NOTES ON THE PSYCHOPATHOLOGY OF ANOREXIA NERVOSA*

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In the classical paper in which he introduced the term 'Anorexia Nervosa', Sir William Gull (1868) criticized the views of several contemporaries on a certain subject and wrote '. . . they have arrived at their opinion against clinical evidence, and partly biased, though unconsciously, by the way we were first taught to dissect and think . . .'. Prof. Cathcart (1940), concluding a series of lectures on the mysteries of alimentation, quoted Mendel, who wrote: 'There is no field of practical importance related to human well-being in which there is greater opportunity for dogmatism and quackery, for pseudo-science and unwarranted presumptions and proscriptions, than in the domain of our daily diet.'

The attitude of patients suffering from disordered feeding habits shows clearly that we are dealing with problems that tend to provoke dogmatic solutions. Nevertheless, it is with such patients that our ignorance of the development of feeding habits and of the relationship of normal feeding habits to normal habits of other types, becomes clear. The man in the street and the mother in the home tend to have definite views—and the baby in the cradle even more vociferous views—on the subject. These views are mostly determined by a long sequence of events, most of which are in the adult unconscious—or to paraphrase Gull: 'they have arrived at their opinion against real knowledge of food and partly biased, though unconsciously, by the way they first fed'.

This holds also for all investigators, since it is by no means easy to approach a patient who has a feeding difficulty unbiased by the effects of the way we first fed and by the way we later developed our present feeding habits and idiosyncrasies. Our first loves, hates, fears and sorrows were so intimately connected with the history of our feeding and our food that, as adults, we cannot easily and with equanimity contemplate a patient starving to death in the midst of plenty. We cannot remain unaffected emotionally by a patient apparently indifferent to serious illness and good food. When we find emotion to be the significant cause of the feeding difficulty we fear to investigate this emotion deeply and intensively. We try to make the patient eat as we do—to protect the patient from death and ourselves from unpleasant emotions.

The syndrome of anorexia nervosa has been defined by many physicians. A psychiatrist would consider that more emphasis should be put on the following points in order to complete the clinical picture.

In his description Gull spoke both of a dislike of food and of an occasional voracious appetite. Now we know that such alternation of signs is characteristic of manic-depressive disorders. Such alternation of feeding habits may partly determine the commonest treatment which exploits the tendency to eat voraciously; voraciousness being, in fact, a sign of the disorder.

The original description by Gull did not include gastro-intestinal complaints, but the later literature did. Such complaints are manifold. They vary from patient to patient and change spontaneously from time to time under any treatment. This may seem a small point, but its importance may be seen in the cases described later.

The attitude to cure is often, and especially recently, expressed in a rather omnipotent vein—as if all patients could be cured. Ross

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(1936) reported, however, six relapses and one death in nineteen patients treated in 10 years, and Ryle (1936) reported that of thirty-seven patients seen during 16 years and followed up, ten did not improve or relapsed, four of these died. This should make us realize that we have much to learn. The treatment in favour in this country is to let the patients know that they are in danger of dying—but that they will recover if they feed—and feeding is insisted upon.

Various methods of stimulating feeding and nutrition have been tried in attempts to give the patient an excess of an essential which is lacking or in attempts to give food in a concentrated form. These methods often play into the hands of the patient, as the primary symptom is often related to an attempt to live on a substance which is not nourishing or on a concentrated food substitute; for instance, the patient who wants to live on air—or to have food in pill form. The disorder has been called an addiction to meagreness and, in some cures, an addiction to an adequate diet may be the result. This is hardly the best basis for feeding habits. Normal feeding habits are not obsessive compulsive.

Hurst (1936) stated that it was only necessary to persuade the patient to eat to overcome the anorexia. The patient was told that the appetite had been lost by not eating. He reported that fifty patients had been treated in 19 years without a single failure. These results are so much better than those reported by all other workers that one remains very curious even after reading his reports. The more severe disorders may have been excluded by being otherwise disguised or the series may have been of an exceptionally mild nature; or a unique and useful type of therapeutic result may have been reported without the details of the successful method of treatment having been described in detail.

Such results may, on the other hand, be related to what psychopathologists mean when they talk of the effect of giving wrong interpretations. The psychopathologist has before him two questions when he sees a seemingly good therapeutic result. First, does it enable him to understand in greater detail the problem seemingly solved? Secondly, has a new pathological defence arisen when the symptoms disappeared and, as far as the origin of the symptom is concerned, is he worse off? One must be on the look out for a conspiracy between doctor and patient to deny or repress important emotional problems. Loss of appetite *may* suddenly arise for emotional reasons. If the doctor says that the food caused the appetite, the patient will know that she is dealing with a person who ignores her deeply significant emotional troubles. Fostering the new delusional symptom 'I believe food causes appetite'—may result in a projection mechanism which enables patients to continue saying: 'Food doesn't stimulate my appetite'. This denial of instinctive appetite is just what we should be trying to cure.

Forcing a patient to eat before offering any other help may sometimes be the cause of the deterioration and of eventual death. In one of the patients I am reporting, I think it is likely that the severe clinical state, which later developed, might have been prevented had intensive psychotherapy been started while she was still considered to be suffering from anorexia nervosa. It is certainly true that a point may come in the development of some patients' illness when psychotherapy alone cannot cure the patients—they must be fed or they will die. But it is also true that a point may come when, if they are treated solely by giving food, they may become psychiatrically more seriously ill. To save a life the help which psychotherapy alone can give may be needed.

Complications, such as severe anaemia (Evans, 1939) and beriberi (Palmer, 1939), may occur during the course of the illness and change the psychiatric picture. They may be cured by appropriate treatment without altering anything, but the symptoms due to the anaemia or beriberi. Recently I have had two patients under psycho-analytic treatment who have had severely disordered feeding habits and have developed anaemia—one

hypochromic and one hyperchromic. Both have recovered from the anaemia under the care of their general physician. The mental condition meantime showed only slight changes. A consultant, who neglected to take the whole course of one patient's life and illness into consideration, was deceived into predicting recovery of the mental condition when the anaemia was cured.

Ryle considers that anorexia nervosa runs true to type and should therefore be separated from other neuroses diagnostically. Most physicians agree that it is difficult to get into touch with the patient's emotional difficulties. Most authors mention the reticence. Many such patients never see psychiatrists, who are as keen to ascertain the psychopathology as the internists are to discuss the changes which can be described in somatic terms. The diagnostic problems may perhaps only become clearer when these patients are investigated psychiatrically as well as somatically. Emotional crises, advice regarding slimming, etc., may be the conscious content at the onset, but to understand why these patients show more specific symptomatology, the unconscious motivation must be known. Unhappiness is frequently mentioned, but little is reported to show that the patients are investigated sufficiently to ascertain how and in what way they are depressed in the psychiatric sense. Most of the literature gives the same list of emotional problems as is brought forward to explain any other type of neurosis, and as yet little has been done to try to trace specific connexions between the symptoms and the instinctive life, the imagination and the interpersonal relations. For instance, in a survey of 117 patients at the Mayo Clinic in 13 years, Beckman (1930) described the patients as preoccupied, apathetic, reticent and negativistic. Nevertheless, the symptoms were such as aroused sympathy in the physicians. Such is notably not the case with schizophrenic patients, but is so with patients of the manic-depressive type. It is difficult for a psychiatrist to imagine physicians being interested in 117 preoccupied, apathetic, reticent and negativistic patients if they were mild schizophrenic. These 117 patients were unable or unwilling to give a cause for their anorexia. In twenty a psychological factor of precipitating importance was discovered, but no details were given.

Weiszaecker (1937) described the psychopathology of two female patients. Both had occasional days of voracious eating. He studied their dreams and contrasted the dreams before voracious eating with those before starvation. He concluded that, before voracious eating, patients dreamt of their mothers, of bodily disintegration and of death; and before starvation, of God, of their fathers, of knowledge and of well-being. He gave no specific interpretation of the dreams. His view was that one of the various ways in which patients might deal with conflicts about their relationship to their mother and father, to imprisonment and freedom, to pregnancy and sterility, and to life and death, was by becoming anorexic. He made no attempt to deal with the dream content in terms of repetitions of specific early-life situations. The content was dealt with more along the line of the universal collective unconscious. His patients' general attitude was 'I will understand just so much as I am understood'. This attitude may give one of the keys to the difficulty of understanding the psychopathology.

Nicolle (1939) contrasted the investigation of a patient with hysteric anorexia with an active 19-year-old girl, 5 ft. 6 in. in height and 5 stone in weight, who ate scantily and had amenorrhoea and constipation. She described psychogenic mechanisms in the hysteric, and it seemed that there was almost a conscious quarrel over food and a conscious refusal to eat. In the other patient the content was not easily understood and appeared to be schizophrenic. The hatred which the patient showed could not be dealt with by 'analysis of the parental transference'. The hatred remained a primitive rage and appeared to be precipitated by an affront to narcissism. Nicolle considered that the psycho-analytic view of

fatness would be that it was a bodily indulgence and so led to guilt. She found that interpretations along this line did not help the patient. Few psycho-analysts would accept Nicolle's summary as an adequate statement of the psycho-analytic view. Her patient gained 1 stone 10 lb. in 9 months, and, after 3 years' experimentation with endocrine therapy, the menses returned.

The following notes about some patients who have been under treatment by me may show where some of the complex emotional problems lie. These patients were not treated by psycho-analysis.

The first was a single woman in her late 40's who ceased work due to tension, depression and 'rheumatism'. In her adolescence she had lost appetite and weight for several months and her menses had ceased. She remained active and was irritated at the treatment of her medical adviser who advised treatment by rest. She recovered after several months. During the treatment of her later illness she admitted that the adolescent illness followed a sexual episode with a relative which she feared had resulted in pregnancy. She starved herself hoping to prevent the pregnancy developing, meanwhile keeping up a front of cheerful activity and successfully hid the anxiety and depression in the background. This history demonstrated how it was possible for a patient with anorexia nervosa to be seemingly cured without receiving direct help in dealing with an important emotional problem.

The second patient was a single woman in her late 30's who had had to give up work due to increased hypochondriacal symptoms which had become worse during the previous 5–10 years. Hysterectomy had been performed due to menstrual disturbance—excessive bleeding and pain. She had recurrent painful joint swellings of short duration, attacks of asthma with fever, spastic colitis, marked anorexia and loss of weight. In her late teens she had lost her appetite and had become very emaciated. Her menses had ceased. She had remained active till treatment by rest in bed was advised. She gradually recovered. During the treatment of her later illness she stated that, before the first breakdown, she had believed that she had become pregnant following an episode with a relative. She tried to starve herself to prevent the child developing. During the treatment of her later illness the relation of many symptoms to a delusion of pregnancy which had persisted unconsciously became clear. In this patient the pregnancy delusion was based on more primitive pregenital phantasies than in the first patient and was not relieved even by hysterectomy. Nevertheless, it did not prevent her from going through in her 'teens an episode of anorexia nervosa from which she recovered.

The third patient was an active, single woman of 24, who developed anorexia, marked loss of weight, amenorrhoea and a downy growth of body hair. At first it was considered that she was suffering from anorexia nervosa. Under the usual treatment for this complaint, she developed other symptoms. She became depressed, sleepless, suicidal, had nightmares and alternated between severe constipation and diarrhoea. Later during psychotherapeutic treatment it was discovered that in adolescence she had had anorexia, loss of weight and amenorrhoea for a few months following an affair with a relative which led her to believe that she was pregnant. Later it was discovered that she had had an unconscious delusion that she contained a baby. During the days when she was becoming conscious of the fact that she believed she had a dead baby in her abdomen, she began to have menstrual pain. The fear of menstruation (which she believed would be the abortion of the dead baby) was so great that it led to severe constipation and bladder distension of such a degree that she had to be catheterized. During the following month treatment was continued and these fears lessened. She began to eat and, a month after her previous menstrual pain, she menstruated normally for the first time in several years.

These three patients show some of the relatively superficial interrelations between

eating, pregnancy delusions and cessation of menses. Such patients are often used as test-tubes for endocrine or vitamin experiments. One wonders how the results can be understood without attempting to study the coincidental psychopathological changes which are occurring. One knows that marked changes occur in the symptoms from day to day without experiment. For instance, the last patient I described shows clearly how the conflict with instinct can alter from month to month. When a physician makes an experiment the patient will put meaning into it and will react in some way or will try with greater or less success not to react at all.

Psycho-analytic investigation has shown many of the deeper or more complex connexions between variations in appetite, weight and mood—especially in depression, manic elation and euphoria.

Various psycho-analysts have found and described detailed psychopathology of feeding difficulties. I think the reason they have not reported patients suffering from the anorexia syndrome as such is that they do not consider it a clinical entity. They believe that it remains as much of an entity as it does because of the manner of approach of those who report most of the instances.

Ryle states that psycho-analytic methods are unwise and may do harm, but gives no evidence for this statement. Jones (1940) reported the successful psycho-analytic treatment of two of his female patients of 40 and 27 during the previous 10 years.

It may be that patients treated by psycho-analysts are not cured and are seen by physicians. It would add to our knowledge if such cases were reported. Psycho-analysis may fail because analysts are still ignorant of a technique adequate for handling severe illnesses, or it may fail because the analytic technique is bad. Psycho-analytic mistakes should be criticized just as should surgical mistakes.

The sweeping statement that no deep analysis is ever required can only be upheld by restricting the diagnosis to those not seriously ill or by using the therapeutic test of success following reassurance as a means of diagnosis.

In the treatment of depression with many types of symptoms, explanation (which usually means saying 'I understand what is the matter with you'), reassurance (which usually means predicting a good future) and firmness (which usually means threatening disaster of one sort or another if advice is not followed) are the time-honoured methods. When applied to anorexia nervosa these methods often produce changes called improvement over months or years as they do in the treatment of depressives.

Ribble (1938) has discovered difficulties of feeding immediately after birth, and has related these to the difficulty of changing from the foetal method of feeding and breathing to the nose-lung and mouth-gut mechanisms necessary after delivery. Frequent repeated stimulation of the oral zone, and consequent absence of oral frustration, was found to have an important bearing on the cure of such feeding difficulties in the newborn.

Schmideberg (1933) reported a child of 2½ who had had severe feeding difficulty since birth and whose weight was 25 lb., the average for a child of 15–18 months. Her mother said the child took food as another child would take medicine. In analysis the difficulty was discovered to be chiefly related to an inhibition of aggressive biting paralleled by a fear that food was an aggressive object.

Psycho-analysts have found that eating difficulties, both in young children and adults, are related to some of the earliest anxiety situations of a paranoid type. While feeding is dominated by cannibalistic phantasies, patients equate articles of food with the loved, hated and feared people, parts of people, and objects in their environment. Food, when eaten, is equated with the objects and organs already felt to be in the body and may give rise to fears of being poisoned and destroyed inside, and of losing or having destroyed one's loved inner possessions.

Klein (1940) wrote that introjection of the whole loved object gave rise to concern and sorrow lest it should be destroyed by the previously introjected bad whole- and part-objects and by the id. The distress and fear engendered in this situation has much to do with the origin of depression. Consequently, one of the earliest defences against an acknowledgement of this problem is anorexia, since feeding on food which represents the whole love object usually results in destructive phantasies.

In the manic reaction denial of the internal problem, omnipotent control and projection mechanisms are at work. The patient with anorexia nervosa may be said to be denying appetite, hunger, emaciation, illness, etc., and to be saying with omnipotent feelings 'I have got plenty of good in me—I can be active and alive and do good to others—I am not dying—I can live on air and water'—and to be saying 'all the trouble is outside....I'll do good to others—food is bad. I'll reject it and not be deceived into believing it is good even though others are.' Nevertheless, this mechanism breaks down as it cannot long succeed. Bouts of voracious feeding occur—often secretly—as if to say—'I'll be a beast and the beast in me is not dead—it will eat'.

Food as a bad object and inhibition of feeding connected with phantasies of bad objects have been much more studied than anxieties related to food as a good object. I have found that unconscious sacrificial motives also enter into feeding difficulties. The denial of appetite and the feelings of omnipotence accompanying it may be defences against the fear that the external good object will be proved not to be omnipotently inexhaustible if it is ever actively fed on in a loving way. The conscious attitude is then 'The only proof that I can love is to deny all desire'. Such patients often have an idealized attitude to some external figure or are very religious in the sense of being preoccupied with an ideal heaven to which they are going.

In this connexion I would like to mention a fourth patient, a single woman, now 50. In childhood, adolescence and early life she was very active and energetic to ordinary observation, but had recurrent depressive phases which were well hidden. Before 30 she began to lose appetite and weight to such an extent that she wrapped scarves about herself to disguise the emaciation. Her menses ceased for a time. Finally, a physician moved her into the more neutral atmosphere of a nursing home, and he was rewarded by being told some details of a very trying family situation. She began to feed better and, in the next 2 years gained from 6 stone 11 lb. to 12 stone 7 lb. (height 5 ft. 7 in.). This weight she retained until 40. At this time a loved relative died and her weight began to vary considerably. She became severely depressed and, after several types of treatment, came under my care for psychoanalytic treatment. During treatment her weight, appetite and menstrual function have continued to vary, but the variations have gradually become more connected with problems with which she is able to deal consciously. The problems are of the type I have just been describing. Her weight has varied even when the food intake has remained constant, and I think that, for further understanding of alimentation, we will need to know not only more about the physiology of digestion and assimilation, but more about the unconscious phantasies connected with sensations arising between the gullet and lower bowel and also more about the influence of such phantasies on assimilation. As has been well known for years manic-depressives frequently present paradoxical gains and losses in weight not related to the coloric intake.

In conclusion, I would like to say that more collaboration is needed in work on the same patient at the same time and at the same place. Psychiatry and psycho-analysis have much to contribute, as also has clinical medicine. The physiologists should help us to understand the low temperature, the low pulse and blood pressure, the poor peripheral circulation, the menstrual variations, the occasional anaemia and leucopenia and the various gastro-in-

testinal disturbances. The endocrinologists and nutritional experts should help us to understand the emaciation, the downy growth of hair, the pigmentation, and any ovarian, thyroid, adrenal and pituitary disturbances. Many have assumed that the anorexia is related to primary inhibitions of endocrine organs. Psychopathologists are interested in the possibility of psychogenic inhibition of organ functions which rarely ever become conscious. Nevertheless, even with such collaboration, we shall be offering our patients less than the best treatment, and our scientific understanding will only be partial, if we neglect the study of those unconscious factors which, when they can be dealt with consciously, may lead to the best integration of the personality and the fullest function of all habit systems.

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