A Case of Anorexia Nervosa

*Robert A. Harman, M.D.**

J. presented as a 24-year-old, white female, married with two children, aged three years and eight months, not working outside of the home, and living with her children and husband, an engineer. She was referred for psychotherapy after her gynecologist suspected anorexia nervosa on the basis of a 34-pound weight loss, amenorrhea, and distorted body image.

J. reports she had been doing well, had completed two years of college with good grades, and had a "good" relationship with her boyfriend, including intercourse with "climax." Four months into her first pregnancy, she experienced a loss of interest in sex, disgust at "being too fat," and a desire to lose weight. She struggled with these symptoms and maintained a normal weight of 124 pounds for her 5 feet 5 inches but continued to function on a low level with depression, no interest in sex, and continual worries about her weight and body image.

During the fourth month of her second pregnancy, she took a turn for the worse and began strict dieting. During the entire pregnancy, she gained only four pounds, and her pregnancy was complicated by severe preeclampsia. At the time of presentation, she weighed approximately 90 pounds, exercised compulsively six hours a day, purged herself with laxatives, slept poorly and was barely able to function. She insisted that she was "so fat, it's gross and disgusting."

J. grew up in a coastal town in California and always felt isolated from other people and different. Her parents divorced when she was 8. Her mother remarried when she was 12. She describes her father as secretive and eccentric (she identifies with him) and her mother as overpowering and manipulative, "wearing the pants in the family." She describes her stepfather as "loud, dishonest, and vulgar."

Mental status exam revealed normal cognitive functions, moderate depression without suicidality, and distorted body image. She denied

*** Medical Orgonomist, Belle Mead, N. J., and Los Angeles, Ca.**

other delusions or hallucinations. She stated she could not express anger or any displeasure directly (except to her stepfather), but complained she could not trust her mother and that people were basically "out for themselves."

Characterologically, she struck me as innocuous, sweet, and likeable. It was as if she did not have a mean bone in her body (maybe no bones at all). Her demeanor was friendly, but she was cool and unruffled no matter what. She was childlike without any particular male or female character. She dressed fashionably, often in designer jeans, sweater, and running shoes. I felt she was sensitive and needed to be handled carefully. Despite this, I felt she had a sharp edge somewhere.

Biophysically, she seemed soft; her handshake was extremely flaccid. She barely appeared to breathe. Her voice was quiet, soft, and tiny. Her field was weak and boundaries not distinguishable.

Initial laboratory evaluation revealed hypokalemia, hypomagnese- mia, and leukopenia. Protein and iron were borderline low. EKG was normal.

Treatment consisted of once weekly character analytic psychotherapy (sitting). I saw her on condition that she see an internist monthly, receive regular blood tests and EKGs, and with the understanding that her condition could be life-threatening and that hospitalization was an option. The patient's goal in therapy was relief of her anorectic symptoms; she did not wish to change her underlying personality or way of life. She did feel that she was "trapped," but could not explain what she meant by this.

My working diagnosis was schizophrenia. Even though the patient did not fit the classical criteria for this diagnosis (1), she met all five of the orgonomic criteria (2). Her subtype was less clear but based on a phallic idealized body image, identification with the male parent, and the feel of the case, I considered paranoid the most likely possibility.

The initial sessions were characterized by long silences which did not seem to disturb her at all. She was waiting for me to become impatient or give up on her. Her silences could have been interpreted as a struggle for control, but this did not get at the heart of the issue. I merely pointed out that her silence meant it would take me longer to understand her. She seemed pleased that this was the case, and I told her so. She began to complain about family members and said she liked men better than women; women could be so "cutthroat."

She began to develop a bright red rash on her neck and throat that

would flare up suddenly during the session with no visible change in emotion. She found this embarrassing, but I told her it was her organism's only way of expressing itself, that a living thing will die unless it expresses itself somehow. She understood this and said she could not express herself verbally because she was trapped in her throat. She revealed that she felt trapped in her marriage as well. The following session, when she spoke of her mother, the rash developed the form of finger marks over her throat. After this she was able to speak more clearly and said she worried about revealing too much about herself, she worried I would find out about her hiding laxatives all over the house, and at the same time felt pleasure in fooling her husband by doing this.

The following session I asked her to move her eyes and to describe the room in three dimensions. She refused to do either, believing I would somehow guess all her "secrets" from her responses. She was able to describe her fear of letting anyone see any emotion (they could use it to manipulate her) and to describe an incident where an older man made sexual advances to her when she was a teenager.

What Reich called her "red thread" was beginning to emerge: mistrust. With her, it took the specific form of hiding her emotions and thoughts and splitting herself off from them. Above all no one could be allowed to *see* her. Her only outlet and pleasure was in her "secrets" and fooling those (such as me) who tried to understand her. From this point, I began to focus consistently on her mistrust.

She began to make consistent progress and by the 15th session, there was a marked change in her appearance: more color in her face, more liveliness in her expression, and most strikingly she appeared much more three-dimensional. This latter characteristic varied with the intensity of her eye block and the extent to which she was "hiding." At first, I ascribed it to my own perception, but it varied consistently with her level of contact throughout the course of therapy.

She then admitted that she had been concealing weights in her clothes when she visited the internist and wondered whether I would "betray" her by telling him. I pointed out the function that her hiding and secrets performed in her relationship with me: They set her up to be betrayed and created a real life situation that reinforced her belief that people could not be trusted (she knew I would not allow her to jeopardize her health). She was able to see for herself the necessity of being more open and of working together with me to make appropriate arrangements with the internist. She told her husband about the laxatives she had hidden all over the house and threw them

away. They began to trust each other more and, for the first time in over a year, she experienced pleasure during intercourse with him.

She began to wonder if her anorexia was not part of her hiding as well — the idea of wasting away into nothing and becoming really invisible had appealed to her. She gained weight, found a job she loved, told her mother to stop interfering (even though this resulted in a loss of financial support). After the 29th session, she stopped treatment. Five months later, I called and she said she discontinued because she had accomplished her goals in therapy. She and her husband reported that she was still happy in work and her marriage and free of somatic distortions at 115 pounds.

Discussion

Although therapy was brief and incomplete, this patient experienced significant relief of her symptoms. Will this improvement last? Her recovery cannot be considered secure as she is still far from orgastic potency, but her new abilities to express herself, experience some sexual release, and make more contact with others may enable her to continue to improve outside of therapy. 1 regret that I agreed to work toward her limited goal of symptomatic improvement, without first presenting the functional concept of health more clearly.

There is much to be learned from this case. It illustrates the power of the energetic approach to diagnosis. A more "classical" case of schizophrenia can often be diagnosed from the psychological presentation alone: Suspicion predominates, and, even if not overt, it is clear from the beginning that it is the patient's primary character attitude. This case was different; elements of control (phallic) and teasing (hysteric) confused the issue. However, the energetic picture was completely clear. I believe the atypical presentation is because, in anorexia, the disease has already progressed to a *somatic* biopathy.

What is the cause of the weight loss in anorexia nervosa? Several possibilities present themselves. Obviously, the throat block plays a role. In this patient the throat block was severe and contributed directly to her general shrinkage (inability to eat or express herself). However, this is not fully in accord with the facts of the case. Her throat block was no worse than the average schizophrenic's and the average schizophrenic does not develop anorexia nervosa. More important, her shrinkage was qualitatively very different from that usually seen from oral or throat blocking (such as depression). She was always quite lively and alert.

Her weight loss could also be seen in psychological terms as a desire to be less visible or to suppress secondary sexual characteristics but to explain it this way would be "psychologizing" a somatic process.

The explanation that accords most with the observations in J.'s case is that anorexia nervosa is a somatic biopathy that occurs in response to the schizophrenic biopathy. Recall that in schizophrenia the withdrawal from contact can lead to direct shrinkage of the brain and progressive loss of social and intellectual functioning (dementia prae- cox) and even loss of the personality itself (flattened affect and other "negative" signs of schizophrenia). I believe that anorexia is a lively person's attempt to prevent that deterioration. Hunger is known to increase alertness, activity, and sensitivity to environmental stimuli (anyone with a dog experiences this daily, and people who fast report a pleasurable "rush" of energy). J. experienced this and equated it with health and well-being. This phenomenon is functionally identical to the psychological manifestation of hypervigilance in classical paranoia. I have seen at least one case of a classical paranoid who went on long fasts to maintain her energy level. Female paranoids are probably more prone to this, because they have less access to frank aggression than males.

This case also illustrates several important therapeutic principles. The patient's central character trait of mistrust is consistent with her diagnosis but did not clearly emerge until after several sessions. I believe it is a mistake to interpret or even guess at the central character trait until it emerges clearly by itself. Each patient is unique and the "same" character trait takes on a different form in different patients and must clearly be seen in its connections with all aspects of the person and her life. Most important it must be seen in the relation with the therapist in a way that the patient can see clearly.

Finally, this patient illustrates that the eye block involves not only the patient's ability to see but also the ability to be seen. We know that the patient's eye block can confuse the therapist (and thus make it hard to see the patient), but this case shows the same phenomenon in a tangible, physical.form. J.'s appearance went from flat to three- dimensional as she progressed in therapy. I believe that this relates to the person's energy field and that a large part of depth perception comes from the direct interaction of energy fields. The reader can observe that a live tree seems to have more depth than a dead one, that the landscape shows more depth on a clear sparkling day, and that lively people are more "there" visually. Some remarkable individuals have so much "presence" and "stand out" so much that all

eyes turn to them when they enter a room. Others are so "flat" that they blend into the walls.

A pleasurable experience of being seen is part of the essential function of eye contact and not being seen is part of the function of ocular armor. Mystics report becoming "invisible" by spacing out, and one child patient reported he went "off" in the eyes "whenever I'm about to get in a fight and then they don't know I'm there" (3). The consistent interpretation of this aspect of ocular armoring was of major benefit in J.'s therapy.

REFERENCES

1. *Diagnostic and Statistical Manual of Mental Disorders.* **Washington, D.C.: American Psychiatric Association, 181-193, 1980.**
2. **Baker, E. F.:** *Man in the Trap.* **New York: Macmillan, 143-145, 1967.**
3. **Crist, P.: "A Problem Child,"** *Journal of Orgonomy,* **18(2): 188-201, November, 1984.**