ships. They did not know how to care and mind. In our view, the failure of their intrapsychic organization reflected itself completely in a failure to organize their lives in a setting of adult, interpersonal relationships within the social group. Their external worlds were crumbling to pieces, as was the state of their inner worlds. The group, in part kept together by the therapist, was a new world where reorganization was made possible.

SUMMARY

The aim of a therapeutic group is primarily to bring change in the individual. The individual can be considered as having an inner space 'inhabited' by inner objects in intrapsychic relationships. Inner objects are constructs of the subject corresponding to various levels of development from the most primitive to the most sophisticated stages. The subject tends to interpret and structure his environment in terms of these groups of internal objects. The more pathological the early stages of structuration of the inner world, the more autonomous primary groups will be, and the more they will impose their structure on the external environment.

Pathological structural activities of each individual in the group will determine the structure of the group, will eventually become manifest, and can become available for conscious working through. Early constructional activity is considered to be centred on spatial activity and on the action of the subject on its objects. Non-verbal structures are thought to be of primary importance in determining ultrastable patterns of behaviour, especially pathological behaviour. Since they might be responsible for acting out, special consideration is given to them in this essay.

The size of groups suitable for deep analytical work is important. The following questions are asked: How many inner objects can a person deal with? How many members considered as inner objects within the group taken as a whole can be held within a group?

The evolution of the group in some ways will be similar to the evolution of the individual from part- to whole-object relationships, and from paranoid-schizoid and depressive methods of functioning to more normal mature activity. A group of schizoid individuals is described to illustrate some of the points discussed.

From 'Universals of Psychoanalysis in the Treatment of Psychotic & Borderline States' by Henri Rey (1994)

4 ANOREXIA NERVOSA

In November 1977 I was invited by the University of Cape Town to spend six months teaching psychoanalytical psychotherapy to students and to the staff. When I arrived, I took over the supervision of a patient, Miss R, suffering from anorexia nervosa. At the Maudsley Hospital I had had a great deal of experience with regard to the psychotherapy of anorexia nervosa. I had made up my mind that there probably existed one particular psychopathology that can be found in those cases, and I wish to describe it here.

What is especially interesting is that the patient was a highly intelligent young woman, a student in psychology, who wrote up her experiences under her own name in a psychology journal (Rouah, 1980). She was treated in a well-organized unit, using a combination of behaviour therapy, art therapy, growth games, and social therapy. Most important was the work of the nurses, each one having a particular task to foster human relationships. It must be said that there were no psychoanalysts available in Cape Town, but the unit was under the able leadership of Professor E. Nash, who was its life and soul, and most interested in the analytical schools.

Apart from a description of her own experiences in the article in a professional journal, there is also a record of the treatment as Miss R experienced it, which I shall present and discuss in this chapter. It is illustrated as well with drawings and collages. The 'psychotherapist' in charge was a very intelligent nurse who reported to the team responsible for the supervision. I was the supervisor for a period of six months. The unit was located at the Groote Schuur Hospital.

HISTORY

The patient was nineteen years old when she arrived in Groote Schuur Hospital. A second-year psychology student, she came from Durban after an unsuccessful attempt at treatment using behaviour therapy to promote weight gain. She was in a severe cachectic condition, weighing about 32 kg

(72 lb) (she is a tall girl, about 5ft 9in). She was barely able to maintain her assertions that she was perfectly well and not too thin. When Miss R arrived in the unit she was still using the usual anorectic behaviour – vomiting, disposal of food and vigorous exercising. She appeared sufficiently depressed at one time to be treated with an anti-depressant and chlorpromazine, unsuccessfully. Shortly after her arrival there was a crisis where Miss R was near death and required intravenous hydration and tube feeding. She developed a very special reaction to her nasogastric tube, which stayed in for a number of weeks. She was quite prepared, even happy, to accept food given to her through it; however, she persevered with an intense aversion to chewing or swallowing food herself.

Miss R's past history showed that her mother was orphaned at an early age, and later in life was rescued from a camp in Egypt by her husband. Her mother is said to have been very dependent, and to exhibit behaviour more like a child than a mother and a wife. Father was a very strong character, and a dominant personality at home and in business. They came to South Africa via the Belgian Congo after its independence. Miss R had an older and a younger sister. It would appear that she spoke with intense rivalry of the sister, two or three years older than her.

As to the onset of the illness, the patient wrote the following:

> Although I denied it initially, I have to accept the painful truth that the changes of pubescence, the increase in size, shape and weight, menstruation and new and disturbing sexual impulses, all presented a dangerous challenge for which I was unprepared and which thwarted what little control I had.

However, things got worse for Miss R at the death of her father, who eight months previously had died of a sudden heart attack that the patient witnessed personally. Mourning her father was very difficult, as her mother insisted that her husband's clothing and other items were left exactly as they had been. The patient felt she was the only one who was coping at all with her father's death, but at the same time she was very resentful that her mother was unable to help her to get through her own grief at her father's death.

The patient talked with a group of people, to whom as time went on she referred as 'her mother'; they included the special nurse, occupational therapist and doctors involved on the unit. She regularly participated in occupational therapy consisting of activities such as growth games, drama and projective art. Her improvement was marked by transition from discussion of sensori-motor relationship to form and 'mother', to symbolic, metaphoric representation of her thinking. The following pages (pp. 49–62) are descriptions of her illness made by the patient herself after she had done drawings which put into symbolic form her state of mind.

GROWTH GAMES

Figure 1

Is this a woman? No . . . a foetus? No . . . a child, then? Wrong again . . . So what is it? Well, there is a long, complicated story attached to her, and the best way to describe her here is that she's a woman in a foetal position.

This sounds very confusing and illogical at first, so let me explain, because this figure is in fact me. I've discovered that there are certain things which are hard to believe until they happen to you, and one of those things is the possibility of growing 'a number of years' in a matter of months. Eleven months ago, I was a foetus, totally helpless, dependent, unaware of myself and of my feelings, in fact, so controlled that I never got round to ever showing what I truly felt or experienced in life. Physically and factually I was put on this earth on 6/11/59, but actually I was 'conceived' about a year ago, and I was 'born' about six days ago. To confuse matters further, I was the foetus and the mother together, so that I have given birth to myself in the form of greater awareness of myself.

I am talking not only of emotional growth, but of physical growth as well, for, when I came into hospital, I had reduced my body to such minute proportions that I was literally helpless and unable to do anything for myself. At that stage, I was the foetus, the tube was the umbilical cord, and the sisters on the ward were my 'mothers'. I was totally dependent on them for being washed, fed, even turned over from side to side every hour on the hour to

prevent bedsores. Emotionally, I was doing no work at the time, because I was too weak physically and, more important, I flatly denied my immaturity.

How could anyone accuse me of being an infant if I had been such a support to my family after Dad died? The cheek of it!!! Hadn't I successfully managed to replace Dad in the home? Everyone had told me what a model daughter (or should I say 'husband' and 'father'???) I had proved to be, and here I had the staff and my therapists denying that!!! I was so bloody angry at the time, but I was only a child, a very small, helpless child.

Now I am mature enough to at least recognize my unrealistic aims in the past, and I really respect my 'mothers' for their farsightedness. Sure, I coped on the surface, but I did it at the expense of my health, for I was destroying myself completely. Maybe, I was doing myself a service too, for, by being my Dad, I was escaping womanhood and its responsibilities.

Slowly, very slowly I started to 'grow' and as I became stronger physically, so I began to work on my emotional growth, only to find that that was a far more painful and slower process than putting on weight so as to regain my womanly figure. For the latter purpose, I just had to eat, but there is no food or pills or any such aids to help one grow emotionally. To do that, I had to admit a lot of painful truths, a lot of concealed and crushed anger towards my parents, and, of course, the painful realization and eventual acceptance of my womanhood.

Coupled with that was the increasing antagonism towards food, which, to me, is the thing, the hateful thing that makes one fat, and ugly, and hateful of my body. First, look at how gross, coarse and disgusting the picture is! Just look (if you can bear it?) at those thighs, at that roll of fat around the stomach! No wonder the woman is still sheltering herself from looking at herself and around her! She thinks she's a disgraceful sight, hence her compulsion, at times, to diet again so as to lose all that flab, even though she's been through the mill once already, and suffered a lot in the process.

To get back to me, I think I am a little beyond that stage, in some respects at least. I have been through the birth now, so that I have come to recognize my new role, and therefore my womanly appearance. I do not fully accept it yet, and in this respect, I still occasionally shied my eyes from looking at my disturbing body-image. I almost feel like a 'grown-up', new, fresh and tender, so much so that I am still a foetus or a very young infant in this new role. My wish for increasing independence is both positive and negative: 1) Positive, because I feel it is high time to break away from home and to recognize my individuality, and my rights as such, as well as give myself a chance to live my life as me, instead of going out of my way to always please others and live by their standards. 2) Negative, because I have this urge to extend my independent status to being in sole and total control of my eating habits. It is my body and I have to be happy with both. 'Just one final warning, woman, your mind is still distorted that's all I have to say' . . .

Here she is drawing and describing the stages she went through to reach this:

THE CHICK AND THE SHELL

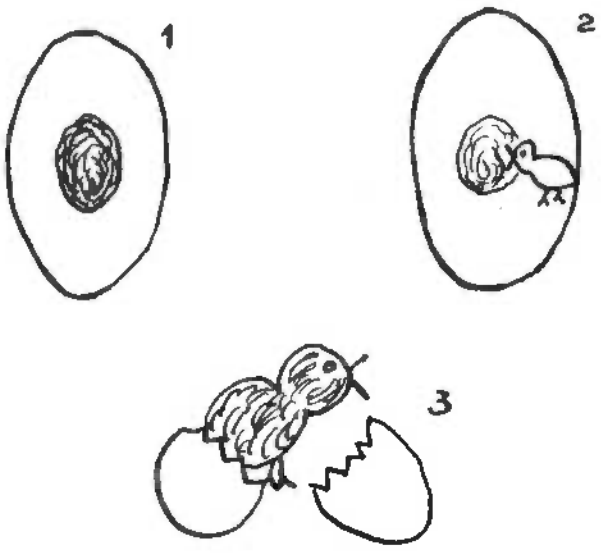

Figure 2

A baby is like a little chick who grows by eating all the reserves in the egg until there is nothing left except the empty dried-out useless shell which it will shatter open, and step out of as a fully grown individual, ungratefully leaving the shell behind, this shell which once fed and protected it.

THE PARASITE AND TREE

The parasite has grown and flourished at the host's expense. It has selfishly sucked up all the goodness out of the tree whose resources are now completely exhausted. It can give so much good and no more, and it is now weak and sick and dying. A dark, heavy, stormy cloud hangs above and before long, the inevitable storm breaks out – it is total devastation, which the tree can't resist.

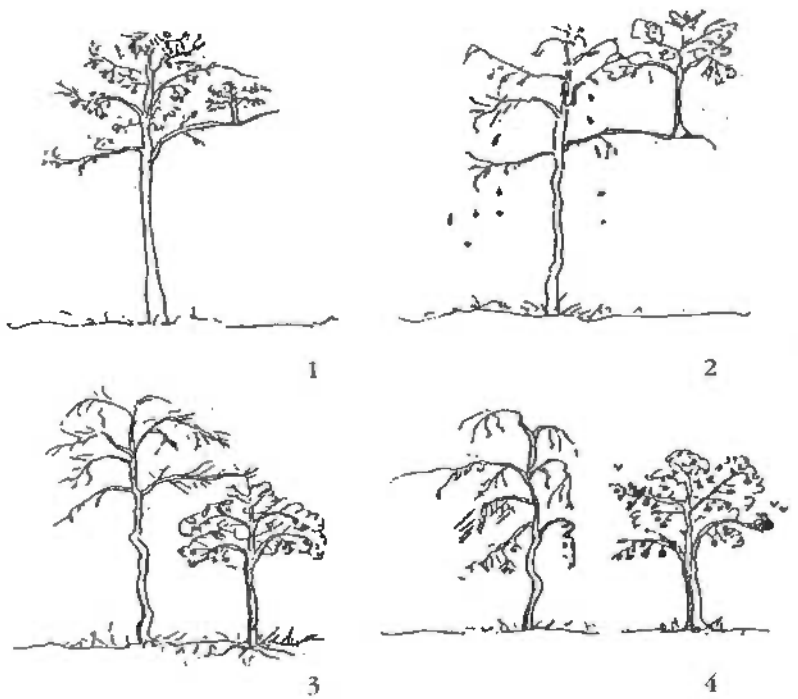

Figure 3

The branch on to which the parasite hangs breaks off and for a while the young tree feels lost, rejected and guilty at having been so gluttonous. It realizes that now it has to stand on its own roots; it is no longer dependent on another for nourishment and growth. If it settles down and anchors itself safely to the ground, it will flourish successfully. If not, it will die. The loneliness is hard to bear at first, and the young tree misses the protection and care that it had enjoyed up 'til now and that it has taken for granted.

It is only when one loses something precious that one realizes its value. As it adjusts itself more and more to its new existence, so the dark clouds clear away, and the sun sends a few warm and welcome rays to shine on to it. The little, helpless parasite has grown considerably since then, so that now, it is a shrub anchored fairly firmly to the ground, putting out roots to meet other plants and creatures around it. It is heading towards adulthood which will mean being productive (hence the fruit) and protective (hence the nests and birds), and it will have to give pleasure to others too by granting shade when it's too hot, and shelter when it's raining. The natural resources on which it depends to grow and survive will always be available. It is up to it to make its needs known and to use those resources adequately.

The parasite flowers and flourishes and the host is bare and totally drained and exhausted. At first it was a healthy tree, until the parasite grew on it and thrived on it at the host's expense. The tree takes in more food from the soil but the parasite is too greedy and increases its intake accordingly.

The parasite continues to blossom, but the tree is not so healthy any more; its leaves are falling and it is becoming diseased. (In pregnancy, the foetus grows regardless of the mother's morning sickness, tiredness, depression or varicose veins.)

A RECURRING PHANTASY

I have, for the past couple of weeks, been attempting to find the link between my fear of obesity and my childhood phantasy that pregnant women swallow their babies.

An individual can be 'obese' for one of two reasons:

1) Overeating,
2) Pregnancy.

In the first case, eating and indulging in food would result in a fat, and to my mind, an ugly and repulsive figure. In the second instance, my phantasy involves that of a foetus being cut up and chewed like food, swallowed, hence landing up in mother's stomach where it would grow and result in the mother's obese appearance. This, the common denominator of the two subparts of my phantasy, is the resulting state of the individual (obesity) which scares me. This had led me to hypothesize the possibility that subconsciously I equate food with a baby being swallowed which to my mind is a barbaric and repulsive act. I feel it is significant that since I have started on this phantasy trip, I have been feeling nauseous very often and have lost my appetite even more.

This little girl (me) seems very aware of her body and the way it is growing. Had growth taken place gradually and at its appropriate time (and here I refer to physical and emotional growth), with my being aware at the time of my body changes, I would have probably been spared all this pain and discomfort and seemingly being a woman but in reality being a young, vulnerable child. But it has not been so. Physically and naturally, I have grown, but emotionally I have remained static hence the resulting discrepancy that I now have to patch up.

IMPRISONMENT

The first picture shows a dark, stormy cloud hanging over the tower in which I am imprisoned. Let the tower symbolize the penis and the cloud the vagina, which contains the egg which, during intercourse, fuses with the sperm

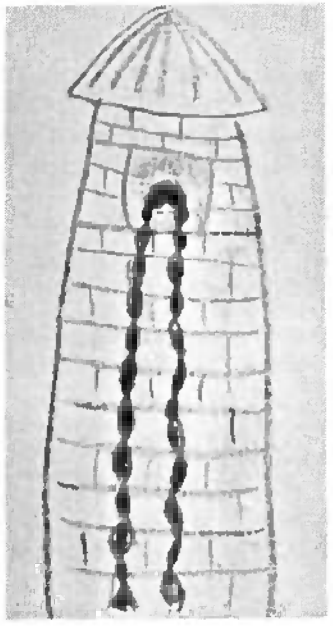

Figure 4a Rapunzel in the Tower

containing the foetus (see Figure 4b). As the foetus grows, so the shell cracks and in time, the infant is born. Normal birth stops there, but I have gone further, for I have given birth to myself. This means that the inner, childish 'me' has had to grow, to meet the apparently mature outer 'me' (my visible self) in order to lessen the discrepancy between the two. However, contrary to my expectations, my 'renaissance' hasn't left me with totally 'brand new' feelings, for I have had to go through a mourning process, mourning for the loss of the advantages of remaining a child.

But this is not all, because I have got this 'thing' about shedding my outer body which has something bad about it. The growing 'me' needs a fresh, new covering, one of which I will not be ashamed. What this entails is for the inner 'me' to grow just a fraction beyond the outer covering which will then crack and be shed. I strongly feel that mourning won't be worked through until I've buried something of myself that I don't like. Crying for the child I'm losing is just not the issue, because 1) the child will always be there to fall back on. It will never die and 2) this child is pure, clean, unscathed by external forces, for it has always been shielded by the outer carcass which now had to be shed. My point is that the child can't be the object of mourning, for it is a positive growth. What is frightening and anxiety-

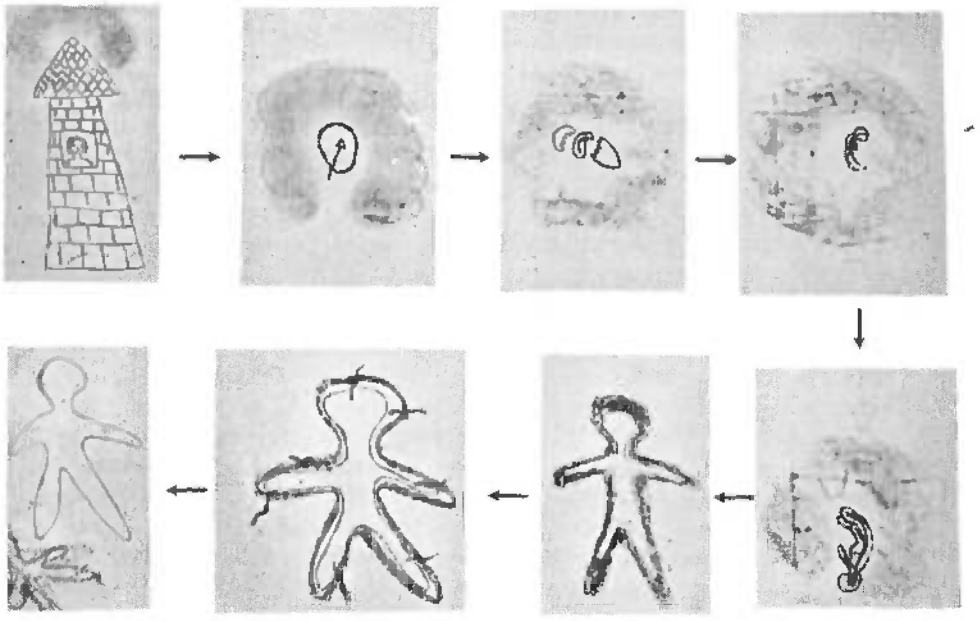

Figure 4b Growing Child Shedding Carcass

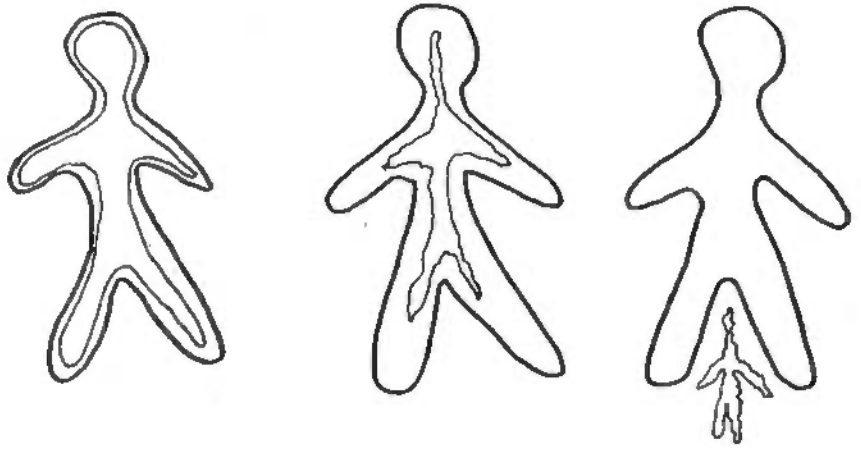

Figure 5 Outer Shell-Excreted Me

provoking is exposing this child to outer forces once the carcass has been shed, for the future is unknown. Will I be able to cope with new demands made upon me? I won't know until I am in that position. It is certainly a risk, but I have to take it, because life is full of risks and decision making. And then, I might find that being an adult can be exciting and rewarding as well . . .

This is the 'me' I've lived with for twenty years: a false, misleading outer shell, protecting a helpless infant that was given no freedom of expression whatsoever, the outer 'mature' me being so much in control. This 'living by double standards' resulted in the discrepancy that has become apparent in the past year, and I realized that I would not be able to keep up my controlled 'mature' pretence for much longer. So, I decided to cut out eating, hence reducing my outer body to match my inner self. This method of solving the problem only led to further complications and proved unsatisfactory, but necessary for my growth process. I reduced myself to a foetus and I've had to grow up from helplessness at that stage to becoming independent and assuming the responsibility of womanhood.

As well as being a child, I've had to be an expectant mother who had to give birth to the child in her, in other words, let that child come out into the open, giving it freedom of expression. It is not mere coincidence, therefore, that in my ninth month of treatment, I was ready to 'give birth'.

This was a difficult experience to cope with and it was difficult:

1) to grasp that I was (and am) a mother and child at once (i.e., adult and child in one, but equally balanced and not the child predominating or the mother having more expression. Each part of me has its say at appropriate times).
2) to grasp that this is a hypothetical pregnancy. There is no baby in me, hence I must not expect to come out of the birth experience as a pin-up.

In the same way that I swallowed the baby bit by bit, it seemed to have come out 'in bits' too, i.e., in a series of bowel actions each one leaving me with an empty feeling inside or feeling that I was losing a part of me that I at once regretted and resented. I regressed into the sheltering and safety of being a child and resented this mass that was making me heavy, sick, uncomfortable and fat. I've thought about the empty feeling further and have concluded the following: this feeling was predominant after every bowel action and it is almost as though, having emptied myself out, the inner 'me' would 'collapse', hence making the gap between it and the outer me very pronounced. Hence I felt a void and a great deal of insecurity and sense of loss. What I seem to have realized and accepted is that the outer 'me' is not the carcass. Rather, the inner 'me' has been excreted and the last step, namely, the excretion of the empty, deflated inner 'me' seems to have taken place. (Figure 5)

And here is the final hurdle of the birth: discharging this empty, useless

mass which is only taking up space in me. I think I've gone through it, because although I don't like my body image, I've come to accept

a) that it is mine;
b) that I am responsible for the way it looks. I've built it up from nothing (eleven months ago) to what it is now, through eating.

I feel that in order to start believing that it is a beautiful body, I need others' opinion of it and proof that it is attractive and not as 'fat' as I see it.

Another reason why I feel that the process is more realistic than the first hypothesis is that now, at the end of the process, the mature real me stands purified and it is not the unspoiled child that is exposed. I feel that I've passed that stage now. I'm not saying I'm a fully developed and adjusted adult but what I do say is that I've grown as much as I can for the time being – the rest will come as I get involved in everyday life, in relationships and situations that will enable me to prove my worth.

This is my hypothesized final step of growth: the inner 'me' growing up beyond the outer 'me', causing it to 'crack' and fall away, becoming the childlike 'me' exposed for the first time. (Figure 6) This process, I hoped, would get rid of my distorted body image that I hate so much, but things have turned out differently. With every bowel action I felt I was losing something of myself, something 'bad' that I wanted to get rid of, hence leaving me feeling 'lighter'. I felt the need, the urge to excrete my past with

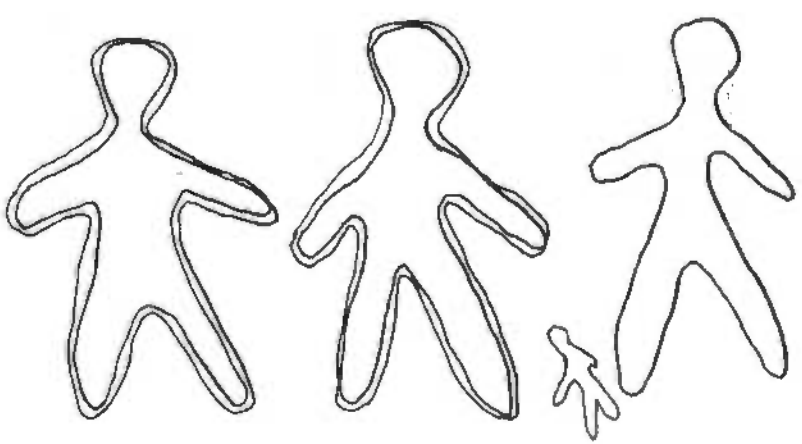

Figure 6 Inner Child Born

all its bad memories, hence purifying my body and this negates the above hypothesis, which accounts for growth but not for elimination of my 'bad' self. Hence, I experienced the following:

ANGER

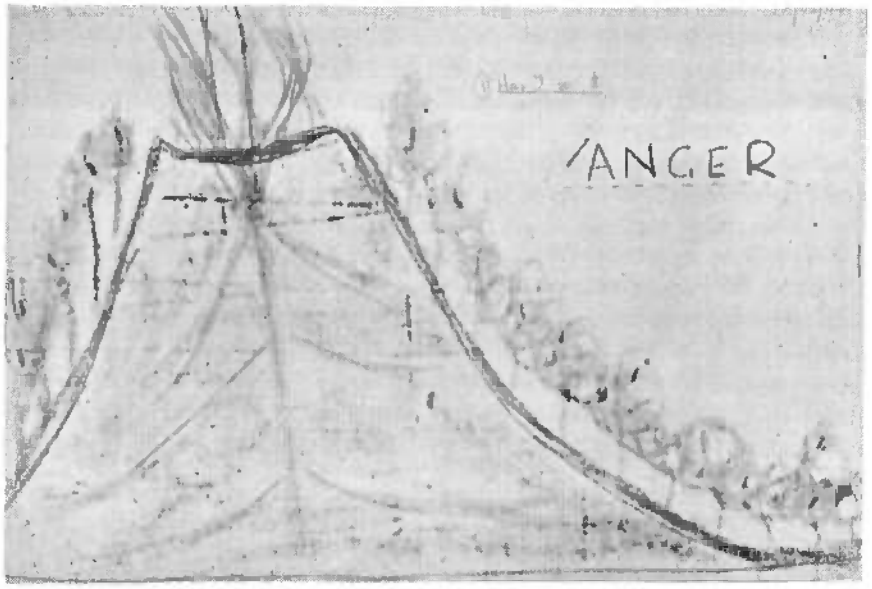

Figure 7 A Volcano of Anger

How I See It

Anger, to me, is like a hot burning volcano – a fire with the powers to destroy and to be productive and positive. The destroying powers of a volcano eruption are obvious, but at the same time, one tends to forget about the fertility of the lava that bathes the slopes (hence the trees in the picture). The same applies to anger: I have discovered that bottling it all up as I have done is destructive in that a massive explosion is bound to result sooner or later and such a situation is obviously harder to cope with than constant minor eruptions or rather eruptions at the appropriate time. I consciously try to show my anger when I feel it and the lesson I've learnt is that a dormant volcano is potentially more dangerous than a constantly but moderately active one. Anger expressed appropriately is definitely positive and I am

pleased to have discovered that anger does not inevitably lead to destruction and violence.

How I Cope With It

I believe that having discovered all that I've said above is one big step forward, but it is interesting to note the sequence of behaviour I have come to discover each time I get angry.

Step 1: The feeling of anger and resentment sweeps through me like a wild fire and it often gets so intense that I believe myself capable of actual physical violence. However, knowing that this would not be a constructive way of giving vent to my feelings, I go to the completely opposite extreme.

Step 2: I shut myself off from others completely, hence turning the anger inwards towards myself and punishing myself; that leads to feelings of self-pity and self-torture, and inevitably (although unconsciously at first) it is not too long before someone approaches me and questions my withdrawn state; it angers me even more because the original feeling is now coupled by feelings of possible rejection and unimportance.

Step 3: The position of isolation I impose upon myself soon becomes unbearable so that eventually I have to admit that my feeling of sadness evolved from anger originally. I find this confession therapeutic even at this belated stage and the satisfactory result of acknowledging and accepting that anger is inside me has provided a further incentive for me to try and voice it:

1) as soon after the incident that has sparked off anger in me as possible;
2) directly to the person concerned.

Anger, Loss and Hurt

Anger, loss and hurt have occupied predominant positions in my life so far and I have had to deal with and cope with the emotions involved. I went about doing that in the manner which seemed best at the time, only to find out that in fact, in the long run, I have failed. That has been a painful revelation, particularly since I channelled all my energy into trying to cope successfully, indeed to the extent of neglecting myself. It is very easy now to think of the 'if's' and 'but's' and 'should's', but that is not the point, in fact, there is no substitution for experience. It is precisely because I have dealt with the past in the way I did that new, more adequate ways of coping have come to light. The past is unchangeable but the present and the future is . . .

In all three instances of anger, loss, hurt, I have been thinking that withdrawal into my shell was the best solution, in this way I was not

burdening anyone else with my problems. At the same time I was being only too willing to listen to and take on other people's worries as well.

Selfishness has never been my scene, but I have realized that I, like everyone else, have got the right to show and express my feelings and emotions, and that doing this would not be a selfish action, but a healing one. Anyway, up till now I have been ignorant of this fact, so that I have simply bottled up my feelings, letting the tension mount until breaking point, putting up a brave and strong front. Whereas, deep down, my heart has been shattered and overwhelmed by grief, pain and sorrow. Why did I not have the right to mourn my Dad openly like everyone else? True, my mother and my little sister needed a lot of strength and comfort, but didn't I too? Even the toughest piece of elastic snaps when it is overstretched, but my surroundings did not realize that (I don't think I did either). On the contrary, they thought that my pretended 'toughness' was genuine, whereas in reality, I was extremely vulnerable and needed to be anchored and comforted.

As I think about anger I realize that I have often visualized myself as a volcano that has remained dormant in spite of the many instances when eruptions could and should have occurred but were suppressed. I have always been the 'good child' so that any expression of angry frustration has always been very noticeable and frowned upon. BUT it is not because the 'volcano' has not erupted that the 'lava' has been boiling inside. On the contrary, it seems that my anger, compounded by my unexpressed feelings of grief, has been rising steadily over the years, so that instead of being subjected to regular, gentle eruptions, I have had to suffer a titanic explosion in one step, and it has become my task to try and cope with it, and devise ways of solving it. The confusion is overwhelming.

Wow! What a thing to be faced with! How do I start? Where do I turn my attention to first? Is it worth all the effort? It seems like it, because there are still lots of angers, griefs and hurts that I will have to confront in the future and that I will have to cope with in a manner different to the way I have coped with such feelings in the past. Perhaps one consolation is that I have a far greater understanding of myself and I can definitely feel that I have changed in many ways, a very significant change being that I have forced myself to learn to openly express what I feel. I don't find it such a strain doing this in the ward, where the staff actually encourage it; but will my new behaviour be acceptable outside? That question really concerns me and yet I know that I have had to and I still have to change; I could not have carried on in the same path as the one I have chosen up till now. Recognizing the flaws in me and trying to change them has been a very demanding and trying experience and I hope that the people around me will appreciate this and will recognize it as a vital and necessary step I have had to take in order to make me a better and more independent individual . . .

AN OVUM

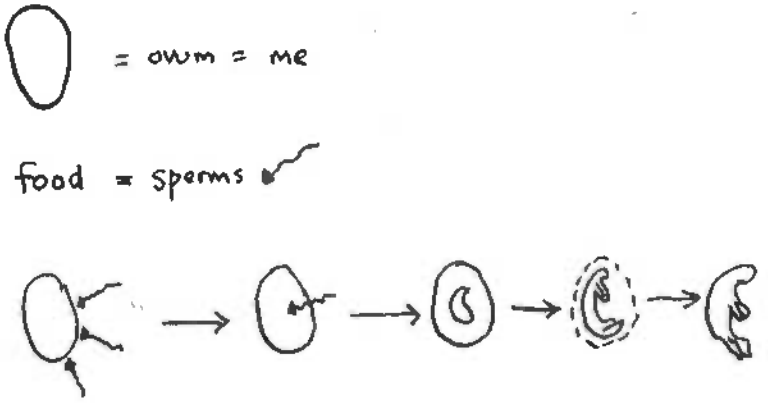

Figure 8 Giving Birth

I am an ovum that has never hatched. If, to me, food equals a plate of sperms, then although I have swallowed a countless number, my shell has been impenetrable, hence I have not allowed myself to be 'fertilized'. But the 'chick' can't remain in its shell all its life and this is the thought that has triggered off my 'renaissance' or rebirth.

Physically, I am growing and in fact I have outgrown my shell which should have hatched long ago. Emotionally and psychologically, I have resisted this because I have felt incompetent in coping with the demands of an adult, mature being. I now seem to have reached the stage where 'fertilization' has taken place even if it's been against my will, this being almost inevitable after swallowing so many sperms and I have ever since had to cope with pregnancy. The time to be born is just around the corner and the way it is happening is not like a normal birth. It is taking place in small steps, each one building up my confidence as an independent, mature woman. The whole process has been accompanied by physical symptoms of pregnancy, so that I do feel the need to 'excrete' the child in me.

I see one trap or pitfall in this whole process, however. Because I am still so obsessed with my image, I only too often take my pregnancy literally so that I tend to think that one day, I'll wake up with a slim and trim figure. But I must realize that this will not happen. The alternation will take place in my mind and in the way I view my body.

SWALLOWING AN EGG

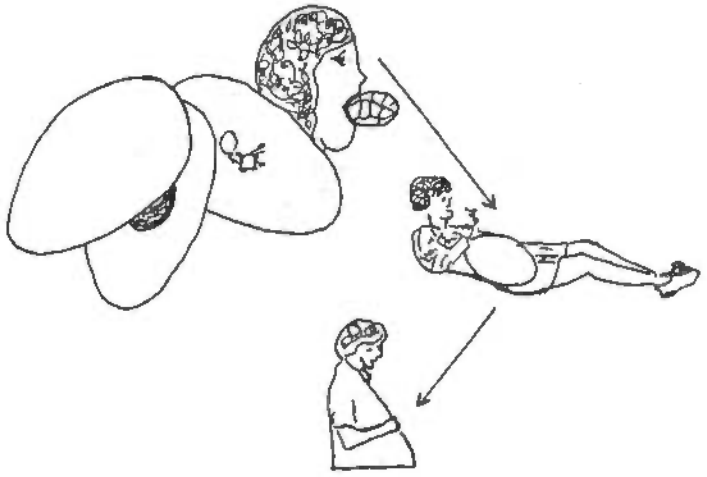

Figure 9 Pregnancy Through Food

An egg, to me, symbolizes potential life, and my phantasy (illogical like all phantasies but real enough to be meaningful and worrying) involves imagining that the egg contains a foetus which will grow in the mother's stomach once the egg is swallowed by her. This phantasy of mine does not repel or nauseate me as much as my first, barbaric phantasy of actually chewing and swallowing a foetus, but the result is still the same regardless: a 'fat', pregnant, mother-to-be with the emphasis on the first two words. I still occasionally resent the idea of my fear of pregnancy, for it goes against my lifelong wish to have a family of my own, to be a model mother and to love my children.

I still tend to think that my difficulty lies with the means of becoming pregnant rather than with pregnancy itself. But then, the 'fatness' principle crops up, and a pregnant woman's figure is not exactly beautiful, but to my mind, being 'fat' as a result of childbearing is excusable and valid, whereas obesity as a result of gluttony makes me ANGRY, RESENTFUL, HATEFUL OF MYSELF AND OF MY BODY. ONE THING I AM CERTAIN OF AND THAT IS, THAT NO ONE WILL EVER CHANGE MY MIND: I HAVE HAD A DECENT FIGURE FOR A LONG TIME NOW, AND LOOKING AROUND ME, THERE ARE MANY MORE PEOPLE WITH THINNER FIGURES THAN ME. WHY IS NO FUSS MADE OF THEM? I AM SICK TO DEATH OF BEING FATTENED UP AND OF BEING BRIBED INTO DOING IT. IT IS MY BODY AND I WILL NOT ACCEPT IT AT THIS UNREASONABLE WEIGHT. I HAVE TO BE HAPPY WITH IT AND OF THIS I WILL MAKE SURE.

DISCUSSION OF THE PATIENT'S MATERIAL REPORTED IN THE TEXT

In this paper I am describing the observable phenomena present in an anorectic's thinking and behaviour, and showing how psychoanalytical understanding adds meaning to these observable phenomena. I later suggest implications for the treatment of anorexic patients. The focus of my initial remarks is the patient's material just reported.

The patient, Miss R, came to treatment because of refusal to eat. This refusal to eat had most important underlying reasons that we have to consider. It was not just food that mattered to her.

The question that gradually came to the surface was: to what consequences was eating what kind of food leading? By using the word 'food' I mean all sources of food, not only in the sense given to 'food', but as a universal substance that any organism, from the single cell to the most complicated organism, must obtain from another organism to survive and to grow. 'Eat or be eaten' – this is the sense we are giving to food and eating; the universal situation of all things, and not only living organisms, is 'capture or be captured'.

It is now necessary to consider a second aspect of the patient's illness. That is, her problems at the time of the menarche. In her own words she writes:

> Although I denied it initially, I have had to accept the painful truth that the changes of puberty, the increase in size, shape and weight, menstruation and new and disturbing impulses, all presented a dangerous challenge for which I was unprepared and which threatened what little control I had. To counteract this fear of losing control, I resorted to rigid dieting and became preoccupied with weight.

Thus at puberty Miss R started controlling food to prevent heterosexual impulses, to prevent womanhood, and to reduce her body to childlike proportions. That is, she tried to prevent all desires and possibilities of becoming pregnant.

The next trauma was the death of her father when she was aged seventeen. She reacted to this event by a kind of manic reaction of being 'in charge' of the situation, and at the same time, in taking the role of husband and father, coping in a manic way with the demands of life. The full anorexic illness developed later, and then she was in a cachectic state, needing tube-feeding to be kept alive.

We must now consider the symptoms Miss R suffered from. First, she hated all forms of fatness. Being fat indicated she had been eating and indulging in food, and the result was an ugly and repulsive figure. Second, she experienced mother's pregnancy as mother eating and chewing the baby

and then developing a fat stomach, which the patient felt would happen to her if she ate.

All this was connected with an impulse to overeat and get rid of the food, or to not eat and starve. Miss R became more and more preoccupied with her body image, desiring the right one, which she considered to be a child and even a foetus; this was normal size. For her to avoid food and starve meant to, first, remain a foetus, and, second, not to be a mother that chews and swallow babies. Food for the baby foetus is made of the mother herself, and this implies that the foetus has to feed on the mother's body. For the 'devouring' mother, the baby is the food that will make her pregnant.

We see here the clue to the anorectic's difficulties. The problem is a double identification of the foetus-baby with the mother, and the mother with the baby. The foetus-baby imagines that becoming an adult implies in reality eating the mother to grow up, and the reversal of this means that to be pregnant would involve the mother in eating the baby. This creation of the baby-eating mother is clearly a projective identification of the baby into the mother. The problem for the anorectic is how to be a growing foetus without eating the mother to a cachectic state, and, in the identification with the mother, not to eat the baby to become pregnant.

'Feeding' is the universal necessity for all organisms to survive and grow up. But if feeding ultimately means the destruction of the baby and mother, then it becomes the most persecuting experience possible and must be controlled at all costs. The patient, before treatment, was not able to cope with this conflict, resulting in a double disaster only avoided by not eating.

It was necessary for Miss R to solve the problem of the double identification by acting physically and simultaneously the role of the mother and of the foetus. She entered into a pseudo-pregnancy, being hardly able to distinguish between its physical reality and the phantasy. As she said, 'This was a very difficult experience to cope with'; it was difficult for her 'to grasp that this was a hypothetical pregnancy'. She added,

> . . . there is *no* baby in me hence I must not expect to come out of the birth experience as a pin-up. In the same way that I have swallowed the baby bit by bit, it seems to have come out in bits, i.e., in a series of bowel actions, each one leaving me with an empty feeling inside or a feeling that I was losing a part of me that I at once regretted and resented.

The patient needed an actual 'acting out' as near as possible to reality to work through her fundamental conflict.

Something very primitive took place before that. Miss R was near death and having to be fed forcibly to save her life, which was done by a nasogastric tube. She developed a special reaction, a very positive attitude, practically an affectionate reaction, to the tube, which was present for a long time. We can only deduce that by not feeding orally she was avoiding doing the wrong things. *In utero* the foetus is fed via the umbilical cord. Only at a later stage

of pregnancy do foetuses learn how to suck their thumb, and even to swallow some meconium, presumably to get ready to suck the maternal breast at birth.

Food in this particular psychopathology is the substance of which everything at first seems to be made. Eating is the way food is obtained. For the 'foetus-baby' and the mother it means eating each other: you either eat or you are eaten. One grows and the other perishes, depending on who wins. But this also means the destruction of the other. Pregnancy through food brings further conflicts of the same order. Even sexual organs are 'made' of food and are the subjects of hate and disgust. Yet the desire for food is enormous due possibly to an innate drive or desire for it after deprivation, or both.

In several chapters in this book I have discussed the primary processes in terms of space and time. I have stressed the importance in early development of 'space-centred' thought – the relative comparison of all processes with their relative, spatial size – and I have given numerous examples. Thus this fundamental basic spatial dimension at first is the 'quantity' of everything. The sizes of instincts, impulses, drives and feelings are in terms of relative sizes. Wishing to be a baby is the reverse of omnipotence in which one feels 'I am bigger/stronger in everything than anybody else.' This kind of necessary wishful thinking based on spatial thinking is one of the main defences at this stage, and may remain so later, for instance in megalomania and mania.

One of the most important common findings about anorexia nervosa is a disorder of the body image. Anorectics maintain that they are of normal size or bigger and fatter than they really are, even when in a cachectic state. This stage of affairs is constantly remarked upon by psychiatrists, possibly as a given genetic characteristic. But another possible condition leading to this belief is not considered. The same kind of remarks apply to food with regard to quantity at first. Food is necessary to grow up, for, as we have seen, taking of food changes relative sizes, creates pregnancy, then a foetus and later a baby. The baby eats the mother, who is the food, and the mother the baby. Therefore, food is prohibited to prevent the baby eating the mother and the mother eating the baby. Greed becomes very important and is the moderator of those processes. Anorexia is the method to compensate for the bulimia. 'Greedy bulimia' must then be compensated for by anorexia – to save mother and baby from being devoured. The feelings for the mother are some primitive form of projective identification of the baby on to the mother; that is, baby-in-mother and mother are given the same impulses and phantasies as those of the foetus-baby.

It is difficult to say at what point the foetus and baby start experiencing the above-described behaviour. I treated an anorexic patient, one of identical twins. Apart from other aspects of anorexia, she also claimed great problems with her sister, which she felt began when her sister occupied the larger portion of the intra-uterine space. Later, as they were living in different

countries, they wrote to each other, always claiming they were starving themselves to weigh less and thus occupy less space *in utero* than the other. Being a very good-looking girl, the patient was asked out by young men. She refused their invitations later because as soon as she ate in their presence she developed a pseudo-pregnancy. She was in group therapy, and offered to demonstrate the 'pregnancy' through eating in the presence of the group members.

Great advances have been made in the behaviour of foetuses *in utero*, and the remarkable behaviour of twins towards each other, showing likes and dislikes. Among other observations using the ultrasonic examination method, and reminding us of our patient's behaviour with the nasogastric tube, is the case of the girl with the cord tied around her at birth and many other fascinating observations *in utero*. All such studies are important to extend research on infant observations to prenatal life, and to establish a better knowledge of the possible continuity between prenatal life and life after birth.

Even more important as a precipitating factor is the sexualization of food to bring about pregnancy. The patient, to be described later, has her childhood phantasy of the mother becoming pregnant, that is, having a baby inside her, by chewing and swallowing a baby. She has described in detail the resulting development due to an increase in ugly fatness – the fatness itself being caused by increased eating to feed the baby, as well as the fatness of the mother containing the baby. Those repressed phantasies were reactivated at puberty and given full expression.

TREATMENT

The psychological material revealed by the patient offers some views with regard to treatment.

First of all with regard to food. It is obvious that the anorectic thinks she is doing the right thing in avoiding food: eating food destroys the mother, who provides life. The mother becomes exhausted, cachectic and dies, as illustrated in the pictures above. This brings about the loss of the mother, who is indispensable to the survival of the foetus and later the baby. Because the baby can only assess the desires and needs of the mother through her own feelings, that is by identifying with the mother, the latter does the same thing in reverse to the baby. Therefore, an essential condition is that the baby must not feed on the mother and vice versa. It seems that it is wrong to insist on the anorectic having to eat to save her life (or that of her mother) without the correct interpretations to make the usually very intelligent anorectic understand the difference between 'eating mother as the only food available, or being eaten'. One must insist on the anorectic's wish to do the right thing, that thinking as she does is right, granted she thinks as she does, but that the

problem is to start considering other ways than that of eating mother or of oneself being eaten.

Together with this problem comes the question of the disorder of body image. This is the result of the double identification of the anorectic. First, being small means remaining a foetus-baby who shows it is not feeding on mother's body. Second, the claim that they are of a normal size is again through the identification with the mother who does not have to feed on the baby. But it further deals with the problem of the mother entering into pregnancy by chewing a baby and swallowing it, as believed by the patient, the stomach becoming visibly 'fat' and showing what has happened. The disorder of the body image has therefore another explanation, and is not really 'abnormal', granted the phantasies that lead to it; it is those primary phantasies that matter. However, those beliefs and phantasies are so strong that they really belong to some kind of delusion. This is therefore what has to be treated. Now, to do this one must have a metasystem in order to explain the system. There are two metasystems available: first, the formation of symbols and their use; second, the transference situation. I shall deal with the symbolic activity first.

I noticed that my anorectics always began to get better when they started using 'symbols' of one kind or another. I realized that they could not come out of their 'delusional system' without a metasystem into which to project and integrate and transform the material into a higher system than the delusional one. Further, the metasystem and the system must at first have been severely split off from each other. The patient was unable, although intelligent and capable of symbolizing, in one system, to symbolize within the food and size system. Therefore, it was important for Miss R to be actively engaged in the various symbolizing activities such as art, growth games and projective art. For within the delusional field, symbolic displacements and representations were beginning to take place through therapy.

There is then the transference situation to be considered. This must be divided into at least two aspects. First, the transference to the individual psychotherapist. Once the transference has started, the delusional phantasies and beliefs can be compared to the interpretations of the therapist. Positive feelings are then able to develop. It is then more possible to make use of the reparative drive, of the desire to save the mother and the babies or foetuses. Saving life arrives as a possibility in lieu of starving, sometimes to suicide. This starving is at the same time representing destruction and punishment, the law of talion.

However, the transference system would not be easy or even possible if another metasystem was not available. That is the interest in symbolic activities, even if it is to prove how right the anorexic phantasies are. The displacement of delusional beliefs to a higher form of belief makes it possible to add another, more advanced, level of thought to that of the foetus or baby. Transformations then begin to be possible, and we are then beginning to deal

with the reversibility of beliefs. For instance, Miss R drew the child inside the mother, then the chick, then the parasite on the tree. These allow a comparison with understandable material as opposed to the very early somatic experience. The work of the therapist and of all the staff of the unit is geared to use this new possibility for symbolization to take place.

One important aspect of the treatment is to keep the patient alive in spite of her delusional beliefs. There can be many cases where it is necessary to use forced feeding, unfortunately against their will, in order to save their life. But we hope that during that time the patient can make some psychological progress.

Another important aspect is the question of control. Who is going to control whom with regard to what? Thus the anorectic will use every possible method to stick to her delusional beliefs and oppose those who want to alter her attitudes. This is part of the strength and size of their beliefs. Even when improving one patient said in the other system, 'I am determined not to change.' This is where the transference towards the therapist and the whole staff is so important. It is through this 'transference love' that the fortress inside the patient begins to yield, and the capacity to make use of the symbols of the metasystem enters into a new model of reality.

This is also where the question of the factor of time comes in. There is a gap between the pathological system and the other ways or systems. Slowly, the two systems or models become nearer, and the metasystems can capture the system and integrate its structures in to a larger system. Food is still necessary to keep alive and to grow, but the 'object food' is a different one from being inevitably the 'foetus-baby-mother-food'. Reality enters more into those early schemas. The baby takes more account of reality.

Another example of the persistence of early sensori-motor schemas is the attachment to and interest in the tube for feeding purposes. It is worthwhile noting here that some studies of babies observed *in utero* and after birth seem to show there is a memory of the umbilical cord which persists after the cord was tied round them. In the case of Miss R the reaction to tube-feeding would indicate that possibly there was at first a satisfactory state *in utero*. Then there is the appearance of the sucking of the thumb *in utero*, to get ready for sucking the breast after birth. Then the appearance of needs, appetite, and then the greed. Subsequently there is the reaction to the breast and sucking. Greed, of course, here is proportional to spatial comparisons. So here we have something that could be, at least partially, a genetic tendency. The identification with the mother would also be partially due to genetic determinants.

The appearance of the full syndrome after adolescence is possibly a reactivation of early patterns due, say, to hormonal factors, and partly to the environment. Due to a very important protein deficiency, hormones at menstruation are now absent. This applies to the understanding of the great anxiety of possible pregnancy, and the problem of the patient facing herself

being pregnant with the baby identified with herself, and becoming a mother identified with her mother as explained earlier. It also appears very important that the fixation to space-centred thinking – the fear of growing bigger, fatter, more greedy, and vice versa staying smaller, anorexic, thinner – are extreme measures of thinking based on early spatial dimensions. Only if the factorof time can be allowed to work on the early models can space-centred thought be transformed, as indicated in other chapters in this book. This is again a vital factor of treatment.

Some similar explanation applies to the anger of the patient. An important part of the anger was against the baby, as mentioned in Miss R's accounts. That spatial factors also apply is indicated by the patient comparing the anger to a volcano erupting and its destructive fury – again strength being indicated by size. When looking at the picture of the volcano one is reminded of Betty Joseph's description of a bitten breast being transformed into an active volcano (1989). The same kind of explanations could also be applied to jealousy, which causes father and siblings to separate baby from mother, this need of mother being an ultimate need.

Another extremely important factor was the death of Miss R's father. Circumstances and certain reactions of her environments made the mourning of father difficult. Instead, and in the actual words of the patient, she had to be 'father and husband'. Thus she extended into not only the role of the father, but in her mind became father and husband, and an enormous problem of identity arose. This identification with a male figure was very much promoted by Miss R's slimming and avoiding fatness and a female figure, and, further, a pregnant one. The patient states how difficult it was slowly to recover the female figure and curves. It is also relevant to stress how much the psychological changes were in fact as near as could be to the psychophysical level and sensori-motor level. It is worth noting that this male identification may be related to the extreme physical resistance and amazing activity shown by so many anorectics, together with a marked inhibition in the production of female menstrual hormones. Possibly compensation may also take place via the suprarenals.

THEORETICAL CONSIDERATIONS

I shall consider in this material what appear to be universals for all human beings, and in what way some aspects have gone wrong in the present case. The most fundamental aspects of development after fertilization is uterine growth. I will only consider some factors involved in our case material. The first factor that comes to mind is food. Food is provided by the mother, first via the placenta and then through the breast (leaving out bottle substitutes). Both *in utero* and at the breast this food supply is coming from a part of the part-object, not the whole object, the mother. This is to my mind one of the universal and fundamental factors. Without that splitting of the source of life

the destruction of the source cannot be avoided, and in the case of the patient, somewhere that system has gone wrong. As cases of anorexia nervosa are about ten times more common in females than in males, it would seem that the defect is connected with the female sex principally, as the mother is the only source of food. I have also been interested in the situation when anorexia happens in men. Working at one time in a very big mental hospital, I asked my colleagues how often they had seen male patients with the delusion of being pregnant. Their answer was astonishing: 'How many cases do you want?' I was immediately provided with three patients, one of whom had simulated pregnancy by filling his trousers with food. I will not expand further on this except to mention the case of Schreber, who essentially had to be transformed into a woman to give rise to another race of men.

That this need for eating appears *in utero* seems to be indicated by the foetus having to suck his or her thumb in order to 'know' how to suck the breast immediately after birth. Swallowing the meconium could also be an indication of the need for food. After birth, crying for food when hungry (and other needs connected with feeding, such as contact with the mother at the breast and in her arms) is of course a rule. So we can see how important is the confusion of the part-object and the whole-object.

It is interesting to note that the first Greek philosophers were interested in the fundamental matter of the universe, which was water for Thales, air for Anaximenes and a kind of ether, or *apeiron* for Anaximender.

The destruction between part-object and whole-object seems to be fundamental in the experience of being one with, or separated from, mother *in utero*. The conduct observed as judged by new evidence in uterine life and at birth seems to indicate that the process of distinguishing the baby from the mother has started already from the beginning and is a fundamental process.

Obviously the role of father seems to be an important factor in this differentiation. One question is, where is father coming in? Is it a kind of genetic ontogenic process existing from the beginning, or is it only beginning with the advent, say, of the Oedipus complex? This implies considering the phylogenetic inheritance of the combined parents.

Is the coming in of the father a new event, however early it takes place, or is there an equally early process of separation of the phylogenetic combined parents, a genetic constitutional tendency? Some schools of psychoanalysis are now considering a view that would imply a kind of gestalt aspect of the combined parents. An accurate exegesis of Melanie Klein's view seems to imply that she was in favour of leaning towards that hypothesis.

This leads us now to the question of the first appearances of spatial factors and of symbolic activity. Space and time elements are slowly being constructed and structured step by step. It stands to reason that the first steps

of this 'mind construction' will depend on what factors are available, and a reciprocal action is inevitable. First, all measures depend on relative spatial dimensions of sensori-motor systems, and then somewhat later on their representation by images and symbols. Small and big, appetite and greed, weak or strong impulses are all dependent on relative spatial dimensions.

Then time is slowly elaborated upon. At first, for instance, a long time is a long distance, until speed comes in and therefore time. The same applies to objects and their domains, the importance of each domain being limited by its size. The passage from sensori-motor schemas takes place through most elementary representation. There are iconic images and then symbols. This very early domination by early spatial factors is beautifully illustrated in our clinical example in which the importance of food is strictly connected with the relative size of the foetus-baby and mother. The size of the hunger and food satisfaction also are similarly connected. Greed is proportional to relative spatial size. Part-objects, for instance, food being not the whole but an acceptable part of mother, are not yet achieved, and we deal here with infinite experiences (Matte-Blanco).

Omnipotence used as a defence of the small against the power of the bigger one depends again on primitive spatial measures. Indeed, at that stage Freud would be great by his physical size, and not by his metaphorical and then intellectual greatness.

It is necessary to return to the question of the combined parents. Using our clinical material we know that the death of Miss R's father played an important part in an exacerbation of her symptoms. It was not possible to introject a dead father and transform him into a good memory, that is, into a good inner object. Instead, a regression to early food and spatial dimensions took place. Having to introject father was equal to eating father and actually becoming him. But that also means that the father's part in separating the combined parents into their individual components could not take place further. This increased the difficulty of the father image becoming a separate unit from the mother. The vicious circle was re-established.

This leads us to the use of splitting by the patient in the early model, which prevented the use of more advanced models for that split-off part. This is the use of a metasystem towards further construction of the system in developments, that is, anorexia nervosa. At first the intensity of the impulses seems to have prevented an extension of the domain of actions of that split-off primitive domain because of the enormous anxiety that paralysed going forward to disaster instead of newer progress; it was split off and suppressed. Further, the role of the male, that is father, is being repressed. To understand that, we must examine the separation of the combined parents and the relative role of the father as well as that of the mother.

The father or the male does not directly help to rear the foetus and baby, he helps with his sperm to allow the ovule to do that. The female develops *in utero* and feeds the baby physically. The male has helped the future human

beings (or other animals in nature) to develop by one special stimulus, the sperm. A similar process, I think, applies to the elaboration of the beginning of images and symbols, starting with concrete representations. The penis provides the first model. Its functions are complementary to that of the breast. When the infant, starting from mother, looks for another object, the father, he must create a link between the mother and this new other object – a 'bit' of the first object must be put into the other object (not to lose mother completely) and impart some of its qualities. They are transformed and become part of one of the first important metasystems. The penis thus becomes also a primitive symbol; it represents something else. The processes continue to evolve, until later 'logos' is achieved. The female is the semantic content, and the male the container or indicator or symbol of the contained plus what it adds to it. (See the example of the Tower in our patient's description.) So the penis or phallus becomes what the French and Lacan call '*au nom du père*' ('In the name of the father').

The description of the mechanisms of the illness anorexia nervosa takes us to consider what aspects of those mechanisms also apply to normal development and where they differ from the pathological. I suggest that the early structures we have described apply to everybody; they are the universal, fundamental basic structures followed by the developing foetus and baby. It is the importance of certain abnormalities at certain stages of development that matters in pathology. For instance, the extent of the splitting or the size and strength of the impulses, say of greed. It is an abnormality of those structures that leads to psychopathology. A defect in the domain of symbol-formation may lead perhaps to schizophrenia. A case example is given in this book (see Chapter 8).

What I want to stress is that psychoanalysts have to analyse the very early mechanisms, the very early sensori-motor schemas, especially the space-centred structures, to be able to alter pathology. It would be very difficult to understand how the analysis, say, of the late Oedipus complex could alter behaviour without at least considering what has happened before, as described for instance in this paper. Those are at first the universals and fundamentals of developmental process as well as, of course, the later structures participating.

It is also important here to discuss the role of genetics and environment. In my paper on reparation (see Chapter 13) I have already discussed that subject to some extent. As shown in the present case there can be no doubt about a genetic contribution. Some structures and mechanisms have been affected by genes in the pathological process; they cannot be entirely attributed to environment. The genes are setting a pattern to the form the illness took. Cases of anorexia are alike in many ways.

However, at what levels can genes be interfered with by the environment? The answer is at least at two levels. First by causing abnormalities at the level of the structure of the genes themselves, and second in the development of

normal as well as of pathological genes. No normal genetic tendencies can develop without some kind of environment, sometimes favourable and sometimes not. This is not only understandable for the development of normal genetic endowment, but also in the case of a pathological contribution by the genes. We have to consider the treatment of some somatic illnesses where it is possible to make good for the defective genes without a cure for them. The same applies to psychic derangement of the personality, behaviour and underlying phantasies and structures. The prejudice is to declare the postulated impossibility to do so in psychological illness if there is a genetic tendency present. Without Freud's mysterious jump from soma to psychic and vice versa the psychological and psychic world could not exist. It is at that level of representation that psychotherapy takes place, a vital place to influence by environment the future development of the psyche. This is why we must take and give full importance to the phantasies of the patients, to know how they have gone astray. They tell us what to do, how to treat and do reparation.

This point can be illustrated clinically with our present patient. We have seen that Miss R had to go through a pseudo-pregnancy to be able to bring about the separation of mother and baby. She writes:

> This was a very difficult experience to cope with and it was very difficult:
> 1) To grasp that I was (and am) a mother and child at once (i.e. adult and child in one, but equally balanced and not the child predominating or the mother having more expression).
> 2) To grasp that this is a hypothetical pregnancy. There is no baby in me hence I must not expect to come out of the birth experience as a pin-up. In the same way that I have swallowed the baby bit by bit, it seems to have come out in 'bits' too, i.e., in a series of bowel actions each one leaving me with an empty feeling inside or feeling that I was losing a part of me that I at once regretted and resented.

She had to go through this sensori-motor experience of pregnancy and birth, and as well seems to have used a model or metasystem of a different level, that is, the excretory system.

We have here perhaps the most important of combined figures, that of the mother and the infant which has to be separated to establish the identity of each component and allow the foetus and infant to develop normally separately. This illustrates the point of view of Melanie Klein negating an early distinction of subject and object. It is in the early appearance of an object relationship (of a kind) in the foetus and still more in the baby that the separation of the combined mother-infant structure can take place. The sensori-motor schema and its representation, however primitive, is the necessary place to begin. Somewhere in his writing, René Thom mentions a distinction with regard to evolutionary theories dealing with orthogenesis being the recapitulation of phylogenesis in a linear unfolding and comparing

this with a possible more economical model when there are two aspects to satisfy in the same process, say the development of male and female characteristics. In phylogenesis the process starts with the two potentialities, and one and the other in the course of their unfolding separate into the two separate entities.

Perhaps therefore, as was suggested, a mechanism of that kind is at work with regard to the combined mother-child structure, the combined parents, the combined male and female entity, the subject–object structure, the part-object and whole object and so on. I have touched on the mechanisms used to separate those combined structures and tried to describe their action. The continuity of the passage from uterine life to life after birth seems therefore to be of great importance to the anorectic. This has been shown through Miss R's own writings and the psychoanalytic meaning which I have given to them in this paper.

The latest news of this brave and intelligent patient is as follows:

> It seems that she is reasonably well, but still perhaps somewhat food- and weight-conscious. Her greatest source of pride is being the mother of three children, five, three, and one and a half years old. In addition, she is running her own personnel consultancy.

NB: The 'special nurse and therapist' is called Patsy McDougall.

POSTSCRIPT: THE RELATION BETWEEN ANOREXIA AND BULIMIA

Becoming anorexic is a defence against bulimia. In these writings by a bulimic patient we see the difficulties with which he is struggling.

'Opposite of anorexia: continuous craving for food, specifically fattening within very short space of time. I ingest a whole loaf of bread, ½ lb butter, knifefuls of sauce, plates of Weetabix, bran, cornflakes, mixed up together in an indigestible mixture (except that I have a cast-iron digestive system and rarely feel sick or ill). Even when stomach bloated and distended, absolutely satiated with food, still compelled to gorge . . . Compulsive and continuous gluttony.

'Almost as if deliberately making myself ugly with obesity, disfiguring my once good figure with gargantuan meals, covering it with layer upon layer of adipose tissue.

'I eat from morning til night, and during the night as well: my use of language is quite literal – not figurative. However much I eat, I still feel starving and can think of nothing but food, and consuming it as quickly as possible, as much as possible, in the shortest possible time. After huge

intakes of food, I then proceed to dream about food and eating, and, upon waking, immediately crave more food. So begins the cycle all over again . . . I constantly have to rise during the night because my desire for food prevents my sleeping.

'I eat anything and everything, frequently too hungry and impatient to eat immediately, to wait for something to be cooked hot which would, in fact, be far more appetizing and satisfying.'