 1985; Sours, 1980; Story, 1976), her grandiose affects and fantasies (Goodsitt, 1983, 1985; Hogan, 1985; Sours, 1980), or her sense of moral superiority (Bruch, 1973; Selvini Palazzoli, 1974; Stierlin & Weber, 1989). Finally, these characteristics of the typical anorectic clearly differentiate her from other diagnostic groups presenting with self-effacement. Thus, the pathogenesis of anorexia must be more complex than the pre-anorectic child's function as a merged selfobject.

It also stands to reason that hypotheses about the genesis of these characteristics of the typical anorectic represent an integral component of any comprehensive etiological formulation of anorexia nervosa. As it is not immediately clear how the anorectic's pursuit of perfection may have arisen, how can one then construct an etiological hypothesis regarding this pursuit of specialness and perfection, or more generally, how does one arrive at a conjecture about past environmental influences on an individual based on her present state?

Science in general assumes that there is a causal link between an object's or a human being's present state and past environmental influences upon that object that holds true across particular instances, even across different categories of objects and human beings. For example, charred objects are hypothesized to have come into contact with fire, even if their original states are not known by the observer, because we have already observed repeated instances where fire had such an effect upon solid substances. Similarly, within the human realm, depressed individuals are often believed to have suffered some past loss or disappointment, be it traumatic or incremental. Thus, using analogical reasoning, an object's present state can be used to conjecture about past environmental influences upon it if we can find similar present states in other objects in which we have been able to observe (or otherwise hypothesize about) these past influences, even if these objects

²⁴ This striving for perfection in the form of a long-term goal or ideal directly related to the self-image accompanied by a certain inflation of mood and of self-concept is to be differentiated from the obsessive-compulsive's more ritualistic attempts to control and render stable the immediate, more mundane environment through the flawless accomplishment of specific concrete actions. Of course, a self-aggrandizing striving for perfection of the self and the more obsessive-compulsive perfectionism are not mutually exclusive, and the typical anorectic may additionally present with this latter form of perfectionism.

²⁵ The limitless quality of this pursuit can be explained through notions regarding black-and-white, concrete operational reasoning (Bruch, 1973; Garfinkel & Garner, 1982; Warah, 1990), but this does not account for the manifestation of such a pursuit in the first place.

are of a different category. For example, the observed effects of certain conditions upon laboratory animals are often deemed to offer valuable conjectures about the effects that those same conditions would have upon human beings. (Of course, this is not meant to imply that analogical reasoning offers some sort of privileged access to objective truth, any more than does the inductive reasoning that pervades all science. Thus, to be truly scientific such conjectures must be couched in a refutable form.)

In order to resolve the present issue, one may want to utilize such analogical reasoning, that is, one may want to examine what is already believed about past influences on other individuals with these present characteristics. The only other psychodiagnostic group which typically presents with such grandiose affects, omnipotent attitude, and preoccupation with perfection and specialness of the self is the narcissistic personality. Perhaps accepted theories of how this trait arose in the narcissistic personality offer a clue as to how the same characteristic may have arisen in the anorectic.

At present, at least three theorists in the area of pathological narcissism, Kernberg (1975), Robbins (1982), and Bleiberg (1988), postulate that individuals with narcissistic pathologies not only did not have their own emotional needs met as children, but also were idealized, that is, perceived as "special" or omnipotent by one or both of their parents, usually the mother. Indeed, Kernberg (1975) differs sharply from Kohut (1977) in that he views narcissistic personality disorder not simply as a developmental arrest at a stage of normal childhood grandiosity (in the practising subphase, at 10 to 18 months of age (Mahler et al., 1975)), but rather as a pathological formation which is due to the additional factor of such excessive idealization of the child. Kernberg (1975) supports this contention by reference to the obvious difference between the haughty, emotionally distant arrogance of the typical narcissistic personality and the open, warm, exuberant grandiosity of the normal child at this developmental stage. Moreover, such a hypothesis appears more plausible than that of Kohut, given that all children who are believed to suffer parenting deficits at this age do not end up with narcissistic pathologies (Kernberg, 1975). (As we have seen, however, Kohut's developmental theories may provide the clue to the parent's *motivation* for this excessive idealization of the child.)

Besides the narcissistic personality proper, the anorectic belongs to the only psychodiagnostic group that regularly shows narcissistic pathology far beyond that found to some extent in virtually all emotional disorders, as evidenced by her ego-syntonic pursuit of perfection, grandiose affect, and sense of superiority, as well as by a number of other personality characteristics, for example, her overt or covert envy of others and lack of genuine empathy for others. Indeed, a number of theorists in the field consider anorexia nervosa to be essentially a narcissistic disturbance (Bruch, 1973; Geist, 1989; Goodsitt, 1983, 1985). Other researchers in the field have not necessarily labelled her

disturbance as such, but their formulations are not incongruent with such a notion. For example, the early Selvini Palazzoli's (1974) situating of anorexia nervosa as a condition mid-way between the Kleinian paranoid-schizoid and the depressive positions is congruent with a view of anorexia nervosa as a narcissistic condition. Similarly, Masterson (1977) views the anorectic as suffering from a borderline disorder, a category which from Kernberg's (1975) standpoint includes the narcissistic syndrome.

Of course, such a relative consensus of opinion is of no direct value from the standpoint of Popperian epistemology, but it remains suggestive at an everyday level, as well as imposing some constraints on one's speculation. Moreover, one could say that the notion that the anorectic suffers from a narcissistic disturbance has not been refuted as yet and hence remains a viable theory. Therefore, if significant narcissistic traits only arise, as Kernberg (1975), Robbins (1982), and Bleiberg (1988) have proposed, in the presence of parental idealizing attributions, one can conjecture that the typical anorectic has also not only been the victim of chronic empathic failure and overcontrol (Bruch, 1973; Geist, 1989; Goodsitt, 1983, 1985; Orbach, 1986; Selvini Palazzoli, 1974; Sours, 1980) in the form of a merged selfobject relationship, but also of such idealization by at least one of her parents.

That is, the postulated merged selfobject relationship with her mother may have taken an idealized form, she may have been idealized by both parents, or she may have been idealized by her father only. This probably varies from case to case, and all that can be postulated generally is that the pre-anorectic child functions as both a merged selfobject to her mother, and perhaps also to her father, and as an idealized selfobject to either or both parents.

The conjecture that the anorectic was both idealized and used in a merger-hungry relationship does not contradict any of the foregoing assumptions or theories. For example, Kohut's (Kohut & Wolf, 1978) merger-hungry selfobject relationships may or may not take an idealized form. Moreover, this argument is not inconsistent with other phenomena observed in the anorectic syndrome. In addition, as will be seen, it is able to account not only for the anorectic's characteristically assiduous quest for perfection but also for her inordinately strong autonomy strivings, neither of which has been adequately explained by existing etiological formulations. Finally, this etiological model appears to not be applicable to any other diagnostic group.²⁶

Figure 1, presented again below, outlines the increasing degrees of specificity of this

²⁶ These comments apply only to recognized *diagnostic* categories, as some individuals may have undergone such early influences and yet apply their simultaneously self-effacing and self-aggrandizing adaptive mechanisms in ways not deemed pathological by society.

etiological model, that is, its narrowing down in its applicability, from the predisposition to personality disorder in general, to the predisposition to self-effacing personality disorders, and thence to the predisposition to anorexia nervosa.

FIGURE 1

Increasing Levels of Specificity of Etiological Model

Parental selfobject
(predisposed to
personality disorders)

**Merged
parental selfobject**
(predisposed
to self-effacing
personality disorders)

**Idealized
merged
parental selfobject**
(predisposed
to anorexia
only
(amongst recognized
diagnostic groups))

Prior Research Findings

The role of idealizing objectifications of children has barely been examined in the literature on any type of psychopathology, and not at all in the research on anorexia nervosa. However, the literature hints at this in its description of the typical parents of anorectics, especially the mother, as referring to their daughter as "perfect" or "special", in spite of the increasing difficulties (Bruch, 1973; Selvini Palazzoli, 1974; Orbach,

1986; Sours, 1980). For even if the pre-anorectic child accommodated greatly and was an unproblematic, "easy" child, one is tempted to ask why it is that she is usually described in such hyperbolic terms. Thus, such reports of perfect or model children likely point not only to her actual accommodation, but also to the parent's delineation of her as perfect. Highly congruent with such a conclusion is the research evidence which suggests that the mother of the typical anorectic has general tendencies towards denial, reaction formation, and over-optimism (Orbach, 1986; Selvini Palazzoli, 1974; Sours, 1980; Stierlin & Weber, 1989). These are manifested, for example, by the mother's often flagrant disregard for certain emotional realities, such as the often less than idyllic state of her marital relationship (Selvini Palazzoli, 1974; Sours, 1980).

Parental Motivations for Idealization of Child

As has already been seen, Kohut (Kohut & Wolf, 1978) postulated that adults who have not had certain selfobject needs met in childhood bring these needs with them into marriage. The need to idealize an omnipotent, infallible, perfect other is one of these early selfobject needs that is often acted out within the couple relationship. However, such an idealization directed toward a marital partner may fail, for example, because of the perceived shortcomings of the spouse.

Thus, as with most selfobject use of children, such idealization processes generally occur in the context of overt or covert marital disappointment. For by serving as an ideal object to an ideal-hungry parent, the child not only protects that parent's equilibrium, but also helps to prevent overt marital conflict by lessening that parent's dissatisfaction with the spouse, since the selfobject needs that the spouse was originally expected to meet are now filled by the child.

However valid Kohut's assertions regarding adults' needs for selfobject relationships may be, there do exist alternative explanations for the parental idealization of children. These other reasons are neither necessarily exclusive of Kohut's position nor of each other. In fact, the use of a given child as an ideal selfobject may be multiply determined.

Robbins (1982), in his discussion of the etiology of narcissistic personality disorder, views the idealization of children as an integral part of the parents' denial of their own vulnerabilities, limitations, and dependency needs. That is, some parents feel a defensive need to see themselves as invulnerable and perfect, but do not believe that they have a viable outlet for directly meeting this need, either due to their external circumstances or due to internal conflicts about self-actualization arising out of their own function as merged parental selfobjects as children.²⁷ Hence, such parents may instead perceive

their child as special, omnipotent, whole, and unlimited in his or her ability in order to enhance their own self-esteem, indeed, in order to see themselves this way.

Similarly, parents who experience significant separation anxiety vis-à-vis their children, as do many parents of anorectics (Minuchin et al., 1978), usually have difficulty in separating and individuating from their own family of origin and are hence seriously compromised in their emotional development and ability to self-actualize. They may thus delegate their own potential for self-actualization and emotional growth to their child by defining that child as whole, omnipotent, and self-actualizing. This notion is congruent with such humanistic-experiential developmental theories as that of Mahrer (1978) who views parents as automatically and unconsciously delegating to their children their own unactualized "deeper potentials". Also writing from a less pathologizing, existential-phenomenological standpoint, Kastrinidis (1988) views the narcissistic personality's quest for perfection as a strong propensity to be whole (cf. Emmrys' (1992) conceptualization of the anorectic's "project" as a desire for self-renewal). And it may be that such a strong propensity in this direction does not arise purely spontaneously within the psyche of an individual, but rather occurs at least partly as the result of parental idealizing attributions. Indeed, Robbins (1982) has pointed to parental attributions toward the future narcissistic individual not only of perfection, but also of *perfectability*.

Finally, parents may feel the need to idealize their children not only because of their own unmet developmental needs or their need to deny their own limitations, but also in order to deny to themselves and others any ambivalence which they may feel towards their children and which is not congruent with their perceptions of themselves as "loving parents".

One may also ask why it is one child in a particular family who is "selected" for idealization rather than another. According to Bleiberg (1988), children with particular attributes may be more likely to be recruited as ideal objects. For instance, precocious development, unusual physical attractiveness, and/or special talents may increase a child's odds of being chosen for such a role in their families. Moreover, even if they are initially idealized, less gifted children may ultimately fail in their attempts to live up to these idealizing projections, thus encouraging the parents to redirect their attributions toward one of their other children. In addition, particular circumstances surrounding a child's birth (such as a death in the family or older parents' longing for a child) may also endow that child with a special significance to the parents (Bleiberg, 1988).

²⁷ Such internal conflict over self-actualization is the case, for example, of many borderline personalities (Masterson, 1981) who, have in fact, been observed to seek out ideal selfobjects, often in their choice of a marital partner (Lachkar, 1992).

Behavioural Transactions in Parental Use of Child as Idealized Selfobject

Parental ideal selfobject use of the future anorectic involves the attribution to the child, in thought and in words, of such characteristics as perfection, "specialness", being the "best", omnipotence, wholeness, being without limitations, calmness, steadfastness, infallibility, and being a source of strength. This image of the child must be kept uncontaminated by such "flaws" as childishness, dependency, helplessness, vulnerability, insecurity, neediness, shame, frustration, anger, sadness, or anxiety.

Operationally, idealized behaviours are reinforced in the pre-anorectic child through the same sort of objectification processes and operant conditioning contingencies described in the sections on the general and on the merged selfobject use of children. That is, the child is not only verbally and non-verbally affirmed to already correspond to the parental idealizing attributions, but she is also actively rewarded for behaving in accordance with these and punished for not doing so.

For example, should the pre-anorectic child manifest vulnerability, frustration, sadness, anger, or other emotional distress, the idealizing parent will tend to deny these in the child, ignoring or re-interpreting child behaviours that might be construed as pointing to these states in the child. Similarly, the idealizing parent is disturbed by, is not responsive to, and is not encouraging of, the infant's normal need signals.²⁸ More specifically, in describing the idealization of the future narcissistic personality, Robbins (1982) contends that the parent's responses to the child's autonomous need signals are tainted with devaluation and withdrawal, as well as accompanied by an attribution of potential perfectability. And, referring to narcissistic children, Bleiberg (1988) asserts that while the idealized child is the apple of the parents' eyes, any signs of "weakness", helplessness, or dependency drive the parents away or elicit humiliation, thereby fostering the child's omnipotence and sense of uniqueness, and discouraging its expression and recognition of normal dependency needs.

How Does Idealization Differ from Other Similar Parental Behaviours?

The use of a child as an idealized selfobject is to be distinguished from the normal parental appreciation of a child that acknowledges and delights in the child's spontaneous being and qualities. Moreover, such appreciation does not involve the parental defensive need to overlook either the child's normal needs, feelings, and individual shortcomings or the

²⁸ Such parental behaviours are, of course, to be distinguished from those of emotionally neglectful parents in disengaged families (Minuchin, 1974), for the pre-anorectic child is not ignored in a more general sense. Rather, as has been seen, the pre-anorectic child experiences a combination of neglect of certain emotional states combined with an intense overall parental involvement in her life.

usual emotional vicissitudes of a parent-child relationship. The parent who uses a child as an idealized selfobject, on the other hand, does experience such a defensive need, as manifested by the hyperbolic, unrealistic description of the child in such superlative terms as "perfect", "special", or "the best". That is, such a parent attributes to his or her child a superiority, flawlessness, and omnipotence that may have little to do with the child's spontaneous way of being or with the child's natural feelings about itself.

Similarly, the parent who mirrors his or her child responds to and confirms the child's innate sense of vigour and personal adequacy in the form of verbal and non-verbal supportive and validating responses to the child's spontaneous gestures and accomplishments (Kohut, 1971, 1977). In idealization, on the other hand, the child's spontaneous needs and gestures remain unseen, unwanted, and unresponded to by the parent. Moreover, basic acceptance of the child is conditional upon the child's behaving so as to confirm the parental attributions of perfection.

The use of a child as an idealized selfobject is also to be differentiated from simply wanting the child to fulfill the parents' unrealized aspirations. (Of course, the two may co-exist and overlap. As well, the latter may be at least part of the motivation for the parental idealization.) For example, the bulimic family stresses achievement and striving for excellence, but the pre-bulimic child is generally scapegoated in a negative way, being overtly criticized or even verbally attacked as not being good enough (Ravenscroft, 1988; Schwartz, 1988).

Fourthly, the parental attribution of perfection to the child can be distinguished from the perfectionism of the more obsessive-compulsive type of parent which appears rather to involve a demand for perfection in more delimited, concrete behaviours and tasks, such as the maintenance of personal cleanliness, for example. By contrast, the idealizing parent may ignore the child when she is not behaving in a happy, non-needy, non-sad, non-angry way and may demonstrate an unshakeable belief in the already extant perfection of his or her child, almost in a magical way or as if by fiat. (Of course, the attribution of perfection as in idealization and the demand for perfect performances as in perfectionism are not entirely mutually exclusive, and this latter form may additionally be present in anorectic families.)

This type of parental demand for perfection also differs from idealization in that it often involves frequent criticism of the child as not being good enough rather than attributions of perfection. In fact, in many such cases the child receives more parental attention when it produces behaviours deemed undesirable by the parent, when it is being "bad". Moreover, such children are frequently ignored when they are being "good", as the parent may have a defensive need to see his or her own "badness" or imperfection in the child.

Thus, the overtly criticized child may feel that it exists for the parent more, that it maintains its attachment to the parent more, when it is being "bad". This is in contradistinction to the idealized child who is more likely to be ignored if it is not fulfilling parental attributions of perfection and who feels itself to exist more for the parent when it is being very "good".

Corresponding Cognitive and Emotional Distortions in Child

Not surprisingly, the pre-anorectic child's emerging sense of self soon reflects the shaping power of the parent's idealizing attributions and injunctions in the form of a number of cognitive and emotional distortions.

1) Firstly, she feels less overtly hopeless than the child who is outright neglected (as in disengaged families, for example) or the child who is repeatedly criticized, for she has developed the expectation of being seen as special by the environment. The disadvantage of this, on the other hand, is that she is also more sensitive to rejection than the child who has been criticized or usually ignored, as she is not used to such rejection. That is, rejection is less congruent with her image of herself and with her expectations of the environment.

2) Secondly, she develops a grandiose false self, an inflated self-concept that bears little resemblance to her innate, spontaneously arising self and that is imbued with such qualities as perfection, specialness, superiority, and invulnerability. Indeed, as has been seen, a number of researchers have described the typical anorectic's haughtiness, grandiose affect, and sense of moral superiority (Bruch, 1973; Hogan, 1985; Selvini Palazzoli, 1974; Sours, 1980). This inflated self-concept, while being a pale substitute for genuine affection and self-love, provides a defense of sorts against many of the child's painful affects and cognitions associated with serving as a parental selfobject in the first place.

3) In concert with such an overall grandiose stance, the pre-anorectic child is left with feelings of omnipotence and a strong striving for autonomy, self-perfection, and self-actualization. As so often mentioned in the literature (Bruch, 1973; Hogan, 1985; Orbach, 1986; Selvini Palazzoli, 1974; Stierlin & Weber, 1989), she appears to worship will and willpower, and manifests a restless urge to achieve something outstanding.

4) Since the specific attributions towards the child are that of perfection, invulnerability, and omnipotence, the child not only feels needy, helpless, ashamed, inadequate, sad, empty, and angry because of the overall non-response to her genuine emotional needs,

but she is also not allowed to express these feelings. For by doing so, she risks the disruption of the parent's much-needed idealization and hence her own emotional abandonment due to the parent's anxiety, depression, anger, or simply temporary loss of interest in her. Thus, the pre-anorectic child has learned to engage in extreme self-control of her emotional states and overt behaviour, and manifests the "pseudo-maturity" so often described in the literature (Bruch, 1973; Hogan, 1985; Orbach, 1986; Stierlin & Weber, 1989).

Furthermore, because she has begun to experience as "me" those emotional states and their accompanying behaviours that elicited parental approval and as "not me" those emotional states that were linked to parental abandonment, to experience shame, inadequacy, vulnerability, and unmet dependency needs for her signifies to be emotionally annihilated, to cease to exist as she has come to define herself. In addition, as mentioned above, she is able to defend against these emotions with her grandiose stance and by earning parental approval for her "perfection". Since her shame, inadequacy, need, and sadness thus become largely "unlived", she is not used to at least tolerating such emotions and they become even more threatening to her should they at some point come to the fore again.

The Combined Effect on Child of Simultaneous Use as Merged and Idealized Selfobject

It is further proposed that the pre-anorectic child's *simultaneous* function as a merged and as an idealized selfobject compounds the emotional and cognitive distortions that, as has been seen, are pursuant upon her function as either one of these. Specifically, the *combination* of these cognitive and emotional distortions give rise to the following personality factors, specific to anorectics among current psychodiagnostic categories, that eventually predispose her to anorexia in the face of the developmental and environmental stresses of adolescence. These personality factors compromise her on-going self-esteem regulation either by further reducing the conditions under which she is able to maintain a relative sense of emotional well-being (as in #1 and #4 below), or by introducing an inherent tension or instability into her self-system (as in #2 and #3 below).

1) Firstly, the pre-anorectic manifests a heightened sensitivity to environmental rejection experiences because of her strong dependence on external validation (arising through having been used as a merged selfobject) combined with the habit and expectation of being seen as "special" (arising through having been used as an idealized selfobject), as compared to individuals who have been used only as merged selfobjects (and do not expect to be seen as special) *or* as idealized selfobjects (and are far less dependent on external validation).

That is, other self-effacing individuals who have functioned only as merged selfobjects may be dependent upon environmental evaluation, but they not only do not have the habit and expectation of being seen as special, but they also often have a self-concept that incorporates notions of "badness", worthlessness, inadequacy, and imperfection. This is the case, for example, of many bulimics and self-defeating or "masochistic" personalities, and of some borderline personalities (Kernberg, 1975). Rejection is thus far more ego-syntonic to such individuals than it is for the future anorectic who, while also being dependent on environmental evaluation, is used to that environmental evaluation taking an idealized form. The pre-anorectic child is, therefore, predisposed to experience even mildly rejecting situations as threatening to her self-esteem. Similarly, the pre-anorectic child is not as used to overt negative self-evaluation as are individuals used only as merged selfobjects, as her grandiose sense of perfection and superiority have long allowed her to defend against overt low self-esteem.

Like the future anorectic, the child who has functioned as an idealized object only, for example, the narcissistic personality, has come to expect positive, superlative evaluations by the environment. Yet while such individuals may experience some deflation in the face of environmental rejection, they are generally less dependent upon external validation than individuals who have been used as merged selfobjects, and they are thus more able to discount others' disconfirming opinions. That is, they are more self-contained and hence more able to maintain their inflation of mood and self-image under such circumstances (Akhtar, 1982; Lerner, 1985; Kernberg, 1975; Wilson, 1989), as compared to the future anorectic who has additionally functioned as a merged selfobject.

In summary, the pre-anorectic child's simultaneous function as both a merged and as an idealized parental selfobject serves to further reduce the conditions under which she is able to maintain a relative sense of emotional well-being in that it gives rise to an overdependence on external validation combined with the habit and expectation of being seen as special. This hypothesis offers a possible explanation for the occasional finding in the literature (Garfinkel & Garner, 1982; Minuchin et al., 1978) that the other's approval and fear of rejection remain central to the anorectic's self-esteem regulation. It also potentially accounts for the observation that the anorectic seems to experience rejection as an outright discontinuity in her self-representation, as a cessation of her very existence (Bernabé, 1976).

2) The pre-anorectic child also evinces a uniquely polarized self-definition consisting of a debased self-image (arising out of her function as a merged selfobject) combined an exalted self-image (arising out of her function as an idealized selfobject). For example, she appears to simultaneously experience feelings of worthlessness and specialness.

This results in a heightened proneness to shame, self-rejection, and self-hatred (due to the discrepancy between the two self-images) and in a concomitant desire to create a more perfect self.

As well as being defined as the emotion that arises out of a failure to evoke the desired response from the environment, shame has been defined as the gap between the ideal and the real self (Lewis, 1971). In the case of the pre-anorectic child, the situation is further complicated in that there exists a discrepancy not only between an ideal self and an underlying, implicit real self, which is filled with a sense of vulnerability, need, helplessness, sadness, and rage, but also between two highly polarized, explicit false-self images. Thus, even at a level of her conscious, false-self adaptive mechanism, one finds an inherent conflict or instability in that she feels pressure from each of the polarized aspects of her self-representation to eliminate the feeling states and actions associated with the other aspect.

This is in contradistinction to the situation of those individuals who functioned only as merged selfobjects (such as many bulimics and self-defeating or masochistic personalities, and some borderline personalities) and present with a more unified, debased self-image usually involving such affects as inadequacy, shame, and helplessness. Since their explicit self-definition is not as polarized as that of the future anorectic, these individuals are able to reach a more satisfactory adaptation in this particular regard. That is, as their sense of inadequacy is not opposed by a countervailing, idealized conscious self-definition, the negative affects that they experience are ego-syntonic and do not give rise to further shame as in the case of the future anorectic. Based on both psychodynamic (Jung, 1916; Kernberg, 1975) and on certain humanistic-experiential personality theories (Mahrer, 1978), such individuals likely do harbour an unconscious, inflated self-image, but as they are not aware of it, they at least have the relative luxury of a more stable defensive system in this regard. This is a luxury that the pre-anorectic child is not afforded, for both her discrepant self-images are more or less conscious most of the time.

Analogously, those individuals who were used exclusively as idealized parental selfobjects, such as narcissistic personalities, also present with a more stable, in this case idealized, self-image. Again, at an unconscious level, these individuals likely do evince a sense of inadequacy and worthlessness, but given that they are not aware of these underlying emotional states, they also experience less shame or self-rejection than does the pre-anorectic child. In fact, as their conscious adaptive mechanisms involve mainly stable, positive affects, those individuals who were used only as idealized selfobjects rarely present for treatment.

In the case of the future anorectic, however, both the debased, inadequate pole and the idealized pole of her self-definition are largely conscious, creating an inherent tension between the two divergent aspects of her false-self system. Hence, she must constantly struggle to restore a sense of perfection to her self-representation. This drive to perfect herself often takes the form of an outright desire to create a new self (Emmrys, 1992; Hogan, 1985), elated "remaking" versions of a "rebirth" fantasy (Hogan, 1985), the pursuit of self-improvement activities as a lifestyle (Orbach, 1986), and a competitive drive to be the "best" or the thinnest (Bruch, 1973). This is not all that surprising, given the degree of shame, self-rejection, and self-hatred to which she is subject due to the polarized nature of her self-definition.

3) Similarly, the pre-anorectic child is uniquely polarized between strong feelings of helplessness, separation guilt, and separation anxiety (arising through having been used as a merged selfobject) and feelings of omnipotence and a strong desire to self-actualize (arising through having been used as an idealized selfobject). Because of the discrepancy between these feeling states, she again finds herself ashamed, as well as subject to the especially strong strivings for autonomy and control so often highlighted in the literature, unlike individuals who have been used only as merged selfobjects (and are relatively content to not separate and individuate from significant others) *or* as idealized selfobjects (and already feel autonomous and in control).

That is, as in #2 above, the future anorectic is subject to pressure from each of the polarized aspects of her self to eliminate the feeling states and actions associated with the other aspect. Hence, one again finds within her false-self adaptation a certain tension and instability arising out of conflicting parental injunctions. In contrast to those individuals who were used as merged selfobjects only, she feels far more of a restless, omnipotent urge to individuate and self-actualize. And, as opposed to those individuals who functioned only as idealized self-objects, she feels herself to be far more lacking in the autonomy and control that she desires.

Indeed, the anorectic's well-documented need for control (Bruch, 1973; Garfinkel & Garner, 1982; Joubert, 1992) can be seen to arise through this disparity between her illusion of omnipotence and her feelings of a lack of autonomy and inability to separate from her parents. Given the great discrepancy between these two aspects of her self-concept, she is again all the more vulnerable to feeling helpless, experiencing shame, and therefore desperately seeking control.

4) The range of behaviours and emotions deemed acceptable by the pre-anorectic child is even more restricted than that of individuals who were used only as merged selfobjects or as idealized selfobjects. As such, she is all the more vulnerable to experiencing shame and self-rejection in the face of normal emotions and needs, even in the absence of others' negative evaluations of her.

Individuals who were used only as merged parental selfobjects do not usually find such emotions as sadness, vulnerability, dependency, and neediness as strongly threatening or unacceptable as does the future anorectic who was additionally idealized. Hence, they are less restricted than is the pre-anorectic child in the emotions and behaviours that they feel free to experience and express. As well, unlike these individuals who functioned only as merged selfobjects, the future anorectic is enjoined to not manifest the shame ensuing upon the occasional emergence of some of these more vulnerable and dependent feelings, as this shame would spoil the parent's idealizing attributions. Hence, she additionally becomes ashamed of her shame, which gives rise to an escalating spiral of shame within her.

Similarly, the individual who has functioned only as an idealized selfobject also has a less restricted repertoire of acceptable behaviours and emotions open to him or her. For instance, autonomous behaviours and aggressive feelings are considered more acceptable than they are for the pre-anorectic child.

Thus, the conditions under which the future anorectic is able to maintain a relative sense of emotional well-being are again further reduced. She is, therefore, all the more threatened by the developmentally determined resurgence of shame, rage, sadness, helplessness, vulnerability, neediness, and aggression in adolescence, and she feels obliged to engage in the prodigious self-control for which she is so well-known.

In conclusion, the pre-anorectic child's simultaneous function as both a merged and as an idealized selfobject gives rise to a uniquely polarized way of being that leaves her with an unusual sensitivity to environmental rejection and a particular proneness to shame. As well, the four personality factors delineated above converge in a simultaneously self-effacing and self-perfecting adaptive mechanism that predisposes her to anorexia in the face of the stresses of adolescence.

Like that of most children with personality disorders, the pre-anorectic child's basic adaptive mechanism can be said to essentially represent a compliance with parental needs and attributions in order to meet her own most primary need, that is, the maintenance of the all-important attachment to her parent(s). This compliance with parental defensive

requirements later becomes generalized into an overall way of being and interacting with others.

Again, for the pre-anorectic child, compliance with parental selfobject needs involves a combination of self-effacingness and self-aggrandizement. That is, she has learned that in order to maintain the environmental approval so essential to her well-being and in order to avoid shame and self-rejection, she must self-effacingly, assiduously strive for perfection as defined by the other, thus transforming her normal needs, emotions, and impulses into the picture of the "model child" so often described in the literature.

The approval by the environment pursuant upon this self-denying perfection-striving becomes, for the future anorectic, the principal bulwark against her underlying shame, inadequacy, vulnerability, helplessness, anxiety, sadness, emptiness, and rage. It is thus not surprising that she later so tenaciously clings to a symptom that essentially represents an application of the same adaptive mechanism (that is, the attempt to secure the all-important environmental approval and to re-imbue her self-representation with perfection) to the problem of coping with the developmental and environmental stressors of adolescence.

Comparison and Contrast with Other Psychodiagnostic Groups

The anorectic syndrome has at times been described as a masochistic (Friedman, 1985), borderline (Masterson, 1977), narcissistic (Bruch, 1973; Geist, 1989; Goodsitt, 19983, 1985), obsessive-compulsive (Kennedy & Garfinkel, 1992; Rastam, 1992), or depressive (Sugarman, Quinlan, & Devenis, 1981) disturbance because of one or several features that it shares with each of these categories of emotional disorder. Yet by very virtue of the fact that it comprises so many of these different features, one can surmise that anorexia nervosa represents a more complex psychopathological entity than any one of these other disturbances. As has been argued in the previous section, the pre-anorectic child's situation can be distinguished along several dimensions from that of those individuals who likely functioned only as merged parental selfobjects, such as bulimics, borderline personalities, or self-defeating personalities, or only as idealized parental selfobjects, such as narcissistic personalities. Her situation can additionally be contrasted with that of obsessive-compulsive or depressive individuals.²⁹

Many bulimics, some borderline personalities³⁰, some self-defeating personalities, and

²⁹ In practice, the distinctions between the future anorectic and these other psychodiagnostic groups are not always as clear as they have here been made to seem for heuristic purposes, for most individual patients present with mixed neuroses or personality disorders (Stone, 1993; Van Praag, 1993).

³⁰ Several different etiologies have been postulated for the borderline personality disorder (Kernberg,

some depressed individuals³¹ can be said to have functioned as merged selfobjects. As such, they may be dependent upon environmental evaluation, but, unlike the pre-anorectic child who was additionally idealized, they do not have the habit and expectation of being seen as special, and they are thus less sensitive to environmental rejection.

Moreover, as mentioned in the previous section, some of these individuals may find rejection relatively ego-syntonic because they have a self-concept that incorporates notions of "badness", worthlessness, inadequacy, and imperfection (Kernberg, 1975). Self-images such as these are believed to arise in the context of overtly rejecting and actively devaluing parenting. The parents of such children often have a defensive need to see their own "badness" or imperfection in their children. Thus, the child maintains the bond to the parent more, and gets ignored less, by producing behaviours deemed undesirable by the parent, by acting "bad" or inept enough to correspond to the parental attributions (Robbins, 1982). Individuals who have been used as devalued or "bad" objects in this manner often actually come to experience criticism as confirmatory of their self-representation. That is, the child's existence is confirmed through the parent's perception and expression of the child's imperfection, unlike the anorectic who is confirmed in her self-image through the parent's perception of her as special.

For example, although the bulimic family stresses achievement as does the anorectic family, the future bulimic is never seen to be good enough in her achievements and is the subject of frequent criticism (Ravenscroft, 1988; Schwartz, 1988). Other individuals who were also used as merged selfobjects may have functioned in this capacity without the added parental attributions of "badness"; they thus present with only a more generalized sense of inadequacy. For instance, not all depressed individuals who functioned as merged parental selfobjects were used as "bad objects".

Finally, as has been seen, many of the conjectured effects of having functioned as a merged selfobject, such as a sense of shame, emptiness, inadequacy, helplessness, and lack of autonomy, are more congruent with the self-images of bulimics, borderline personalities, and self-defeating personalities since, unlike the anorectic, they did not experience countervailing idealizing attributions.

1975). The hypothesis of merged selfobject use likely applies most exactly to the borderline personality of the type described by Masterson (1981) and Kernberg (1975). This type of borderline personality is notable for his or her extreme difficulty with separation and individuation from the maternal figure. It should be noted, however, that Masterson's and Kernberg's definitions of the borderline personality disorder overlap to a significant degree with that of other researchers in this field.

³¹ A significant proportion of patients diagnosed as depressed may have undiagnosed, underlying borderline or self-defeating features (Kernberg, 1975; Masterson, 1981). It is to this type of depressed patient that the present comments are applicable.

As mentioned earlier, the narcissistic personality who, like the anorectic, manifests themes of power and perfection, is also believed to have been used in an idealized parental selfobject relationship. As such, he, too, has come to expect positive, superlative evaluations by the environment. But while narcissistic personalities may experience some deflation in the face of environmental rejection, they are generally less dependent upon external frames of reference than individuals who have been overcontrolled as merged selfobjects, and they are thus more able to discount others' disconfirming opinions (Akhtar, 1982; Kernberg, 1975; Lerner, 1985; Wilson, 1989). This is in contrast to the future anorectic who has additionally functioned as a merged selfobject and is thus more dependent upon others' evaluations in order to regulate her self-esteem.

As also mentioned previously, the narcissistic personality presents not with a polarized, simultaneously inflated and debased self-image, but rather with conscious grandiosity combined with unconscious inadequacy and low self-esteem (Akhtar, 1982; Kernberg, 1975; Lerner, 1985). This self-representation serves as a stabilizing force which the future anorectic lacks. Hence, the narcissistic personality does not suffer shame, self-rejection, and self-hatred as overt as those of the anorectic. He therefore manifests a less urgent need to re-imbue his self-image with perfection, less of a drive to self-perfect, and less of a theme of self-renewal than does the anorectic.

Finally, because narcissistic personalities were not utilized as merged selfobjects, they are less passive, accommodating, and self-effacing. As a result, they are less polarized and less conflicted about the sense of power and omnipotence that arises out of their function as idealized selfobjects than is the future anorectic, and they thus feel less driven to strive for autonomy.

Similarly, while certain anorectic behaviours can be seen to resemble those of the obsessive-compulsive individual (Garfinkel & Garner, 1982), the early childhood experiences of the obsessive-compulsive can be distinguished from those of the anorectic. The obsessive-compulsive's early environment is believed to have been less predictable (Guidano & Liotti, 1983), either in actuality or because the child was less able to decode parental expectations (due to the child's lesser ability in this regard or because the parents' signals were less clear). In fact, many obsessive-compulsive individuals are believed to have been subject to a milder version of the classic "double bind" whereby the parent is alternately rejecting and nurturing (Guidano & Liotti, 1983). The child therefore experiences its environment as unstable, changing, and not within his control.

This is in contradistinction to the situation of the pre-anorectic child who instead of being alternately rejected and nurtured, is consistently idealized while being consistently

emotionally neglected and enjoined to efface her own feelings and needs. Her environment is thus at least rendered stable through the superficial approval and even idealization of her false self. That is, her environment is made relatively predictable and controllable by her compliance with the demand for merger and with the idealizing attributions. As has been seen, the contradiction for the anorectic lies not so much in any changeability in her environment across time, but rather in the countervailing nature of parental attributions which eventuate in an internally polarized, and hence inherently unstable, false-self system.

As a result of the unpredictability and instability of his early environment, the obsessive-compulsive comes to engage in repetitive, ritualistic attempts to structure and control his immediate reality, including the non-human environment. This can be distinguished from the anorectic's more long-term, overblown quest for perfection of the self, accompanied by feelings of grandiose omnipotence and superiority. That is, the anorectic demonstrates relatively less the methodical, plodding perfectionism of the obsessive-compulsive than the tenacious belief in her own perfectibility, in a magical omnipotent way, as if by decree. Of course, these two tendencies are not mutually exclusive and the anorectic often additionally manifests some of the former tendency.

Finally, the obsessive-compulsive experiences his or her obsessive ideation as intrusive and ego-dystonic (Giovacchini, 1984), whereas the anorectic is seriously concerned with her thought content. Similarly, the obsessive-compulsive feels out of control because of his compulsive symptoms, whereas the anorectic feels more in control because of her compulsive behaviours.

The situation of the depressive individual can also be contrasted with that of the anorectic. Like the anorectic, many depressive patients did not get their early nurturance needs met (Guidano & Liotti, 1983; Winnicott, 1965). Yet unlike the depressive individual, the anorectic was rewarded with superficial attention and approval for her compliance with parental selfobject needs. As already mentioned, this conditional approval afforded her some sense of control over her environment. Thus, she experiences less learned helplessness and less awareness of abandonment and loss than do many depressive individuals. Moreover, parental idealization has allowed her to further deny her actual helplessness and abandonment.

Another way of conceptualizing these differences is to say that the depressive individual generally demonstrates less false-self development (Winnicott, 1965) than the anorectic. He tends to be more in touch with his real self and more aware of his unmet nurturance needs, as well as, in some cases, of the insufficiently nurturing nature of his early relational experiences. For the pre-anorectic child, on the other hand, conditional

approval has reinforced her will to perfect her false self, and she is more motivated to strive for an ideal than for the pleasure of her real self.³²

Conclusion

As has been seen, the hypothesis of idealization combined with use in a merged selfobject relationship constitutes an explanation of the predisposition to core-group anorexia nervosa which is specific *across* diagnostic groups (that is, it applies only to this diagnostic group) and which is relatively general *within* this group. (That is, it applies to most individuals within this group.)

It should be noted that just as there may be many self-effacing individuals who do not fall into any *diagnostic* category and rarely present for treatment as they are content to allow others to take advantage of them, which experiences are readily available in the average environment, it is possible that there are few individuals who are both self-effacing and perfection-seeking who never present for treatment because there are many ways to act out these characteristics without becoming officially clinically symptomatic. These individuals have probably always existed and perhaps some of them are only now coming to the attention of professionals because a major currently validated mode of "perfection", namely thinness, when carried to an extreme, becomes physically life-threatening, unlike previous modes of self-effacing perfection-seeking (for example, striving to be a saintly, self-martyring, all-sacrificing wife and mother).

Hence, for the present etiological hypothesis to be specific only to anorectics amongst *all individuals*, as opposed to amongst *all diagnostic categories*, factors influencing the self-effacing and perfection-seeking individual's degree of preoccupation with body weight must be added. These factors are already outlined in the literature: a strong emphasis on physical appearance and slimness in the more immediate milieu, at least partially due to the larger sociocultural milieu, and/or a history of having been overweight at an earlier age.

However, existing multidimensional etiological theories that incorporate this latter factor do not explain her pursuit of thinness as an ideal of perfection, her competitiveness and needing to be the best or thinnest, her sense of omnipotence and superiority, her strong autonomy strivings, or her proneness to feelings of rejection and shame. (Her seemingly

³² Again, this foregoing of pleasure in favour of the quest for perfection is not to be construed as an inherently masochistic or self-destructive act. Rather, it represents a tradeoff whereby the pre-anorectic child effaces less essential needs in an attempt to preserve the environmental approval so vital to her self-esteem regulation and, indeed, to her basic ontological security, given that she feels herself to exist only when positively reflected in the eyes of the other.

limitless quest for perfection and for autonomy are not necessarily simply a compensation for the results of having functioned as a merged selfobject, for patients in other psychodiagnostic categories who have also been used as merged selfobjects, such as many bulimics³³, borderline personalities, and self-defeating personalities, do not develop such propensities.) It is these phenomena within the anorectic syndrome that the hypothesis of the parental use of the pre-anorectic child as both a merged selfobject and an ideal selfobject attempts to address.

Is the hypothesis that the anorectic was idealized consistent with other accepted observational data about the anorectic? It is not only consistent with these, but may also prove useful to a conjecture, for example, as to the genesis of her well-documented body image distortion.³⁴ That is, the idealization hypothesis accounts for the inflation of her self-image that, when combined with a fixation at the sensori-motor level of functioning (Hogan, 1985; Sours, 1980), may offer an explanation as to why she feels her body to be larger than it should be (cf. Jung's comments on "body inflation" with regard to Nietzsche's psychopathology, in Jung, 1988). Moreover, her countervailing self-effacing tendencies may lead her to abhor this psychological "fatness" or inflation all the more.

³³ Most bulimics are of normal weight and appear far less preoccupied with the pursuit of perfection as thinness than with the elimination of a sense of inner "badness" (Ravenscroft, 1988; Schwartz, 1988).

³⁴ This is not a starvation effect as some seem to believe, as starving individuals without anorexia nervosa do not experience this phenomenon (Garfinkel & Garner, 1982).

VIII. THE PRECIPITATION OF ANORECTIC SYMPTOMS

Introduction

An individual's predisposition largely determines the type of syndrome that he or she may develop; precipitating factors interact with these to trigger the actual onset of symptoms (Garfinkel & Garner, 1982; Vandereycken & Meermann, 1984).³⁵ There is no single precipitant of anorexia nervosa, and for many anorectics more than one precipitant can be identified. Furthermore, the precipitants of anorexia do not differ from those reported to be initiators for other emotional disorders. This fact serves to highlight the centrality of predisposition in the "choice" of symptomatic outcome. Yet what the precipitants of anorexia nervosa do appear to have in common is that they all reportedly result in a lowering of self-esteem and an increase in self-consciousness (Beumont et al., 1983; Garfinkel & Garner, 1982).

As discussed below, in the future anorectic, such feelings may be triggered by a variety of developmental, interpersonal, family systemic, and/or other environmental stressors that she faces with the onset of adolescence. Many of these events readily evoke both shame and self-rejection in her because of the predispositional factors outlined in the preceding chapter, that is, her extreme reliance upon environmental validation combined with the habit and expectation of being seen as special, her constricted repertoire of emotions and behaviours deemed acceptable, and the polarized nature of her self-definition and autonomy strivings.

Precipitating Factors

Developmental Stressors

Some researchers estimate that some 20% of the general population experiences some degree of emotional upheaval in the face of the developmental challenges of adolescence (Offer & Schonert-Reichl, 1992). For the pre-anorectic this includes the resurgence of long-repressed emotions such as anger, sadness, inadequacy, helplessness, sexual longings, and unmet nurturance needs (Crisp, 1980; Sours, 1980). As has been seen, these feelings are highly ego-dystonic to the anorectic, given her restricted repertoire of

³⁵ Of those people with a predisposition to a given emotional disorder, only some actually develop it (Garfinkel & Garner, 1982). This is because not all individuals with a predisposition to a certain psychiatric illness are equally exposed to precipitating factors. In addition, there may be mitigating factors in some individuals' environments (for example, the presence of an understanding grandparent or teacher) that allow them to compensate for their predisposition and to cope with stressful, precipitant-type events in a non-symptomatic manner.

acceptable emotions pursuant upon her function as both a merged and an idealized parental selfobject. They hence give rise to shame, self-rejection, internal conflict, anxiety, and a heightened need for self-control.

As adolescence also represents a second separation-individuation phase (Bleiberg, 1988; Mintz, 1985), all this is compounded by renewed, developmentally determined autonomy strivings that place the future anorectic in a bind. For wanting to separate and individuate evokes shame, separation guilt, and separation anxiety in her (Friedman, 1985; Goodsitt, 1985), while not achieving autonomy eventuates in shame and self-doubt (Erikson, 1968). This situation is further complicated by the particular intensity of her strivings for autonomy and self-actualization, arising out of the idealizing parent's attributions of omnipotence and perfection. Hence her shame in the face of her non-attainment of such normal developmental goals is that much more intense.

Environmental Stressors

As the future anorectic moves out into a wider and more demanding social world at adolescence, she is, like most individuals, subject to a greater number of interpersonal challenges than when she was a child. Among the most frequently cited precipitating factors in the literature on anorexia nervosa are environmental rejection experiences at the hands of her peers (for example, critical comments from peers about her physical appearance or weight) (Bruch, 1973; Garfinkel & Garner, 1982; Selvini Palazzoli, 1974).

Furthermore, even if she is fortunate enough not to encounter such rejection experiences, it is unlikely that she will find many people outside her family to idealize her and find her "perfect" or "special". That is, for the first time she may be unable to win the environment's approval through her "model child" behaviour. For behaviours that readily elicit the parents' approval and idealization will hardly impress her peers. Moreover, adolescents may be more likely to react negatively towards someone who is in the habit of seeing herself as special than are young children.

Such experiences are far more problematic for the pre-anorectic than for other individuals due to her strong dependence on external validation combined with the expectation of being seen as special, as outlined in the previous chapter. Firstly, as the other's valuation of her is all-important, she is unable to modify her construction of others' rejections, as would a less other-focussed individual (Bernabé, 1976; Goodsitt, 1985). Moreover, unlike the narcissistic personality, for example, who rebounds fairly quickly from rejection experiences as they do not correspond to his conscious grandiosity (as well as because he is less dependent on external validation), the anorectic's overt false self comprises both a grandiose pole and a self-effacing, debased pole, thus making her all the

more vulnerable to an acceptance of negative environmental evaluation of her.

Secondly, as a child the pre-anorectic felt in control because, despite her parents' rejection of her spontaneous self, she was at least the superficially admired, idealized centre of her parents' world. As she now moves out more and more into the world of her peers, she experiences no longer being the idealized centre of attention as uncomfortable and ego-dystonic. Indeed, because of the expectation of being seen as special, a wide variety of circumstances will be experienced as rejection. Thus, unless she is actively affirmed as somehow special by the environment, she is prone to strong feelings of shame. And as she does not find it acceptable to experience, never mind express, the shame that usually arises out of such experiences, this feeling remains unprocessed, unintegrated, and all the more threatening and distressing to her.

In addition, the literature mentions separations and losses as environmental precipitants of anorexia nervosa (Crisp, 1980; Garfinkel & Garner, 1982). These types of experiences are also believed to lead to shame (Lewis, 1971), and in this sense affect the future anorectic in a manner similar to that of rejection. Finally, the pressure to take on new responsibilities and ways of being congruent with her age level (Joubert, 1992) also proves problematic for someone so rigidly entrenched in one particular mode of behaviour, namely self-effacing, self-perfecting parent-pleasing.

Family Systemic Precipitants

If parents use their child as a selfobject, the emotional equilibrium of the parents is disturbed when, during adolescence, the child moves into a position no longer complementary to the parents' selfobject needs (Shapiro, 1989). Furthermore, this disruption of a central selfobject relationship in the family negatively affects the emotional well-being of other family members, whose equilibrium in turn depends upon the parent who is now suffering a sudden disturbance in self-esteem.

As has been seen, in adolescence the future anorectic is faced with the reappearance of painful emotions, developmentally determined autonomy strivings, and environmental rejection experiences, all of which eventuate in shame and self-rejection.

This emotional distress is amplified within the family system, as the idealizing parent(s) experience(s) disappointment, loss, and/or narcissistic rage at the child's increasing failure to live up to their idealized attributions, and therefore withdraw(s) from the child emotionally or overtly or covertly reject(s) the child. As well, one or both parents may withdraw from the child during adolescence for one or more of a number of other

reasons. For example, a *volte-face* or sudden abandonment of a once-favoured child, occurring not long before the onset of symptoms, has been observed by Selvini Palazzoli (Selvini Palazzoli & Viaro, 1988) in many anorectic families.

Such parental withdrawal or rejection in turn leads to greater shame and self-rejection within the child, as she begins to feel abandoned by the parent(s) who once idealized her, which in turn leads to greater negative affect and intensified selfobject needs on the part of the parent(s). Thus begins a vicious escalation which must eventually be resolved through the introduction into the system of a symptom that will satisfy the now intensified needs of all parties involved.

In addition, as has already been emphasized in much of the anorexia research (Bruch, 1973; Garfinkel & Garner, 1982; Minuchin et al., 1978; Selvini Palazzoli, 1974), the normal developmental thrust towards further separation and individuation from the parents at adolescence is also highly problematic for the anorectic-to-be. For as she has functioned as a merged selfobject to at least one of her parents, she experiences both internal and family-systemic pressures against this separation. Indeed, behaviours that herald autonomy and individuation are experienced by the parents not as a desirable goal for the adolescent, but rather as a personal injury to which they react with anger and the withdrawal of affection. Compounding the problem, the future anorectic's overreliance on parental approval interferes with her capacity to react against such constraints imposed by her parents' defensive needs.

Such explanations have not, however, been able to account for the fact that many other individuals subject to such parental pressures against separation (for example, bulimics, self-defeating and borderline personalities, and some depressive individuals) do not present with autonomy strivings as strong as those of the typical anorectic. The hypothesis of her simultaneous use as a parental idealized selfobject may offer this explanation, for serving as a parental ideal selfobject likely fosters in the pre-anorectic child a sense of omnipotence and a strong drive to self-actualize. As already mentioned, it may be the discrepancy or tension between these feelings and her separation guilt and anxiety that lead to her particularly strong need for greater autonomy and control.

One can surmise here the beginnings of both an intrapersonal and a systemic vicious escalation, as the anorectic's attempts to individuate lead to ever greater separation guilt and anxiety within her and to ever greater separation anxiety and clinging in her parent(s). And as also mentioned previously, the anorectic here again finds herself in a bind whereby she feels shame if she does behave in an autonomous fashion (due to parental rejection) and also if she does not (if Erikson's (1968) developmental theory is correct).

Conclusion

All or most of the above stressors of adolescence have been postulated to eventuate in shame and self-rejection for the future anorectic. Shame has been described as one of the most painful and devastating emotional experiences that an individual can experience and all humans are believed to be highly motivated to avoid it (Lewis, 1971). And while shame and self-rejection are not unique to the anorectic, her ultimate way of coping with these is, due to the predispositional factors highlighted in the previous chapter.

The Anorectic's Strategies for Coping with Stresses of Adolescence

The Failure of Prodromal Withdrawal

As the pre-anorectic struggles to cope with the stresses of adolescence during the prodromal phase of her illness, she finally simply withdraws socially in an attempt to avoid the distressing experiences altogether (Bruch, 1973; Selvini Palazzoli, 1974). In fact, this stage of anorexia nervosa is characterized by a loss of interest in peers and by increasing isolation from her family. But her problems are hardly over, for unlike the schizoid or avoidant personality who more or less successfully uses such an adaptive mechanism on an ongoing basis, the pre-anorectic is too dependent upon external frames of reference (Goodsitt, 1983, 1985) to be able to regulate her self-esteem for long without environmental approval.

As well, in concert with her intensified autonomy strivings, the pre-anorectic's prodromal withdrawal may represent a more or less conscious attempt to shift to a greater self- rather than other-focus. Yet again, this is not a viable long-term solution for someone so dependent upon the ongoing approval and reflection of the other. Moreover, in trying to adopt more of a self-focus during this prodromal withdrawal, she likely becomes all the more aware of the developmentally determined upsurge of long-suppressed and highly threatening emotions such as anger, sadness, inadequacy, helplessness, neediness, and sexual longings.

Re-applying an Earlier Strategy

As the future anorectic's rigid control of her emotions begins to weaken under the influence of the internal and environmental stressors of adolescence, she feels ever more at the mercy of these previously suppressed, ego-dystonic emotions and seeks to re-establish control, to find relief from her feelings of shame and generalized emotional distress. As a child she has learned to maintain the environmental approval so essential to

her well-being, and to thus avoid shame and self-rejection, by complying with parental selfobject needs. As has been seen, for the pre-anorectic child, compliance with parental selfobject needs involved self-effacingly striving for perfection as defined by the other, thus transforming her normal needs, emotions, and impulses into the picture of the "model child" so often described in the literature.

That is, in her function as a merged parental selfobject, she has been enjoined to radically efface her own needs, while through her capacity as an idealized parental selfobject, she has been enjoined to strive to appear perfect. Thus, due to her childhood conditioning, self-effacing and self-perfecting have become associated with the relief of emotional distress. Moreover, these operations have become internalized as a generalized coping mechanism. The pursuit of perfection *qua* a societally validated thinness through dietary restriction adequately fulfills both parental injunctions and their corresponding internalized tendencies; it hence serves as a coping strategy suited to her specific predisposition. Excessive slimming can thus be seen as simply a more "adult" version of an earlier adaptive mechanism.

In essence, the way that the future anorectic has learned to exert control over her environment and changing circumstances is through *self*-control, rather than through direct control of the outer environment,³⁶ that is, she seeks to re-imbue her self-image with perfection in order to secure or maintain its approval. Furthermore, her symptom offers a ready solution to the conflict between her separation anxiety and her intense strivings for autonomy and control, for it symbolically confers the illusion of autonomy (Bruch, 1973; Garfinkel & Garner, 1982; Joubert, 1992; Sours, 1980), thereby lessening the shame of her not truly being able to separate from her parents, a shame that is intensified by the internalization of parental idealizing attributions of omnipotence and self-actualization. That is, her symptom appears to confer control over the environment (through food refusal), while making her all the more accommodating to the original parental demands in the form of highly self-controlling, self-effacing, perfection-seeking behaviour that ultimately eventuates in her even greater dependence on her family.

This self-denying perfection-striving becomes, for the future anorectic, the principal bulwark against her underlying shame, inadequacy, vulnerability, helplessness, anxiety, sadness, emptiness, and rage. It also represents a viable compromise between countervailing tendencies both within her and between her and the environment, for it allows her to be both self-perfecting and self-effacing, both self-sufficient and dependently needy, both autonomous and non-separate. It is thus not surprising that she later so tenaciously clings to a symptom that essentially represents an application of an

³⁶ In the later stages of chronic anorexia nervosa, some anorectics do, however, become overtly controlling, especially towards their parents (Bruch, 1973; Crisp, 1980).

earlier adaptive mechanism, the goal of which is to secure the all-important environmental approval and to re-imbue her self-representation with perfection, to the problem of coping with the developmental and environmental stressors of adolescence.

Choice of Symptomatic Pathway

Since her "model-child" version of self-effacingly perfecting herself in order to please the other no longer helps her to avoid feelings of rejection and shame, nor to meet the new developmental press for autonomy, the pre-anorectic adolescent must find a new form in which to apply her coping strategy. The anorexia research is rife with explanations for her precise "choice" of symptom, that is, the perfecting of her body through slimming (Hsu, 1983). These will be briefly reviewed here and complemented with alternative formulations and reflections.

Several authors have observed that it is far less painful for the anorectic to attribute her feelings of inadequacy and shame to a controllable, outer factor such as being overweight rather than to an inner sense of worthlessness (Edelstein, 1989; Selvini Palazzoli, 1974; Sours, 1980). The overriding preoccupation with her weight is thus a camouflage for her deep-seated self-doubt, and her overweight body image a concretization of her self-loathing (Bruch, 1973; Selvini Palazzoli, 1974). This defensive displacement of her problems from her emotional self to her bodily self serves to reduce the discrepancy between the debased (merged) and idealized poles of her self-definition.

Similarly, since one of the major ways that women in our society are considered to be pleasing to others is through their physical appearance, especially in the form of thinness, she may decide that improving her physical appearance by slimming down may forestall future shame and rejection experiences, especially if she has been teased about her weight and/or there is much emphasis on slimness in her immediate milieu (Garfinkel & Garner, 1982). Thus, while most women diet because of shame over the appearance of their body, because of its non-correspondence with the societally sanctioned ideal of thinness (Orbach, 1986), the anorectic may begin a diet not only for this reason, but also because she hopes to avoid her more pervasive shame by becoming ever more perfect and pleasing to the other in the form of slimness. Hence, "global" shame is reduced to a more manageable "local" shame, and this local shame is then addressed through dieting. Moreover, dieting is a major vehicle of self-transformation for women in our society; as has been seen, the anorectic's function as an ideal object upon whom are projected the parents' own self-actualization tendencies, combined with the sense of worthlessness arising out of her use as merged selfobject, converge to create in her a particularly intense self-loathing and desire for self-renewal.

This seeking of the other's approval by striving for limitless heights of perfection in the form of thinness would not present any more of an obvious problem than her earlier model-child behaviour, or indeed than other rigid characterological adaptive mechanisms, if it were not applied to the biological arena, for here she runs headlong into concrete, physiological limits that no amount of denial can circumvent. And were thinness not so validated and highly prized by the larger society and by her immediate milieu, she may very well have chosen a different avenue of self-perfection. For example, in another socio-historical context, the typical anorectic would likely have been tailor-made for the convent life with its emphasis on dependent obedience, self-effacement, and the seeking of spiritual purification and perfection. Indeed, as the anorectic is so dependent upon external valuation, a major constraint on her symptom "choice" is that it represent a consensually validated form of perfection-seeking.

On the other hand, her symptom choice may be opportunistic. That is, she may begin to diet for the same reasons as do non-anorectic women, to simply reduce the local shame related to the body's appearance. Or she may initially lose weight due to physical illness. When the positive reinforcement that she receives from her environment for this weight loss gives a temporary boost to her self-esteem, she quickly becomes addicted to this form of self-perfecting, deciding that it is the solution to all her woes (Edelstein, 1989; Garfinkel & Garner, 1982).

Alternatively, given that her early bodily needs were met to a large extent while her feelings and thoughts were rarely confirmed or even acknowledged by her parents (Bruch, 1973), the anorectic may only conceive of herself as a body and hence choose to focus her self-perfecting efforts on this aspect of her being. Indeed, in many respects the anorectic and her family resemble the "normotic" personalities described by Bollas (1989). Such individuals do not see themselves "as other than object[s] (ideally smart and spruced up, productive and sociable) among all the objects of the material world" (Bollas, 1989, p. 324). They refuse to entertain the inner life of the self and are oriented not toward the inner and the psychic, but toward the outer and the material. The self is valued only for its external functioning, for how it appears to the other. The anorectic, too, has been noted to suffer from a gross deficiency in the area of subjectivity (Bruch, 1973; Goodsitt, 1983, 1985; Orbach, 1986; Sours, 1980) and to be mainly concerned with concrete, outward appearances (Sours, 1980; Stierlin & Weber, 1989). Thus, it is not improbable that the anorectic, like the normotic personality, sees herself largely as a concrete object or merely a body.

Similarly, several authors in the field (Bruch, 1973; Selvini Palazzoli, 1974; Sours, 1980) view the anorectic as focusing her efforts on her body because, given the degree of control her mother exercises over her life, her body seems the only domain still

controllable. Conversely, the anorectic may view her body's needs and functions, for example, menstruation, as independent of her control and as therefore threatening and in need of perfecting (Orbach, 1986).

Finally, the anorectic may view her body as the problem because she genuinely perceives it as overweight, because of a disturbance in her body image. As mentioned previously, Jung (1988) attributes a sense of body inflation to ego inflation. This dynamic is likely operative in someone as fixated at the sensori-motor stage (Bruch, 1973) and as inflated as the anorectic appears to be. (On the other hand, some authors (Edelstein, 1989; Vandereycken & Meermann, 1984) have conceptualized the anorectic's body image distortion as simply an excuse to maintain her pursuit of perfection as a global adaptive mechanism, for, as seen earlier, if she no longer feels the need to perfect herself in this one area on which she has focused all her attention, she risks becoming aware of what actually ails her.)

Conclusion

In conclusion, then, anorexia nervosa can be seen to arise out of the interaction between the predispositional factors described in Chapter VII. and the developmental, interpersonal, familial, and/or other environmental stressors of adolescence that eventuate in shame and self-rejection, in the context of a society that highly values thinness for females.

That is, due to her highly restricted repertoire of acceptable emotions, the developmentally determined resurgence of ego-dystonic feelings eventuates in shame and anxiety. Furthermore, she also finds herself highly prone to feelings of shame and self-rejection in the face of unfamiliar rejection experiences, due to her strong dependence on external validation combined with the expectation of being seen as special. In addition, developmentally determined autonomy strivings are intensified in the future anorectic by the internal discrepancy between her sense of omnipotence arising out of her function as an idealized selfobject and her sense of helplessness arising out of her use as a merged selfobject. All of these reverberate throughout her family system, as her parents' emotional equilibrium is disturbed by her increasing inability to fulfill their (both merged and idealizing) selfobject needs. This further eventuates in her finding herself trapped in a bind whereby she feels shame and/or guilt both for trying to separate and for not separating.

After the failure of social withdrawal in the prodromal phase, the pre-anorectic attempts to again eliminate her distress as she did during childhood--by trying to avoid rejection,

shame, and self-hatred through perfecting herself--now age-appropriately in the form of thinness (due to sociocultural, familial, and/or peer attitudes to body weight, as well as to other possible factors). And ironically, it is the self-effacing aspect of her polarized self-definition that affords her the degree of self-denial to carry out such an arduous and seemingly limitless quest for self-perfection.

IX. THE MAINTENANCE OF ANORECTIC SYMPTOMS

The Normal Dieter and the Anorectic: Local Vs. Global Shame

Any theory that seeks to explain the maintenance phase of the anorectic syndrome must be able to account for the anorectic's inability to stop dieting when she reaches a moderate weight, while other women who undertake diets are able to stop. The non-anorectic woman likely stops dieting when she reaches a moderate slimness because she has now eliminated the local shame or dissatisfaction of not being at what she considers a desirable weight (or before that if she finds food restriction more aversive than not being at her desired weight).

The anorectic, however, is unable to stop dieting because she is doing so for reasons that go well beyond that of the non-anorectic dieter: as noted earlier, instead of attempting to eliminate the merely local shame or dissatisfaction of feeling overweight, she is trying to undo a far more global shame.^{37,38} This shame is global because it involves her self-definition, and it becomes all the harder to deny because of the increased internal conflicts, rejection experiences, and other stresses of adolescence. To the extent that the anorectic's explicit focus on the local shame of still being "overweight" allows her to avoid experiencing the more global nature of her shame, she is highly motivated to continue dieting. Indeed, to admit that she is already "perfectly" slim would expose her to the more global, and far more devastating, nature of her shame.

Furthermore, since her strategy did initially appear to alleviate some of her shame, it seems to her that by continuing to diet she will be able to eliminate even more shame. And yet, as the elimination of local shame through weight loss does not truly eliminate the more pervasive, at least partly unconscious, global shame, she feels the need to perfect herself further. Thus, as she clings to what she comes to see as her last hope for ever eliminating this shame and self-rejection, she becomes addicted not to perfection, but to *perfecting*. To put this another way, the anorectic *temporally* brackets the distress that the stresses of adolescence no longer allow her to deny. Thus, it is now only the hope of a *future* perfection that allows her to defend to some extent against her present

³⁷ Of course, the local shame of the non-anorectic dieter and the global shame of the anorectic represent extreme poles on a continuum, with given individuals situated at varying points along this dimension.

³⁸ The bulimic also appears to experience a more global shame than does the "normal" dieter, but to her this shame is less ego-dystonic than to the anorectic, for the typical bulimic, not unlike many borderline personalities, has often served as a "devalued object" to one or both of her parents (Ravenscroft, 1988; Schwartz, 1988). That is, she has often been defined as someone who is imperfect, flawed, inept, etc., and hence, unlike the anorectic, she experiences environmental rejection as relatively congruent with her self-image.

anguish.

Systemic Factors in the Maintenance of Anorexia Nervosa

As so often pointed out in the literature, continued weight loss also serves an important function systemically, for the anorectic's cachexic state renders her more helpless and dependent on her family, which prevents parental separation anxiety, shame, decompensation, and/or rejection of the anorectic for trying to separate (Bruch, 1973; Garfinkel & Garner, 1982; Minuchin et al., 1978; Sours, 1980). Indeed, the anorectic family often appears curiously unconcerned about their daughter's physical (not to mention emotional) state, resists her hospitalization, subtly undermines treatment by encouraging her to act out, or even presses for premature discharge (Crisp et al., 1974; Garfinkel, Garner, & Kennedy, 1985; Hsu, 1983). As well, another member of the family often sharply deteriorates as the anorectic recovers in treatment (Crisp et al., 1974).

As for the anorectic herself, she is at less risk of decompensation, for she experiences less feelings of rejection by her family, less separation anxiety of her own, and less shame or guilt for trying to separate in the first place, at the same time that she is afforded the illusion of autonomy that helps her to avoid shame.

Vicious Escalations in the Anorectic Syndrome

Unfortunately, the compromise represented by the anorectic symptom is not truly successful, for the anorectic eventually finds herself trapped in a number of vicious escalations.

While the anorectic's coping strategy initially reduces shame and other negative affect (as did her childhood version of the same strategy), it eventually exacerbates these as her weight continues to drop to even lower levels, and she finds herself caught in a vicious spiral. For as her emaciation becomes more obvious, she begins to experience additional distress due to critical comments from family and friends and due to the secondary effects of starvation, including the weakening of her emotional defenses. The resulting renewed intrusion of unacceptable affects and her mounting concerns about self-control give rise to more self-rejection and shame. Again, as her attempted solution was initially successful in alleviating her emotional distress, and as she feels that she has no other avenues open to her (Bruch, 1973; Joubert, 1992), she continues to utilize this adaptive mechanism for the reduction of her distress, with the result that she experiences even more distress and needs all the more desperately to continue to diet.

In addition, the countervailing tendencies towards self-effacement and self-perfecting within the anorectic conspire to create another vicious escalation of her situation. The more that she struggles to self-perfect in compliance with the parental idealizing injunctions internalized as a coping strategy in childhood and the more that her successful weight loss reinforces her sense of omnipotence and superiority, the more the opposing parental injunction that she remain an invisible, merged selfobject, gives rise to shame and the urge to efface this inflation. Moreover, as shame is ego-dystonic to the more idealized, inflated side of her self-definition, she gets caught in another vicious escalation whereby she becomes ashamed of her shame. She therefore again attempts to imbue her self-image with perfection through further slimming, which in turn gives rise to more inflation and shame over her inflation, and so on. Again, the anorectic symptom of continued weight loss appears to neatly fulfill both internalized injunctions (to self-perfect and to self-efface) and thus offers the anorectic some degree of adaptation to her situation. And in seeking relief from her problems through her symptom, she comes to need this symptom all the more, thus continuing the vicious escalation.

Finally, at a family systemic level, while the anorectic's symptoms help avoid a more profound decompensation in both herself and her parents, they may culminate in a vicious escalation in this arena as well. For her increasing debilitation may lead to ever greater separation anxiety and clinging in her parents, which leads her to desire autonomy all the more. This in turn gives rise to increased separation anxiety and guilt within her, which causes her to diet all the more which again provokes anxiety in her parents, and so on. In addition, in the chronic stages of the syndrome, these normally highly conflict-avoidant families may become more openly argumentative. These conflicts are, however, rarely resolved, and they have, in fact, been observed to reinforce the symptom through repeated cycles of shame, rage, and guilt within the anorectic (Scheff, 1989).

Conclusion

In summary then, the anorectic's misapplication of a local solution to a global problem, the family systemic factors so often cited in the literature, and certain intrapersonal and interpersonal vicious escalations all conspire to entrench her even further in her symptom.

X. THERAPEUTIC IMPLICATIONS

Introduction

Despite the voluminous amount of research on anorexia nervosa, the prognosis remains relatively grim for its victims (Crisp et al., 1977; Hsu, 1980; Steinhausen & Glanville, 1983; Szmukler & Russell, 1986; Thompson & Gans, 1985). Even in those cases where more or less normal eating patterns have been restored, the patient and her family often remain crippled by a variety of cognitive, emotional, and relational deficits (Bruch, 1974; Crisp et al., 1974; Garfinkel & Garner, 1982; Thompson & Gans, 1985). Hence, there exists a pressing need to improve existing psychotherapeutic approaches to this syndrome.

Such refinement of therapeutic processes, while often appearing to proceed by trial and error, is in fact usually informed by at least implicit predictive hypothesizing about what will occur in response to a given intervention. One way to enhance the predictive power of such hypotheses is to base them on etiological theories that are as specific as possible to the particular disorder that one is treating. For without clear conjectures as to the precise cause of a given disorder, the temptation is all too often to resort to a mere treatment of presenting symptoms.

In this spirit, the following chapter outlines both the general indications for treatment and the therapeutic implications that arise from the more specific etiological model offered by the current work.

General Indications for Nutritional Restitution

It is generally agreed that the treatment of anorexia nervosa involves two interrelated tasks--the reinstatement of normal nutritional patterns and the resolution of the underlying psychological problems, including disturbed patterns of family interaction (Bruch, 1973, 1977; Garfinkel & Garner, 1982; Orbach, 1984, 1986; Vandereycken & Meermann, 1984).

It is difficult at best to do effective psychotherapy with a starving patient, and relatively normal eating patterns must first be restored. For example, certain anorectic behaviours, such as the extreme preoccupation with food, are secondary effects of severe malnutrition (Chediak, 1977; Crisp, 1980; Garfinkel & Garner, 1982); these have such a distorting effect on all psychological functioning that no true picture of the individual's emotional situation can be gleaned until the nutritional deficiencies are corrected. In fact, the course of anorexia nervosa may be unnecessarily prolonged when a therapist indulges in the

unrealistic expectation that the patient will automatically gain weight once the symbolic meaning of her food refusal and her underlying conflicts have been made conscious (Bruch, 1977).

Of course, coercive correction of the syndrome's most obvious symptom (that is, the emaciation) does not represent meaningful treatment of such a complex disorder, either. Force-feeding and behaviour modification have traditionally been the treatment methods most frequently used to ensure weight gain during the anorectic patient's hospital stay. Unfortunately, claims for their efficacy have all too often been made without the benefit of follow-up studies (Bruch, 1974, 1977). Under the pressure of persuasion, force, or threats, patients often quickly gain weight, but lose it again equally rapidly once discharged from the hospital (Bruch, 1973; Edelstein, 1989; Silverman, 1974).

Moreover, some studies have shown that enforced weight gain can be psychologically damaging to anorectic patients and bring about a long-term deterioration in their condition that in some cases eventuates in suicide (Bruch, 1974, 1977; Silverman, 1974; Vandereycken & Meermann, 1984). In fact, the very efficacy of such approaches as behaviour modification may increase the inner turmoil of patients who feel manipulated into relinquishing control over their bodies and their lives. It is now generally accepted in the field that weight gain proves beneficial to the patient only when it is part of an integrated treatment programme that incorporates a resolution of the underlying individual and family issues (Edelstein, 1989; Garner et al., 1982; Vandereycken & Meermann, 1984; Stierlin & Weber, 1989).

In essence, the therapist who treats anorexia nervosa is caught in an ambiguous role that implies fostering a greater inner sense of autonomy in the patient while at the same time encouraging a much-dreaded weight gain (Bruch, 1986). Two possible strategies have been offered for the resolution of this dilemma:

Firstly, intravenous hyperalimentation avoids the patient's being coerced to take food by mouth or through tube feeding. Significant weight gains are often achieved without the struggle over eating so traumatizing to the patient (Bruch, 1977; Vandereycken & Meermann, 1984).

Secondly, in those cases where weight is stably low, but not dangerously so, the therapist may contract with the patient to not intervene regarding her actual food consumption, provided that she agrees not to go below the weight at which she is originally assessed (Orbach, 1984). The joint assumption (which may not initially be accepted by the patient) is that she ultimately should be at a healthier weight, but that for the present,

psychotherapeutic treatment must proceed with as little interference as possible. In this way, the patient's defensive needs are respected in order to avoid damage to the initially fragile therapeutic alliance and to forestall the patient's further deterioration due to a sense of again having lost control over her life.

General Indications for Individual Psychotherapy

The literature has pointed to the need for long-term, in-depth psychotherapy if the core-group anorectic is to overcome her considerable emotional and cognitive deficits (Bruch, 1973, 1977; Garfinkel & Garner, 1982; Hsu, 1980; Orbach, 1984, 1986; Vandereycken & Meermann, 1984). As the anorectic is severely deficient in the area of subjective awareness of her own inner experience, the central thrust of such treatment is to help her to recognize impulses, feelings, and needs that originate within her, through the therapist's confirmation of self-initiated expressions, with a view to helping her to eventually separate and individuate (Bruch, 1973, 1985; Goodsitt, 1983, 1985; Masterson, 1977; Orbach, 1986; Selvini Palazzoli, 1974; Sours, 1980).

There is, however, one important exception to this principle in the early stage of treatment. As the patient denies the pathological and ultimately self-destructive nature of her symptoms, the therapist must help her by gently, but consistently, questioning and confronting her denial (Masterson, 1977). Similarly, given the typical anorectic's blanket denial of any problems in her family relationships, she should also be helped to gradually recognize the contribution of these relationships to her deep-seated sense of dissatisfaction and isolation (Swift, 1991).

Another vital aspect of individual psychotherapy with the anorectic is the effort to repair her typical cognitive defects and distortions, for example, by using the cognitive therapy model proposed by Beck (Beck, 1976 in Garner & Bemis, 1985): As well as heightening the patient's awareness of her own thinking, the therapist should help her to recognize the connection between certain thoughts and maladaptive behaviours and affects. She could then be encouraged to examine the evidence for the validity of particular beliefs, for instance, the typical anorectic assumption that if she were thin, life would be perfect. In addition, the patient could be helped to substitute more realistic and appropriate interpretations, and to gradually modify the underlying assumptions that determine her more specific beliefs. Of course, these probes and suggestions ought to occur in an atmosphere of acceptance, rather than one of direct confrontation, so as not to reinforce the sense of inadequacy and distrust of her own thoughts that she already experiences (Garfinkel & Garner, 1982; Garner & Bemis, 1985; Garner et al., 1982).

Given that there has been so much false-self development in the typical core-group anorectic, the therapist must also avoid colluding with the efforts of the patient to establish a relationship based on superficial compliance. That is, with these patients there is a clear danger of pseudo-agreement, whereby they will seem to accept interpretations and even elaborate on them even though these interpretations mean nothing to them on an affective level (Swift, 1991). In fact, as they are ever preoccupied with the image that they create in the eyes of the other (having relied for so long on winning the superficial approval of others as an adaptive mechanism), anorectic patients often attempt, from the very first session, to discern the therapist's needs, the unwritten rules of the therapy, and the ways in which to keep the therapist interested in her (Kearney-Cooke, 1991). This caution is particularly pertinent as the essential goal of therapy is to help the anorectic to modify her personal identity (Guidano & Liotti, 1983), to build up a new personality after all the years of faked existence and impression management (Bruch, 1985), to become a self rather than a selfobject (Goodsitt, 1985). At the same time, it must be recognized that where there has been so much false-self development, initially the therapist can only speak to the patient's false self about her "true self" or underlying emotions, needs, impulses, and thoughts (Winnicott, 1965).

Implications of Current Etiological Model for Individual Psychotherapy

As most psychotherapeutic interventions are based to a greater or lesser extent upon the explication of behavioural, emotional, and/or cognitive patterns of which the patient is not aware, the major contribution of any etiological model lies in its permitting the more precise identification and interpretation of such patterns.

While the above-described indications for the long-term intensive psychotherapy of the core-group anorectic take into account the emotional and cognitive deficits arising out of her earlier function as a merged parental selfobject, they do not address the presumed effects of her hypothesized simultaneous function as an idealized parental selfobject. Hence, the major therapeutic implication of the current work's conjectures is that they would permit the clinician to more readily recognize and process with the patient these particular cognitive and emotional distortions when they are, in fact, observed to occur in the individual instance.³⁹

³⁹ From a positivistic, data-driven research perspective, one may well ask whether such a *modus operandi* does not inject a rather unhealthy dose of observer bias into the situation and merely lead to a reification of the clinician's pre-extant beliefs about a given disorder. Yet even the most data-driven research is generally constructed for the express purpose of verifying an already extant hypothesis. Indeed, if one does not have a conjecture as to what phenomenon one might expect to observe, one may very well not recognize it when it is present. Moreover, to the extent that the hypothesized phenomenon is properly operationalized, even if only within the therapist's mind, the clinical situation can become an informal refutational test of the conjecture in question which can be used to inform future research

That is, the clinician could help the patient to examine and gradually begin to question the internalized injunctions and self-images arising out of her hypothesized use as an ideal selfobject, namely, the expectation of being seen as special, the sense of omnipotence and grandiosity, the felt need to self-perfect, and the non-acceptance of those negative affects that point to her actual vulnerability.

In addition, the therapist could help the anorectic to gradually identify and modify those distortions arising out of her *simultaneous* function as a merged and idealized selfobject. For example, the patient could be aided in understanding and eventually attenuating her heightened sensitivity to environmental rejection, as well as the proneness to shame and self-rejection which arises out of her highly polarized self-concept, her polarization between omnipotence and helplessness, and the highly restricted nature of her repertoire of acceptable emotions and behaviours. She could also be helped to identify how her polarized way of being and her adaptive strategies arose and are maintained in her particular relationships with significant others.

Particular attention should be paid to the processing of shame as this is one of the affects most defended against in anorexia nervosa. Indeed, therapists all too often overlook the shame experience (Lewis, 1971, 1988), which in the case of the anorectic would represent a replication of her relationship with her parents where her most important inner experiences went unnoticed. For as with all ego-dystonic affects, if a patient can be helped to identify and experience what it is that she is defending against, she can begin to give up the defense in question, in this case, the dieting behaviours. Moreover, the anorectic should be aided in understanding how her shame and self-rejection is maintained and intensified by the series of polarizations presumed to exist in her personality. The therapist may need to be particularly vigilant in helping the anorectic to process the shame that will probably arise as she gradually gives up her grandiose, self-perfecting tendencies.

Practically speaking, the anorectic's shame could be therapeutically processed in the following manner. The clinician could first interrupt the being-ashamed-of-shame cycle by interpreting the cycle and de-stigmatizing shame as an emotion through appropriate psychoeducational discussion, self-disclosure of therapist's personal experiences with shame, and so on. It may be especially helpful to reframe shame as a natural response under the circumstances in which the anorectic often found herself. The patient could also be aided in identifying and allowing herself to experience her shame, self-rejection, and attempted defenses against shame in the context of particular instances of questions. Of course, like all hypotheses about given psychopathological conditions, such conjectures could very well be (and doubtlessly often are) misused by the individual clinician to carelessly confirm, rather than to attempt to refute, pre-extant beliefs.

environmental rejection.

Finally, such therapeutic interventions should include a behavioural component, with the anorectic being encouraged to experiment with new behaviours of her own choosing which would help her to modify her self-identity along less polarized, healthier lines.

General Indications for Family Therapy

As well as intensive individual therapy, the clarification and resolution of the underlying family problems through family therapy is an important aspect of the treatment for anorexia nervosa (Crisp et al., 1974; Stierlin & Weber, 1989; Yager, 1981). In fact, treating anorectics without involving their families frequently leads to relapse when the family system is rejoined (Minuchin et al., 1978; Sours, 1980; Stierlin & Weber, 1989). For to the degree that certain family interactions are believed to be pathogenic or even only sustaining of symptoms, then a determined attempt to alter these interactions either directly or by working through their psychopathological underpinnings can be expected to be therapeutically beneficial to the anorectic daughter (Yager, 1981). That is, changing her family context should change the anorectic patient's responses and experiences.

The first goal of such family therapy would be to maintain each family member's self-esteem, while helping them to deal with the immediate worry, fear, and shame arising out of the daughter's illness. The longer-term goals are to help each family member to become more autonomous and less enmeshed, to strengthen appropriate coalitions, and to enable family members to resolve conflicts in a healthier fashion (Minuchin et al., 1978; Yager, 1981). This aspect of the therapy will also attend to the concerns and anxieties of each family member that preceded the onset of the daughter's illness. That is, parents and children alike need to feel attended to by the therapist in terms of empathy, nurturance, and tension regulation. For only once the parents have experienced this for themselves, can they learn how to provide it for their children (Stern, 1986). Moreover, if the needs of all family members are not appropriately addressed, the therapeutic benefits to the anorectic patient may prove short-lived and/or another family member will develop symptoms.

Implications of Current Etiological Model for Family Therapy

Since the pervasiveness of developmental deficits in both the typical core-group anorectic patient and her parents points to moderate to severe character pathology, it is probable that the parents' selfobject needs have not changed significantly over time or even with the onset of anorexia. Hence, the anorectic likely continues to be subject to similar experiences as in childhood, that is, to withdrawing, shaming, rejecting, or "narcissistic-

rage" responses from one or both parents if she does comply with their emotional needs and defensive requirements in the desired manner. In fact, cycles of shame and rage that appear to be grounded in such family dynamics have been identified in studies of anorectic family transactions (Scheff, 1989). Hence, predispositional hypotheses outlined in the current work can be seen to inform the family treatment of anorexia nervosa in significant ways. For while present models of family intervention in anorexia nervosa appear to adequately address the enmeshment and merged parental selfobject use of the anorectic daughter, they do not deal with her hypothesized simultaneous function as an idealized parental selfobject.

The therapist working with core-group anorectic families should, then, be vigilant to the parents' attempted idealization of the symptomatic daughter, the offering of conditional approval for "perfect" behaviours, and/or the covert or overt rejection of her for failing to fulfill this selfobject function. Such transactions should gradually be clarified, interpreted, and eventually interrupted and the parents and their daughter helped to find other ways of interacting with each other. In this respect, the therapist should ideally work at multiple levels, including individual imagery and experience within the family members, moment-to-moment interactional sequences, interactional sequences extending over longer periods of time, patterns of adaptation to developmental stages, and patterns of influence across generations (Dym, 1985).

Most saliently, the parents could be encouraged to explore and modify their selfobject needs to whatever extent reasonably possible. In this regard, the therapist is frequently used as a selfobject by the family members, including the parents, in order to further their emotional development; this often frees the children from their functions as selfobjects to their parents. Given that one is here dealing with moderate to severe character pathology, it is overly optimistic to hope that parental selfobject needs will be greatly altered, but parents can often be helped to find other ways of meeting these needs, for example, within the marital relationship. In this regard, marital therapy may prove useful by helping the parental couple to bond more, especially as it has been observed that the parents of anorectics are often much more centred on their children than on each other (Minuchin et al., 1978; Selvini Palazzoli, 1974; Stierlin & Weber, 1989).

Of course, hypotheses regarding anorectic pathogenesis in the context of certain types of family relationships should be used to help rather than blame families. Indeed, in order to cement the therapeutic alliance and to protect all family members' self-esteem, the family's attempt at adaptation should initially be accepted rather than challenged. In line with the research in the strategic therapies, it should probably be positively connoted (Mahoney, 1979). Moreover, change could even be discouraged (not paradoxically, but

genuinely) because of the potential for decompensation in one or more of the family members should crucial symbiotic bonds (however pathological they can be seen to be) be disrupted too abruptly.

In summary then, as the ways in which one member of the family uses another to regulate his or her own emotional well-being are identified and modified, and as all the family members' vital selfobject needs are responded to by the therapist, the possibility then arises for more mature relationships among the family members and for the anorectic patient to relinquish her symptoms.

XI. CONCLUSION

Some Limitations of the Present Work

While making certain contributions to the etiological theorizing in anorexia research, the current work is, of course, not without its share of limitations. A number of these are outlined below.

Firstly, possible innate dimensions of the pre-anorectic child's personality are barely addressed, as in virtually all etiological research in psychopathology (aside from adoption studies seeking genetic causes). For instance, perhaps it is a congenitally strong will that leads the anorectic not only to be able to persist with such extreme dietary measures, but that also, ironically enough, allows her to begin suppressing her needs and spontaneous initiatives in order to accommodate to the environment and meet her own most primary need, that of attachment to the parental figure, in the first place. Of course, it is highly unlikely that such a temperamental factor alone could explain anorectic pathogenesis, and it would probably be seen to interact with the effects of family relationships, sociocultural variables, various precipitants, and other aspects of a given patient's situation.

Secondly, the attempt to present the predispositional phase of the current etiological model in a refutable form cannot be said to be all that successful. Such empirical testability of the thesis' central hypotheses await a more careful delineation and operationalization of their key concepts.

Furthermore, the description of the pre-anorectic child's simultaneous function as both a merged and an idealized parental selfobject represents an oversimplification for heuristic purposes. This is an issue in all nomothetic research in personality or psychopathology in that the individual case is rarely this neatly categorizable.

Finally, it is not always clear what feelings or other aspects of the anorectic's experience are conscious, pre-conscious, or unconscious at any given point in time. Even psychodynamic formulations of different psychopathological syndromes, which of course derive from the metapsychology that evolved these concepts, all too often overlook this issue. This problem is even more rarely addressed in most empirical psychological research which appears to assume that the subject is largely transparent to himself. Given the heavy reliance on such measures as self-report instruments, this seems to be an important issue that the field of psychology would do well to address more thoroughly.

Future Research: Some Epistemological Considerations

One obstacle to developing a more scientific approach to the elaboration of more efficacious psychotherapies lies in the tendency of both clinicians and researchers to see their work as applied areas somehow divorced from theorizing about this syndrome (Guidano, 1991). This dichotomy between applied and theoretical research is, however, losing favour as investigators begin to realize that empirical observation necessarily involves a differentiation of "events" from a background of *a priori* assumptions and that there thus are no such things as observable facts without prior theorizing (Lakatos, 1974 in Guidano, 1991; Popper, 1972). Hence, as in the natural sciences, such as physics, empirical research can be seen as a method that complements, rather than supercedes, the theoretical research that is the basis for scientific progress in any discipline.

In the field of anorexia research, this dichotomy between basic theorizing and applied areas has led to psychotherapeutic research that is overly technique-oriented and theoretically simplistic. All too often important practical considerations, such as the search for immediate solutions to the problems of critically ill patients, lead to therapeutic models that proceed on a largely *ad hoc* basis and neglect significant theoretical contributions in the field.

Furthermore, virtually all of the empirical research in the field of anorexia nervosa is conducted along positivistic, data-driven lines. That is, it induces general statements from the particulars observed in a given research study. And this despite the fact that it has long been accepted in natural science, for instance, that it is not logically legitimate to argue from a particular to a general (Hume, 1964), but only from a general to a particular. This latter procedure is what occurs, for example, in the refutational testing of a theory utilizing a Popperian-type methodology. On the other hand, much of the theorizing in the field, especially within the various psychodynamic orientations, proceeds with virtually no concern for the empirical testability of the conjectures in question.

In line with the above considerations, it is therefore suggested that a stronger link be forged between theorizing about anorexia nervosa and research on the treatment of this syndrome. That is, this research should ideally be theory-driven; additionally, these theories should aim at empirical refutability. Such research could, for example, initially attempt the operationalization of some of the concepts contained in already existing theories with a view to ultimately empirically testing them. Similarly, future theorizing in the field might involve a greater concern for the eventual testability of the hypotheses involved.

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