

STARVATION AS SELF-PRESERVATION: THE PARADOXICAL NATURE OF
ANOREXIA NERVOSA THROUGH THE LENS OF SCHIZOID PHENOMENA

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ABSTRACT

Anorexia nervosa is a disorder that affects millions in the United States and has the highest mortality rate of any mental illness, estimated at or above 10%. The majority of sufferers are female, though the number of male cases continues to increase. The current study seeks to explore and interpret the internal experiences of females with anorexia through the lens of British object-relations theories regarding schizoid phenomena. This dissertation offers a review of the current clinical and psychoanalytic literature on female anorexia, as well as current empirical findings. There is also a summary of the theories of Guntrip and Laing on schizoid mechanisms, along with a discussion of psychological aspects of modernity as discussed by Sass and Bordo. This study utilizes published memoirs of women in recovery from anorexia, and through narrative inquiry methodology explores the hypothesis that anorexia is an attempt to alleviate and resolve schizoid concerns. In the analyses, thirteen themes emerge that capture the paradoxical nature of anorexia, in which the sufferer engages in a process of destructive self-preservation. Central to these findings is a self-annihilating narcissism that describes the internal experiences of preoccupation and self-loathing within the sufferer, as well as a desire to become a person without needs and without a body. These are shown to provide a protective boundary between the internal self and the external world. In an attempt to assert a sense of self through starvation, the sufferer exists in a state between being and non-being, which often leads to serious medical complications and sometimes death. Lastly, these paradoxical themes tie into literature on the schizoid condition, which provides insight into the contradictory experiences of anorexia. The splitting that occurs in anorexia between an inner self and a body self appears to parallel the splitting within

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the schizoid, which protects the person against fears of annihilation, engulfment, implosion, and petrification by the other.

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The Paradoxical Nature of Anorexia Nervosa Through the Lens of Schizoid Phenomena

In this project, I propose that the unique external symptomatology of restriction and starvation found in anorexia nervosa can be viewed as an attempt to resolve internal struggles with schizoid fears and concerns, as defined by the British object relations theorists Fairbairn, Winnicott, & Guntrip. Through a psychoanalytic lens, the experiences of the anorectic can be framed as result of schizoid anxieties from early childhood. It is my goal to examine the anorectic's internal organizational structure using her own words and descriptions to more fully understand why the person has "chosen" this disorder.

I have chosen to focus specifically on anorectic behaviors, restriction and starvation, because they appear to indicate different underlying issues in the eating disorder sufferer than binge/purge behaviors (Bruch, 1973, 1988). To further clarify, while a person with predominant anorectic symptoms may at times engage in bingeing and purging at various points in her illness, the subjects in this study presented mainly with restriction and starvation. This is important to distinguish because often this subset of patients, those who predominately engage in anorectic behaviors, place a value judgment on eating disorder symptomatology in that anorexia is superior to bulimia. If or when these patients do engage in bulimic symptoms, they regard themselves as a failure. They strive to only engage in restricting behaviors that are actively cultivated and viewed with pride (Claude-Pierre, 1997). My purpose is to further investigate what a person gains by shrinking her body to take up less space, and how the splitting that seems to occur during starvation results in an inner psychic self and a body self that is experienced as "not me."

In the current clinical and research literature, it is well documented that both women and men suffer from a range of eating disorders (Claude-Pierre, 1997; Reindl,

2001). Historically, however, the majority of patients suffering from eating disorders in the literature and research have been female. For the purpose of this research, the focus will be exclusively on the female anorectic's experience. This was decided because the construct of gender is significant on an individual and societal level, and is an important factor in self-development (Phillips & Pope, 2002). Therefore, I will not comment on the male experience of anorexia and for simplification purposes, I will use the female pronoun when referring to the anorectic. Also of note, the term "anorectic" will be used when referring to a person diagnosed with anorexia and the words "anorectic," "patient," and sufferer" will be used interchangeably throughout the paper.

Psychoanalytic literature includes discussions on the potential origins and purpose of anorexia and its behaviors beginning with Freud in 1889, who discussed anorectic symptoms in terms of underdeveloped sexuality, equating a loss of appetite with a loss of libidinal energy (Bemporad & Herzog, 1989; Castelnuevo-Tedesco & Risen, 1988). Since Freud, different schools of psychoanalysis have developed their own theories about the origins and manifestation of anorexia, which include: a defense against split off id impulses in puberty that are dangerous and frightening (classical), an inability to "achieve individuation in adolescence" stemming from a relationship with the mother (ego-psychology), a disorder of a "weakened self's paranoid reaction against a powerful bad object" that became associated with a body self (object relations theory), a manifestation of a desire within the family to "maintain a pathological equilibrium in the home" (family and interactional), and a deficit in "empathic mirroring and idealization during childhood" (self psychology) (Bemporad & Herzog, 1989, p.1).

Empirical research has also linked anorexia with various personality organizations and disorders, including obsessive-compulsive disorder and personality disorder (Cassin & vonRanson, 2005; Lilienfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006; Serpell, Livingstone, Neiderman, & Lask, 2002), borderline personality disorder (Lilienfeld et al., 2006), and a form of narcissistic personality disorder, or a “borderline psychosis,” (Goodsitt, 1977).

Otto Kernberg (1995) has delineated three dimensions of personality characteristic found in anorexia populations, the first two being: 1) affective personality disorders such as depressive-masochistic and sado-masochistic personalities, and 2) hysterical-histrionic personality disorders, and narcissistic personality disorders. For the more severe cases, Kernberg notes a third possible personality dimension, obsessive-compulsive, which includes schizoid and paranoid personality. Kernberg’s (1995) own research shows that the most common personality types of anorectics are hysterical, histrionic, borderline, and narcissistic. Bemporad et al. (1992) found that 77% of their participants with eating disorders in general had a personality disorder, predominantly borderline personality disorder. Lastly, Bromberg (2001) in his clinical work with eating disorder patients discusses the trauma elements of these disorders and discusses symptoms in terms of dissociative characteristics, especially for anorectic patients who present with binge/purge behaviors.

Anorexia Nervosa: What is Already Known

Anorexia nervosa in general has become a serious issue for researchers and clinicians in the past thirty years due to a large increase in cases in many Western

countries, particular in the United States (Claude-Pierre, 1997; Pipher 1994; Reindl, 2001). This disorder can be both physically and emotionally dangerous, and can lead to death by medical complications or suicide. Anorexia also has a reputation among clinicians and family member alike, as being one of the more difficult disorders to treat since the sufferer is often very resistant to giving up her behaviors, even if her medical health is at risk (Bruch, 1988; Claude-Pierre, 1997, Reindl, 2001). The clinical and research communities in the fields of psychiatry, psychology, anthropology, sociology, and feminism have each worked to make sense of these symptoms and develop the most effective treatment and awareness.

In the *Diagnostic and Statistical Manual 4th Edition, Text-Revision* (2000) (DSM IV TR or DSM) the diagnosis of anorexia nervosa requires an individual to meet the following criteria: (i) refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected); (ii) intense fear of gaining weight or becoming fat, even though underweight; (iii) disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and (iv) in postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles). The specific types include: restricting type (during the current episode, the person has not regularly engaged in binge-eating or purging behavior), or binge-eating/purging type (during the current episode, the person has regularly engaged in binge-eating or purging behavior) (p.589).

Additionally, there are numerous cases of eating disorder sufferers who do not meet the criteria for one of the defined disorders and receive a diagnosis of eating disorder, not otherwise specified (NOS). While attempts are being made in the upcoming DSM 5th edition to address this issue (i.e. remove the criteria of 85% weight maintenance and amenorrhea [www.dsm5.org]), there are currently many patients that receive this diagnosis even if their predominant symptomatology is restricting (Reindl, 2001).

According to the Renfrew Center Foundation, it is currently estimated that in the United States 1 in 5 women struggle with an eating disorder or disordered eating, while the National Eating Disorders Association (NEDA) estimates that 7-10 million women and 1 million men suffer from a clinically diagnosed eating disorder in the US (www.nationaleatingdisorders.org), and NIMH estimates that the lifetime prevalence of anorexia nervosa is 0.6% of the US adult population (www.nimh.nih.org). The National Associations of Anorexia Nervosa and Associated Disorders (2003) report that in 86% of individuals the onset of the disorder took place by the age of 20 and only 50% of individuals report being recovered after treatment, though many do regain functioning. The overall mortality rate for anorexia in each decade is on average 5%, the highest of all mental disorders. This rate increases to 20% once the patient has had the disorder for over 20 years. Based on these devastating figures, it seems possible that most people either know or have interacted with someone at risk in his or her daily life. In the following sections, I will outline some of the basic issues that have been identified as contributors to the development and manifestation of anorexia.

It is important to note that the majority of works I will be citing come from the clinical literature, as well as speculation from experts on anorexia. A list of these

clinicians and experts includes, but is not limited to: Bruch (1973)(1979)(1988); Chernin (1985); Claude-Pierre (1997); Garrett (1998); Geist (1989); Pipher (1994); Reindl (2001); Zebre (1993). At times when empirical findings are cited for support, this distinction will be made.

A Deficit of Self

Numerous clinical experts (Bruch, 1988; Claude-Pierre, 1997; Geist, 1989; Reindl, 2001), as well as empirical research studies (Karpowicz, Skärsäter, & Nevenon, 2009; McLaughlin, Karp, & David, 1985; Williams et al., 1993), cite a deficit in a sense of self and low self-esteem as a major contributing factor to anorexia. Many anorectic patients state that they do not feel like they have a concrete sense of self and experience intense anxiety when trying to define it (Bruch, 1979). Geist (1989) describes that the traumatic experience in infancy resulting from a lack of empathy from the caregiver leads to “psychic emptiness, loss of creative living, and fragmentation, resulting in psychological depletion, loss of vitality, and threats to self cohesion” (p.10). Geist goes on to define anorexia as disorder of self pathology, which leaves the sufferer without a foundation to which esteem can be attributed. Anorectics often believe that they are never good enough and must continuously alter themselves in order to appease others, to avoid rejection due to their perceived uselessness (Claude-Pierre, 1997; Reindl, 2001). Bruch (1988), one of the first clinicians to propose an understanding of the internal experiences and the function of anorexia states:

Deep down, every anorexic is convinced that basically she is inadequate, low, mediocre, inferior, and despised by others. She lives in an imaginary world with an assumed reality where she feels that people around her-her family, her friends, and the world at large- look down on her with disapproving eyes, ready to pounce on her with criticism . . . All her efforts, her striving for perfection and excessive thinness, are directed toward hiding her fatal flaw of her fundamental inadequacy. (p.6)

Before they developed anorexia, many sufferers presented as content and well-adjusted, appearing like the perfect daughter for parents who perceived them as considerate, eager to please, reserved, and rarely disobedient. Bruch (1988) highlights that this excellent, even superior behavior itself can be an indication that the child is wrestling with more fundamental problems. When their child begins to starve herself and withdraw from others, her parents are shocked to find that she is not doing well, and are left wondering how something could be wrong when everything seemed so right (Bruch, 1988).

Anorexia as a Coping Mechanism

Anorectic patients also report feeling unable to accomplish anything worthwhile and view any failure or shortcoming as a sign of internal badness in the clinical literature (Claude-Pierre, 1997; Pipher, 1994). As a result, life experiences become overwhelming and sufferers describe that before their disorder, they had limited coping skills to handle stress and anxiety (Reindl, 2001). Geist (1989) cites that the above-mentioned failure of empathic attunement in infancy prevented the anorectic from internalizing basic soothing and tension-regulation structures, which as she get older translates into an inability to self-regulate internally. This leads the person to search externally for a regulatory mechanism to handle everyday stress. Claude-Pierre (1997) states that while the sufferer may choose an eating disorder as a coping strategy, the illness itself is just a symptom of

an underlying problem, which she terms “Confirmed Negativity Condition” (p.35).

Claude-Pierre goes on to stress that treatment providers and caregivers alike should not become fixated on the behaviors in which the anorectic is engaging, but on the underlying condition that first caused the search for these behaviors.

This perspective seems applicable to many maladaptive coping mechanisms, such as self-harm behaviors (cutting, burning, etc.) and substance use, which are often employed in an attempt to make life more manageable. The downfall of these more “ineffective” strategies is that they mostly relieve immediate anxiety and often cause more harm than help in the long term (Linehan, 1993). In the moment of pain however, anorectics cite that their behaviors are a viable solution for feelings of worthlessness (Bruch, 1988; Claude-Pierre, 1997; Reindl, 2001; Zebre, 1993). If an anorectic does try to abstain from restricting without a replacement coping mechanism, she is left tolerating an even greater level of anxiety. Sociologist Catherine Garrett (1998) believes that because eating disorders are rituals, albeit ineffective ones, the person must implement some other method to fill that void (p.85). Treatments with the highest success rates are ones that provide replacement coping skills while internal regulation mechanisms are being formed (Linehan, 1993).

An Inability to Express Negative Emotion

Healthy coping mechanisms may also not be available to these individuals, due in part to suppression of negative emotions in the early family environment (Bruch, 1979). Empirical research studies also show that many anorectic patients had difficulty and avoided expressing negative emotions (Davies, Schmidt, Stahl, & Tchanturia, 2011;

Geller, Cockell, & Goldner, 2000; Pascual, Etxebarria, & Echeburúa, 2011). Many sufferers report that anger or upset feelings were discouraged and sometimes openly reprimanded growing up. Because the child naturally experiences these emotions, she comes to believe that there is something wrong with her, not the environment, for possessing these “nasty” feelings and thoughts (Bruch, 1979, 1988). When this is paired with the belief that she must always please her parents to continue receiving their affection, she fears she must never express her internal “badness.”

Bruch (1988) explains that when the person is praised for her good behavior, even if it is put-on or false, it “reinforces her fear of being spontaneous and natural, and interferes with her developing ability to express or even identify her true feelings” (p.5). Because the sufferer is unable to completely rid herself of these thoughts and feelings, she experiences great shame and comes to believe that even her most basic needs are not allowed (Reindl, 2001). Great effort goes into hiding these feelings of shame that can go largely unrecognized by caregivers. The sufferer interprets this misattunement as evidence of her unworthiness, and concludes that she must never demonstrate any wants or needs (Reindl, 2001).

The Issue of Control

Control is often cited in the clinical literature and the empirical research as an important element in the development of anorexia, as it relates to issues of success and safety, and can create a sense of structure for the person’s internal chaos (Geist, 1989; Horesh, Zalsman, & Apter, 2000; Williams et al., 1993). Due to the deficits in self and a lack of internal coping mechanisms described earlier, the anorectic feels she has little to

offer others and believes that she is unable to affect the world in any other way.

Controlling and producing results through anorexia is her way to become someone who matters (Claude-Pierre, 1997).

Unlike other maladaptive coping strategies, there are inherent difficulties in using food for control since the “ultimate” level of success in anorexia requires the sufferer to fight against the body’s drive to consume food when starving (Bruch, 1979). Eventually, the anorectic’s goals become impossible to sustain, yet she can fail to recognize or care about the serious consequences of her actions. She becomes caught in the conflict between needing food to live and starving to maintain her sense of self. She does not believe that she can have both (Bruch, 1988; Claude-Pierre, 1997).

Furthermore, the recovery process almost always leads to feelings of loss of control as her behaviors are taken away (Claude-Pierre, 1997, Reindl, 2001). The anorectic patient is in a more difficult position in recovery because unlike substance abusers or those that self-harm, the anorectic is exposed to her “trigger” on a continual basis and actually must engage with it to survive (Reindl, 2001). Overall, the notion of control is complex and is often intertwined within other issues, and thus, will continue to be an element of discussion in other sections.

The Role of the Family

In many clinical theories the family is a major factor when discussing the origins of eating disorder pathology (Bruch, 1973; Geist, 1989). Closely tied with the issues of emotional suppression, the dynamic of the family environment may at times intensify the child’s feelings of worthlessness and lack of control, while in other cases, the caregivers’

response or lack of response seems directly related to the development of anorexia (Bruch, 1979; Geist, 1989, Gordon, Bereisin, & Herzog, 1989). However, Claude Pierre (1997) warns that focusing on the family environment as the ultimate or only cause of anorexia is reductionistic. She goes on to say that for treatment in particular, models that point fingers at parents can hinder progress, even if their behaviors are in part responsible for their child's pain. Claude-Pierre states that it is important for parents to realize that though they love and care for their child, they may have inadvertently contributed to their daughter's state of distress.

Susan Haworth-Hoepfner (2000) in an empirical research study examined the role of the family and culture in eating disorders. She found that the characteristics common in eating disorder families (critical environment, coercive parenting control, and a prominent discourse on weight) do not individually lead to an eating disorder in the child. It is when these factors are found in combination with other conditions that eating pathology arises. The role of the family is similar to other factors, in that it is a contributor to the illness, not the sole cause. Haworth-Hoepfner concludes that further research is needed to examine if the role of the family is equally important in all cases. Thus, the impact of the family in the development of anorexia should be determined by studying the specific experiences of each patient.

Issues of Ethnicity

Eating disorders, especially anorexia, have historically been identified as a problem among white, middle class females in the United States. It has only been in the recent past that researchers have begun studying this problem in other ethnic groups

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within our own country, as well as around the world. Though much of the research still suggests that white females are the predominate group in the United States to be affected by anorexia, the numbers of reported cases among women of color have increased (Striegel-Moore, 2003).

Empirical researchers have speculated whether this increase is due to actual new cases of the disorder or to the fact that women of color with anorexia have heretofore gone under-recorded. Striegel-Moore (2003) has looked further and suggests that there are likely many cases of women of color that are not counted within these numbers. She found that while the overall numbers of women treated for eating disorders are usually much lower than those actually afflicted, black women were markedly less likely to have received treatment than other groups. Striegel-Moore speculates that this may result partly because clinicians still view eating disorders as a “white girl” problem and thus fail to recognize the symptoms in women of color. In one study, a Hispanic American woman reported that after visiting her doctor for severe weight loss and yellowing of the skin, she was told that it was impossible for her to be anorexic, even at her suggestion, because she was not white (Daniels, 2001). Such discrimination may lead to fear and distrust of mental health professionals and further silence women of color to speak up about their eating disorders.

Another empirical study by Gordon, Perez, and Joiner (2002) found that when women of color experienced more acculturative stress, that is, pressure to assimilate into a different culture to minimize differences, they reported higher levels of eating disorder symptoms. Perez’s results show that Hispanic women were found to report the highest level of acculturative stress, and that these women reported disordered eating symptoms

at levels as high as that of white women. It is important to note that all of the women in this study were college graduates, thus level of education may have been an indicator of acculturative stress and also of eating disorder symptomatology. This information, coupled with the possibility that clinicians are failing to diagnose women of color, may prove that the problem of eating disorders for many ethnicities is more urgent than we have previously assumed. As Western culture becomes more embedded in other societies, its values, such as perfectionism and success, are becoming internalized. This means that women in westernizing countries now must come to terms with our values in order to define who they are, which may create specific problems in self and identity that manifest through issues of food and the body.

Lastly, Reindl (2001) makes the point that not every woman who grows up in Western culture develops an eating disorder, and argues that culture may not be the only or even the primary factor in the development of an eating disorder. Research is still needed to further investigate the role of culture in all ethnicities in development of eating disorders.

The Influence of Media

The current depiction of women in the main stream media has become unattainable for the average person and at times even the images in print or video have been doctored, highlighting that no one can really achieve this ideal (Kilbourne, 1987). While this has a great impact on many females, it is important to realize that the media alone do not cause a person to develop anorexia (Claude-Pierre, 1997; Reindl, 2001). The distinction that separates the typical dieter from someone with an eating disorder has

been called “normative discontent,” which is when person is unhappy with her appearance but does not suffer from a psychological disorder (Kilbourne, 1987). The issue of body size and “feeling fat” for the anorectic versus the average discontent woman is that the anorectic’s weight loss does not stop when she reaches the range of the ideal. Some anorectics state that they are not concerned with media image and actually do not want to be admired for their appearance. They may actively avoid displaying their bodies by wearing oversized or concealing clothes. While there are anorectics whose weight loss behaviors started in order to achieve a certain look, Claude-Pierre (1997) conceptualizes this as a trigger for those who were already experiencing much deeper and more fundamental deficits within the self.

Garrett (1998), a recovering anorectic herself, describes the confusion that can occur for others who believe the problem for anorectics is something external. She has found that this is in part due to the language of thinness and fatness used in the disorder. Drawing on her experience, Garrett explains: “I knew very well when I was anorexic that I was thin but this did not stop me from feeling fat, in relation to my ideal, not to objective, visual reality” (p.50). She stresses the importance of feeling fat, even though she could at times recognize that this was not physically the case. Her actual appearance was of little impact, because inside she was still not measuring up to her ideal. In her narrative research, Garrett (1998) found that none of her anorexia participants cited “vanity” as a primary factor in their illness, although they were concerned about how others perceived them in terms of worthiness and acceptability.

When Garrett was writing in the late 1980’s, there was limited understanding of this perspective. In recent years, this appears to have changed as can be seen in the

modeling industry as runway models with a BMI below 18, including supermodel Kate Moss, were banned from Madrid's fashion week in 2006 (www.womens-health.org.nz), in 2010 Designer Victoria Beckham banned size 0 models from her fashion show (<http://www.dailymail.co.uk/tvshowbiz/article-1311086>), and in March 2012 Israel passed a ban on severely underweight models in fashion advertising (<http://today.msnbc.msn.com>). However, there still seems to be limited awareness in the greater population of some aspects of anorexia that are highlighted by Claude-Pierre (1997), including instances of sufferers picking food out of the garbage because they believed they were undeserving of nourishment. She goes on to explain:

Much of the mystery has arisen less because we lack the knowledge or wisdom to understand what drives people to destroy themselves, but because we are all too ready to explain their behavior in some of the most authoritative and misleading clichés of our culture. (p.3)

Starvation as Voice: The History of Restricting in Females

Fasting and anorectic behaviors have been noted throughout Western history, beginning with religious women in medieval times that utilized starvation as a vehicle for self-expression. Many historians and anthropologists have spent time examining the restricting behaviors of medieval woman, which has been termed "holy anorexia." There is also discussion about how holy anorexia compares to the modern version of the disorder, anorexia nervosa, in which is dated back to the second half of the 19th century in Western Europe and in the United States (Brumberg, 1988; Sella, 2003; Vandereycken & Deth, 1994). While some (Bell, 1985) link the medieval and modern anorexia to be part of the same disorder, others (Brumberg, 1988) highlight that though the behaviors may be similar, they are not the same disorder. What is of interest historically, is that as far back

as the 1200's, women were using their bodies and food consumption to communicate something internal for which words were not possible or allowed.

Rudolph Bell's *Holy Anorexia* (1985), Vandereycken & Deth's *From Fasting Saints to Anorexic Girls* (1994), and Joan Jacobs Brumberg's *Fasting Girls, The History of Anorexia Nervosa* (1988) provide detailed histories of fasting behaviors in woman, including the cultural elements that that may have led to restricting becoming prevalent throughout history. There have been many names for these women, including fasting saints, fasting maidens, and miraculous maids (Brumberg, 1988).

In medieval Europe, in the years between 1200-1500 there were religious females that refused to take in food and would fast for long periods of time. Their ability to sustain themselves on very little was viewed by others as a female miracle (Bell, 1985). The most famous of these women was Saint Catherine of Siena (1347-1380), who used fasting to exemplify her superior female holiness (Bell, 1985; Brumberg, 1988; Vandereycken & Deth, 1994). Catherine's form of food was prayer, which she believed provided nourishment for her soul instead of her body, and the only sustenance she would take was the "holy" food of the Eucharist (Bell, 1985). For pious women during this time, of which there were many documented cases, starvation allowed an attainment of an ideal purity (Bell, 1985).

While Bell makes the connection between holy anorexia and the modern day version, Brumberg (1988) states that these fasting behaviors, while similar, were pursued for very different reasons. Brumberg goes on to argue that the symptom of "loss of appetite" in medieval times may have been a secondary symptom to a myriad of organic or psychological disorders. Also, Catherine of Sienna was reported to engage in multiple

behaviors of “punishment”, which included flagellation, scalding herself, and sleeping on a bed of thorns, that may suggest other pathology (Brumberg, 1988; Vandereycken & Deth, 1994).

Lastly, Brumberg notes that modern anorexia is not a “loss of appetite” but an active denial of food that takes place “under extreme control” (p.42), which differed from the many cases of medieval fasting. Medievalist Caroline Walker Bynum (1985) states, “it is only modern historians, who have given food-rejection its startling and privileged place in medieval women’s piety” (Bynum, as quoted in Brumberg, 1988, p.45). Bynum suggests that Bell’s work pays too much attention to the fasting behaviors in these medieval women that were just one of many in that they engaged in for greater piety.

In the 17th and 18th centuries there was a decline in fasting behaviors along with a disavowal of traditional practices, resulting in less desire for religious piety (Brumberg, 1988; Vandereycken & Deth, 1994). However, there remained small pockets of restrictive eating patterns in Europe, in which stories of fasting maids existed in towns that held on to a strong Catholic tradition (Brumberg, 1988). It was reported that these women were “young and humble” and made a point to avoid regular food, instead dining only on “delicate things,” such as roses and tulip petals, which were meant to “underscored her purity” (Brumberg, 1988, p.47). When the printing press became available in the 16th and 17th centuries, case descriptions of restrictive eating were published and became topics for intense debates in the surrounding environment. Many doctors and clergy worked to substantiate or disprove these claims, which led to the discovery that many of these girls were found to be eating secretly at night (Brumberg, 1988).

In the late 19th century, cases of fasting continued to be discussed in medicine, while the public expressed skepticism over any claims of restricting women. When a case of fasting was shown to be true, doctors and the clergy, all men, recommended as treatment the removal of romantic writings (Brumberg, 1988). Brumberg writes:

When the claim to “live without eating” was raised, it sounded to the ears of most male physicians like a cry for irrationality and for a peculiar and archaic form of female empowerment. In this way, fasting girls posed a basic challenge to the ideological and professional structure of modern science. (p.74)

It was during the latter half of the 19th century that modern anorexia emerged in both Western Europe and the United States, during the Victorian era of reserve and self-control (Brumberg, 1988; Vandereycken & Deth, 1994). The refusal of food by young women was seen as quite problematic to Victorian sensibility, and starvation became imbued with issues of class, gender, and family dynamics (Brumberg, 1988). Brumberg highlights that unlike the fasting saints of the middle-ages, the modern anorectic, typically daughters of middle class bourgeois families, searched for “perfection in terms of society’s ideal of physical, rather than spiritual, beauty” (p.134).

During this time, several doctors became famous for treating these young women, including Sir William Gull in England in the 1860’s, and Charles Lasègue in France starting in 1873 (Brumberg, 1988). Gull’s main contribution was to describe anorexia nervosa as a separate illness, in that it was not the same as the fasting found in psychotics or those with an organic illness. He saw the illness in women primarily between the ages of 16-23. Lasègue became famous for treating *l’anorexie hystérique*, and was the first person to suggest that starvation was due to interpersonal conflicts between the patient and her parents. Brumberg (1988) notes: “in effect, it took a Frenchman, convinced of

the manifold delights of the palate, to suggest the basic connection between love and food in the making of anorexia nervosa” (p.129).

Lasegue wrote of an emotional cause of the illness and noted the onset to include many issues of adolescents, including: inappropriate romantic expectations, blocked education or social opportunities, and struggles with parents (Brumberg, 1988, p.129). He highlighted that family meals, which had become an integral part of the middle class life in France, were dramatically disrupted by the daughter’s refusal to eat. The symptoms he found in these women were strikingly similar to that of anorexics today, emaciation, debility and anemia, loss of menstruation, chronic thirst, dry and pale skin, unrelenting constipation, atrophied stomach, anemia, vertigo, and fainting (Brumberg, 1988, p.133). Brumberg writes that the attention that these behaviors received by the family demonstrated the “breakdown of patriarchalism in its most extreme form: daughters were asserting emotional and economic claims on the late-19th century family” (p.134).

In these middle class families, material gifts were also a sign of parental love, as well as an indication of their social status in the community. Love and food, says Brumberg, became intimately connected. During this time period, mothers also began to take a more active role in her children’s lives, including matchmaking and marriage, which if executed correctly, could further elevate the social status of the family. Brumberg found writings by one young anorectic girl who stated: “I do not think that girlhood is always such a very happy time; at least not to thoughtful girls” (p.135). In addition, Brumberg notes that in the middle class at this time, eating correctly “emerged

as a new morality” (p.136), and helped separate the middle class domestic life from that of the working class.

Along with these new interpersonal connections in the family, the potential for enmeshment and interdependence increased. Privacy, especially for the adolescent girl, was discouraged, and Brumberg describes a “greater difficulty establishing autonomous psychic space” (p.137). When speculating on why these girls used food during this period of time, Brumberg suggests:

Refusing food at the family dinner table was a silent but potent form of expression that fit within the Victorian conception of decorum at table. Refusing to eat was not as confrontational as yelling, having a tantrum, or throwing things; refusing to eat expressed emotional hostility without being flamboyant. Refusing to eat had the advantage of being ambiguous. (p.140)

Because the family valued status and the material wealth of the middle class, the daughter’s refusal of her parents’ offerings became quite powerful.

It was also conceptualized during this period that, at the time of Freud, refusing to have “flesh” was a disavowal of sexuality, since indulging in food and sex were not considered proper for respectable young women (Brumberg, 1988). Brumberg describes the potential destructive nature of food in Victorian times, including a fear of gluttony and ugliness, and “secret eating” was known to take place, since some believed that “women should never be seen eating” (p.178).

As the Victorian era came to an end in the early 20th century, an undesirability of fatness from a medical point of view became prominent in 1930’s and 40’s, which reframed food as something potentially dangerous (Brumberg, 1988). The physical and health risks of being overweight in woman became a “character flaw and a social impediment” (Brumberg, 1988, p.186).

Also of note, modern consumers in the first decade of the 20th century began to purchase outfits in preset sizes (Brumberg, 1988). As a turn towards controlling weight was implemented through calories restriction, Brumberg writes that excess weight implied a lack of control, and overweight women, “constituted a failure of personal morality” (p.243). As more products became available to alter and enhance appearance, the idea was born that “beauty could be purchased,” and products were sold as a form of “self-improvement rather than self-indulgence” (p.248). In the latter half of the 20th century, Brumberg notes that food became associated with a new type of holiness, which turned the body into a temple that needed to be maintained and worshipped.

When Brumberg was writing in the 1980’s, she spoke of the importance of female identity and how a woman’s appetite, whether for food, success, career, or sex, had become important topics for discussion. Today controlling “appetites” remain important aspects of female identity. For Brumberg, an increase in the incidence of anorexia requires a look at culture as the “critical variable” (p.257) in understanding its psychopathology. She notes the rise of a “secular addiction to a new kind of perfectionism, one that links personal salvation to the achievement of an external body configuration rather than an internal spiritual state” (p.7).

Anorexia in Modern Western Culture

Since the 1980’s, there continue to be multiple conversations taking place across a variety of disciplines to discuss the impact of culture on the female form, as well as disorders like anorexia and bulimia. While it is beyond the scope of this literature review to provide a complete understanding of anorexia in today’s culture, I will spend some

time discussing particular psychological and feminist perspectives that are relevant to my research questions. Specifically, Susan Bordo in her work *Unbearable Weight:*

Feminism, Western Culture and the Body (1993), dedicates an entire chapter to anorexia nervosa and posits “psychopathology as the crystallization of culture through the example of anorexia” (p.139). In an attempt to understand why this disorder has experienced such popularity within the past few decades, she explores how “a variety of cultural currents or streams find their perfect, precise expression in [anorexia]” (p.142).

Bordo references the Greco-Christian traditions of dualism to highlight the separation between a lived, experienced self and a body, physical one. By studying how the physical body has served as a historical medium of power, Bordo wonders why the female body has traditionally been more vulnerable than that of the male in Western culture. She concludes that women, over men, seem to historically be associated with the realm of the body, and is valued as inferior in contrast to the mental, cognitive realm of the male. She finds this curious that the female body, which is uniquely remarkable in its ability to grow and sustain life, is positioned as less powerful and thus subject to control by men. In exploring the meanings around female appetite, and control, Bordo comments that dieting and restricting lead to a rejection of hunger, and therefore a view of hunger as a “dangerous eruption from some alien part of the self”(p.143), which in turn leads to further disempowerment of the female form.

Bordo also refers to Descartes and the split between the bodily and the mental, in which the body becomes experienced as alien or “not-me.” Within the works of Plato and Augustine, there is also a rejection of the body in that it serves to limit or confine the mind and that the body is seen as the enemy and a distraction (Bordo, 1993). If the goal

of anorexia is to break this connection between the body and the mind, the purpose becomes to kill off the body entirely, and thus cease to experience hunger and desire (Bordo, 1993). The anorectic, in attempt to rid herself of the act of hunger, actually becomes obsessed with the concept and is “haunted” by it. The sensations of the body become foreign to her, and as Bordo notes, those with anorexia have problems differentiating sensations that begin in the body, such as temperature, emotions, and anxieties. Thus the fears of the anorectic, gaining weight or becoming fat, become akin to a fear of “becoming all body” (Bordo, 1993, p.148). The goal of the anorectic is to become the ruler or “tyrant” of the body, to gain control. However, Bordo comments that the paradox of this condition is that, “[its] most outstanding feature is powerlessness” (p.154).

As noted by Bruch (1988) and other specialist in eating disorders, anorexia becomes the controller, the “dictator,” often referred to as “the little man,” “Ed”, or sometimes just “he.” This male controller rules over the other self, the body self, which needs to be controlled, reigned in, and tamed due to its impure nature and lack of will power (Bordo, 1993). When hypothesizing meaning behind associations with gender, Bordo postulates that there are two levels of meaning to “genderness” in anorexia: the fear of the traditional female role in society and its limitations, as well as the deeper fear of that which is female, with its “nightmarish archetypal associations of voracious hungers and sexual insatiability” (p.160). The body is something that can never be quenched or full. In puberty, the corporeality of the female body becomes too scary to confront, and anorexia becomes a fleeing from the conscious fear of the body’s takeover of the self.

In feminism, the struggle against the confines of the traditional female role in the home and in society has been demonstrated by many since the Victorian times such as in the hysteria that Freud encountered, the hallucinations of Charlotte Perkins Gilman in *The Yellow Wallpaper* (1892), and within the feminist literary voice of Betty Freidan in the *Feminine Mystique* (1963) (Bordo, 1993). What Bordo points out is that the protest of these cultural norms by the female is “written on the bodies of anorexic women” (p.159), but not readily discussed within the conscious political dialogue (Bordo, 1993). The rejection of such a life sustaining measure as taking in nourishment forces one to realize the level of fear residing within the anorectic female. Bordo has found that the words often found in anorexia are a metaphor for the fears of the feminine: “hungering, voracious, extravagantly and excessively needful, without restraint, and always wanting too much affection, reassurance, emotional and sexual contact, and attention” (p.160).

She also notes that anxiety over the uncontrollability of female hunger seems to heighten during “periods when women are becoming independent and asserting themselves politically and socially,” such as during the first wave of feminism in the later 19th century (p.162). She likens the creating of the “S-curve” tighter corset found in the second half of the nineteenth century to the metaphorical corset found in modern dieting since the early 1980’s. These are attempts to control and restrict the female body during times in which it may be of the most threat. Bordo ends her chapter commenting on the current cultural message in the west for women about their bodies and how the anorectic is a prime example of certain power relations at play, and “surely how deeply they are etched on our bodies, and how well our bodies serve them” (p.163).

In a later chapter of her book, Bordo (1993) comments on the metaphor of the

body within a postmodernist perspective, stating that this new understanding of the body “whose very unity has been shattered” and instead provides a multiplicity for the body, in which it can shift and change to reveal “endlessly new points of view” (p.227). The fragmented postmodern body is free to change its shape and location at will, and in this metaphor “our locatedness in space and time and thus for the finitude of human perception and knowledge” is also shifting (Bordo, 1993, p.229). She posits that perhaps the postmodern body is “no body at all” (p.229). In a postmodern society, getting rid of the body itself opens up space, which is reminiscent of the anorectic’s wish to decrease the presence of her physical body completely in order to gain the freedom to be herself.

Schizoid Phenomena and Anxieties

Perspectives in Modern Psychiatry & Psychology

Throughout the history of modern psychiatry the use of the word schizoid or “schizotypy” has held various meanings, depending on one’s theoretical orientation. Today in the diagnostic and nosology field, schizoid is often associated with the schizophrenia spectrum of disorders and specifically refers to a personality disorder within the DSM IV TR (APA, 2000). While it is important to define this particular usage of the term schizoid for purposes of breadth, the meaning of the word schizoid throughout the rest of this paper will be based on the broader definition of schizoid phenomena discussed by the British object relations theorists in psychoanalysis during the 20th century, which will be described in detail in the next sections.

The DSM describes schizoid personality disorder (SPD) as a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in

interpersonal settings, beginning by early adulthood and present in a variety of contexts. Specifically, an individual with schizoid personality disorder: (i) neither desires nor enjoys close relationships, including being part of a family, (ii) almost always chooses solitary activities, (iii) has little, if any, interest in having sexual experiences with another person, (iv) takes pleasure in few, if any, activities, (v) lacks close friends or confidants other than first-degree relatives, (vi) appears indifferent to praise or criticism of others, and/or (vii) shows emotional coldness, detachment, or flattened affectivity (p.697).

In the current literature, 90% of the accounts of schizoid personality arise out of psychodynamic contributions via case descriptions (Emmelkamp & Kamphuis, 2007). Some suggest that meeting the DSM criteria for SPD can increase with age, which may indicated not a change in personality organization, but a change in activities and level of socializing as people get older (Emmelkamp & Kamphuis, 2007). In a study comparing SPD with schizotypal personality disorder, only the factor of level of openness was found to distinguish the two empirically, in that lower levels of openness to experiences was more associated with SPD and higher levels with schizotypal PD (Emmelkamp & Kamphuis, 2007). It has been suggested that traits such as hostility and self-consciousness are positively associated with schizoid symptoms, including a propensity for self-focus in social situations (Emmelkamp & Kamphuis, 2007). Studies have also linked prenatal nutritional deficiency with a greater risk of SPD, suggesting an associated risk for congenital anomalies of the central nervous system (Emmelkamp & Kamphuis, 2007).

Also, in a discussion of schizoid personality in *Madness and Modernism* (1992), Sass describes the change that has occurred regarding the usage of the world schizoid.

Currently, the DSM schizoid description refers to a much narrower population than that described by Bleuler & Kretschmer. Sass notes that the older version of the term included individuals that would now be diagnosed with avoidance and schizotypal personality disorder. This distinction is important for Sass because this previous usage by Bleuler and Kretschmer describes those with schizoid organization as actually having powerful yearnings for closeness and connection with others. In this older and broader description of the schizoid, the person ultimately distances his or herself and withdraws due to his or her emotional hypersensitivity and early childhood experiences, not because of a lack of desire and enjoyment of others (Sass, 1992).

Lastly, the British object relations theorists discuss schizoid phenomena in relation to a type of existence and experience of being in the world, which similarly captures this broader definition of schizoid by Bleuler and Kretschmer. Thus, the British object relations theorists refer to individuals who may not be “schizoid” in the modern DSM nosology, but are found to be preoccupied with schizoid concerns due to a combination of emotional hypersensitivity and fears and anxieties from early childhood.

British Object Relations Theories of Schizoid Phenomena

In discussing schizoid phenomena in the psychoanalytic literature, there is often a language of hunger, emptiness, fulfillment and devouring that suggests not only a link to the somatic or body, but also to issues around the literal taking in and refusing of what one needs to survive. Writings on schizoid phenomena by British object relations theorists Fairbairn, Winnicott, Guntrip, and Laing all describe schizoid organization and concerns as having central issues around need and refusal on the most primitive and basic

levels. There is an inherent divide between the inner realm of experience and the outer body self that encounters the world, leading to the notion of a split or a divided self.

Laing states that this division is in response to the terrifying and overwhelming fear of being devoured by another, or as Guntrip poses, a fear that *she* may actually devour what she most needs and loves. What is interesting to explore through object relations theory is how the person with this organization learns to conceptualize and react to the outside world in a schizoid manner.

Guntrip and the Object Relations of the Schizoid

In the beginning of his work *Schizoid Phenomena, Object Relations and the Self* (1969), Guntrip discusses the differences in object usage by the depressed and the schizoid individual. He posits that though the schizoid may at first look like the depressive in her loss of desire for an object, Guntrip points out that the depressive actively rejects an object with a sense of anger, hatred and frustration, all which suggest a relationship between the self and the desired object. For the schizoid however, the distinction is that there is a fearful retreat from the object and an inability to express feelings towards the object, unlike the passionate disavowal or rejection of the depressed. With this the ego becomes a neutral observer and at a distance, no longer feeling anything in reaction to giving up the still needed and desired object. As a result, there is no relationship experienced with what is being dismissed (Guntrip, 1969).

Guntrip references Fairbairn in discussing the primary goal of libidinal energy as not searching for pleasure per se, but for the desired object itself. Without this relationship, Fairbairn writes the ego is unable to give life meaning. He believes the ego

itself cannot develop in isolation (Fairbairn, as cited in Guntrip, 1969). Guntrip posits that this is where the problem of the schizoid lies, in the inability to go after and take in the desired object. There is a fear that the desired object, the other, will not be able to survive the schizoid's powerful and hungry need. She worries she will destroy that which she loves and wants. In response to this fear, she cuts herself off from objects, in an effort to deny this basic need. She believes this is only possible by retreating into a shell of herself, into a realm dominated by abstractions and ideas, where only fantasized object relations exist. Guntrip also notes the importance of temporality in developing the ability to make meaning within one's existence. Without a sense of time connecting isolated memories and objects, no meaning can be derived, leaving the person with a sense of emptiness.

How this initial fear of her own destructiveness develops is explained in the infant's experiences with the maternal breast. For the depressive, Guntrip states that she is able to express her anger and resentment when the breast is taken away, and retaliates on the mother when the breast returns by "biting" back. For the schizoid, when the breast is taken away there is a fear that it will not return, and instead of anger, which suggests a future relationship with the breast, the schizoid only feels more hunger when it is gone (Guntrip, 1969). In response to losing what she desires, the schizoid feels longing and emptiness. The yearning for love from the mother becomes synonymous with the yearning for hunger, and when the breast returns the impulse is to devour all of it, since the infant is unsure when nourishment will next be available, if at all. The breast becomes a desired but deserting object.

This experience, in combination with her temperament and sensitive nature, leaves the schizoid feeling unwanted and unable to make sense of her feelings of need. This devouring desire is seen as destructive and she learns early on to equate need and love with her ability to destroy. Because she does not want to obliterate what she most desires, she is driven into withdrawal and learns to feel no hunger to keep safe (Guntrip, 1969). In order to save the object, there is a loss of interest, and thus a loss of hunger. There is little evidence of the anger and guilt that would be found in the depressive's object relations. Guntrip states that because her love is so destructive, she retreats into the complete opposite mode, indifference, to protect all the objects that she loves. As a result, she is often left with a sense of futility and meaninglessness about the world.

It is interesting to note that Guntrip employs a language of hunger and devouring to relay the dilemmas facing the schizoid. In his work, he even provides clinical examples of how this retreat from objects can be played out in a literal retreat from physical nourishment as well, stating:

The schizoid's basic problems in relation to objects derive from his reactions to the breast, food and eating, and naturally play a large part in his struggles to solve these problems. His reactions to people and the food are basically the same. (p.30)

Even though he (or she) is hungry, he rejects both food and people and is left feeling empty inside. He can only eat alone (Guntrip, 1969). Guntrip describes a "constant oscillation between hungry eating and refusal to eat, longing for people and rejecting them" (p.31). This fear of devouring and swallowing is also projected on to others in the world, which she assumes have similar destructive powers to her own, which can be used against her. This poses a dilemma of "relationship as mutual devouring," where she is left no choice but to withdraw to protect herself from destroying and being destroyed.

The Paradoxical Nature of Anorexia Nervosa Through the Lens of Schizoid Phenomena

The schizoid person quickly learns that relationships are dangerous and not to be entered (Guntrip, 1969).

Laing's *The Divided Self*

Many of the themes I have just outlined from Guntrip can also be found in R.D. Laing's *The Divided Self* (1960), as he was greatly influenced by the British object relations theorists. Laing provides his own language to discuss the fears and retreats of the schizoid personality in terms of the body. Instead of focusing on the realm of objects, he focuses on the sense of ontological security and embodiment felt by the individual. For the schizoid, she experiences herself as only a partial or incomplete self. Here the preoccupation of the schizoid is not with devouring objects, but with preserving the self in response to the anxieties of ontological insecurity (Laing, 1960).

In healthy development, Laing states that a person develops and reaches ontologically security, which is when someone learns to be comfortable and confident in being an authentic self. Laing describes this person as having a sense that they exist in their own flesh and blood, within their body. If, however, over the course of development something interferes with this process, it results in some form of ontological insecurity, leaving the person with a lack of cohesiveness in the self. Such a person is missing essential aspects of self-identity, which prevent her from fully realizing that she is an independent, unified person. This lack of cohesion leaves her in constant fear that she might be destroyed at any moment, and she becomes preoccupied with preserving the self rather than gratifying herself with relatedness to others.

These ordinary circumstances of living, such as forming bonds with others, threaten her low threshold of security. Laing points out that it is important to understand these threatening feelings in order to make sense of an individual's seemingly bizarre behavior. Because the insecure person often feels a threat to her existence, she looks for some concrete way to keep herself alive and feeling real. This threat results in the ontologically insecure person developing an "unembodied" self, a sense of detachment from her own body as a form of protection. She does this, Laing describes, to cut off all ties to the world, since it is through the body that she comes in contact with others and the environment. The body begins to feel like not part of who she is and becomes part of her outer, false self. If the body or outer self is disconnected from who she is on the inside, then her central being, her inner true self, can be protected. The unembodied self cannot foster a relationship with the world directly because the anxiety and threat from others is too great.

Laing delineates three essential anxieties felt by the unembodied schizoid in the world, which also resonates with the fears described by Guntrip. Instead of focusing on what the self is capable of however, Laing emphasizes the potential destructive nature of "the other." The first of these is engulfment, which is a fear of being swallowed or eaten up in the presence in contact with another. Safety from this is found in isolation. The second is called implosion, which Laing's references as similar to Winnicott's idea of impingement of reality. The schizoid feels herself to be already empty, using a metaphor of a vacuum, Laing writes that this emptiness becomes who she is and how she sees herself. The dilemma is then that her natural desire to be filled threatens her identity and any contact with the world holds the danger of entering her and thus suffocating her from

the inside out. It is a fear of being filled: a need to remain empty. As she defends against implosion, she develops her identity as someone who lives “without.”

The third, petrification, involves the fear of being the object of another, unable to remain a separate self when desired. In defense, she turns herself “into stone,” unfeeling and inorganic, to prevent the possibility of being consumed by this other (Laing, 1960).

In a sense, she forgoes her autonomy as a means of safeguarding it. Unlike in healthy development, the unembodied person does not have a sense of her own body, of her flesh and blood, as being part of who she is, for she does not feel substantial. Her body’s feelings, desires, and pain are not her own, which prevents her from truly existing in the world.

Thus, the unembodied self cannot foster a relationship with the world directly because the anxiety and threat from others is too great. Instead it is her detached body-self, her false self, which interacts with the world (Laing, 1960).

Schizoid Concerns and Modernity

Sass’ Separated Self

Sass discusses the topic of schizoid personality in light of modernity in his book *Madness and Modernism* (1992). Sass also references Laing’s *The Divided Self* (1960), about schizoid concerns when describing the split between the external body and the internal self. As Sass notes, schizoid personality is the character organization most linked with schizophrenia in current western psychiatry. One of the hallmarks of a schizoid person is a lack of “harmony with their bodies or with the environment, and typically, their emotions do not flow in a natural and spontaneous way” (p.77). The description of an “as-if” quality, which is understood as the feeling that the person is just

playing a part or acting in some way, is often associated with schizoid persons.

In his chapter, “The Separated Self”, Sass lays out the argument that the schizoid attitude, found in the works of Kafka and Baudelaire, actually “reflect the culture of which they were a part” (p.89). One of the most distinctive and pervasive features of modernity is the intense focus on the self, both as a subject and an object of experience, as well as on the value and power of the individual. Though this allows for certain strengths, it also brings with it “isolation” and “loneliness” (Sass, 1992). As with the schizoid experience, this focus on the self in culture leads to what Sass calls “a rift in one’s connection to the world . . . [and] the rift in the self’s relationship to itself” (p.90).

Modern philosophy began with ideas of Rene Descartes that consciousness is recognized not as having “direct access to the external world” but to only inner ideas that “somehow represent the world” (Sass, 1992). This distancing of consciousness from what is known requires a certain detachment and “disengagement” from the self and its thoughts, which leads to something called the reflexive turn. Sass (1992) defined this as “involving recognition of the inevitable participation of one’s own mind in every act of awareness” (p.91). He further demonstrates that the schizoid experiences of disengagement, reflexivity, and isolation can be found throughout modern culture. Modernist trends in philosophical thought, as well as observations in anthropology and sociology, highlight a movement towards a separateness of the individual from her environment, which emphasizes the awareness of being alone in one’s experience (Sass, 1992). Sass continues by drawing upon the works of Nietzsche and Heidegger to describe the “essence of the modern age” (p.95), which is the juxtaposition of the person as “the ultimate subject before whom and for whom the world will appear as a kind of

‘picture’” (p.95). This “unreal” of the real world leads to awareness that the self is just a character in one’s own internal play (Sass, 1992).

This awareness leads to a second split described by Sass (1992), the self from itself, which parallels a form of self-consciousness in which the focus is not on the self as the “knowing center” but as “an actor in the world and a potential object of awareness for others”(p.97). This “uncoupling,” described by Sass parallels the division expressed by Laing, between an external, public body self, and an internal self that is felt to be the true or real self. This separation from the “role distance” (p.98) of the self is an idea associated with modern Western society. Starting in the Renaissance, the notion of the inner self as perceived from the outside, as well as the multiple roles that a person plays, has led to such greatly valued concepts as sincerity and authenticity. Sass notes that these terms signify a shift from valuing the other over the self to valuing being true to oneself. A turning towards the inner and gaining distance from the public, body self, is a classic maneuver of the schizoid for protection from the dangers of the external world. For the schizoid, an attempt to be true to oneself requires gaining independence from the unauthentic body self, which leads to further isolation and removal from the lived world.

Sass also describes a more active form of separating from the inauthentic body self that is “flaunting the falseness of one’s behavior as a way of suggesting the existence of a hidden true self” (p.103). Through the work of Hegel, Sass demonstrates that negating the self can be a way to find its true paradoxical nature, in that:

By flaunting the most problematic aspects of the social self-its theatrical self-consciousness, its inconsistency, its separation from the inner life- that one achieves a higher integrity, almost, in fact, a new kind of authenticity. (p.105)

He highlights this flaunting through examples in the arts and literature, such as Warhol, as perhaps someone whose “inner self had been rendered contentless” (p.106), describing a detachment from the body and from the greater environment. This feeling of emptiness can often be found in schizoid people resulting from the theatrics and mimicking that serve as protection (Sass, 1992). Within this exaggeration of a role, there is often a sense of irony found within the act, which Sass points out is a salient feature of the modern art movement.

In addition, when reflecting on the schizoid’s disposition, Sass writes of the theory proposed by Kretschmer of the hyperaesthetic schizothymic disposition, which is deeply sensitive and easily vulnerable. With this sensitivity, there is also a sense of inferiority, which the schizoid must defend against. In Nancy McWilliams' paper *Some Thoughts about Schizoid Dynamics* (2006), she writes that concerns with fragmentation, diffusion, and annihilation anxiety are much more common in the schizoid experience than in separation anxiety. The schizoid is also at risk to occasionally suffer from psychotic terrors, even if she is healthy and in the neurotic range. Similar to Kretschmer, McWilliams discusses a constitutionally sensitive temperament that is noticeable from birth. As an infant, the schizoid may be frequently over stimulated when held or cuddled. For the infant, touch is a conflictual notion in that she is “both frightened of it and want[s] it” (p.12). McWilliams also discusses the work of Khan, who observed that schizoid children show the effects of cumulative trauma, suggesting that their sensitivity affects the processing of small rejections by others over time.

Personality Organization and Anorexia

Current Research on Anorexia and Personality Disorders

The link between eating disorders and a specific personality disorders seems to have varied results in the empirical research. Some evidenced-based studies have linked certain personality traits to anorexia and bulimia, such as high constraint and persistence and low novelty seeking in anorexia, and high impulsivity, sensation seeking, novelty seeking in bulimia, which are also associated with borderline personality disorder (Cassin & von Ranson, 2005).

There are also attempts to link anorexia with obsessive-compulsive disorder or obsessive-compulsive personality disorder through empirical research (Lilenfeld et al., 2006; Serpell et al., 2002). However, other evidenced-based research (Grilo et al., 2003) has concluded that while there is a common co-occurrence between eating disorders and personality disorders, “they do not differentially co-occur across certain common disorders” (p.162). Grilo et al. (2003) also found that patients with co-morbid personality disorders do not differ in levels of eating disorders compared to those with an axis I co-morbidity. Furthermore, other research studies have shown that rates of personality disorders can decrease with the reduction of eating disorders symptoms (Ro, Martinsen, Hoffart, & Rosenvinge, 2005), which draws into question the permanency of these personality disorders.

What seems most interesting about this topic can often be found in the case examples from practicing clinicians linking anorexia and restrictive eating with schizotypy and schizoid personality in the current journal literature (Nagata, Ono, & Nakayama, 2007). Yorai Sella (2003), in her paper discussing the bodily self in

treatment for restrictive anorexia with patients in Israel, suggests that the anorexic symptoms are part of a preverbal self. She discusses schizoid features in a group of restrictive eating disordered patients who experience a “splitting off of bodily needs” and who seek “sanctuary in a world rich in fantasy” (p.45). Her therapeutic work with patients with anorectic behaviors will be discussed more in depth in a later section.

Lastly, empirical research investigating the relationship between body weight and personality disorders across gender, demonstrates that only underweight women, not men, were more often likely to meet the criteria for schizoid personality disorder, while overweight women were more associated with higher rates of paranoid, antisocial and avoidant personality disorders. (Mather, Cox, Enns, & Sareen, 2008). In conclusion, further quantitative and qualitative research is still needed to parse out the connection between specific eating disorders and particular personality organizations.

Bruch on anorexia and psychosis

In her psychiatric work, Bruch (1973) discusses the importance of the body and food in those suffering from psychosis. She notes that confusion about bodily states and making identifications with the body have been observed in patients with schizophrenia. She goes on to discuss that what is central to a psychotic experience, is a “gross failures of ego functioning” (p.76), meaning a lost ability to manage and maintain a sense of self moving forward. She notes that in schizophrenic disorders, thought disorder and distortion occur without affecting the intellectual capacity of the person, and it is “failure to properly categorize the world, or an over-inclusiveness” (p.76) in thought, which leads to an lack of ability to parse out irrelevant information. She refers to the fact that those

with psychotic organization and functioning are unable to figure out what matters and what does not, what is actually experienced and what is not, and she links these characteristics of misattunement with the body.

Bruch draws on the work of the clinician, Nicolle (1938), who “considered true anorexia nervosa as a serious mental disorder, often a prepsychotic state” (Nicolle cited in Bruch, 1973, p.219). Bruch writes that Nicolle drew attention to the “potentially schizophrenic aspects of anorexia and compared the affective state with that described in the early diagnosis of schizophrenia with both exhibiting shallowness and the cutting off of all feelings” (Nicolle quoted in Bruch, 1973, p.219).

Also, Bruch (1973) describes the schizoid-like reaction in patients who are more disturbed in reality testing and often “misinterpret the whole eating function” (p.244). They may present with fear of vomiting or refuse food due to feeling not worthy of receiving “nourishment.” Bruch discusses the idea that anorexia has a “schizophrenic core” that the field has been “reluctance to recognize” due to an outdated and misunderstood notion that this would render the diagnosis “untreatable” (p.282). She illustrates this underlying core by describing a case in which a therapist failed to help the patient become more clearly differentiated, and thus inadvertently in furthered the person’s “schizophrenic development” (Bruch, 1973, p.283).

Lastly, Bruch describes three areas of disordered psychological functioning that can be found in anorexia, including: 1) a disturbance of delusional proportions in the body image and body concepts, 2) a disturbance in the accuracy of the perception or cognitive interpretation, as well as a manifestation of falsified awareness of a bodily state as hyper-activity or denial of fatigue, and 3) a paralyzing sense of ineffectiveness, which

pervades all thinking and activities of anorexia patients (p.254). All of these areas described can relate to a more disorganized and psychotic-like experience, which are exacerbated when the brain's functioning is disturbed or interrupted in the state of starvation.

Souls without Skin: the Therapeutic Work of Yorai Sella

Yorai Sella, a therapist in Israel, works with patients with restrictive anorexic eating patterns, and in her paper, "Souls without skin, bones with no flesh" (2003), delineates certain body-oriented aspects of treatment within a psychoanalytic framework for this population. She also proposes a theoretical understanding of anorectic behaviors that takes into account early attachment experiences. Sella makes a connection between restrictive eating and schizoid object relations discussed by Klein and Fairbairn, providing one of the few identified published sources that directly link schizoid anxieties and anorectic behaviors.

Sella begins her piece by highlighting that anorectic symptoms may represent a part of a "preverbal self" (p.38) that began to form during early experiences in infancy, a time before proficient use of language. She connects these symptoms to subcortical parts of the brain that are most prominent at infancy, where "emotional memory"(p.41) takes place, and that the advanced prefrontal cortex is not yet dominant.

Based on Sella's experiences with anorectic clients, it became clear to her that these women from very early in their childhood had to choose between developing a separate self with a sense of safety from others, or being "taken over" by the caregiver in order to receive love and nourishment. She describes them as being faced with a

“punishing choice between self-agency and nourishment” (p.37). She states that as infants, they were demanded to “precociously maintain their own self-regulatory symptoms” (p.37), which later led to more compulsive behaviors in attempt to create and maintain control. As a result of this demand, the infant and later the anorectic, is unable to “adequately assess” (p.37) her own bodily states. Sella suggests that a muscular tension and a spatial distance created and held physically in the body of anorectics are attempts to “maintain [a] schizoid type self-cohesion and [a] sense of autonomous-authentic self” (p.37).

Sella refers to Melanie Klein’s description of the good and bad breasts to make sense of the infant’s dilemma of an imposing mother that forces a choice between a “nourishing breast” and a “space-offering breast” (p.45), which are experienced as mutually exclusive. The infant must choose between nutrition/care and “allowed independent movement, space, and expression” (p.45). This creates a split between two needs: being able to move and breathe on her own and feeding and being held by the caregiver. Sella cites Lowen’s (1970) observation on connecting this dilemma with the sucking impulse and the infant’s freedom to breathe. In his research, some infants could not breathe and ingest food at the same time, in that “ingestion constricted their throats to the extent that it hindered their ability to breathe freely” (Lowen 2007, quoted in Sella, 2003, p.45).

Because the anxiety and trauma of this time period occurs when language is not available, Sella believes that verbal “inputs” used in traditional psychoanalytic therapy are unable to provide “nourishment” for the anorectic in treatment, and are instead experienced as “penetrative and constrictive”(p.39). Sella even describes that patients

have found interpretations to be “shoved down their throats” (p.39). For these patients, language seems to “pertain to aspects of themselves that they experience as inauthentic, and conceive of as reactive to an impinging environment”(p.39).

While Sella does not directly comment on the theories of Laing (1960), I found myself greatly reminded of his work when reading her article, particularly his three anxieties of the schizoid: annihilation, impingement, and petrification. In connecting Laing’s work with the struggles of the anorectic, it seems that the split between a true inner self, and a false self that interacts with the world, parallels the experience of the anorectic in that her body becomes “not me,” while her inner self becomes “the only thing that is me.” Consequently, the anorectic’s body provides a buffer to the outside world and prevents the inner self from being intruded upon or invaded. From this point of view, the anorectic acts out this splitting in the self and as her illness progresses, her corporeality becomes further excluded from her sense of self.

Sella goes on to note that ethological and neuro-psychological research supports the idea that pre-verbal memories and their related behaviors are common in eating disorder patients. She states:

The perceived threat of being in close proximity to others and the perceived sense of security in withdrawal and seclusion are related to the embedded “bodily” memories organized around the struggle for autonomous maintenance of boundaries and space. (p.41)

Furthermore, to create a sense of continuity and a cohesive narrative in a sense of self, Sella writes that a “rhythmic dialogue” (p.42) is needed as a basis for the temporal organization of reality. For the anorectic, she is prone to experience ruptures in this continuity, which were experienced in infancy as failings of the environment to support and attune to her needs (Sella, 2003). When breaks occur in adolescents or adulthood,

her body may experience increased stress or the flight-or-flight mobilization of the sympathetic nervous system, which is known to increase vigilance, can make a person feel on edge or jumpy, and reduce activity in the digestive system, including salivation. While ideally a person only experience this fight-or-flight response when needed for danger, anorectic patients have been found to have a prolonged and more constant experience of this increased nervous system arousal, experiencing a decreased appetite and an inability to properly digest food (Sella, 2003).

Another notion discussed by Sella is that many of her patients with anorectic symptoms held very strongly to rigid rules, citing that these provided them with a sense of self-control. Patients told Sella that they felt that “letting go” of these rigid rules, even though they were self-created, was not possible and would result in a “disintegration of some crucial aspect the self” (p.43). She writes that this rigidity seems to be deeply necessary, or as one patient put it, “life-preserving” (p.43).

Sella found in the histories of her patients a fear of annihilation in the present, coupled with an experience of an impinging mother in the past, where the mother needed to have the infant perform bodily function based on *her* own schedule, as opposed to the natural rhythm of the child’s body. This again resonates for me with the anxieties of Laing. When reading Sella’s description of her patients’ physical transformation during severe restricting, I found myself also reminded of Laing’s third anxiety, petrification. Her patients presented with pale colorless skin, stretched over bones, with little flesh or softness remaining, as the body had begun to digest their fat and muscle during starvation. For these patients, the process of becoming the most ill, and often the “best” anorectic seems to mimic this Laingian offensive strategy of turning the self into “stone,”

to prevent others from petrifying her first. As she whittles her body to a skeleton, the anorectic succeeds in becoming a statue, practically lifeless, and thus impenetrable by others.

Sella also found that many of her anorectic patients are unable to discern and name even their most basic bodily cues, such as fatigue, discomfort, or pain. She cites one example in which a patient would show up to session with her midriff exposed, unaware that it was chilly outside or that she was cold (p.44). Sella also describes the “smallness” of these patients, who seem to literally and emotionally take up little space in the room. They often sit quite erect and with rigidity, which Sella describes as a type of “muscular armor” that provides protection and distance from others (p.44). She describes the interpersonal interactions with her patients in the room and how they often experienced her “nourishing verbal interventions” as akin to being “caged, choking or suffocated” (p.44). One patient spoke of how coming into close contact with another would make her “own physical body less clearly defined,” and created the sensation of “shrinking or putting on a different body, face, a mask,” as if her own body was set aside (p.45).

Sella relates this split to the feeling some patients have with loss of boundaries when they were visited unexpectedly or when they received a spontaneous phone call. These “intrusions” elicited an uneasiness in these patients that was often concentrated in the abdominal area. The question of closeness and staying separate, literally the protection and separation provided by “one’s own skin,” notes Sella, is not felt to be a safe and static boundary (p.45).

Sella also discusses Fairbairn's (1940) writings on schizoid dynamics, drawing a connection between the caregiver's rejection of "oral greed" and consequent "splitting off" of needs of the body, along with a retreat into a safe and full fantasy world (p.45). This split is understood by the patient through a type of intellectualization that is often found in schizoid organization. Food becomes connected with closeness and the choice becomes one between "suffocation and penetration" (p.45). The anorectic believes hunger felt in the body should be denied, along with a need for or a dependence on others for survival. To achieve this, the body is split off, and over time, no longer feels like part of the self. This retreat from others can make the patient seem at times "far away," and not always present in the moment, making the patient herself feel distant from her own interactive experiences (Sella, 2003).

The anorectic patient is also often extremely sensitive and attuned to others, which Sella calls "fulfilling the role of a 'receptacle' to that which was not named" (p.47). Sella discusses one patient's case in length, describing how she would have to manage her feelings of being over-stimulated or penetrated to the point of suffocation, which Sella interprets as "both a schizoid closing off and the development of an intense guilt-ridden violent fantasy world, and a masochistic "containment" of all that had been prematurely 'put' into her" (p.47). The only way the patient was able to assert herself and her needs is through the landscape of the body. Sella writes:

In refusing to succumb to bodily needs [the patient] unconsciously sensed she was preserving this bodily autonomous domain intact, safe from invasion by "foreign bodies"- be they food, intimate gestures or emotionally laden words connoting emotions that she felt it was required of her to contain. In her more regressive states this bodily freedom and independence would be felt to be tantamount to her very existence, gaining precedence over very basic needs such as food, warmth, shelter, and emotional support. (p.47)

Lastly, despite an inability to always process experiences through language, some of Sella's patients utilized metaphors to express their feelings. One in particular created artwork that captured her desire to "dissolve into the ether" (p.46). One of this patient's pieces was titled "Soul without skin, bones with no flesh," which Sella borrowed for the title of her article. These words are striking and visual, conjuring up a tragic yet beautiful image that speaks to the struggle that the person with anorexia endures, to fight for and protect her freedom to be a separate self.

Is Anorexia an Attempt to Overcome Schizoid Anxieties?

In light of the theories and observations of schizoid anxieties, I am left wondering about the connection between them and the development of anorexia. What I have been particularly struck by is the language of object-relations theorists when discussing the dynamics of the schizoid in regards to hunger. There is a focus on being full versus empty, of yearning and hunger, and the need to go without to be safe. There is fear of a voracious desire to devour what one wants and needs, yet there is also a time when purging the inside is necessary to be whole.

The paradoxical language that seems inevitable when discussing schizoid experiences is also quite relevant to the experience of the anorectic. The sufferer is attempting to assuage her anxieties of being in the world by cutting off her supply of nourishment, both with actual food and with relationships to others. In the beginning stages of anorexia, she begins to break ties with friends, families and lovers, along with food. There is a desire to be isolated and out of reach, thus she retreats into an isolated

anorectic world that she believes will prevent others from swallowing her up or tearing her apart.

Unfortunately, isolation allows the destructiveness of anorexia to continue without the sufferer realizing she is in danger. As she retreats into herself, her environment is replaced by a fantasy world in which she is able to enjoy a sense of freedom. The anorectic takes in this fantasy that tells her that she must remain in this world if she wants to survive, which leaves her fearing that any participation in the real world will jeopardize her sense of being. This model can illustrate why it is difficult for the anorectic to end her relationship with her disorder, while those on the outside can only see “reality,” i.e. its destructive nature.

Though Laing never commented specifically on anorexia, he writes that in this process of dissociation the mind creates a “psychic tourniquet” (p.133) for the body. This seems quite relevant to anorexia in that the sufferer appears to be cutting off her body from her life source in order to save the remaining inner self. If the body does not “die,” then the inner self is still in danger. The problem becomes that the physical ramifications of these acts, serious medical complications or death, may not be realized until it is too late. Thus, instead of viewing anorexia as an attempt to die, through Laing we can conceptualize anorexia as a struggling act of life. Laing also explains that the unembodied individual fears petrification or depersonalization, a fear that is symbolic of someone stealing her soul and rendering her inanimate, taking the very essence of who she is. In defense of this fear, Laing states the schizoid petrifies herself, to prevent the other from first doing it to her.

Thus, through starvation the anorectic turns her outward appearance into a statue-

like state, as if encompassing a living death. The same concerns with fragmentation, dissolving and turning lifeless discussed by Laing (1960) and McWilliams (2006) appear very real and present within the anorectic. I am postulating that the development of anorexia becomes a solution to what the sufferer believes she is missing or has never received. It is something that is all encompassing and reliable, a type of substitute object-relation.

The object relations theories also give us material in attempting to understand the early years of woman who develop anorexia. In terms of attachment, there is often an enmeshed or conflictual relationship with a parental figure. The needs of the infant were either met sporadically, or not at all, creating an insecure and unsafe sense of the world. The mother may force the infant to attune to her own needs instead of the other way around. The sensitivity of the schizoid also resonates with the attention to details anorectics pay to others and her environment. The desires to please those around her and to be perceived as perfect are important to many anorectics, who also hold order and rules in high regard. It appears that schizoid concerns and phenomena are present in the language of the anorectic world, and that the unique external symptoms of restricting and starvation are an attempt to resolve an internal struggle with schizoid fears and anxieties.

This has led me to wonder and finally hypothesize about the purpose of anorectic restricting behaviors. Through the lens of schizoid object relations, it seems that anorexia is an attempt to *preserve* the self and an affirmation of *life*, as opposed to a passive suicidality or a destructive attempt to rid the self of life. This is accomplished by getting rid of the body self that poses a danger in connection to the outside world, in order to exist safely as her true inner self. The dilemma for the anorectic is that she cannot

continue to live without a body and may end her life while inadvertently trying to define it. Thus, the purpose of this project is to uncover and describe the meaning-making process of the person with anorectic behaviors in order to piece together a theoretical understanding of her internal experience. This may also help translate the purpose and intent of the anorectic to outsiders who find these behaviors difficult to understand.

Methods

Narrative Research Methods: What Are They and What Can They Provide

As discussed, I propose that an individual develops and maintains an anorectic style (namely, anorectic eating behavior and the related cognitions needed to maintain such behaviors) in order to help her build a sense of self that feels most authentic to her true nature. In the process, she ascribes meaning to her behaviors, thoughts and feelings in way that is congruent with this new construction of the self. Specifically, I am interested in the process of how she develops meaning through the lens of anorexia, as well as how she arrives at a place of feeling most ‘like herself’ in the context of this disorder. There already exist numerous important and valuable quantitative studies that contribute to our understanding of anorexia by examining the symptoms of the disorder at a distance through the isolation of variable of interest. There is significantly less research that explores the intrapersonal experience of anorexia in its totality.

I have chosen to investigate the living experiencing of anorexia using a qualitative narrative research methodology, which will help to build a bridge between the current published scientific research and individual clinical descriptions of the disorder offered by practicing therapists. Catherine Kohler Reissman (2008) refers to narrative analyses as a “family of methods for interpreting texts that have in common a storied form” (p.11). Research using narratives offer a theoretically driven analysis of life stories that are less often the subject of rigorous scientific study, including published stories, memoirs, and literature. While there are numerous case studies in the clinical literature that provide fruitful and thought-provoking analysis on an individual level, these cases are often not

discussed within research parameters and are not always generalizable to the greater population. As a result, these contributions can be omitted from the research data bank.

The specific method that I will be using is called narrative inquiry, which is distinguished from other types of storied research in that it “embraces narrative as both the method and the phenomena of study” (Clandinin & Connelly, 2000, p.18). Pinnegar and Daynes (2007) draw on the ideas of Clandinin & Connelly to further illuminates the difference of narrative inquiry from other types of qualitative research methods:

Through the attention to methods for analyzing and understanding stories lived and told, it can be connected and placed under the label of qualitative research methodology. Narrative inquiry begins in experience as expressed in lived and told stories. The method and the inquiry always have experiential starting points that are informed by and intertwined with theoretical literature that inform either the methodology or an understanding of the experiences with which the inquirer began. (p.5)

Before describing the specific methods and analyses of this research project using narrative inquiry, I will first address some relevant concepts that arise when studying narratives in general, and how these issues are relevant to the topic of anorexia.

When designing the method of investigation for this project, I found myself returning to the written work of therapists who focused their attention on experiences with their patients, which included discussion of the process of therapy itself. There is often discussion in these articles about the mutual discovering and reconstructing of a patient’s narrative, resulting in what is hopefully a more coherent and meaningful sense of self. In my own experiences as a therapist, I have observed similarities between negotiating both the nearness and distance within the therapy frame, and I have experienced the dance described by narrative researchers that requires a continual shifting between the parts of the data and the narrative as a whole (Reissman, 2008). In both

situations, there is a need to be present and “near” the information, while also maintaining distance to allow for a critical examination of the process.

Donald Polkinghorne (1988) notes that Freud’s utilization of case studies was narrative work and his treatments involved reinterpreting past “meaningless events into something coherent and meaningful” (p.121). When constructing a narrative, Polkinghorne continues, there is movement beyond the “mere events” towards a process in which the events become significant to the person within the relevant themes of her life. It is in the story created by the self that “reveals how the person punctuates or organizes her world, and it therefore provides a clue for discovering the basic premises that underlie the person’s actions and cognitions” (p.182).

Reissman (2008), in her writings on methodology as a narrative inquiry researcher, notes a “connection between biography and society becomes possible through close analysis of stories” (p.10). She speculates that an increased interest in narrative forms of research has occurred in recent years because these methods can provide an understanding of current happenings, which may be due, she says, to an increased “preoccupation with identity” (p.7).

In response to criticism about the subjectivity of narrative research in general, Polkinghorne explains that the concept of validity in psychology has become confused by its limited definition in reference to tests or measuring instruments. In qualitative research, validity has a much broader meaning in that results need to be well-grounded and supportable. Through case studies, Reissman believes that “conceptual inferences about a social process” (p.13) can be constructed by generalizing from the data to theoretical knowledge. She quotes one of her students who described narrative research

as a “proverbial ferry between the abstract and the concrete, between cognition and behaviors, and between the symbolic and the material” (p.16).

Temporality in Narrative

The issue of temporality is important when discussing the construction and interpretation of narratives. Polkinghorne (1988) states narratives itself provides a “symbolized account” (p.18) of what has taken place, which includes the dimension of time. When a person begins to construct a narrative, she uses a temporal organization to link different pieces together in a framework of time, i.e., chronologically, even if her lived experience in the moment did not take temporality into account (Polkinghorne, 1988). Polkinghorne writes that narrative “transforms the mere passing away of time into a meaningful unity, the self” (p.119).

Narrative researchers Clandinin & Connelly (2000) pay particular attention to the issue of temporality in their model of narrative inquiry methodology, stating there is a “tension between seeing things in time versus seeing things as they are” (p.30). In order to capture this temporal component in their research methods, they created a “three-dimensional narrative inquiry space” (p.30). They conceptualize that to obtain narrative understanding, the research must work within a three-dimensional space that includes a dimension for time, a dimension for the personal and social, and a dimension for place. They also describe four possible directions within this three-dimensional space, including inward and outwards, backwards and forwards. Specifically, they define *moving inwards* as the internal conditions of the person (feelings, hopes, moral dispositions), *moving outwards* as the existential (the environment), while *moving backwards and moving*

forwards takes place along the temporal dimension (past, present, and future). Thus, a true understanding of a narrative requires a simultaneous experience and exploration of these directions, along each dimension (Clandinin & Connelly, 2000).

Reissman (2008) also discusses the importance of context and time in narrative research, stating that the focus in analysis is on “a particular actor, in a particular social place, at a particular social time” (p.11). The benefit of narrative work is that the very nature of this work seems to lend itself to a discussion about the culture in which the individual exists. Freeman (1997) notes that in narrative, we are able to go beyond the focus of the individual in attempt to say something about the culture that this phenomenon has taken place. This is of utmost importance for the phenomenon of anorexia since the manifestations of restricting and starvation have been documented to link specifically with the cultural and societal experience of females over history.

Freeman (1993) also explains that by living in a specific culture, narrative “cannot help but tell us about the mode of its construction, about the complex interplay of influences responsible in significant part for its very shape” (p.160). This suggests that only by understanding the context in which the anorectic lives can her struggle for selfhood be completely understood. In studying narrative, Freeman (1997) believes that researchers have found a way to “become engaged with history” (p.174) through not only a particular life but through the culture and historical time in which this person lived.

Autobiography in Narrative Research

When deciding what form of data would be best for this research project, I was drawn to the numerous published autobiographies and memoirs of anorexia that are often

popular among patients actively suffering from eating disorders. These accounts are not only rich in detail and information about the development of anorexia and the internal world of the authors, they are also already in narrative form. After living through and recovering from anorexia, these authors have been able to look back through their personal memories, diaries and journals, and even medical charts, to construct a narrative of their illness. As a result, these texts are available for interpretation through a theoretical lens. Unlike the published articles and case studies by therapists and researchers that are presented with a specific and therefore limited focus, these memoirs are an opportunity to use “raw data,” including the diary and journal entries, in their original form. Further, many of these published memoirs are themselves literary works of merit, as each author utilized highly personal, poignant and purposeful language to describe her experience.

Freeman (2007) describes the use of autobiography, such as these memoirs, as fertile sources of information for the narrative researcher. He writes:

There is reason for seizing on autobiography and memoir as an inroad into exploring the dynamic features of narrative inquiry as applied to the study of lives. And that is that it can help show how and why narrative inquiry might lessen the distance between science and art and thereby open the way toward a more integrated, adequate, and humane vision for studying the human realm.
(p.120)

The notion of the intersection between science and art is one that Freeman revisits often in his work, stressing that narrative holds a unique position at the meeting of these fields. As expected, when discussing first person accounts that retell the past, the question of “truth” can be questioned. However, as with psychotherapy, the idea of knowing “the truth” is replaced by understanding the truth of the person at that particular moment her

or she is doing the telling. In autobiography, it is exactly this experienced truth of the person that is available to the reader (Freeman, 2007).

Freeman goes on to notes that “in autobiographical understanding, there is no object, no text, outside the self- it is made sense out of through poesies- through the interpretative and imaginative labor of meaning making” (p.129). The autobiography therefore becomes an enlivened place to uncover the internal experience of a phenomenon. A text of an anorectic’s experiences of her caregivers, environment, and culture, vis-à-vis her temperament and world-view, allows the reader to witness the unfolding of her distress which culminates in her choosing starvation as a solution. Through the knowledge and theories developed and cultivated by the researcher, Freeman (2007) notes that the work “will not only be informative, but ideally, *artful*, such that the person in question can live on the page” (p.129).

This leads Freeman to an interesting conclusion about the role of narrative research in autobiography and what he believes to be the task of both the author and the researcher. In autobiography, the author makes sense of the multitude of data from her life, and she chooses what is important and necessary for her story. Freeman challenges the narrative researcher to “move beyond clichés” (p.141) that are tired and already told, to think about the poetry of the writing. He ends with the idea of a poetic science, one that can exist in narrative work, that will not only increases theoretical and research knowledge, but also increase our “sympathy and compassion for the human realm” (p.142).

The Hermeneutic Circle

In narrative investigation the interpretation of data or “text” is a hermeneutic process, that is, a search for meaning through interpreting data within theoretical and practical knowledge. In narrative research, it is important to discuss the concept of the hermeneutic circle, which describes the circular structure of understanding the text as a whole that can only come from understanding its individual parts, as well as the idea that the individual parts can only be understood in the context of the whole. Thus, neither the whole nor its individual parts can be made sense of without referencing the other (Gadamer, 1975).

Polkinghorne (1998) discusses hermeneutics as a technique used during analyses of narratives that notes underlying patterns across stories. In analyzing the data, there is not an “algorithmic outline, but a move between the original data and the emerging description of the pattern” (Polkinghorne, 1988, p.177). Freeman (2004) comments that in stories, beginnings and the middles determine the endings, and at the same time, knowing and understanding the beginning and middle is determined by the ending itself. He writes: “only when a story has ended, it is possible to discern the meaning and significance of what has come before” (p.65). In commenting on his previous work *Rewriting the Self* (1993), Freeman relates this process to how the self is constructed, in that when making sense of the past the self is “reconfigured” in a way that “moves beyond what has existed previously” (p.77). The self takes on or becomes something new based on incorporating the meaning of what has already happened.

Hans-Georg Gadamer, a German philosopher who studied with Heidegger, wrote at length about the hermeneutic circle. For Gadamer (1975), understanding is always

historically limited, and thus the notion of objective, true knowing, without the time and context of the knower, is not possible. In discussing the inherent prejudices, or “fore-meanings” that the knower brings to examination and interpretation, Gadamer states that it is impossible to fully escape these preconceived notions. She is, however, able to take a critical distance to examine these prejudgments. What is crucial, Gadamer continues, is that the knower identifies and understands the fore-meanings or “bias” that she brings to the text. Instead of striving for a neutrality or lack of bias, the knower needs to become aware of her pre-judgments. Thus, the idea that the knower brings biases to understanding is no longer something negative that need to be eradicated, but “just is” and should be understood within the process of knowing.

Regarding prejudgments and the human sciences, Gadamer (1975) states “research in the human sciences cannot regard itself as in an absolute antithesis to the way in which we, as historical beings, relate to the past” (p. 283). It is these prejudices that show the connection with history and tradition. In light of the historical and cultural context of anorexia, our own prejudices are present when entering the hermeneutic circle and the finiteness of understanding of a phenomenon is always situated within history. These prejudices serve as an outline when starting an interpretation and are constantly examined and revised in light of the new “parts” discovered in the research. For Gadamer, when approaching a specific standpoint, the knower already comes to it with a formed opinion based on knowledge and understanding of the topic to be examined. As she incorporates this new information of data into the understanding of a topic, the original concepts move and change. However, the original idea needs to be present to identify how the new information relates or how a topic should be examined in the first

place. This process of understanding is constantly “determined by the anticipatory movement of fore-understanding,” in that the knowing does not become something that is “perfectly understood,” but something that is “most fully realized” (p.293).

In discussing the hermeneutic circle in his writings, Dobrosavljević (2002) references Heidegger's notion that the circle is not “logical fallacy” or *circulus vitiosus*, but is instead the interpretative process that is part of our cognitions. In fact, it is the scientific method that is in danger of *circulus vitiosus* in that it seeks “strict, fixed notions” (p.607). In hermeneutics, concepts are not fixed and, as such, time and fluctuation in meaning are allowed. Gadamer describes that in hermeneutical understanding, “anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts that are determined by the whole themselves also determine this whole” (p.291).

In his thesis, Dobrosavljević (2002) argues that we exist in the world of praxis and in this world, the knowing is not of “rigid principles” but of “moveable outlines” (p.607). Thus, hermeneutical interpretation exists in this world of praxis. As we strive to understand, we do not truly get to “know” the thing that we study, but we “more or less illuminate it” (p.610). This is important to note because any research about the internal experience of the anorectic must rely on her interpretation and choice of language to describe her internal experience, of which she may not be fully aware. Given that the only access to her internal world comes via her verbal expression, using a hermeneutic method seems most appropriate in its acknowledgment that there are very real limitations to the extent that “knowing” is possible.

This is reminiscent of the process of understanding the relationship between patient and therapist in psychotherapy. While the therapist does not forget that he or she is a unique self with his or her own ideas or “pre-judgments” when listening to the patient, the therapist is constantly working to know and understand his or her own prejudice and how such preconceptions threaten to alter his or her understanding of the narrative under construction. The therapist is limited by his or her own pre-judgments and must work to understand these limitations in context, so as to allow for other possibilities of understanding.

Summary of theoretical justification of narrative methodologies. In summary, it seems that a narrative methodology provides an appropriate model of investigation for the study of the internal experience of the anorectic. In particular, the autobiographical texts of women who have suffered with anorexia can be interpreted in light of the leading research, which will maintain a clinical richness in the data without losing analytic precision and the rigor of science. Freeman (1997) writes: “narrative is the basic medium in which humans speak, think, grow into selves and understand others. In this sense, it is the most fitting and appropriate language we would use to comprehend human lives in culture and in time” (p.175). Obtaining this type of information is not difficult because as Jerome Bruner (1990) explains, we already informally live our lives in narrative, that is, we already experience our lives in the form of “stories.” The advantage of focusing on the story as a whole, according to Reissman (2008), is that paradoxes can be examined and understood. Considering that the inner world of anorexia is often paradoxical, a

methodology that allows this to be further investigated seems most appropriate.

Freeman (2007) writes:

Narrative seems able to give us understandings of people in a way that more “objective” methodologies cannot. Because they often emerge from a true, rather than false, scientific attitude . . . one that practice fidelity to the whole person, the whole human life, in all of its ambiguous, messy, beautiful detail. (p.134)

Procedures: Narrative Inquiry Methodology

The method of investigation of this research project is narrative inquiry, conducted in the spirit of Freeman (1993, 1997, 2004, 2007), Reissman (2008), and Clandinin & Connelly (2000). As discussed earlier, narrative inquiry is a specific type of qualitative design that uses the narrative form as its primary source of data. Part of the difficulty in describing the procedures of this methodology is that there is not singular method uniformly employed to conduct the data analysis. As such, in order to assist the reader, I will describe in as much detail as possible the steps that were taken to obtain, assess, and interpret the data.

The selected narratives for this project are six published memoirs by women that satisfy the following criteria: each provides a firsthand account of an eating disorder in which anorexia was predominant; each discusses the cognitive, physical, and emotional experience of anorexia, as recounted by the author of each memoir; each recounts the author’s experience of anorexia through memories, interactions with others, diaries, and treatment notes; and, in each case, the author’s purpose in writing and publishing the memoir was to help increase understanding of anorexia, as well as help support and encourage those who are currently suffering. The memoirs selected included: *Biting Anorexia* (2009) by Lucy Howard-Taylor; *Diary of a Stick Figure* (2000) by Lori

Gottlieb; *Diary of an Anorexic Girl* (2003); by Morgan Menzie; *Hollow* (2010) by Jena Morrow; *Linger No Longer* (2009) by Rae Swenson; and *Wasted* (1998) by Marya Hornbacher. In addition to these six memoirs, the following were included to provide supplemental data: a published case description and analysis of a Victorian-era patient who suffered from restrictive eating by Ludwig Binswanger in “The Case of Ellen West,” published in *Existence* (1958), edited by Rollo May, and documented interviews and photographs by Lauren Greenfield (2006) in her book *Thin*, that took place at the Renfrew Center in Florida, a residential eating disorder program.

Once the memoirs were selected, a thematic analysis was conducted as defined by Reissman (2008), where content is the exclusive focus. A first reading took place with each book to become familiar with the story and details of each author. Notes and ideas were taken regarding examples of behaviors, thoughts patterns, and emotional patterns, as well as demographic and personal information. These included: eating disorder symptomatology, presence of bulimic symptoms in addition to anorectic symptoms, age of onset of illness, duration of illness, lowest body weight, social environment, family environment and the quality of interpersonal relationships, number of times in treatment and the length of treatment, number of hospitalizations, and the number of relapses.

A second reading of each memoir was then conducted with potential categories in mind to assess each for “additional statements that related in a general way to the larger concept” (Reissman, 2008, p.64). This reading was used to locate themes within and across the sources, looking for cohesive as well as disparate details, while noting the narrative structure of each work. In particular, these themes came out of the internal representations of each author during their illness, including diary and journal entries

from that period, as well the conceptualizations of their disorder while in recovery. In this analysis, the narratives were treated as units and remained intact, as opposed to being reduced into fragments. Included in this step of analysis was a consideration of why an author chose to tell her story “in that way” and a consideration of details to figure out the “how” and the “why” of the telling (Reissman, 2008). After the second reading, additional passes through each text took place as the emergent themes became further concretized. Through this analysis, the hermeneutic process of moving between the whole of the texts and their parts was constantly taking place, and the bias and prejudgments within myself were constantly being assessed and examined.

Embedded in this analytic process is an emphasis on using specific quotes from the data to provide support for the themes and overall hypotheses. In the continual readings of a text, Clandinin and Connelly (2000) state, “plotlines are continually revised as consultation takes place over written materials” (p.132). In revisiting the data again and again with a thematic and narrative outline in mind, I was able to constantly shape and redefine this thematic blueprint to develop full and rich interpretations by weaving together quoted texts from each author. As the structure of the interpretation continued to be built and refined, theoretical information was also intertwined with the quoted text, since, as Reissman (2008) notes, narrative analysis is ultimately built on a theoretical argument, as opposed to statistical analysis or coding. The theoretical foundation and support for these analyses include: *Beyond Anorexia* (Garrett, 1998); *Conversations with Anorexics* (Bruch, 1988); *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within* (Bruch, 1978); *The Golden Cage* (Bruch, 1979); *The Hungry Self* (Chernin, 1985); *The Secret Language of Eating Disorders* (Claude-Pierre, 1997); *Sensing the Self*

(Reindl, 2001); & “Self Psychological Reflections on the Origins of Eating Disorders” (Geist, 1989) in *Psychoanalysis & Eating Disorders* (Bemporard & Herzog, 1989).

While working through the texts, I also noted paradoxical elements that arose within each narrative, and I used a balance of theory and data to make sense of these instances (Reissman, 2008). Additionally, I continued to keep in mind the context and importance of culture when connecting the data with the theoretical understandings (Reissman, 2008). While refining my hypothesis, I was also aware of the limitations of this methodology, which includes the assumption that each author envisions the same meaning in the words that they choose. This made it of utmost importance to examine the understanding of the language used by each author, to prevent any simplifications or reductions in meaning.

In agreement with Polkinghorne, Reissman states that the validity of the final analysis depends on the coherence of the final report and interpretation. These interpretations of anorexia contribute an additional perspective, one from the point of view of the sufferer, which extends the current theoretical understanding of this disorder, and provides a jumping off point for future research that employs other methodologies.

Results

Delving into these raw and honest portrayals of anorexia, I found myself immersed in lives of these women and I was able to place myself within their narratives. I achieved this by observing several seemingly contradictory aspects of anorexia that appeared to be taking place at the same time. The data revealed that anorexia does not operate using a conventional or “normal” logical structure. It instead operates using its own principles and sense of order. These contradictions, or paradoxes, became my guide to navigating the anorectic world. In order to accomplish this, I had to leave behind any preconceived notions and enter into this other realm governed by a logic uniquely its own. By putting aside a desire to “know” in more traditional “outside” terms, I became free to accept the rules and guidelines, which were clear and obvious to the women who lived this disorder. Through their descriptions, I was able to see how they delved into this world of polarities that could not be reconciled in their surrounding environments. While it is unclear how these women learned the rules, they were each able to operate within them. These women figured something out in anorexia that was previously unknown yet deeply necessary.

In following sections, I will delineate several prominent paradoxical themes through examples in the data, and present them in an order that I believe best parallels the journey into and ultimately out of anorexia. These paradoxes were generated by the logic of anorexia, and through them, an outsider can gain insight into the purpose, choices, and course of this disorder. Also, throughout the interpretation of the data, I have woven theoretical support from the clinical literature, as is done in narrative inquiry analysis, which help to contextualize the individuals experiences of each of these women. In the

discussion section, I synthesize these interpretations with the schizoid object relations literature, to provide a complete conceptualization of anorexia as a preserving defense against schizoid concerns and anxieties.

The presentation of these results begins with the first paradox, which articulates what anorexia provided for each sufferer that compelled her to continue to engage in its harmful behaviors. While outsiders may see self-starvation as violently destructive, these women attest that anorexia was, and for some still is, in fact, an assertion of living, a preservation of the self, and something that validated their existence. This brings to light a *destructive self-preservation* that seems to lie at the heart of the anorectic experience. To understand this seemingly contradictory explanation of “why anorexia,” we now turn to the writings and stories of these women.

A Destructive Self-Preservation

The question of why someone would turn to restricting food in a time of distress is not immediately clear. For each of these women, anorexia provided them with a way to deal with life during a troubling period. Rae Swenson (2009) in her memoir *Linger No Longer*, put into poetry what anorexia meant to her:

The highs and lows- you were there- you lightened it all and made it so much less.
You haunt me like a scar on the face, unavoidable and inconceivable. And I will
never forget you. You are in my mind, unavoidable and inconceivable. Of
everything, why was it you? And why don't you fade? And why can't I forget?
You, my protector and my pain.

Rae refers to her anorexia as “the Voice,” describing that it first shielded her from the distress in her life. Similarly, Lucy Howard-Taylor (2009) in her memoir *Biting Anorexia*, reports that anorexia allowed her to “not feel anything,” because it did the

feeling for her. As her body entered a state of starvation, it began to eat away at itself from the inside, bringing to Lucy's awareness a physical sensations of wasting away. She notes that this process works because it leaves little energy to focus on the emotional pain that was so great before restricting. For Lucy, worrying about her weight was somehow easier than tolerating the pain of her perceived social inadequacies. She writes, "anorexia: a wonderful way to calcify all your problems without touching them once!"

Marya Hornbacher (1998) in her well known memoir *Wasted*, seemed aware of what focusing on her body allowed her to accomplish, that is, essentially shifting her distress into the arena of the body. "The problem in your life is your body. It is defined and has a beginning and an end. The problem will be solved by shrinking the body." Her previously undefined pain and sadness became concretized and transformed into a tangible and solvable problem. In recovery, Marya is able to reflect on how ultimately anorexia did not deliver what it appeared to promise, but at the time it seemed like her best option. "Anorexia was my big idea, my bid for independence, identity, freedom, savior etc. The path to my salvation."

Bruch (1988) notes that at the time anorexia manifests, the underlying problem has been alive for some time. Anorexia becomes the vehicle that speaks for the sufferer with a message she has previously been unable to express. It brings to her awareness what she had failed to achieve in being an autonomous, worthy human being (Bruch, 1979; Claude-Pierre, 1997).

Morgan Menzie (2003) wrote her book *Diary of an Anorexic Girl* based on her own experience with the illness. However, she choose to tell her story through a fictionalized version of herself she renamed Blythe, in a diary format. This allowed

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Morgan, as the character, to convey her thoughts and feelings about her illness. At a point when Blythe finally reaches her first goal weight, under 100 pounds, she rejoices in this “wonderfully fragile number,” stating that it felt that she was “meant to be in double digits.” She felt she had finally achieved doing something well. Later that same day when her mother confronted her about her weight loss, she was able to fight back with a new resolve, recognizing that “no one would make me stop the only thing that had made me happy in the past year.” Months later when her weight had increased again into the three digit range, she created a new plan that had the following formula:

“Happiness=losing weight. Therefore, don’t eat until reach actress weight range.”

When Rae began restricting anorexia, she states that she finally could dance to her own drum, “no matter how tiny the beat.” She believes that this was a small yet “tenacious” part of her that refused to surrender to the wishes of others, which continued to grow as her disorder progressed. “I found that it was I who could ultimately decide the course of my life, whether it was to live or die!” For the first time she felt agency over her life and a newly developing sense of self.

Reindl (2001) explains that those with eating disorders experience great emotional turmoil and the behaviors allow the person to tolerate her previously unbearable feelings. The most comprehensive and complete understand of eating disorders is one that explains how the behaviors allow an individual to “turn her psychic pain, which she fears is not legitimate, into physical pain, which is indisputably real” (p.4). When in emotional pain, the sufferer often feels that her torment will never end, and thus, she fears that she will never feel “normal.” To convert her psychic pain to the physical relieves the anxiety and discomfort of her emotional life (Geist, 1989). Lori Gottlieb (2000) writes about her

experience with anorexia that took place most during her eleventh year in her memoir *Diary of a Stick Figure*. When hospitalized for her severe restricting behaviors, she found herself alone on her half birthday, so she made a wish for herself. “I’d wish to be the thinnest girl at school, or maybe even the thinnest eleven-year-old on the entire planet. Then I’d never have to worry about dieting anymore.” As she was about to make her wish, she stopped herself, concerned that if her wish came true right then, what would she wish for on her actual birthday when she turned twelve. She wondered: “what are girls supposed to wish for other than being thin?”

Anorexia also calms and soothes the sufferer through its “concern” for her. It is perhaps the first time she feels taken care of in a manner that is similar to the one she adopts to take care of others. For Jena Morrow (2010) it was this care that made anorexia so captivating. “An eating disorder in the beginning is like being in love. Who needs them [other people] when you have this? It satisfies your needs- it’s all you need.” In a therapy session later on in recovery, Jena revealed that of all of her symptoms, including cutting and burning when she was forced to eat, nothing helped her manage her feelings like starvation.

Marya also speaks of anorexia as a lover and how she allowed herself to be enveloped in its care. Her anorexia would “breathe like a lover” into her ear, or “stand over her shoulder” as she gazed in the mirror looking over her body. Anorexia was “absorbed” and infatuated with “each inch of [her] skin and flesh.” It “worked her over” and touched her with “rough hands that thrill.” She felt enthralled and enlivened under its gaze. “Nothing will ever be so close to you again. You will never find a lover so careful, so attentive, so unconditionally present and concerned only with you.”

Rae, like Jena and Marya, saw anorexia as the answer to her loneliness, and it too was her “first love.”

Anorexia is really one response to a universal dilemma- the despair that you are alone. [That] comes from feeling that who you are unloved and unlovable, that comes when you don't know how to love yourself and your voice is quashed and silenced under layers of self-doubt, fear, and muted anger.

She describes that she craved more than just “thinness,” but the “implication of thin.”

She likens the disappearing act of the body in starvation to a “Houdini-inspired” trick, as daring a feat as walking on hot coals. “You wish for that invisible, vibrating wire that hums between lovers, implying a private touch.” Anorexia somehow revealed for the first time a desire within her that she longed to be fulfilled.

Lucy's anorexia was a companion that understood her and withheld judgment, unlike many others in her life. In a letter written to her parents during treatment, Lucy tries to explain how anorexia was there for her when they were not. “When you get angry with me, I have a strong urge to retreat back into the familiar behaviors of the eating disorder. Because ‘it’ understands me and ‘it’ doesn't judge. ‘It’ comforts me and doesn't threaten.” In anorexia she found the attunement and attention she had always craved and had not received. In the much later stages of recovery, Lucy was working with a therapist that described her anorexia and depression as the best things that could have happened to her, or anyone in her position. When she questioned him about what he meant, he responded that these experiences gave her the rare opportunity to discover herself.

When Bruch (1979) began observing and documenting the eating disorders behaviors of many of her patients, she found that those with anorexia almost always experienced feelings of ineffectiveness. “It is against this background of feeling helpless

vis-à-vis life's problems that the frantic preoccupations with controlling the body and its demands must be understood" (preface). Bruch (1988) also describes that the various changes in these patients' lives, especially during the transition into adolescence, motivating them to search for something that would help them manage their overwhelming feelings. At the time of puberty a girl can feel she is expected to accept these changes and confidently move on to the next phase in her life. For someone who feels insufficient and unsupported, she finds herself ill prepared to cope with these drastic changes.

Rae notes that whenever she was overwhelmed, "I let my mind be consumed with thoughts of food and exercise. Everything else simply faded away; nothing else mattered." Ata, a patient at the Renfrew Residential Center for Eating Disorders in Florida, mentions in her interview that "the best anorexic is the one who's six feet under." While she describes feeling ineffective at most things, she "knows" how to be a "good" anorexic. "It's a person who lives inside of you. It was a distraction- I didn't want to deal with anything in the world. No one came to me for anything because I was sick." She describes her body as her tool and instrument, and how it served as her voice when she was unable to put her feelings into words. "I think that it protected me all these years. I don't know if I would have survived without it. I was able to not feel what I couldn't deal with for so long . . . The eating disorder was a way to calm that down and to soothe it."

Cheryl, also at Renfrew, felt that after her childhood sexual abuse she didn't want anyone to look at her. "I wanted to be invisible. If anyone looked at me . . . I just had to get smaller. I wanted to stay thin like a little girl." As her body began to shrink she

started to feel safe, stating “anorexia made me feel good. It made me feel like nothing could ever happen to me, that I could be so thin and still walk around. It made me feel like Superwoman. It made me almost invisible.” She believed that if no one could see her, they could not hurt her. Anorexia became something essential in her life in order to keep living.

The Role of Fantasy in Childhood

Many parents and loved ones wonder how anorexia enters the life of the sufferer, especially when the pressure to be thin or look a certain way did or does not dominate the home or peer group. While the purpose of this paper is not to demonstrate the origins of anorexia per se, it is worthwhile to examine some aspects of these women’s lives before they began restricting. As mentioned in the literature review, Geist (1989) describes that ongoing disruptions in the “empathic connectedness between parent and child” prevent the child from taking in and making “soothing and tension-regulating structures” her own. It is for this reason that the person must quietly and silently turn inwards to gain as sense of vibrancy and life, highlighting the second paradox experienced by the sufferer of anorexia, *fantasy as the other object*. For many of these women, they describe intense childhood fantasies, which often focused on playing out painful fears and anxieties.

Rae, Lucy, Lori, and Marya all reference a vibrant and lively imagination in childhood. They also spoke of retreating into fantasy for comfort or soothing. Rae writes that in her imagination, “I was self-sufficient- I had everything I needed.” She would play games with neighbors or by herself that she was a servant girl to a wealthy family. She had no one to take care of her, thus allowing her to enact and demonstrate this self-

sufficiency. In another imaginary game, she was a lost child, “jumping from abandoned despair to forced self-reliance.”

Reflecting on these times of play, Rae remembers them fondly. However, with this fantasy life she also learned at a young age that she should hide certain things about herself from others, things that should not be discussed. “Even then I knew they were secret, and to risk telling the secret was to risk being judged and to feel ashamed of what was an authentic expression of how I felt, what I longer for, and who I was.” Being the youngest of several children, Rae felt she became “easy to ignore” as a child. Given the hectic nature of the home life around her, she remembers deciding to take up less space, leading her to spend most of her time in her own head. The message she perceived was that she should not impose her needs on those around her and should instead focus on being self-reliant.

Lucy also retreated into “imaginary universes growing up,” where she could be anything she wanted and had unlimited power to save the world. For Marya, she describes her journey into her eating disorder as akin to the journey taken by Alice into Wonderland, “going through the looking glass” into a new world, “where up is down and food is greed, where convex mirrors cover the walls, where death is honor and flesh is weak. It is ever so easy to go. Harder to find your way back.” Unlike Alice however, she writes that anorexia ultimately lied to her because she was not able let go and return home. Marya notes that the beauty and the danger of a rich fantasy life is that it is quite powerful. “The depth and breadth of my imagination became a threat unto itself. Passion is strange. Mine is fierce, all-encompassing, a fiery desire for life.”

Lori found her flair for life and intelligence usually elicited some negative response from the adults around her. She was often told to be quiet, to stop being rude, or to stop taking back. In one of her early psychiatric sessions, she was eager to tell the doctor about a recent vivid dream she had, which happened to poignantly capture her anorectic fantasy. In the dream, she found herself starting to laugh and as she opens her mouth, air blew in. “It tasted like everything mixed together- it tasted like everything and nothing at the same time.” Her mouth began to get so full that she almost couldn’t breathe. “I tried chewing the air so I could swallow, but it wouldn’t go down. It just stayed there.” She feared she might die, so she kept chewing harder and harder. “Then all of a sudden I could breathe again and I was full.” As she is telling the dream, her psychiatrist interrupted her and demanded that she stop making things up and wasting both of their time. She was devastated because he was not listening, *and* he stopped her before the most crucial part of her dream. In her chapter, entitled “Chewing on Air,” she finishes the dream for the reader. “But the best part of the dream was when this wave came along and carried my boat up to heaven. I wasn’t scared about not surviving anymore, because obviously I survived just fine chewing on air.”

Feeling Out of Place From Within

Many of these women commented that throughout their lives they often felt like the odd person out. Whether this was actually true or a manifestation of their own anxiety, they perceived themselves as unacceptable at the core and unworthy of being included. Many experts cite these feeling as a crucial element in the development of an

eating disorder (Bruch, 1988; Claude Pierre, 1997; Reindl, 2001). This raises the third paradox for the person with anorexia: *feeling out of place from within*.

Rae's family moved around many times in her childhood and as a quiet and shy person, she often felt like the person outside looking in on others. She felt "anonymous" and that she had to "pretend to have something to do" in front of others. "I had no tools for navigating this system [school]." She recalls a certain song lyric that as important to her at this time that seemed to capture her sense of loneliness: "*I am a rock. I am an island.*" Entering yet another new school at 14 years old, Rae remembers singing this song to herself as she would run for her new cross country team. As she tried to fit in with certain crowds, she would afterwards feel fake and stupid, and eventually distance herself. After several attempts at trying to fit in, she did not feel comfortable and was again left alone and depressed. It was in this state of loneliness that she discovered anorexia.

Lucy felt she could put on a good show for others, and was able to "comically show off," though she was really embarrassed most of the time. "I amused people but did not really bond with them. I taught myself to be funny, because funny kept you somewhat socially afloat." She began to realize that she could create a separate, false self to show and entertain others, which was different from her true inner self that was quite sensitive and shy. Like Rae, Lucy was very lonely and began to believe there was something inherently wrong with her. She believed others would not be interested in her unless she was "better" so she lied at school many times in order to amplify her appeal. Around others, she wrote of a "hovering panic" in which she could "play the act and keep the audience laughing" but later "retreat into pillows and the pages of a diary." She was

left crying at her own “falsity” and “pretense,” and would ask herself “why can’t you just be real?” Like Lucy, the pain for Rae became worse at night, and she would often sit on her bed or even in her closet, waiting for someone who never came.

Claude Pierre (1997) explains that anorexia is “the culmination of negative subjectivity turned against the self and this hypercritical subjectivity will cause her to interpret every comment made to her as a negative reflection on her” (p.32). This was well illustrated by Lori as she describes how her mother would tell her from a young age that she should not go around talking openly to others, including those in the family. She wrote in her diary the following observation: “I guess as you get older you just have to keep your real feelings inside, like a secret, but I’m kind of a blabbermouth, which got me in trouble.” Lori would often get punished by her mother for saying how she really felt, as well as encouraged to hide parts of herself that were not as “pleasing.” She remembers being confused by instructions to hide her real thoughts, while also being told to make up lies instead. Her mother called her abnormal for caring too much about non-girl things like “math,” and would wish out loud for her daughter to be less “unique.” Lori recalls one parent-night at school during a time that she had excelled in many subjects and had just won the science fair, only to be asked by her mother, “why can’t you look more like your friends?”

For Morgan, she writes in a journal entry for Blythe at the age of thirteen that reflects on her internal badness. “I’m loud and obnoxious at times, with a selfish streak.” She goes on to write that there is just too much of her, though she knows to play it calm and cool around others, making sure to keep these “bad” thoughts inside of her. She

divulges the truth she most fears in another entry later on: “If you really knew me you wouldn’t like me. If you knew the real me, you wouldn’t like me at all.”

Marya has written at length about feeling out of place in her own skin and how her body never felt comfortable as well. “It has always seemed to me a strange and foreign entity. As far back as I can think, I was aware of my corporeality, my physical imposition on space.” In this uncomfortableness, she remembers thinking that she was the only one who felt her body brought on guilt for having needs. Through multiple environmental influences, as well as her own internal experience, Marya states:

Somehow I learned before I could articulate it that the body-my body- was dangerous. It was dark and possibly dank, and possibly dirty. And silent, the body was silent, not to be spoken of. I did not trust it. It seemed treacherous. I watched it with a wary eye.

Marya’s body was not safe because it was not an acceptable part of her.

Jena experienced a similar feeling of being at odds with her body, which started at the young age of three. While she writes that she has never been close to “fat,” her earliest memory of her body was that it was too big. She remembers pinching the skin of her stomach until it left a “stinging red welt in the shape of toddler fingers.” She had already learned to hate her body and punish it for taking up more space than it should. “I was awkward. And there was entirely too much of me.”

When recounting childhood memories, Rae writes eloquently about her struggle with her family, “I remember feeling smothered that their expectations were too high. When I expressed feelings that threatened these expectations, I felt pushed against rather than understood, and I desperately wanted to be understood.” Rae’s anorexia would soon serve as a buffer against these expectations. As she developed her disorder, she describes that it “expressed my conundrum.” Anorexia provided her relief from the scrutiny and

desires of others. “It locked away my sadness at not being understood, while I expressed my pain in the destruction.”

Anorexia also helped Rae develop a separation from others so that she could coexist in a family with unpredictable boundaries. She remembers the desire for recognition from her family left her feeling quite lonely, as if again she was on the outside looking in. She was caught between a hope to be noticed by her family and experiencing their presence as overwhelming. “Sometimes there was very little space and other times, the distance felt immerse.” At the beginning of her anorexia, she wrote about this in her journal. “I want to be heard, I need to be seen, respected as my own person- not sure how to say this, if it is okay to feel, so instead I’ll disappear.”

Lori writes about her wish to be invisible in the early stages of her anorexia, having felt at one point that invisibility might actually be essential for her survival once she began getting so much negative attention from her parents. Ironically, as Rae and Lori started to physically shrink, they became the subject of much attention and scrutiny in their families. The result of the anorectic’s vanishing act often brings about a hyperawareness from her family after years of misattunement. The sudden onslaught of concern, including potential criticism, is thus experienced as intrusive and overwhelming, leading the sufferer to further commit to her illness.

Lucy was terrified of being seen as “bad” by others, and always wanted to be “good” and liked. Early on in her restricting behaviors, her family brought her to a doctor who went on to comment that she “certainly didn’t look anorexic.” Lucy became embarrassed and was devastated to feel like she was even failing at anorexia. She took this as a challenge to “prove him wrong,” vowing to succeed in this pursuit. Like Rae,

Lucy felt unnoticed and was stuck in a conflict of wanting to be seen while also wanting to disappear. “It was too big. The world was too big and there were too many people. And at the same time I was too big, too noticeable. Please, God, let me melt into the pavement.” As an adult, Lucy realizes that she did not know how to exist as separate from others when she was younger. When others did reach out to her, especially in the throes of anorexia, she would, “shrug away from them so they would feel her spine.” She felt the urge to “crawl inwards” to go into hiding and not come out. She found herself wanting to yell, “you can’t see me,” to avoid other’s scrutiny.

Marya’s was mother was a powerful and shaping force in her childhood and felt her mother could, with just a look, “zap me into disappearance.” She, like Lori, was told to quit acting like a child, even though that was precisely what she was. Marya writes that both of her parents associated love with food, and love with need, resulting in a forbidden web of desire between food, need, and love. Growing up with parents that constantly argued before divorcing, Jena remembers feeling guilty that she was sad when her parents fought or talked poorly about each other. She only ever felt angry with herself for being fat, never upset about their separation or at her parents themselves. At this time, she had already learned to translate any uncomfortable feelings into “being fat,” which allowed her to regulate and calm herself in times of distress by focus only on food and losing weight.

While eating disorders are understood to be a multidetermined illness, it is worth examining some of the messages communicated to the authors from their caregivers (Bruch, 1979; Chernin, 1985; Geist, 1989). Marya, Lori, and Jena, all received feedback and warnings about the dangers of abundance, arrogance, and becoming ‘too much.’

Jena's mother warned about her "getting chubby" if she was not careful, speaking of fatness as something that could sneak up on a person or even just happens out of the blue. When Marya was fourteen and accepted to an art high school, her step-grandmother and mother made sure to comment about how she would probably "get a big head, and think she was really something now." Marya wonders in her writing why they felt it was necessary to prevent her from thinking she was special. "What a terrible person I would be if they both allowed me to go on thinking I was talented and smart."

When Lori had just begun restricting her defiance to eat interrupted the family trip and sent her mother into a rage. Lori notes that she was called "embarrassing, selfish, crazy, and some other things I can't remember right now. She [her mother] was screaming so loud she was practically breaking my eardrums. The worst part was she said she wouldn't love me if I wasn't her daughter. 'I hate you!' she screamed."

Separation between the parent and child can be difficult, and at times it seems as difficult for the parent as it is for the child. In "The Case of Ellen West" by Ludwig Binswanger (1958), Ellen was a Victorian woman known to suffer from restrictive eating behaviors, despite being overweight. Her history and symptomatology have been well documented, including an enmeshment with her parents. It is noted that at the age of 18 on trip with her family, she could never be alone, that is away from her parents, and would beg for them to return. It was the time after the trip that Ellen could no longer eat unencumbered. Two years later Ellen broke off an engagement to be married due to her father's wishes. In her diary, she complained that she had "no home anywhere," conveying feeling of being lost and unanchored.

Geist (1989) has found that anorectic patients are often precocious children and have taken on a “mothering role” in the home. Lori and Jena often found themselves “taking care” of their mothers, whether it was Lori holding her mother’s hand while she, the child, was getting blood work, or how Jena constantly felt like the parent-child roles with her mother had been reversed after the divorce. Jena distinctly remembers having to give up her own needs to emotionally take care of her mother. Rae’s experience was that when she was upset or sad, those in her family walked away from her. “I did not understand my worth because my entire identity was determined by others, how they responded to me. I starved my body, made it nothing, just like my sense of self was starved.”

She also notes that in her family’s culture, the emphasis was on what the person was doing and producing, instead of how one was feeling. She writes of feeling judged by her parents as inadequate, wondering if it was because she was the youngest or quiet and introverted, or both. For whatever the reason, she felt the message to her was, “we don’t trust that you will become a wonderful person in your own right, we must watch you and direct you.” Bruch (1979) describes that many of her anorectic patients could no longer tolerate living under the thumb of their parents. “They would rather starve than continue a life of accommodation” (preface). Bruch describes the journey into an eating disorder as a “blind search” for a separate and substantial self, and how anorexia is a struggle to achieve this separation. In choosing to live with anorexia, she believed that these women and girls are taking a stand for their independence and worth against their parents and the world.

Regaining a Control That Cannot be Controlled

Eating disorders often emerge during adolescence, a time in life where control gains new meaning and purpose. Experts (Bruch, 1979; Chernin, 1985; Claude-Pierre, 1997) have hypothesized that control is a central issue during adolescence because girls, in particular, feel that they are no longer in charge of their bodies, and the future suddenly seems more unpredictable than in childhood. For a girl who already feels uncertain about her sense of self, the start of puberty can leave her feeling violated and powerless. Food becomes an area in her life that she can control, while also allowing her some say over the changing shape of her body. In this a time of internal chaos, anorexia can lend her a way to assert her autonomy. Bruch (1988) documents how through the body and food consumption, a person can regain a sense of control and power.

She denies herself nutrition as a way to assert power over her body. She makes it her kingdom where she can be the absolute dictator, demanding it to go without. To not give into the demands, she feels she is accomplishing something superior and fulfilling the highest virtue. She feels better and more worthwhile when losing weight. She feels the only way to assert herself is through not eating. (p.54)

In this process of perceived empowerment, the sufferer enters a fourth paradox of anorexia, *a control that cannot be controlled*. While at first, the person experiences relief and calm over her life, she soon finds that her illness, the voice of anorexia, is actually the one controlling her.

Lucy experienced a desire to make life simple when she began restricting and eventually settled upon a specific goal weight because it was “nice, round clean- nice and even, ordered, simple.” The order and concreteness of this number provided her with a solution to her mounting sense of anxiety in her pre-adolescent years. At the start of anorexia, the person can experience an initial sense of relief as she begins to lose weight

and her anxiety initially decreases (Bruch, 1979). Lucy felt in “excellent control of [herself] around food,” as she was able to deny something while others gave in to their “weakness” of needing to eat. Rae also remembers feeling powerful and “full of iron will” when she began restricting, and soon achieved a level of discipline that made her feel exempt from food.

Bruch (1988) notes that though the anorectic is “eternally preoccupied” with food, she is able to deny herself through implementing rigid control. The distinction of anorexia from a symptom of lack of appetite is important because the anorectic *does* experience hunger and is at times overwhelmed by her desire to eat. It is only through this extreme self-control that she is able to abstain. As Bruch continues to describe, this leaves the sufferer with an ongoing fear that at any moment she will lose control and give in to temptation, which results in a further heightened sense of vigilance and rigidity.

These issues were very prominent for Marya in her eating disorder and she writes how restricting provided her with the “illusion” that she was in charge. “The convenience in having an eating disorder is that you believe, by definition, that your disorder cannot get out of control, because it is control.” To maintain this balance, a tremendous amount of thought, order, and planning must be held with absolutely no flexibility or diversion from the plan. Often the sufferer can be found writing or reciting numbers, making elaborate calculations in her head of calories and exercise to arrive at a number she must reach to remain in control.

Marya goes on to note that in the beginning of her disorder, she felt a power that was a “perfect response to a lack of autonomy.” In an environment where she felt unable to regulate her emotions and responses to others, she developed a system that allowed her

to scrutinize and dictate what went in and out of her body, and it served as a concrete message to others. Marya believes that it said to those around her “you cannot control everything about me.” She goes on to further explain the extent of her thoughts. “It lets you imagine that you are controlling the extent to which other people can access your brain, your heart.” When Marya became severely anorectic for the first time, she notes that she “did not feel afraid” of herself. While she knew she was still a mess inside, reaching this level of starvation became linked to a sense of agency for the first time. “I always connected my ability to get control over my rampant needs and desires to my ability to starve.”

When Jena was in recovery and was forced to eat, she remembers looking back on her anorexia and longing for the safety and security it provided. “I longed to run full-speed back into the black cave of sickness that had once brought me such solace. I missed my frailty, my naked bones, the feeling of shrinking away from the world.

Anorexia seemed familiar and welcoming.” When she began restricting, she noticed that she took up less physical space in the world, which gave her a feeling of excitement and pleasure in her “success.” Anorexia often presents a strong and persistence voice that encourages the sufferer to “stay the course” in the face of temptation or weakness. Jena remembers at the residential facility how her anorectic voice encouraged her to fight through the treatment process. *“She’s never known how amazing it feels to be this thin. Get rid of the muffin, just do it, before you give in. Don’t be weak!”* Jena, like Marya, writes that she often missed her anorectic lifestyle, including the power and the allure of control it provided her for the first time. In recovery however, Jena learned that anorexia ultimately lied to her by selling a false promise of a life of control and autonomy. In

truth, anorexia took over her life and became the very opposite of control and empowerment. In its progression it left her more lost and powerless than before she became sick.

These women spoke of their illness as taking a turn that left them no longer feeling in charge of their choices and behaviors. The anorectic voice ultimately became one that battered their self-esteem and challenged their self-worth in a way had never experienced. Bruch (1979) writes that as the anorectic starts to lose weight, she experiences a sense of pride and superiority, yet her victory is short-lived because no weight will ever be “good enough” for anorexia. She is then compelled to keep losing, leading to a downward spiral from which she cannot escape. For all of these women, they had flashes of realization that anorexia was defeating its original purpose, yet they were too locked in and did not know how to escape. These moments of awareness were often short-lived and it took many years and great effort for most of these women to break free from anorexia.

Rae describes herself as a prisoner to anorexia in her head, stating:

[I was] trapped by obsession that had taken control of me when I was not looking. I felt tricked and robbed of myself at times. Realized I was no longer making the choice not to eat. Rather I was no longer allowed to eat. Rules had taken on life of their own.

Even as Rae began to notice this shift in power, she remembers only the feeling that she could not eat because ‘the voice’ told her she was not allowed. It never crossed her mind to argue back and to challenge it, and she was unable to realize that anorexia was there to serve her needs, not the other way around. As the physiological effects of starvation began to take over, Rae lost her energy, along with her spirit and ability to speak for herself. While attempting to be a stronger self, she realizes in hindsight that she lost

completely to “the Voice.” She describes the trickery of its encouragements that told her to keep going literally on nothing. It would tell her she was strong and she should not “ruin everything by eating.” When she did feel like giving in or giving up, she says the Voice became angry and would call her “worthless, disgusting, weak, fat, and stupid.” She would find herself pushed to prove the Voice wrong and in turn worked even harder at her anorectic behaviors.

Rae thought anorexia would allow her to harness a will of her own, yet in recovery she is able to see that this was just an illusion. “I lost my power to yet another thing, another pressure, another voice that was not my own. It was an evil trick, an unfair trick.” Rae remembers the first moment she noticed her illness changing from empowering to imprisoning, when she received her feeding tube. While she was sedated the doctor surgically inserted the thin tube up her nose, down her throat, and into her stomach, and she was hooked up to an IV so that her liquid nourishment could be monitored. As she was walking out into the waiting room after the procedure, she saw her father’s somber face and she “knew something” had shifted. “I felt broken, a sad shadow of what I had been. The tube made me see how far away I was from the person I used to know as myself.” Despite this reflection, it took years after this procedure before Rae was ready for recovery.

Lucy discusses the biological effects of starvation and the irony of how starving herself to get a stronger voice ultimately failed because it resulted in her “ceas[ing] to think independently.” When severely underweight, Lucy remembers the “weight and stodginess” of her brain, which prevented her from concentrating in class at school. The mental and emotional work that anorexia needed soon became impossible to maintain

with a starved brain. Coming through recovery, Lucy talks of how anorexia latched on to her and lied to her. “It makes you believe that it is your true identity, your true calling.” It gave her a false promise of defining a new and improved self that others would want to know and be around, a self that she would be happy to have. The truth, Lucy writes, was anorexia “destroyed my life.”

Not being able to control yourself is terrifying. The odd thing is, anorectics assume that they are in total control of this process, when in reality they are slowly and progressively handing control to the anorexia. To that demon . . . anorexia has its own logic that isn’t compatible with conventional reason.

The dilemma in anorexia is that in the search for control, the sufferer engages in behaviors that cannot be stopped.

Throughout the phases of illness, recovery, relapse, and again recovery, Marya writes that anorexia initially worked to calm her anxiety and fear by providing control, yet it soon began to run her life, to hurt her, and in the end, almost kill her. Even at 52 pounds and given a week to live, she was still caught in her anorectic mindset and wanted to hold on to her illness. She describes that she wanted to “cling to the idea that this will save you, it will, in the end, make things okay.”

Jena remembers in the earlier stages of her anorexia a point when her restricting took a dramatic shift from facilitating weight loss to a more “sinister and twisted” purpose. “I no longer wanted simply to get thinner; I wanted to shrink, in every sense of the world. Actually, it was no longer a matter of what I wanted. It was, after those first twenty pounds, a matter of pure, unmitigated obsession.” In her disorder, Jena writes frequently about the internal voice of anorexia that became her tormentor. “*You’d better hope they never find out what a fraud you are. They think you have real talent. You’ve got them fooled. You’re nothing.*” The voice of anorexia, which Jena refers to as her evil

twin, also used shame and criticism to keep her going. It would always cite that the reason for any failure or misstep was due to her being “too fat.”

In these shaming, self-defeating moments I was suddenly and inexplicable fat-fatter than I had been the moment before. I would grab the flesh of my belly, or inner thigh, and pinch until the tears stung my eyes, leaving bluish-yellow bruises the following day.

When Jena reached a dangerously low weight she grew soft, fur-like hair all over her body called lanugo, the body’s attempt to keep warm with little insulation. At this time she frequently blacked out and lost consciousness from starvation. In treatment as she began to put on weight to regain physical functioning, the voice of anorexia thrashed and increased the intensity of its remarks. After calling her a pig face in the mirror of her car, it would taunt her, saying that she should never to look down in front of others, because in doing so they would surely see her double chin.

In recovery at the Renfrew Center in Florida, Kathy, a 48 year-old woman with severe anorexia, remarks in her interview that there is “nothing good on me anymore.” In a photograph that accompanies her words, the reader can see that her emaciated form makes her look years older than her stated age. Her skin is pale and papery thin, and her mouth sinks in due to a loss of many of her teeth. She describes that her recent physiological state has deteriorated and she is now leaking fluid through her skin. Despite these severe health risks, she states that she still does not feel her life is in danger. She frames her treatment as a “fight for sanity more than anything . . . The only one who’s going to control my body is me. They violated me and they weren’t going to do it anymore.”

Also at Renfrew is Cara, a 31 year-old woman, who remarks that anorexia makes her feel safe. “I felt the smaller I was, the more protected I would be- I didn’t want to

feel anger- by not eating, I didn't feel those things. But I didn't feel anything else either."

In recovery she is trying to free herself from anorexia's grip. She notes that the only thing she has ever done with her life to date is change how she looks. Her only goal has been to be thin and stay that way, so she would feel like an absolute failure if she started to recover. She is left with an excruciating choice between getting better and destroying her entire sense of self, or concentrating all of her energy into succeeding at anorexia, even if it costs her life.

Changing the Outside to Change the Inside

In relation to this idea of control, many of these women felt that if their physical appearance changed, it would also bring forth a change internally. Their worry about how to alter an inner sense of inadequacy became replaced with the idea of transforming their physical shortcomings into something desirable, in the hope that their selfhood would experience this same transformation. It is in this shift of pain and distress from the psychic to the physical that a fifth paradox of anorexia exists: *change the outside to change the inside*.

Bruch (1988) writes that anorectic patients have in common a "severe dissatisfaction about themselves and their lives," which they transfer "to the body"(p.4). She has found that as they continue to feel overwhelmed by the demands of their lives, their fragile sense of self is further damaged and feels pushed to its the limit.

Rae notes that as she began to restrict, she felt different in her body. "I felt lighter, harder, stronger as I lost weight- as if I could walk on air. The more weight I lost, the easier it became to forget my body altogether." As her weight dropped, the burden of

her body became less and less. She describes the different ways that her body no longer felt like a burden. “I couldn’t feel clothes on my body . . . I didn’t feel my legs touching when I stood feet together.” Her goal soon became to reduce her body to its bare essentials- literally to the bare bones. As her body began to shrink, it started to feel less and less like part of herself. Rae reached a point when she could look at her body in the mirror, and no longer feel like it was part of her identity. “Gradually my mind and body became so separate that I rarely made the connection that my body was part of me.” Rae felt her body became a machine that had no feelings, and only needed to be “maintained,” like a car, and “had to look polished, trim, hard.”

Morgan, as Blythe, writes of the changes she experienced in anorexia. As she went for a run one day on a very low calorie intake, she described, “colors are brighter but lines are blurrier... I’ll go from weighty hotness to a floating coolness. The legs that were at one moment heavy logs seem to take flight and I’m running on air.” As Lucy starved her body, she frequently had the feeling of watching herself from above, dissociating from her body in a way that made her feel her body was not her own. She writes of her desire to be rid of her body.

I want to starve myself into oblivion- translate my self-hatred into something tangible. I want to waste away into absolutely nothing and never have to feel anything again . . . I just want to get rid of myself. I just want . . . to cease to exist in a bodily fashion. I just want to dissolve into transparency.

In feeling utter hatred for her physical being, anorexia allowed her to put all of her energy into reducing the body to its smallest and least imposing form. “I’m going to exercise and exercise until I melt all this disgusting crap from me. Maybe then I’ll find a lovely, confident, socially extroverted Lucy beneath all this emotional residue.”

Marya's sense of self-hatred was not only for her outside shell, but spread to her inside, fearing that her ugliness had seeped into her inner being. She hoped that she could reduce the "disgusting" outer layer of herself, she would also be able to transform this inner grossness that she harbored inside. "I didn't know what lay beneath the skin I wore. I didn't want to know. I suspected it was something horrible, something soft and weak and worthless and stupid and childish and tearful and needy and fat." As she was writing her story years later in recovery, she reflects that this shrinking of her body provided a "carving away at the body to- symbolically and literally-carve up an imperfect soul." She somehow felt her external disappearance would in turn reduce the same awfulness she believed resided deep within her. In getting rid of the body, the anorectic also seems to reduce contact with others and the outside world. Morgan, as Blythe, writes of her desire to run away and "be in the middle of nowhere," to be "devoid of human contact," so that she could be free to write, run, and restrict as she pleased.

Jena also writes about the desired emotional and mental effects she hoped would've come from physically shrinking her form. She believed that through starvation she could escape the aspects of herself that were dark and dangerous. As her body began to take up less space, she felt "safe" not only from others, but from her own internal "badness." In the case description of Ellen West, Binswanger (1958) describes that during her adolescent years Ellen first experienced a dread of getting fat, leading to fasting and taking long and grueling hikes. Even indoors she would not be content to sit, but would circle around others, with the intent to reduce the size of her body.

One of the goals in anorexia includes the need to "take up" the least amount of space as possible. Claude Pierre (1997) explains that the anorectic grows tired of trying

to achieve perfection, and this energy is diverted into “an attempt to be the smallest and sickest” (p.54), of those around her. Claude Pierre goes on to describe the “subtle reality of this mindset is that the sufferer needs to be the best at being the least deserving” (p.54). Marya also echoes this observation, stating that sufferers grow tired of “seeming impressive . . . As a rule, most of us never really believed we were any good in the first place.” She remembers when she was on an inpatient eating disorder unit and lying in bed next to equally gaunt and frail anorectics, none of them would entertain using the nurse call button. Each seemed unwilling to give in to a “weakness” that came from getting help and thus wanting to get better. Marya notes that this mindset is rigid and very resistant to change, even as the body is failing. “None of you are really sick- you don’t warrant worry.” Marya also wanted to avoid others because contact with someone else reminded her that she was a person and thus someone to be taken care of. “This felt to me profoundly false, and I felt I did not, in any way, warrant such care, such contact. Contact with another body reminds you that you have a body, a fact you are trying hard to forget.”

Melissa at the Renfrew Center in Florida told the interview that when she was in the hospital at her lowest weight, 52 lbs, the staff had wanted to put her in a nursing home because they felt she was just wasting a bed there. At this low weight, her body had begun to eat her muscles and would have soon moved on to her organs. As she lied there with atrophied muscles in a feeling of paralysis, she would hear them discuss how she was “taking up space” that could be used for someone else. Morgan, as Blythe, also hoped that losing all of her ‘awful fat’ would make her happy and “finally feel good about herself again.” She, like Marya, writes of being in the hospital and how she was

not “really sick.” She felt she did not warrant needing to be there because she wasn’t nearly thin or small enough to be really sick. She remarked, “I don’t feel thin or depressed enough to be anorexic.”

Rae remembers her wish to weigh literally nothing, to be a zero on the scale, and cease to take up any space at all. In a family therapy session before being hospitalized, her older brother remarked that whenever he came home from college, there was less and less of her “left,” which gave her a great thrill and satisfaction. This desire to take up the least amount of space coincides with Rae’s belief to not bother others or “obtrusive.” Her physical shrinking allowed a literal interpretation of this fantasy, rendering her presence less imposing as it became smaller. Rae recalls the pleasure she had in feeling light, “like I didn’t have to carry anything.” In starvation, Rae felt able to disappear, which somehow helped her take “away the pressure” in her life. In treatment, Rae found the process of gaining weight almost unbearable, feeling as if she were overtaking others and the room around her. As she began to ‘fill out’ she panicked when her “arm was no longer sinewy and bony.”

Before anorexia, Lucy felt like a “nothing” and “a waste of [too much] space.” She labeled herself as the odd person out, believing she was too much of some things, paired with “not enough” of something else, something that was crucial and likable. This left her in a constant worry being enough, both emotionally and physically, including how much space she was “allowed” to occupy. “I felt there was just too much ‘me’ in relation to ‘them’; the faceless them, the society of acceptables.” When Lucy first read a memoir of anorexia in the beginning of her adolescents, she became fascinated with the idea of someone “vanishing ... a gradual fading of self.” This seemed like the perfection

solution to her feeling like too much. She decided she could just shrink herself to a more reasonable size.

Lucy, like Rae, came to disown her body in anorexia, which at the time seemed to satisfy her discontentment. “Starving- self-annihilation- is ridiculously compelling- I was my own morbid entertainment. A disembodied denial warped everything.” She writes that she would swing in and out of her body, have fantasies of cutting off her flesh, or melting it away. She intensely wanted to disappear, to do something to “whittle all the shit away from me and expose my true self . . . I didn’t want to have to make a decision. I wanted to escape.” She recalls one time in the shower that she just stood there letting the water run over her, not realizing she had to wash herself for some time. She intentional did this slowly and carefully, aware of “not wanting to identify this body as mine.” Later in recovery, Lucy found a picture of herself as a young anorectic teenager and was surprised that it actually appeared in the photo that she had no body. “My face is ghastly pale, with skin taut over cheekbones and skull, eyes dark and veiled, head somehow supported by a sinewy and bony mess of a neck. It is all a wicked lie.”

Jena also experienced her body as something she wanted to “cut up” and get rid of. “I spent most of my time concentrating on the changes taking place in my body, noting every new bone and symptoms with glee.” She felt that at this time the ‘real Jena’ was not present. It was her “shell (or my skeleton?),” she comments, that was “free to experiment, to go a little crazy, to test the choppy waters of uncharted territory.” Since her body had transformed in anorexia to something she no longer cared about, “it” could now explore, be reckless, and live with abandon. Like all of these authors, Jena recalls in detail the physical effects of starvation. Initially, she describes a sharpening of the

senses, “the palpable sense of power over the flesh and over the self, and the sneaking suspicion that you have become invincible.” In this state Jena believed she could transcend the limits of the biological body, unlike those around her who were bound by their humanness.

The changes that took place in Marya’s body made puberty a difficult time for her. She remembers the preconceived notions she had about becoming a woman, which included dissociating from, and developing spitefulness towards, the body. It also meant that she would always find herself wanting, since the needs and desires of a woman’s body seemed too dangerous to claim. As a young teenager, Marya remembers the period right before going to boarding school as the last time she was free before anorexia took over.

The girl I knew as myself was about to disappear. She was about to become no more than the blank spaces in the mirror where my body had once been. She was about to become no more than a very small voice.

As a passionate person, Marya seemed to recognize early on the potentially harmful side of her intensity. “I sought out what I mistook for the passionless state of starvation.”

Like Rae and Lucy, Marya stopped seeing and feeling her body as her own. “You begin seeing it instead as an undesirable appendage, a wart you need to remove . . . Anorexia is a complete removal of the bearer from the material realm.”

Ellen West wrote of feeling at odds with the social expectations for women, which she felt required her to be “silent and grin like a puppet.” She expressed in her journal of wanting to be seen as a “human being with red blood and a woman with a quivering heart,” yet she was unsure of how to manage the conflict of her needs and the social norms imposed on her. Later in her illness, Ellen describes feeling “stuck” in her

body, as well as dreading getting fat with intense longings for food. Ellen also wrote poetry in her journal, including one piece in which she describes being a “discarded shell, cracked, unusable, worthless, husk.” Like the women discussed, she felt her body was worthless and a hindrance. At times she would be found beating it with her fists. As her restricting increased, she wrote of becoming more withdrawn, including feeling as if she were in a glass ball, no longer reachable by others.

At the beginning of her anorexia, Lori remembers a time in a store with her mother in which she saw a collection box at the register for an organization providing food for starving children. She distinctly recalls the picture on the box of a young underweight girl from a third world country, “with thin arms and legs and huge eyes.” As she gazed at this girl, she thought, “I wish I was that beautiful.” Lori realized that while others saw this girl as someone in need, to her the girl seemed to have it all. “The secret on the girl’s lips was pretty obvious: ‘ People think I need help because I’m hungry, but they’re the ones who need help. At least I’m thin.’ I could tell that’s what she was thinking.”

Later on in a therapy session with her psychiatrist, Lori was asked to draw a picture of her ideal body shape. After she handed him her drawing, he handed it right back to her saying, “this is a stick figure,” like she misunderstand his directions. He told her to try drawing a realistic picture of how she would like to look and not to worry about her artistic ability. She tried to explain to him that she heard him the first time and that this was *exactly* the way she wanted to look, but he didn’t understand. He told her she wouldn’t be alive if she looked like that drawing. For Lori a stick figure, that is a person without a “body” was precisely that for which she was striving.

An Empty Fullness

A sixth paradox that emerged concerns issues around feelings of “enoughness,” which includes the concepts of fullness, emptiness, longing, and need. This can be described as an *empty fullness*, which captures the phenomenon of the person feeling full or satiated precisely by refusing to eat, particularly while others are eating. This satisfaction can become intensified when others eat something that the sufferer herself has prepared.

Rae would often make food for others and watch them eat without joining in herself. “When I would not let myself eat, nothing pleased me more than to see someone else eating, especially something I had made for them. I wanted to eat, and I derived vicarious pleasure by making food for people and seeing them eat it- it satisfied me somehow.” It was as if through feeding others, she was able to somehow feed herself. Bruch (1988) describes a patient of hers who was very smart and all-consuming with thinking about food and her body. Bruch states that the patient felt so diffuse and undifferentiated from others that she would often feel taken over by another person, as if she was assuming his or her identity. As she watched the person eat, she would feel full, figuring out how to have others eat for her without having to take anything into her body.

While in school during her lunch period, Lori always threw out her food and sat in the library, feeling content and satisfied to “read more diet books and make lists of food I won’t eat.” During starvation, Marya wanted to talk about food all the time, stating “you want to discuss tastes; what does that taste like.” Lucy experienced great satisfaction when making food by following a recipe perfectly, finding the experience deeply satisfying, “almost like eating it myself.” Ata, a patient at the Renfrew Center, would

watch the food network and “eat through her eyes” as if she could derive vicarious pleasure to satiate a bodily desire.

At one point it is reported that Ellen West became very ill after a period of restricting and also swallowing 36-40 thyroid tablets a day. It was described that she had “trembling limbs” and had to “drag herself through her physical torment,” but noted feeling “spiritually satisfied” because she felt thin. Like Rae, Ellen would also enjoy watching others eat and often demanded that those around her consume large amounts, and she secretly carried weights as she was being weighed. On an eating disorder inpatient unit, Marya remembers one woman doing something “positively erotic with her mouth to an apple,” spending time licking and slowly biting at the piece of food. When Marya asked her what she was doing, the girl replied, “making love to it.” Rae remembers feeling her physical emptiness was something that needed to be “endured and suffered through” yet also “embraced” at the same time.

When Lori first started restricting she remembers feeling happy that she was not eating anything. “I was hungry, but it felt neat, like I was *flying* or something. My whole body felt empty inside.” After losing a significant amount of weight Marya felt “utterly pleased” with herself because she was starting to disappear.

The act of becoming invisible is, in fact, a visible act, that rarely goes unnoticed. There is a strange sort of logic to this: We expect, in this world, that human beings will bear a human weight and force . . . I’m not saying erasing the body is magic, but it feels magical.

By transcending the normal limits experienced by everyone around her, Marya felt that she was special. Jena also remembers taking pleasure in defying the natural limits of the body.

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It disturbs me now to remember how pleased I was being told that I weighed next to nothing. I felt very strongly then that I could never go back. I had a desperate need to stay skinny, and I renewed my vow to do whatever it would take.

Jena's goal had been to reduce her body to its least workable state, so when she achieved this she felt great pride and triumph.

Taking pleasure in the physical results of becoming empty manifested for many of these women by touching and exploring their emaciated bodies. Lucy writes of lying in bed on her side, so that her "flesh [fell] away." She would take hold of her hipbone with her hand, and feel comforted because "empty spaces are just so simple." She experienced pleasure when realizing that there was less of 'her' around, resulting in her feeling satisfied, or "full" precisely when she was most "empty." In a journal entry, Lucy reflects on why she enjoyed it when her body was bare and vacant.

The obsession with bones is very odd . . . Perhaps it's about wanting to strip everything back to the beginning, the very essence of being. Perhaps this reflects my need for order and simplicity in a chaotic and pressured life. As though I need to peel off all the unnecessary slabs and residue and expose myself for who I really am. For me. No longer hidden by fat and detritus.

Lucy often felt compelled to count her bones under her clothes with her hands, acting on her intense need to physically feel them in the moment. She became preoccupied with measuring the space and gaps between the parts of her body, the negative spaces carved out by her decreasing flesh. "I was obsessed with creating space, hole-less and gaps. Turning something into nothing. Melting what had been there into air and into the past."

As a talented writer, Lucy captured this experience in poetry.

bones pearly and smooth,
they protrude, through flesh,
they are clean, perfect,
stripped of ugliness,
whittled down, the bones sand,
pure and flawless; the essence of being. . . .

it's lonely here, it's empty here,
devoid of feeling,
life flutters,
life quivers,
and goes out . . .

Marya would also touch her body, feeling for her bones. She remembers a time in which she was able to fully grasp her pelvic bone sticking out under her skin, like “twin toy hatchets.” She would make frequent trips to the mirror and examine herself, letting her fingers read her body, “like Braille, as if an arrangement of bones might give words and sense to life.” When she was hospitalized for the second time at a weight of 60 pounds, she remembers lying in bed and knocking one boney knee against the other. “Tapping them together, a steady singsong rhythm: clickclickclickclick.” She, like Lucy, became obsessed with studying the hollow spaces her body created in different positions.

I became very concerned with the gaps, space between bones, absent places where I was certain there had once been flesh but couldn't quite remember when . . . I dropped my pants and looked at the gaps- pressing my legs together as hard as I could, I'd look at the gaps between my calves and thighs. The space around it, to see if the space had grown or shrunk- cut the hipbone in my hand- knock on it- listen to the hollow sound. My lower body like a wishbone. I took my rib cage in my hands, curved my whole hands around the twin curves of bone.

In her work, Bruch (1979) found that while her patients had a hard time seeing themselves in the mirror as thin, they could often *feel* it, writing “through touch the anorectic can recognize the thinness of skin pulled over bones” (p77).

As Jena's skeleton began to reveal itself under her flesh, she became obsessed with seeing her bones and getting rid of anything “extra” on her body. Like Lucy and Marya, she found comfort in touching her bones. She describes the terror she felt in treatment when she realized her skeletal frame would soon be covered over. “The thrill of lying alone in a dark room and feeling my bones would soon be gone, replaced by an

unimaginable panic at the metamorphosis of a body I would no longer wish to claim as my own.” At the residential treatment center, Jena recalls seeing a fellow patient for the first time standing in line at the medication window. “Her extremely bony arms wrapped around her as she curled into herself as if imploding. The back of her ankle was nothing more than a naked cord wrapped in a paper-thin skin, the way her body didn’t seem to be there at all.” Jena saw beauty in this girl in how she had achieved the image of carrying nothing extra on her body.

Marya writes of a time during recovery when she was at a healthier body weight and experienced a bout of sickness that left her much thinner. She remembers clearly the feeling of rediscovering her “skin and bones” that appeared in her diminishing flesh.

My ribs thrust themselves forward through the skin, proud. In the mirror, my hands play them, a hollow instrument. My hands make their way to the sway of my back, snake down to press the twin knobs at the base. My hands, shy as hands meeting up with an old lover, touch lightly, in that breathless disbelief; are you really here? Have you come back to me at last?

The emotional experiences of each of these women became further enhanced as their bodies entered the physiological state of starvation. As Marya points out, “pure adrenaline kicks in when you’re starving and you’re high as a kite.” She describes everything as having a “heightened intensity” and how sensory information became sharper in the beginning. As mentioned before, Lori found her first restricting period to be enjoyable and though she was hungry, she felt like she was flying and her “whole body felt empty inside.”

Well into anorexia, Marya wanted to see how long she “could go running on fumes” and wanted to “find the bare minimum required to subsist.” Rae describes starvation as a “strange state,” in that “you are half dead and yet somehow you walk

around in a state of euphoria.” She experienced a false sense of energy, which allowed her to continue her running and schoolwork with little to no food.

Rae also describes how she learned to suppress her feelings in striving for emptiness. “I pushed my emotions back down because feelings were too much.” She felt “too full” when she recognized her emotions, especially during her weekly visits to her counselor. She discovered that if she skipped her appointment, she could “convince” herself that she was “empty.” Unfortunately, this relief was temporarily. When she was overcome with emotions, Rae would feel physically full and had a need to “swallow” her negative feelings. For many anorectics, emotions are overpowering, and they become “overstuffed” as if they had just indulged in rich and sickening meal. Restricting allows the anorectic to starve out her emotions, as if she could rid her body of feelings like a 19th century doctor starving a fever from the body. As Rae ate less and less, she felt she had more room inside of her to “swallow” and push down her feelings. “I became so good at squashing feelings, at holding up the façade that I lost the boundaries between what was real, and what was not. I lost the ability to know what I felt. I lost myself.”

A Built-in Measure of Success . . . That Can Never be Reached

For most of these women, anorexia provided a direct way to measure their sense of worth and accomplishments, especially when other aspects of their lives were not going well. The emotional experiences within each day became dictated by their success or failure to maintain their food intake and weight goals. While at first, the sufferer felt pride and satisfaction at her accomplishment, she found that each new achievement was no longer “good enough” as soon as it was reached. She was only briefly allowed to

reflect on her success before anorexia turned towards its next target. It is here that a seventh paradox is formed, *a success that can never be reached*.

When Rae began running cross-country her freshman year of high school, she invented math games to do in her head around calculating calories, which were easier to ruminate over than her failure to connect with peers at her new school. It was at this time that she stated to think “maybe just a few more pounds and I’ll feel even better.” As she continued to lose weight she received positive comments about her appearance, which reinforced her running and restricting behaviors. This marked the beginning of Rae linking her self-esteem with losing weight in order to improve her feelings of loneliness and depression.

When Lori’s thinness became more visible at school, she started receiving positive attention from peers, and was soon after sought out by others for her “expertise.” “Then everyone started crowding around me and asking questions all at once, like I was a movie star or something. I know this sounds conceited to say, but by the end of the lunch period, I was almost as popular as I used to be.” Before anorexia, Lucy was already prone to feeling like a failure unless her outcome was 100% successful. She believed that the chances of her accomplishing her dreams in the future, which included protecting those suffering from the injustices of the world, was directly linked to how close she came to achieving her goals of perfection in all areas of her life. To her it seemed clear that if she did not uphold her own standards, she would be severely limiting her chances of doing something great. Lori also created standards of perfection and success for herself, demanding that her teachers give her A-pluses on her report card, even though the school did not assign grades higher than an A. This same striving for perfectionism

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was seen in Ellen West, where it was noted that she was very ambitious in her schooling, and would “weep for hours if she did not rank first in her favorite subjects.”

Once Rae became entrenched in obsessive anorectic thinking, every task and action became a test, “a performance to show others that I was not a failure.” She comments that for much of that time, she experienced an overall feeling of worthlessness that “was so thick it was suffocating.” To fall short of her goals resulted not only in disappointment, but also highlighted everything that was wrong and useless about her as a person. As she began to achieve success in restricting, Rae experienced “a deranged sort of strength and pride,” which pushed her to keep going in her lowest moments. She developed a sense of specialness that left her feeling “superhuman” by giving up something that “everyone else had to do.” “Self-starvation is a means of escape whereby a person find a false sense of liberation.” Rae felt powerful in denying her bodily needs, as if she had figured a new and evolved way of being that was not constrained by food. “Starvation [is] about perfection, strength, and control. A person cannot afford to feel if she wants control and perfection. That is what my eating disorder was to me- it was my striving for perfection.”

Inevitably, in the search for the perfect amount and the perfect weight, each of these women learned that whatever they accomplished, it would never be enough to satisfy the standards of their illness. It is the nature of anorexia to continue to push the person to the next goal, the next prize, preventing her from indulging in any triumph for too long. The relationship with starvation and food becomes a game that is “fraught with shame,” says Rae, where even the slightest slip or fall below anorexia’s expectations is devastating. Rae remembers that when she ate more than “allowed,” she would feel

paralyzed by the upset feelings that came over her. The Voice would criticize her, reminding her that the rules were strict and non-negotiable. Even in moments when Rae followed the rules perfectly, her satisfaction only lasted for a moment. What she and many others eventually learn in recovery is that the goals of anorexia are elusive, always moving targets that seem to slip out of reach as soon as the sufferer nears her achievement. The focus always remains on what she has not yet accomplished.

Bruch (1988) explains that when an eating disorder sufferer does something well, it is expected and not worthy of celebration. However, when she tries to tackle areas where she cannot stand out, she believes this failure at perfection is because of her deep inadequacies. Many of these women have a history of ruminating on what they did not or could not accomplish, and often turned these “failures” into a source of anxiety that would eventually fuel their fantasy of perfection in anorexia (Chernin, 1985). Jena describes the “distorted reasoning” she had in her “convoluted mind” around the pressure she felt to be the most sick. The only way she felt she could legitimize her presence, and thus accept treatment, was to be the most deserving and the most in need of care. When Lori entered the hospital, she remembers feeling great pride at hearing from her doctor that she was “an excellent case” of her illness. She had finally succeeded at becoming special and admired, and had become recognized for doing something “great.”

At the Renfrew Center, Alisa describes “the beauty of this disorder” as a striving for something that can never be reached. She speaks of being addicted to the process of anorexia, always with the focus that she “just wants to be thinner.” No matter what weight she achieves, the perfect weight is just always a little bit less. When Rae’s mother brought her to a doctor out of great concern over her weight loss, Rae was furious. She

felt her mother was trying to ruin her success in an “underhanded and sneaky” way by thinly veiling her intentions under the pretense of caring. Morgan, as Blythe, responded to a concerned friend who asked about her weight loss with a renewed vigor for her anorectic goals. “If he wants to worry about me, I’ll just have to give him something to worry about. I’m running twice as much tomorrow.”

From her clinical work, Bruch (1979) writes about the difficulty for the anorectic sufferer to give up her behaviors, even if she can acknowledge that they are dangerous.

The longer the illness lasts and the more weight they lose, the more anorexics become convinced that they are special and different, that being so thin makes them worthwhile and significant, extraordinary, eccentric or outstanding. Each one has a private world to describe the state of superiority she strives for. They are validated at first for these behaviors. (p.74)

Asking the anorectic to give up her disorder not only undermines what she is trying to achieve, but also comes across as an attempt to eradicate the very essence of who she is as a person. When Rae entered the hospital she was terrified of becoming ordinary and losing her special status, especially when surrounded by others just like her on the unit. Out in the world she felt anorexia made her unique, but on the unit she was just one case among many. Finding others being successful at “her thing” was extremely damaging, and made her feel less powerful.

Bruch (1979) explains that someone in this situation holds onto anorexia because its “misconceptions and self deception serve as a protection against the deeper anxiety of not being a worthwhile integrated person capable of leading her own life’ (p.79). As anorexia progresses and the sufferer’s goal weight decreases, she believes each new number will finally bring her happiness (Bruch, 1988; Claude-Pierre, 1997). The false promise of anorexia is that it will never provide a substitute for the internal structure of

self-worth that she is lacking (Geist, 1989). At best, it is a short-term and immediate comfort that will eventually diminish over time. Eventually, the allure of *one more pound* or being *just a bit thinner* overpowers the sufferer and she ends up losing more than she gained. As perfection is always a step out of reach, the anorectic seems akin to a lost wanderer in the desert heading towards a mirage. The closer she gets to her target, the less visible it becomes before it disappears altogether.

Becoming a Person Without Needs . . . Without a Body

The sufferer appears able through her illness to play out a fantasy that she does not have needs, which stems from a belief in childhood that her needs are overwhelming and cannot be met (Geist, 1989). She has come to connect the needs of her body as “demanding,” and thus reasons that a denial of the body will allow her to become a better person. It is here that an eighth paradox of anorexia comes into play, a striving to become *a person without needs and without a body*.

In session Jena’s therapist asked her whether she believed it was wrong to want others to worry about her. She responded, “of course it’s wrong. It’s selfish.” When asked a follow-up question about what was selfish about concern and attention from loved ones, Jena was unable to explain, instead she repeated herself and added, “we should not feel like we need other people to notice us all the time.” Jena felt that asking to have any of her needs met was burdensome and overwhelming for the person, blurring any distinction in her mind between demanding things from others all the time and the idea of asking at all.

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Lucy also identified with this wish to not need others. With anorexia she became convinced that she did not need anyone's help in her "pursuit of perfection," and in fact believed the opposite, that the inclusion of others would only impede her progress. It was very important for her to "do" something great with her life in order to help others, not to take care of or pity herself. Rae writes of "mastering the façade" that she had no needs and remembers the pride she felt in believing she did not want anything from anyone. In the process of recovery, many of her symptoms and anxieties have subsided, yet Rae is still "deathly afraid" of needing someone else. "What felt so satisfying in my fantasy was that I didn't need anyone. It is far more painful to realize you do need someone and there is no one there."

During one phase of her recovery, Marya describes that part of the reason why she chose anorexia was her multiple fears around need and interactions. With this illness she could avoid "needs, food, sleep, touch, simple conversation, human contact, and love."

I was anorectic because I was afraid of being human. Implicit in human contact is the exposure of the self, the interaction of selves. The self I'd had once upon a time was too much, then there was no self at all. I was blank.

Marya believed that her anorectic body sent a message to not only the world, but also reaffirmed something for herself. "It seems to say- I do not need." Her anorectic body allowed this communication to happen with her having to verbalize anything. It was perhaps her inability to identify and put into words her feelings and desires was actually her greatest fear.

This wish to not need recognition and help from others, at times literally not to be *seen* by others, can be viewed as an attempt to rid the self of the parts of which she has

learned to be ashamed (Bruch, 1988; Reindl, 2001). These feelings of negativity and neediness are put onto the body, and the sufferer's goal becomes to reduce these parts that she has rendered extraneous. She restricts and denies the body in the hope that it will shrink and "disappear" from lack of nourishment. In their writings, these women describe the desire to reduce and shrink their body was a way to feel better."

Rae believes that a separation of body and mind is a central development in an eating disorder experience. She views her past starvation as her way to separate from the physical and material world. In the dissociated state of anorexia, her body no longer felt like it belonged to her, becoming instead "simply my tool, my disappointment, my faulty wrapper." Rae remembers some of her happiest moments in anorexia were when she felt the most "mechanical," and as she continued to starve, she became intolerant of any of her body's needs. "It disgusted me that I even had to eat at all." With so much at stake, she could not have her body compromise her pursuit for perfection. "The only way to do this," she writes, was to "completely detach from my body."

Morgan, as Blythe, wrote a poem that captured her feelings and conflict about having to exist within a body.

If I could be where I wished,
whenever that wish occurred to me,
I'd rarely ever be seen.
For if I could,
I'd set myself free,
Free to disappear and just watch,
as the actors step on stage,
and with every glance a turn of the page,
in the book of my life,
which I'd write for myself.
To write a wish, a wish to go unseen,
for that would set me free.

To reduce the burden of visibility, Morgan wished she could leave her physical being behind to freely exist as herself, away from the critical eye of others.

Marya believed with anorexia she could “starve that part (dangerous, bad, needy)” of her away. She writes that the “anorectic operates under the astounding illusion that she can escape the flesh, and, by association, the realm of emotions.” Even though everyone must eat to stay alive, she remarks that it seems “blatantly obvious to you that this is not true- you do not eat, you live.” This illusion remained robust and intact for Marya, even as her functioning began to deteriorate. “The awful paradox is that, to me, it seemed that my emotional survival, my basic personal integrity, was dependent upon my mastery, if not total erasure, of my physical self.”

Marya further states:

You stop seeing your body as your own, as something valuable, that totes you around and does your thinking and feeling for you. You begin seeing it instead as an undesirable appendage, a wart you need to remove. “I have a body,” you are likely to say if you talk about embodiment at all; you don’t say, I am a body.

Lucy describes in anorexia as having to “sacrifice my brain to a starving body: that is, literally and biologically eat it.” Starvation then becomes an elegant solution to the problem, as the body will “takes care of itself” in starvation by eroding from the inside out. Like Rae, Marya, and Morgan, Lucy felt “exempt from biology,” thinking she could continue to live without food. “I’d just be able to get thinner and thinner until I reached some magical, enlightening ‘end’ that wasn’t death exactly, but . . .” Her fantasy was that as her body exponentially shrank, she would gain security within herself, and finally be able to focus on more important matters, including her aspirations of saving the world.

A Self-Annihilating Narcissism

Embedded in the thoughts and language of each of these women was both a desire to preserve and protect the self, as well as a desire to destroy and be rid of parts of the self. Anorexia becomes a full-time job that takes up their energy and time. It is at this crossroads that a ninth paradox of anorexia emerged, a *self-annihilating narcissism*. It is a self-attention coupled with harsh self-punishment; a preoccupation with the self and a detesting of the self.

The obsessive nature of restricting and counting calories, coupled with a constant denial of the body's need for nutrition requires a hypervigilance to maintain. In a moment of weakness, the sufferer may find herself giving in to food, and jeopardizing her entire operation. From the outside, the person seems overly concerned with herself, especially in moments of pride when she denies an action that everyone else *must* do (Bruch, 1979; Claude-Pierre, 1997). On the other hand, those with anorexia are constantly criticizing and degrading themselves, believing they are unworthy of even the slightest validation or care. They find themselves inadequate and inflict punishment when they do not reach their impossible standards (Bruch, 1988; Claude-Pierre, 1997). There are even documented examples of anorectics eating food out of the garbage or off the floor feeling that they do not deserve to eat fresh food (Claude-Pierre, 1997; Hornbacher, 1998; Reindl, 2001).

Rae confessed in a journal entry during her illness that she was sick and ashamed of herself, yet “utterly wrapped up” in herself. “I can’t escape my mind and I can’t live with it anymore.” She felt as if she were going mad, hating herself and her “casing,” i.e.

her body. “It betrays me and I betray it.” Rae writes about the strangeness of holding these paradoxical beliefs within herself at once.

[It is an] oscillating between the fear of death and the fear of gaining weight. Sometimes knew I was sick, yet as I sat watching friends eat lunch, I was perfectly convinced that I was the strongest person on earth. Somehow, I had escaped human weakness. I did not feel hunger, I did not need food, and even if hungry. I was able to refuse it unlike anyone else. I never had feeling that I deserved to eat like everyone else.

In the early twentieth century, Ellen West wrote of a desire to get out of what she described as a “preoccupation with the self.” Before being hospitalized, Lori would constantly revise her plan to reaching her goals, which required her to maintain an obsessive level of thought in calculating and readjusting after the unpredictable journey of each day.

If I gained weight, I’d drink only liquids for two days, then I’d eat 500 calories per day for two days for energy, then I’d eat 400 a day until I get thin. But if I lost weight, I’d just eat 400 calories a day until I get thin.

Marya describes that she would spend hours in front of the mirror, but not for the sake of vanity. “On the contrary, my vigilance was something else- both a need to see that I appeared, on the surface at least, acceptable, and a need for reassurance that I was still there.” Without physically seeing and feeling herself, it became difficult to know if she still existed. Becoming so preoccupied with herself felt necessary for Marya, because she already decided that others were incapable of keeping her in mind.

It really seems to you that the sky will fall if you are not personally holding it up. On the one hand, this is sheer arrogance; on the other hand, this is a very real fear. And it isn’t that you ignore the potential repercussions of your actions. You don’t think there are any. Because you are not even there.

Marya recognizes that it may be difficult for outsiders to grasp that both loathing and “arrogant self-absorption” can take place at once, and how starvation was the perfect

solution for both her pride and her punishment. These two polarities can exist, she states, because “you’ve split yourself into two. One part is the part you’re trying to kill-the weak self, the body. One part is the part you’re trying to become- the powerful self- the mind. This is not psychosis, this (is) splitting.” She goes on to reflect the following:

It is equally possible that the anorectic is attempting to demonstrate- badly, ineffectively, narcissistically- a total independence from the helpless state of childhood, from the infinite needs that she recognizes in herself and will annihilate in any way she can.

As Marya came close to death, she says she failed in the moment to make the connection between “success and self-annihilation,” that would “in the year to come, nearly kill me.” In gaining distance in recovery, she observes the irony of how hurting herself and striving for perfection both fueled her anorectic behaviors.

What all this grandiosity covers- not very well I might add- is a very basic fear that the real world will gobble you up the minute you step into it. The fear too is a fear of yourself; a completely dualistic and contradictory fear. On the one hand it is a fear that you do not have what it takes to make it, and on the other hand, a possibly greater fear that you do have what it takes, and that by definition you therefore also have a responsibility to do something really big.

Lucy writes of her own dilemma that took place in the realm of the body: the desire to both disappear and to be seen in the act of disappearing at the same time. She wanted to tear down her body to something “frail, fragile, breakable,” all the while carrying herself in a manner that screamed strength, defiance, and an unfaltering power in the face of adversity. Lucy speaks of the “conflicting desires of the anorectic to be seen simultaneously as fragile and flimsy and autonomous and controlled,” thus she describes anorexia as “the biggest contradiction of all.”

Like Lucy, Marya also observed this contradiction of disappearing visibly. She stated she wore her thinness, “like a badge of courage, an emblem of difference from the

rest of the world.” The overwhelming anxiety of being seen juxtaposed against a displaced, yet very real wish to be noticed as someone who matters. Rae captured her pain and conflict in wrestling with these conflicts in the following journal entry:

Can you go too deep? Can you travel the depths of your mind so far you lose all awareness of what’s real? Where nothing touches you anymore, no one can reach you? Where your biggest fear becomes yourself. Can you isolate yourself so totally that you no longer realize you’re lonely? And those you love become obstacles and chores and you can’t touch them; you no longer see them, because all you can see is yourself. They won’t save you because they can’t. Any why is it on the journey back you realize you are more alone than you have ever been, and you are so afraid sometimes you can’t breathe? Yet you keep going . . . keep climbing, keep falling . . . you just keep going.

Jena also struggled with the contradictions in her illness, describing the strangeness of having low self-esteem and “a Messiah complex all at once.” As she began restricting, she remembers “relishing and resenting” the attention from others. In recovery, she had to face these opposing aspects within herself. “We are at once introverted and extroverted, both wanting to hide and to be seen, especially once we have begun to take on that curious pallor of the half dead.”

The Illogical Logic of Anorexia

The inner struggle that takes place in the anorexia is intensified and distorted as the physical effects of starvation take hold of the body and brain. As the sufferer falls deeper into the anorectic “rabbit hole,” as Marya has described, the more distorted becomes the person’s logic and cognitive functioning. Many of these women found that starving created a sense of madness, leaving them in a psychotic-like fog that envelopes a separate way of being in the world than they had before experienced. It is in this realm that a tenth paradox of anorexia can be found, an *illogical logic of anorexia*. This

The Paradoxical Nature of Anorexia Nervosa Through the Lens of Schizoid Phenomena captures the mindset that encapsulates the sufferer in anorexia's guiding principles and mindset.

While often the descent into this world goes unnoticed by the sufferer, in the process she develops a new way of seeing and thinking. When the anorectic is entrenched in this world, her friends and family see her as resistant to admitting how irrational she has become, resulting in anger and frustration at her perceived stubbornness. In truth however, she is unable to see their point of view in the throes of her illness, and as others try to pull her back to them, she responds by digging her heels harder into the "anorectic ground." In the experiences of each of these women, they describe that only in the journey towards recovery and health were they able to recognize the bizarre nature of their previous thinking and behaviors.

In recovery, Rae has awareness of the delusional and obsessive nature of her thoughts in anorexia, but at the time lacked the ability to realize this "strangeness."

I didn't notice that my thoughts were strange. Of course, I never voiced them out loud; I assumed they were normal. I never questioned my actions or habits. My thoughts had slowly morphed into an illogical obsession, but, as surprising as it may seem, I remained unaware that there was a problem.

Rae has now learned that when the body drops below a certain weight the mind "truly becomes unable to think correctly and to reason." When Rae was at this point, she had no idea how her thinking had changed and could not realize that it was different from that of others. "In anorexia, I thought everyone around me operated this same way."

Lucy was also unaware of the changes in her thought process, as she wrote in her diary at the time. "My brain feels more and more logical and true as others tell me it is more and more irrational." Jena remembers a similar experience in that she could not understand the high levels of concern from her friends and family, even as she continued

to physical deteriorate. As they kept reaching out to her as she become more sick, she found their “onslaught of care” to be intrusive and alienating. She believes this was because she could not understand their concern and instead experienced them as just trying to control her.

You, the sufferer, have no capacity for seeing the reality they see. Your eyes simply do not work anymore. You see yourself, indeed, through a glass dimly, and that image grows dimmer with each passing day and with each pound lost.

Lori found herself one time in her psychiatrist’s office attempting to bargain and reason with him to prevent being hospitalized. “I promised I’d do anything just please don’t make me go to the hospital. He wanted to know what I meant by anything. He asked if I meant eating, but I never meant that. When I said anything, I meant anything I could *do*. I can’t eat if I’m this fat.” What was so obvious to Lori was that asking her to eat was not possible because restricting was not something she was choosing to do, but something she had to do. She felt it was something she had to do, as necessary as breathing or blinking. The strategy her psychiatrist employed to try and catch her in her willfulness did not work because Lori was operating under a different understanding of herself and the world.

Those with anorexia often adamantly avoid all fattening foods, including by touch or even smell, out of fear that the calories will somehow seep through their skin or enter their body through the olfactory system. Rae remembers the long list foods she “could no longer touch” when anorectic, while Lucy describes the feeling she had in anorexia that the rules were “deeply necessary” for her continued existence. Lucy experienced a time in when she believed she could feel her recently ingested food morphing into fat in the moment, resulting in a state of sheer terror. She writes:

I thought I could feel the food leaching out of my stomach to collect in globules under my skin. I fearfully ran my hands over my stomach, my breasts, the tops of my thighs. Nothing. I almost laughed at myself. How ridiculous. . . I seriously considered the possibility of the food squeezing my heart and lungs and leaving me to die. Breathless and bloated.

Marya describes that there are “pure foods” to the person with anorexia, named as such because they are “less likely to taint the soul with such sins as fat, or sugar, or an excess of calories.” Like Rae, she would not even think about touching something like butter, for fear that it would “seep through the skin of fingers, making a lipidly beeline for your butt.”

Bruch (1979) in her work discusses a patient who had was overwhelmed by the potential engulfing qualities of food and she felt the food she consumed would remain in the same state in her body as it had been on the plate. She believed it became part of her being and gained an ability to wield power over her. As Bruch and the patient discussed this fear in session, the patient was overcome by a “sudden blankness, like an electric shock.” She reported that she had a flash of an image that felt like a nightmare, one in which she was suddenly eating the flesh off a human body.

Jena writes that there was a point in her starvation that her potassium levels became severely low, causing a serious threat to her health. Upon learning this information, including that she would improve with consuming more potassium, she suddenly developed a fear of bananas. She states that she took pleasure in “teetering precariously on that tightrope between a beating and non-beating heart,” and wanted to remain in a fragile state. She did not want to get better, especially if the cure involved eating. Jena was also plagued with “food dreams” that were lavish in detail, where she would indulge in piles of food. She would awake from one these dreams in a cold sweat

accompanied by intense fear and anxiety, and always had to quickly remind herself she had not consumed any food in real life. When she was still unsure of the truth, she came up with a way to prove it to herself. “You press hard on your concave belly- pushing deeper until you feel that ever-comforting lump- your spine.” Only after this “test” was she able to calm down.

In anorexia, Lori developed intense anxiety around vicarious calorie consumption. When she was admitted to the hospital, her first observation was that the windows did not open, which to her, meant “all the steam from the food would be going straight into my stomach.” Part of Lori’s meal plan during her hospital stay required that every beverage she consumed needed to contain calories, thus the staff would not leave a cup in her room to prevent drinking water from the sink. Lori would not cup her hands under the stream from the faucet to fill up on water because she feared consuming extra calories from the soap. Her calorie contamination anxieties were the most heightened by one doctor in the hospital, whom she found to often have food smells on his breath. As protection, she would hold her breath when he was examining her to prevent her breathing in any of his “food calories.” She writes of one time where her system failed.

Just when I forgot about holding my breath, he signed right into my face. Today his breath smelled like chewed up sausage- 210-calories per serving. I figured maybe about a third of it went up my nose, so I’d have to give up my slice of bread for lunch to make up for the 70 calories.

In the moment she tried to cough in the hope that some of the calories would come back out, but she still gave up her bread later that day “just in case.”

Lori’s battle to resist food during her hospital stay was a constant struggle, which she eventually surrendered to avoid receiving a feeding tube. Before surrendering to her meal plan, she contemplated taking poison for suicide to avoid the tube and gaining

weight, inspired by Madame Bovary from her school reading. She quickly rejected this idea out of fear that if it failed she would wake up fatter from the calories in the poison. In anorexia, Lori found food to be so intrusive that she worried she could be ambushed at any time.

Morgan, as Blythe, writes of a time during her illness when her grandmother came to visit. At the sight of her granddaughter being so thin, she commented to the rest of the family that they needed to get some meat on Blythe's bones. Hearing this elicited a vile and crude image in Blythe's head that left her stunned and silent. "I pictured myself being tied down while all of my relatives pasted strips of raw meat to me like paper-mache."

For these women, it appeared that their sense of self became further fragmented as they delved deeper into starvation, and for many their sense of temporality was disturbed. Marya states that in her anorexia, "the experience of chronology ends- time and language twist upon themselves and become something else. Tenses, past, present, and future, lose their meaning." Jena recalls a time in which she stood still on a staircase for almost an hour, "lost in time, trapped mid-flight." Without a sense of linear time, sustaining a coherent sense of self becomes extremely difficult (Garrett, 1998). This is perhaps why many of these women stopped thinking and speaking of themselves in the first person in their anorexia.

Rae's therapist commented to her that she always talked about herself in the second person, using you, when discussing her feeling. The therapist interpreted that this distinction in language allowed Rae to appear like she "wasn't herself," and avoid having to name her feelings as her own. Marya also writes that she lost a sense of herself in the

first person, including “that sense of being in the world that writing requires.” When Jena’s weight dropped below 100 pounds, her experienced shifted from first to third person. She writes that in this state she felt like a lesser version herself, as if she were “playing a two-dimensional character, not me at all, so therefore I had no personal responsibility.” Later on in her treatment, as her weight continued to drop dangerously low, Jena was forced to receive a feeding tube. During the procedure, she remembers the moment of dissociation that shifted her experience from the first person in her body, to the third person, “as though I watched the procedure from the doorway.”

While Lucy does not describe a distinction of switching out of first person, she cites several times in which she did not feel rooted in her body, as if her body failed to still be something that was alive and adhered to the laws of physics. She also refers to a “black spilling in from my mind out,” to explain many occasions of disorganization while she was starving. One time in class she became distracted by her wrists and watched them intently, “just in case they got bigger.” Another time she was sitting in a wooden chair and became preoccupied with her arms compared to those of the chair, feeling like her appendages were no more a part of her than the pieces of the chair. When Lucy was at one of her lowest weights, she recorded in her diary a feeling like her head did not belong to her, and that she felt so “horribly flattened and like a nonentity,” that she could “barely discern” herself from her exam booklet or the carpet in the room.

I can hardly move my figure. Indescribable. I haven’t the energy. And all the while . . . a complete absence of value. I am transparent; I dissolve and swallow silence. Gone. I’m somewhere outside of myself. I think I might be going mad.

Like all of the authors described above, Lucy stopped experiencing a connection to her body. During these periods of starvation, most of these women became obsessed with

examining and exploring their bodies. Marya recalls a time when she felt “vague surprise” at finding her arms and legs were attached to her body, describing that she had “a spatial relations crisis, becoming increasingly disoriented in my skin and annoyed at my own height and width and elbows and knees.”

Rae remembers not wanting to be able to feel her pants around waist, while almost a 100 years earlier, Ellen West was reported to enter a deep depressive state when she would feel any pressure at her waist. Lucy recalls a time of panic because she imagined that her thighs had suddenly grown larger and she could not discern if it was real. While she tried to reassure herself her legs had not changed because her weight was the same as yesterday, the voice of anorexia popped up and presented an alternative explanation. *“But they are. Your fat has just redistributed itself overnight, that’s all.”* At another time, Lucy caught a glimpse of herself in the mirror and was “able” to recognize how truly thin she had become. However, in the next moment, she began to “see” her body as if it had grown back her flesh and fat, seeing only this much larger and distorted image. As much as she tried to return to her actual reflection, she found “no amount of squinting” could bring it back.

At the Renfrew Center, Shelly told the interview that she literally cannot stand the feeling of the intravenous nutrition entering her body through her feeding tube implanted directly into her stomach. She believes she has to “get the food out of her,” which she accomplishes by sucking the liquid from the hole in her stomach with a syringe. She states that she has heard girls on the unit say that getting “the tube” is the ultimate status symbol that you are “really anorexic.” Shelly can recognize the conflict that arises in achieving this level of status that also results in definitive weight gain.

Jena remembers a time when she was driving and she became very distracted by her thighs, “which were squished against the driver’s seat.” She tried to imagine what they might look like twenty pounds lighter, “when there would be far less to squish.” In another instance while driving, she suddenly felt as if she had “grown” a double chin. When she checked her face in the rear-view mirror she swore she saw one in the reflection, “or at least the start of one,” similar to Lucy’s panicked thought that her thighs had grown overnight.

As part of the experience of anorexia is that any unpleasant or uncomfortable emotions are converted into feelings of fatness (Bruch, 1979). Later in her anorexia Jena reached a point in which lost the ability to recognize her body as “this concept of thin,” and began to feel fat all the time, “Not only do I see phantom fat, but I feel it too. I feel like I am living inside a fat person’s body.” Earlier on in her restricting, Jena started taking her grandmothers Alzheimer’s drug to accelerate her weight loss, since she discovered it had the side effect of “complete loss of appetite.” Jena remembers the voice of anorexia taunting her: “*fat cow, greedy thief.*” She also started taking her dog’s thyroid medication by the handful. As she ingested the “little blue tablets” over the course of the day, she “transformed . . . into an insomniac gray zombie, glassy-eyed and perpetually agitated, in constant motion.” This misuse of medications helped her reach an ideal anorectic state that she would again achieve in severe starvation: “disengaged, dissociated, and unfeeling.”

Lucy also used a language of “fatness” to refer to any undesirable feelings about herself. In a diary entry, she wrote, “I’m . . . drained. Just drained and . . . knobby. In a fatty sense. Not a bony sense. But don’t talk sense to me . . . *you of all people know how*

irrational this is.” Like Jena, Lucy would use feeling fat as catch all for anything negative. Lucy would also wonder what others thought of her body. She spent most of the time “plagued with the worry” that any attention or glances towards her must be due to her “fatness.” She would always be terrified that someone would see her and then determine she was not “thin enough to be considered anorectic.” While in a later stage of recovery, Lucy stumbled upon her journal from the previous year, a time when she was at her lowest weight. In a moment she was flooded by memories and images:

Bones-and-skin cold hunger dark gray tears beige wrists jumpers hair anger
hipbones loneliness frozen faces and trapped eyes scales walking suspicion
crunches running-up-and-down-the-hall-endlessly-when no one was home special
k salad lies gum no seatbelts and walking in front of buses voices glances no sleep
and nightmares fog silence- one second and entire year flashed in and out.

Lori was often unable to accurately see her physical reflection in anorexia. She describes a time in the hospital when she borrowed a pair of jeans from a girl on the unit that she *knew* was “much taller and thinner.” She was certain that they would not go over her waist, yet she easily pulled them up and they immediately fell back down to her ankles. She was stunned and could not “figure out why.” “I didn’t know why the jeans fell off, but I was pretty sure I was still right about Shereen being thinner than me.” Even with this proof Lori could not be convinced that she was thinner. She recalls only one time when she was able to piece together that the extremely thin person in the mirror was in fact her reflection:

Whoever decorated the ladies’ bathroom was madly in love with mirrors, so I kept seeing the skinny girl everywhere. She was a stick figure. Then I noticed how the girl also has on an ugly frilly dress and lots of blush, but when I turned around to look, I was the only person in the bathroom. Except the girl couldn’t be me because she was so skinny . . . Finally I turned on the hot water and washed all the makeup off my face. That’s when I knew for sure it was me. I couldn’t believe it! I looked disgusting, I used to want to be a stick figure, but now I’m not so sure.

This experience was rare and fleeting for Lori, which is often common in the thick of anorexia. While these moments are important in the long term, they often lack the impact that friends and family hope for. The recovery process is often slow and painful, as will be discussed in the next sections.

To Live or Not to Live: Suicide and Anorexia

The issue of suicide when discussing anorexia can be confusing for someone on the outside who is watching a loved one starve herself, seemingly to death. Family and friends worry their loved one is engaging in a slow form of suicide, since the sufferer's behaviors can lead to fatal results. However, when discussing the issue of dying and the body with the sufferer of anorexia, it is no longer as simple or clear-cut to understand. In this issue of suicide an eleventh paradox of anorexia takes place, *anorectic death versus suicide*, which captures the sufferer's ambivalence about her existence, including her desire to survive as a self without a body.

What the inner experiences of these women have illustrated is that they employed anorexia as a mechanism to cultivate something within, to preserve some small yet vital part of the self that they had identified as significant. Yet the destruction of the body can be seen as an attempt to literally and figuratively kill off a part of the person in order to reach this goal. Lucy clarifies that for the anorectic in the middle of illness, she does not consider the biological ramifications of her choices. "Let's not get caught up in the biologically ugly death by starvation. The desire isn't always to die; it's to disappear." As is often the case in anorexia, the explanation is not "either/or," but "and."

Bruch (1988) states that though anorectic patients may die from their condition, it is not death they are after but the urgent need to be in control of their own lives and to have a sense of an identity. It is only in the despair of being too weak, or not being able to achieve their goal of self-determination that suicidal despair appears. Jena writes that in her anorexia she “tried very hard to die over the course of my life, all the while under the impression that I was trying to live.” As she was caught in the paradoxical nature of her illness, this attempt at making life bearable would have eventually killed her if sustained. It was only in recovery, after breaking free from her anorectic mindset that she was able to see how close she came to death. When Jena was dangerously underweight, she found comfort in being sick and embraced it “as a way of life rather than as a means toward death.” Anorexia gave her a way to be in the world and she was not going to let anyone take that away from her. On the inpatient unit in a therapy session, she was asked what she was trying to *do* in her illness:

- I’m just trying . . . to live.
- And having an eating disorder makes life easier?
- Yes, Somehow it does, even though I’m sure that doesn’t make sense.

At the Renfrew Center in Florida, Brittany describes the perpetual blue shade of her hands and feet, as well as the special hosiery she must wear on her legs to increase her circulation. She told the interviewer that she wears them like a badge of honor, enjoying the process of showing them off, declaring to the world, “I have anorexia, look at this.” She is quite straightforward about the issue of life and death around her illness: “I don’t want to die; I want to live and be the perfect anorexic, so I’ll have my feeding tube to keep me alive while being sick.” In the treatment, she has found a way to exist in this tension of preserving her being while still denying her body.

When Marya's eating disorder was first discovered at the end of eighth grade, she remembers feeling very satisfied that she was worth "giving a shit about. . . I was getting to be a successful sick person. Maybe I would almost die and balance just there . . ." It was at this point that she discovered that teetering on the edge of death gave her something she needed. As she moved deeper into her restricting, her sense of self loathing and hatred also increased, which further perpetuated her behaviors to starve away her "bad parts" in order to present something acceptable to the world. "It [the brain] will try, in a last-ditch effort to keep your remaining parts alive, to remake the rest of you. This is, I believe, different from suicidal wish of those who are in so much pain that death feels like relief, different from the suicide I would later attempt, trying to escape the pain."

It is important to further clarify this distinction between destroying the body and suicide for the purpose of taking one's life. Most of these authors expressed that while they did not want to die in the depths of anorexia, in treatment as they felt their illness being taken away, they were left looking to death for relief. Lucy writes about this difference in that anorexia was to make herself smaller, "to the point of nothingness," while in treatment as she rapidly gained weight, she entered a period of darkness from the panic and experienced her first suicidal thoughts. In order to avoid treatment, she thought, "I'll try to die instead."

In her recovery process, Rae wished for death as an alternative to the flooding of feelings that she was experiencing with anorexia. During this time she believed that "a small part of me cared if I died," leading her to wonder, "is this the self? Maybe it was the self I had never paid attention to." Perhaps it was the part of her that she had being

trying to find and nourish all along. When Lori was placed in the hospital to increase her weight, she plotted cunning and creative ways to trick the staff into believing she had ingested more calories than she had actually consumed. She was eventually found out when she failed to gain weight and was threatened with “the tube.” When confronted with this reality that she would not be leaving the hospital without gaining weight, she experienced her first suicidal feelings. As a result, she created the following list:

Reasons why I should kill myself:

Won't get the tube

Won't have to be ladylike

Won't have to talk to Dr. Gold about control

Won't have to see Dad's vein pop out

Won't have to go shopping with Mom

No one makes you eat when you're dead

Won't have to be a secretary my whole life if I grow up fat

It's the only way to get out of the hospital without weighing 60 pound

Despite these feelings, she was not able to come up with a viable plan. She noted in her diary that it was much easier to “decided to kill myself than actually doing it.” Ellen West found that as she began to restrict her food intake, her depression and suicidal feelings subsided, at least for some time. It was also noted that when Ellen was sick with a fever as a young girl (pre-anorexia), she became upset when the fever broke and she began to recover, because she had wished to die.

Marya addresses the issues of death and suicide throughout her memoir. Her first memory of suicide occurred in childhood, before she became anorectic. There was a news story of a young girl in town who lit herself on fire and burned to death. Marya remembers knowing that the girl had anorexia. “She left a note saying she couldn't go on because she couldn't stand to live inside her body anymore. Too heavy a weight to bear. My first thought: I can understand that.” When Marya was deep in her anorexia and in

the hospital, she found herself actively wishing for death as she was being pushed to give up her eating disorder. “You want nothing more, every day, every fucking day.” On an inpatient unit, extremely under weight and being forced to eat, Marya remembers wanting to die, right then and there.

I had this idea in my head that dying would be lovely, a simple loosening of the ankle shackles that held me to the ground. I would lift off into the sky, float over the iced white streets, yes that was death, and I was a princess trapped in a cage, dying of a broken heart. That was death.

Instead of experiencing death as a loss, she saw it as her ticket to freedom, a release from her pain. At this time, she was “eating just enough to feign life.” When she was 62 pounds and eating almost nothing but laxatives, she was “shitting water and blood.” This was the first time she realized how someone could kill herself by accident. Despite this awareness, she continued to lose another ten pounds and was given a week to live.

Surprisingly, after spending so many moments actually wishing for death, Marya made an unexpected choice.

I got curious: if I could get that sick, then (I figured) I could bloody well get unsick. So I did. Am. However you want to put it. Obstreperousness, which as a character trait is extremely exploitable in the energetic annihilation of one’s own body and individual self, is also very useful in other pursuits. For example, life.

While suicidal thoughts and urges can be different for each sufferer at various times during illness and recovery, the experience for each of these women was that suicidal feelings seemed to arise as they were faced with the terror and fear of losing anorexia.

Destroying the Masterpiece that is Anorexia: The Pain of Recovery

Recovery from anorexia is unique compared to other disorders like anxiety and depression, in that the process often begins before the sufferer is ready to give up her

disorder or wants to get better. For each of these women, anorexia was something they have cultivated and perfected for many years, something for which they had sacrificed almost everything. The treatment for all of these women began at the point of regaining physical functioning, where weight gain was an inevitable and necessary component of treatment. As a patient, the sufferer will be told to ingest more calories in one day than she may be used to consuming for an entire week. This process was emotionally and physically excruciating for these women, as discussed in the previous section around suicidal urges emerging during the recovery process. It is here that a twelfth paradox of anorexia came to light, *recovery as torture*.

Rae notes that the “healing process chewed me up and spit me out.” She experienced her doctors as trying to destroy her “masterpiece,” a piece of art that “so beautifully expressed my experience of the world.” For Stephanie, age 14, at the Renfrew Center, she also felt her anorexia was something great, something she had perfected over the years. “This masterpiece that I painted, they’re just ruining it and I can’t do anything about it.” For many with anorexia, their home environments involved confusion around boundaries with others, and often their caregivers oscillated between intrusion and dismissal (Chernin, 1985; Geist, 1989). As a result, trusting and relying on others is very difficult and seems dangerous, something to be avoided. When the person enters treatment, she becomes “a patient,” and instantly loses control over what goes in and out of her body. This results in panic because up until this point, she had absolute say over every step and calorie. The anorectic also suddenly loses her specialness in her identity in treatment, particular in a residential or inpatient setting, as she becomes one of many who are emaciated and sick (Bruch, 1988; Claude-Pierre, 1997). Lucy vividly

remembers that as she gained weight and looked “like everyone else,” she felt dread and fear. The thought of seeing herself in the mirror became appalling and she would not leave her apartment, convinced that no one could handle her “utter grossness.”

When Rae began treatment for anorexia she found her homework of daily food diaries to be invasive and a complete loss of privacy. In reaction to this intrusion, she often lied in her calories and exercise numbers, to protect what little she felt was left of her own. It became one thing she could have that they, her doctors, could not, and it felt necessary for them to not know everything. Rae even experienced the office of her nutritionist as a “suffocating room full of brochures and plastic pieces of food,” which would always make her feel sick. “It was suffocating both physically and mentally. It was someone trying to take control. I could not breathe when I walked in that room.” What was being evoked in her was deep yet indescribable at the time.

It is only later in recovery that she is able to see how the nature of her treatment recreated a crucial enactment of her childhood experience of never being taken into account by others. “[The] therapist never asked if he could take away my anorexia, he just tried to take it away. He repeated the pattern that so many people seemed to, taking without asking.” Rae’s experience is quite common, as it is often the case that an underweight anorectic is in danger and her weight must increase to regain physical and cognitive functioning. As a result, the patient’s wishes and sense of agency, that is the sense of self she has desperately been trying to cultivate in her illness, can be discounted or invalidated as others try to save her life.

When Lucy was admitted to an inpatient setting, she felt like she had stopped living. She would lay in bed for days, not able to move or care about anything but

“holding on to the anorexia.” As discussed in the previous section, suicidal feelings appeared for Lucy as she felt her anorexia was being taken away. In this unbearable pain and anxiety, she states, “You would prefer to die. You will try to die.” For Lucy it felt like an “excruciating choice between anorexia and life.” The pain of losing her only comfort left her unable to regulate herself and sent her into pining for her previous “ordered and flattened existence.” Bruch (1979) writes that the treatment for those with anorexia should aim at helping the sufferer achieve a more competent, less painful way of handling the problems of living. The goal is create a life without needing the eating disorder to cope and soothe the self. The question becomes how to bring this about.

When Jena agreed to attend a residential eating disorder facility, she was overcome with terror, knowing that the “thrill of lying alone in a dark room and feeling my bones would soon be gone, replaced by an unimaginable panic at the metamorphosis of a body I would no longer wish to claim as my own.” To further illustrate her point Jena engages the reader by asking him or her to conceptualize the extent of her fear for him or herself.

Imagine being told that over the next few months, you are systematically going to mutate beyond recognition into the thing you fear most and you will begin to understand the horrific anxiety an eating disordered person feels as she stands at the brink of unwelcome physical restoration.

One thing that helped Lucy get through her inpatient stay was the awareness that she could always go back to anorexia if she was “unchanged” by the treatment process. Anorexia would still be waiting in the wings once she was discharged. During the time after her hospitalization, Lucy describes the agony of regaining her physical and emotional health. There were many moments in which she desperately wanted anorexia back in her life, illustrating the almost inevitable turn towards relapse that many sufferers

experience. She specifically remembers times in which she was able to both grasp the concept that recovery was possible, yet she still craved the soothing darkness of her illness. In a diary entry from one of these times, Lucy captures the siren-like call of her anorexia begging her to return.

Sometimes I just want to give up. Or at least allow myself to. I could reacquaint myself with my bones again . . . erode my rationality . . . embrace madness once more . . . and write poems until I died. A huddle of bones and gaping spaces. It isn't romantic but it's so goddamn tempting.

For several of these women, the invasive feeding tube was a necessary stipulation in their treatment to gain weight, which is most often placed up the nose and down the throat into her stomach, but a tube can also be surgically inserted directly into the stomach. Rae writes of the moment after the tube was placed and the first liquid meal was hooked up to her IV. As she watched the formula climb through the tube, she remembers knowing with every part of her body what was happening. "Like an addict, I started shaking. I was tense and thought I was going to lose it. For me, this was the ultimate relinquishment of control, and control was all I had left along with my fear- my fear of gaining weight, which was inevitable now." Rae opens one of her memoir's chapters with a poem that describes the visceral intrusion she experienced with "the tube."

Taking home the Tube
Slithering down my throat
burrowing a single hole in my wall.
Filling my nose, my ears, flooding my senses.
I must remember why; I must stay calm.
Oh, but he screaming is starting inside,
and the straining is overtaking my body.
Don't crumble the wall.
Please don't ruin it all.
It's snaking through my stomach,
penetrating my soul.

And someday it will make me better.
I must remember why; I must stay calm.
I feel the screaming rise.
It flows out of my eyes.
The tears are starting to fall,
washing over pieces of my wall.
And suddenly I can't remember why.
I don't want to remember why.

When Lori was threatened with “the tube,” she experienced thoughts of suicide, as discussed in the previous section. For her, getting the tube signified the ultimate loss of control and she was not prepared to give herself over to the doctors by whom she felt so misunderstood. She knew that with this procedure, she would no longer be able to pawn her food to other patients, flush it down the toilet, or trick the nurses into charting more calories than she had actually consumed. On an inpatient eating disorder unit, it can feel to the patients that they are being treated as young children when they are forced to eat their bread and drink their milk. A photograph from the interviews at the Renfrew Center shows two young women holding hands at the cafeteria table for support as they each try to eat a chocolate chip cookie.

As the body regains its strength and the brain resumes more fluid functioning, new and long forgotten feelings begin to surface (Bruch, 1979). The emotional experience in the beginning of recovery floods and can overwhelm the sufferer, who has spent much her time trying to register as little feelings as possible (Bruch, 1988, Reindl, 2001). When Jena began to gain weight, her feelings of depression increased, despite the many psychiatric medications she was given. The act of growing left Jena worried that she no longer looked sick to others. “I’m not ready to be normal. I’m not done needing to be sick you know?”

In a therapy session, Jena was asked to describe what her disorder offered her that wellness did not, and why being normal would be so terrible. She replied, “It means no one will know anything is wrong with me . . . I’m scared . . . Of living.” When encouraged to say more, she elaborated: “Failure, disappointment, loss, grief, embarrassment, shame, it’s all just too much. I need to be perfect, or at least good enough.” Through anorexia Jena had learned that by being sick and importantly *looking* sick, she could hope to receive, or at least be offered, some semblance of care.

Stephanie at the Renfrew Center was overcome by feeling trapped in her new, more substantial body as she gained weight. “I’m just gross- I hate myself- thinking about chewing all the time- my goal is to be happier and the only way to be happier is to be skinny. I’m not ready to let go.” Morgan, writing as Blythe, hated herself in treatment for becoming what she most dreaded: average. “I’m not cute, and now I’m not starving myself, so I’ve lost that desperate waif look to be replaced with what . . . melancholy average.” It seems that for many of these women, the physical manifestation of not being well allowed them to capture something important for which they had no words, as if their skeletal frame or pale and colorless skin was louder than any scream or cry they could muster. The loss of anorexia, including the anorectic body, is great for the sufferer. By looking “normal,” she fears she will blend in to the background and fall out of the awareness of others (Bruch, 1988). In treatment, she will no longer be thin and fears she will be alone, resulting in a tragic lose-lose situation.

Since anorexia is first explored as a way to cope with uncomfortable and messy internal experiences, it is often the only strategy the sufferer has to manage and regulate the self (Bruch, 1979; Claude-Pierre, 1997; Geist, 1989; Reindl, 2001). The awakening

of emotions in treatment is not only painful, but it asks the person to tolerate these without the one thing that worked to soothe her in the past (Linehan, 1993). Jena describes a time in treatment when she realized her old methods of soothing were not possible as she gained weight. In the past she would wrap her fingers around her bony arm, “letting my thinness comfort me,” yet in recovery her finger would no longer reach all the way around her upper arm.

Accompanying this outpouring of feeling also came an intense negativity towards the self for these women. Rae writes, “before in anorexia I knew how to punish myself, but in recovery I learned how to truly hate myself.” In a journal entry Rae questions with what she will be left after anorexia is gone.

I struggled with feelings that I did not want to have, I struggled with a developing identity that I was not sure I wanted to develop, and I struggled with a body and eating behavior that I was positive I did not want. Before my struggle had at least been a quiet one . . . Every day I hate myself more and quite frankly I would like to die right now.

As Rae gained weight, she also found it unbearable to be an anorectic “stuck in a healthy person’s body,” having that part of her identity no longer visible to others.

Lucy felt similarly as she gained weight and uncovered feelings in treatment. “You will hate yourself with passion- you will want to rip the fat off, shred it and tear it, cause yourself as much pain as possible.” Even when she felt like taking her own life, it too seemed unacceptable because she believed she “wouldn’t be thin enough in the coffin.” She found every comment and every look by others to be shaming, impinging, and intrusive. If her nutritionist was too positive towards her, it must have meant she was fat. If the anorectics on the inpatient unit near her outpatient psychiatrist looked at her,

she was convinced it was because they were shocked to see such a fat person in treatment for anorexia.

When Lori became overwhelmed and frustrated in the hospital, she impulsively tried to harm herself with a pair of scissors, eventually passing out in the act. When she awoke with a bandaged arm she saw the nurse who had discovered her sitting by her bed, even though it was well past the end of her shift. Though this nurse was the only one that took the time to listen to her, Lori still found it hard to believe that anyone would spend time with her because they wanted to or that anyone was concerned enough about her to stay.

At 16 years old, Marya was transferred from an eating disorder unit to a long-term residential child and adolescent unit as a last resort before being sent to a state hospital. On a unit with many different ages and disorders, Marya's treatment focus shifted from food to her avoidance of emotions. She describes that she had no idea how to handle this new approach because the focus on what lay underneath her issues seemed terrifying. "I didn't want to know what laid beneath the skin. I suspected it was something horrible, something soft and weak and worthless and stupid and childish and tearful and needy and fat."

As she tried anything to distract and avoid sitting with herself, the staff resorted to taking away her books, something she reacted to with utter rage. Without any distractions, she was left with her own thoughts. She eventually formed a connection with a young boy who "adopted" her because she looked sad. What became most painful was the awareness that "the staff gave a damn about the residents." Like Lori, she had not often had this experience, leaving her with the realization that she had no idea what

she was longing for or needed, only that she was in need. Despite this first step, Marya would be in and out of hospitals for the next two years until she was barely alive at 52 pounds. Four years after this point of almost dying, and more than double the size, Marya is able to more fully explain why giving up her anorexia was so difficult.

To give up a long-standing eating disorder, one that developed at precisely the same pace as your personality, your intellect, your body, your identity itself, you have to give up all vestiges of it; and in doing so, you have to surrender some behaviors so old that they are almost primal instincts. I had to give up the only tried and true way of handling the world that I knew, turning instead to things untested, unproven, uncertain.

Lucy was also unsure of how to “be” if her anorexia was taken away. She describes the difficulty in giving up “something from yourself that you believe to be an integral part of your identity.” During the recovery process she would often wonder what she would be without anorexia. “I have gagged myself for so long I can’t remember a pre-anorexic time. Will there be anything left? Anorexia is my reality, losing weight is my reality.”

In Recovery, Not Recovered

In a therapy session at the beginning of her treatment, Jena began to cry and asked her therapist the following questions: “When does the fear go away?” When asked to clarify, she replied, “of living without my disorder. Of letting go.” For Jena, the long and intense moments of recovery often left her wondering if she would ever be able to be and feel any different. Marya explains that she still does not find herself “cured” because “it,” her illness, is part of her and thus cannot not be cured. “But it has changed. So have I.” She writes that it is hard to imagine being done with something that will always be a part of her. It is this mindset that relates the thirteenth and final paradox found in the

data, the idea that a person who suffered from anorexia will always be *in recovery*, *not recovered*.

As it has been highlighted throughout the data, anorexia served an important, perhaps even vital role for each of these women. Reflecting on her illness and its aftermath seems to allow the person to hold both the enlivening and destructive aspects of her experiences, and to see how anorexia was a necessary step in discovering something that needed to be worked through. In many clinical writings, (Garret, 1998; Reindl, 2001) women have explained that their eating disorder made visible a crisis of self that they could not articulate at the time. The optimal outcome of treatment from anorexia has been described as discovering and integrating the parts of her inner, authentic self, which will result in her becoming a complete and autonomous person (Bruch, 1988). Reindl (2001), in agreement with Bruch states:

What is most salient to [those in recovery] is not *recovering* something they once had but *discovering* capacities they had never fully experienced and learning to acknowledge and accept aspects of themselves that had never been acknowledged or accepted. (p.283)

Rae believes that each person has their own “empty, dark space that feels utterly alone, terrified, and worthless,” and that each person has their own way to “defend and battle against this space.” Anorexia was her way of dealing this part of her, and while she no longer engages in anorectic behaviors, she knows the dark space inside of her still remains. She has just found a new way to manage it from within. Garrett (1998) found in her research on anorexia that the participants felt their illness was an essential aspect of their growth and development. They believed their anorexia needed to happen, or they would have been doomed to a life in which they were passive and incomplete beings.

In the recovery process, Jena felt like she was witnessing her identity being “covered over by forty pounds of flesh,” leaving her to wonder if returning to “extreme thinness” would bring her back to a calm and peacefulness. Ultimately however, as she has learned about herself and her strengths in treatment, she has been able to keep fighting. In recovery, she feels she has, “managed to chisel a small crack into the corner of the thin, soundproof glass that separated me from the rest of the world. Not enough to escape, but enough that I could return later and chip away more and more, if the spirit moved me, and if I dared.” Rae writes of “asserting freedom” and developing a voice of health, which requires “taking risks, even small ones.” Also in treatment, she has learned the importance of boundaries, no longer able to “ignore the need” to separate some from her family. In a journal entry, Rae challenged herself and the recovery process and asked, “when can you trust that you are complete? Who do I let in, and whom do I spit out? How do I ever know?” The idea of negotiating closeness with others based on her needs and desires presented new and unexplored frontier.

At Renfrew in Florida, Shelly describes how upset she feels about giving up her anorexia, since she has no backup plan for a self. “It’s like a big piece of my identity is gone.” She states that she loves her eating disorder while also hating it just as much. She is perpetually in conflict about wanting to give it up and can’t bear to see or picture herself without it. “I’m scared of the fucking world and I don’t know how to live in it. How to be in the world.” She can’t imagine who else she could be or how else to manage her experiences.

Rae notes that recovery at its best taught her how to manage the ups and downs of life and feelings without being “self-destruct as a way of shielding oneself.” In the end,

she had to struggle with the reality that there is more to her than just anorexia. Lucy was glad to come to the realization that she did not need the mask or fakeness that she put on for others, she was glad “to get rid of the false self that was always happy, making jokes, silly, making others laugh.” In recovery Lucy has found incredible strength among other survivors and has become a staunch anti-anorexia advocate, hoping her work will help those who are currently struggling. She is firm in the notion that many traditional approaches to treatment are “ineffective, wrong, and focuses on attitudes held by bewildered parents and doctors, not of the sufferers themselves.” Her goal with her own story and working with others is to offer the voice of the sufferer so that it can continue to be integrated into the current literature and treatment models.

When Marya was told that her death seemed imminent, she became enraged at others telling her what would happen. With a self-ascribed petulant attitude, she remembers thinking, “well fuck you then I won’t,” and started the process of trying to live. After the long and slow road of recovery, Marya scoffs at words such as “well, recovered, or fine,” finding herself most comfortable in a place of “all right,” a place that she is proud to have arrived. She writes that this requires an “interesting balancing act,” that may even give the impression that anorexia is still possible, if desired. As Lucy described earlier, Marya seemed to need the comfort of anorexia in the wings *just in case*. This idea of a safety net may allow the sufferer to strive towards unknown and scary places in recovery.

In the end, Rae concludes that she has changed quite drastically over her experience with anorexia. It happened first during its inception when the Voice first arrived, stating, “nothing made me change like my ‘sickness’.” It allowed her to explore

a self and search for ideas and thoughts of her own. While anorexia gave her an entry point into this discovery, she is glad that it was through recovery that she was able to express and advocate for herself without destroying her body. In a final message to the Voice, Rae writes the words that would eventually become the title of her book:

Linger no longer
My hell, my companion.
Your arms were cold,
But oh so inviting.
No more.
I felt the warmth
And though the chill still lingers,
I wish to be cold no more.
Here come my life
And my arms are wide open.
No longer are my hands cemented
over my eyes.

Discussion

The purpose of this research project was to illustrate how anorectic restricting behaviors may allow a person to alleviate internal schizoid anxieties and concerns resulting from ruptures in attunement in early childhood. By interpreting the narratives of recovering anorectics through the schizoid object relations lens of Fairbairn (1940), Guntrip (1969) and Laing (1960), anorexia can be conceptualized as an attempt to build and preserve a sense of self, instead of a passive suicidal wish or complete self-destruction. The splitting that occurs in the schizoid was applied to the anorectic experience of dissociating and disavowing the body, which results in a true internal self and a false body self. In the words of Laing, anorexia can be seen as creating a “psychic tourniquet for the body” (p.133), in which the sufferer attempts to destroy this false body self in order to protect her true inner self. Thus, the breaking down and ridding of the body in anorexia can be viewed as a manner of self-preservation, even though it often has devastating consequences.

Starvation as Self-Preservation

At the heart of this research was the question of *why anorexia*, that is, why anorexia is “chosen” by certain individuals and for what purpose. For the women in this study, the answer began with the first paradox that emerged from the data, starvation as a form of destructive self-preservation. They describe how anorexia seemed like a necessary step in their development, and that it allowed them to express something important and vital about their internal situation. As Marya writes, anorexia was her “bid for independence” and her “path to salvation.” Rae describes anorexia as her protector

and her pain, and that through her illness she found a way to “dance to her own drum” for the first time. Lucy describes that anorexia gave her a way to transfer her abstract and overwhelming emotional distress into a discrete and manageable “problem” to solve in her body. She says she no longer had to feel her pain, because anorexia did the feeling for her. Lori found anorexia gave her what she most wished for: to be thin and thus acceptable. Jena and Marya also spoke of their anorexia as a lover that satisfied their needs, and was “unconditionally present,” while Morgan found restricting to be the only thing that provided her with happiness. These women each discuss how they believed restricting made their lives better by offering a solution to an already present underlying problem. It is here that the paradoxical nature of anorexia was first made apparent: in the act of asserting and creating a sense of self and a way of living that felt “authentic,” these women began a process of starvation that was at first enlivening and “filling,” which dissolved into physical deterioration and a deadened existence.

The question was then raised, why continue with anorexia once the “enjoyable” part disappears? The answer, as expected, is complex and full of contradictions, which encapsulates the sufferer’s desires, ambivalence, and fears. A decoding of this seemingly contradictory illness came through the schizoid theories of Guntrip and Laing, which are themselves paradoxical in nature. By understanding the anxieties and defenses of the schizoid, a unique sense and logic of anorexia is discovered. By viewing these paradoxical anorectic themes as schizoid in nature, it seems that as anorexia’s heightened sense of being in the world fades, it is replaced by an equally desirable flattened existence, which prevents the sufferer from recognizing and metabolizing her emotions, including her pain and distress.

Thus, the shutting down of the body on a corporeal and cerebral level serves its own purpose for the sufferer that allows her to hang in the balance somewhere between being and non-being, between life and death. As will be discussed further, she figures out how to become most full when she is empty, and learns to escape the demands and requirements put on her by her environment, while remaining within it. Framing the paradoxes of anorexia as a type of schizoid defense helps create more complete and nuanced answers to the question of “why anorexia.”

The Role of Inner Fantasy in Childhood

The clinical literature describes that in infancy, the needs of the anorectic child were often met sporadically or not at all, resulting in an insecure and unsafe sense of the world. For some, the mother may have actually forced the child to attune to her own needs, which further disrupts internal biological rhythms in infancy (Geist, 1989; Sella, 2003). Sella, in her clinical work, makes a link with an impinging mother and her anorectic patients’ fears of annihilation in the present.

Guntrip (1969) explains that for the schizoid, the disappearance or inconsistency of the caregiver is responded to by the infant with fear, as well as greater feelings of longing and emptiness. She is left with the anxiety of her hunger going unfulfilled, which results in increased feelings of hunger. This response is different from the depressive, Guntrip states, because the schizoid does not anticipate a future relationship with the mother object and thus cannot experience anger when it is taken away or when it deserts her, she can only experience longing. Guntrip goes on to describe that for the

infant, the yearning for love from the mother becomes synonymous with the yearning for hunger.

As a result of this neglect, the child can come to believe that there is something awful inside of her that has caused this response, instead of viewing her environment and caregivers as limited (Klein, 1946). As a defense, she engages in a splitting of her good and bad parts, and engages in the fantasy that she can become all good and therefore worthy of love and acceptance from others (Geist, 1989; Guntrip, 1969). Guntrip states that the child, because of her unmet needs, fears that her yearning has the potential to devour what she most desires. In response, she retreats within herself to play out her wishes, where only fantasized object relations can exist.

Many of these women studied spoke of an active fantasy life as a child that seemed to replace a sense of being known and connected with others. In this, a second paradox was found, *fantasy as the other object*, where the imagination and fantasy life of these women served as the idealized fantasy object. Rae's describes elaborate imaginative play where she was a servant or an abandoned child, and Lucy states that as a child she was constantly lying and "augmenting" reality to gain acceptance. Marya describes her fantasy and passion from early on as potentially dangerous and used the image of Alice falling down the rabbit hole to capture her journey into her eating disorder. Lori writes of her creative energy and passion as parts of her for which she was constantly reprimanded or quieted by adults, leading her to internalize shame and embarrassment for being "herself."

It is through this idealized version of the self in fantasy that these women could be rid of their bad and shameful parts and become someone worthy of receiving love.

However, as Rae and Marya point out, they also had the recognition early on that these fantasies should remain secret. Guntrip notes that the schizoid holds a fear that actualizing her desires would destroy that for which she loves and feels longing. In this dilemma, she cannot risk expressing her needs and wants. Guntrip goes on to describe that for the schizoid, no one seemed to know or express concern over her deeper internal life as a child, leaving her to “manage it in secret.” (p.79). Lastly, Guntrip writes that by spending time in the internal fantasy world, the child is able to withdraw from the world to some extent, while also defending against a loss of the ego by “complete regression and depersonalization” (p.82). For each of these women, they seemed to have already learned in childhood that satisfying these desires was only allowed internally, in imagination, and should not be pursued in reality.

Feeling Out of Place from Within

Early empathic failures often lead a person to develop without a solid foundation of who she is and what she is worth (Geist, 1989). Additionally, her caregivers may fail to meet her needs, which in the process leaves her feeling socially awkward, inadequate, and uncomfortable in her skin. All of the women studied reported feeling out of place within their environment, their families, as well as in their own bodies, which highlights a third paradox found in the data, *feeling out of place from within*.

Fairbairn (1940) describes that the schizoid may feel empty or experience a sense of loss when she believes she must give emotionally to another. In defense, he states that she can “play the role” of someone who appears to be socially giving, but is “really giving nothing and losing nothing, because [she] is only playing a part, [her] own

personality is not involved” (p.16). It is in this defense of not giving but also not taking in, that the schizoid can remain safe and also “not filled,” without becoming drained by others.

These women were aware that any sense of belonging they felt was false because others were not really connecting to their true selves, whether it was putting on a front for others like Lucy or trying to fit in with different crowds like Rae. Lori and Morgan were told that they were too much and too loud for others, while Jena and Marya both report from a young age not feeling comfortable in their bodies. Jena had learned to hate her “fatness” as a toddler and Marya felt guilt and shame for having needs located in the body. Fairbairn goes on to state that in this playing roles technique, the schizoid “secretly disowns the part [she] is playing” (p.16), leading to a separation of this false outer self, which eventually becomes associated with the body for the anorectic. As she further withdraws into herself, the schizoid can begin to feel that she is not at home within her own skin. Fairbairn comments that often the schizoid can be left feeling like “the odd man out” (p.22).

Also related to this feeling out of place, was a desire by each of these women to both be seen by others while also wanting to be invisible. Laing explains that interference in the normal development process results in ontological insecurity, which includes a lack of cohesiveness in the self. This leave the schizoid unable to feel that she exists within her own flesh and blood, and within her body. As Sass (1992) describes of the schizoid, there is rarely a feeling of “harmony with their bodies or the environment” (p.77), resulting in a detached and “as-if” experience with others. This helps to explain

the dilemma for each of these women who experienced conflict around being “known” and “seen.”

Before anorexia, they experienced a sense of not being recognized by others, as they often interacted through their false or “put-on” selves. This perpetual feeling of being an outcast at every turn set the stage for each of them to channel their hatred and disgust towards the body, which transforms their emotional pain into something physical. While these women developed a wish for their bodies to disappear, they also wanted for recognition of their separate selves and authenticity. It was in this conflict that they turned to anorexia as a viable solution.

A Control that Cannot be Controlled

Restricting of any kind encompasses a denial or a withholding of something needed or desirable. With food, restricting can be viewed as a way to not “feed” an inner badness, and a way to prevent growth of undesirable parts. Thus, restricting of food becomes a solution for the anorectic to “starve” away her awfulness. In discovering restricting behaviors, the anorectic finds a way to regain a sense of control over herself, her internal chaos, and her physical inadequacies. She also develops a concrete way to control her size and gain power, which each of these women noted was important for a sense of safety and validation. However, anorexia provides an illusion of control, which captures the fourth paradox of anorexia, *a control that cannot be controlled*.

Guntrip (1969) writes that for the schizoid, the body becomes an outer shell as she retreats into an “intellectual life of thinking and obsessionality” (p.65). The schizoid can also be observed to take on a mechanical manner, or seem to be in a “cold neutral state of

mind that freezes everyone around but is safe for the person concerned” (Guntrip, 1969, p.65). By retreating into a cognitive space of numbers and rules, the sufferer of anorexia can be seen as participating in a schizoid defense of deep intellectualization to the point of excluding the external world.

Lucy and Marya write about the sense of mastery they experienced as they exerted control over their hunger, particularly in front of others. They describe the illusion in anorexia that their thoughts and behaviors were the embodiment of control, especially when fighting the urge to eat. Rae and Jena also describe the pleasure of not giving into the temptation of food, especially in treatment. Jena remembers her anorectic voice reminding her how amazing it feels to be so thin, which was something her “normal weight” counselors would not be able to understand.

Each of these women also describes the point in which their anorexia took a turn and actually became the ultimate loss of control. Rae and Jena recall that by the time they realized anorexia had lied and taken over, they were already trapped within its grasp, while Lucy describes the point where she “ceased to think independently” from her illness. Anorexia’s encouraging voice is transformed into the sufferer’s biggest and most biting critic, bullying her into maintaining her obsessive weight loss behaviors. As Lori expressed to her psychiatrist, she could not give up anorexia because eating had become something she was not *allowed* to do. Rae states that at this point in her illness, it never occurred to her that she could stop or give up anorexia. Marya also believed life without anorexia was not an option. Several women at the Renfrew Center in Florida also spoke about the issue of control and how even in their emaciated states, they still believed they were in charge, even though their doctors and therapists would argue the opposite.

Guntrip describes that as the schizoid participates in this initial defense of withdrawal, she actually is left at risk for more intense dangers. As Fairbairn notes, “the ego cannot develop in isolation” (p.15), and as the schizoid moves further inward, she is vulnerable to a collapse and a disappearance of the self. To fight against this, Guntrip states a schizoid patient commented, “I’ve got to concentrate on myself. I mustn’t forget about being ‘me’ or I’d lose myself” (p.104). He explains how she developed a system of obsessive repetition that kept her “putting off the dread moment when something would be finished, ended, done with” (p.105). Through this repetition, she was able to stave off the “end” and thus keep herself feeling alive as a person. He goes on to describe that this continual activity is necessary, because the schizoid’s “primary security is always in doubt about its ability to keep itself in being from moment to moment” (p.105).

For the anorectic, as she becomes defined by her weight and her calorie intake, her sense of calm and control is replaced by panic and terror. Each of these women found that because anorexia could never be satisfied, they always needed to keep going in order to remain “real” and “alive.” In light of the schizoid’s obsessionality described above, as the anorectic retreats internally and loses control over her illness, she develops a constant level of activity to maintain her sense of self and continuity in her experience. At this stage, she comes to fear that any deviation or break from “it” (her illness) will result in internal collapse and complete annihilation.

Changing the Outside to Change the Inside

When a person first engages in restricting, she believes she has found a physical and concrete solution to rid herself of her inadequacies. Since the child can experience

her neediness as stemming from desires of being hungry for more than she was offered, her neediness can become associated with the body (Bruch, 1979; Reindl, 2001). This sets the stage for the body, hunger, and the notion of “taking up space,” to become an arena for which the person with anorexia attempts to resolve the problems of her “having too much” yet also “not being enough.” Within this struggle, a fifth paradox of anorexia emerged: *changing the outside to change the inside*.

Laing (1960) describes that the ontologically insecure schizoid develops an “unembodied” self that results in a detachment from her own body as a form of protection. She does this to cut off all ties to the external world, since it is through the body that she comes in contact with others and the environment. As the unembodied self develops, the schizoid is left feeling more unreal than real and more dead than alive in the process of divorcing from her body. As discussed above by Guntrip earlier, in the face of this deadening the schizoid must find some way to keep herself going. Laing explains that due to the schizoid’s “low threshold of security” (p.42), she feels that she is constantly being threatened from the outside world, which drives her to completely break ties with her body. In moving further inwards, the schizoid must now rely on her internal experience to remain feeling alive, which can be accomplished by this obsessive activity.

In anorexia, her extreme ruminations and obsessions about weight loss can be seen as attempts to keep herself going, and that by minimizing contact with the external world, she is protecting this endeavor. In focusing all of her energy on fixing her “body problem,” the sufferer creates a singular goal in the hopes of alleviating her distress. The voice of anorexia seems to encourage this internal withdrawal, promising the sufferer that if she follows all of the rules, she will remain safe.

As the women in this study began to restrict, they discuss how they shifted their focus from an internal problem to an external one about appearance. Not only did this seem more manageable, but it also gave them hope that if they made changes on the outside, they would go through an internal transformation as well. Rae describes the pleasure she had when noticing her body was lighter and had become less of a burden. Morgan and Lori write of the intensified sensory experience that came from being underweight, such as a sense of floating or running on air. Lucy enjoyed the feelings of detachment she developed from her body as she continued to restrict, and wrote of her wish that when her outer shell was reduced, she would find a “lovely and confident Lucy” underneath. For Marya, she feared that the ugliness of her body had already seeped into her inner self, so in starvation she hoped that as her body whittled away, so too would the awful part inside her, resulting in something acceptable and presentable to show the world.

As discussed above, when the schizoid moves inward and detaches from the body, it results in a deep sense of separateness and distance from others. This distance also seemed to be desired by the women in this study as they progressed in their anorexia. Jena and Morgan describe how they wanted to reduce contact with others so that their awfulness would not be seen. As they witnessed their bodies becoming smaller, they felt as if they were gaining strength, and finally developing the ability to become separate people in their own right. Each of these sufferers also noted how isolating from others allowed them to more freely participate in their illness. What they each seemed unaware

of however, was that in escaping the dangers of the outside world, they had made themselves susceptible to entirely new dangers and anxieties from within.

An Empty Fullness

Guntrip (1969) writes that schizoid fears can take form around food and eating, as he demonstrates with a case example of a woman who was unable to differentiate between her hunger for her husband and her body hunger. At times when she felt desire, she would indulge in the least frightening option, food. Reindl (2001), Bruch (1988), and Sella (2003) all describe that a person with an eating disorder has confusion in interpreting levels of “enoughness” in her body. Sella describes that her anorectic patients as infants had to “precociously maintain their own self-regulatory symptoms” (p.37). She believes that this translated later in life as an inability to “adequately assess” (p.37) their bodily states. When it becomes ambiguous for the anorectic whether she should “take in” or not, she opts for the safer choice of remaining empty. To provide a replacement for actual physical and emotional sustenance, the sufferer engages in a constant stream of thoughts and behaviors to keep her going, as highlighted in the previous two paradoxes. She can thus acquire a satisfied and “full” feeling, while still remaining physically empty, which captures the sixth paradox in the data: *an empty fullness*.

For these women studied, they found themselves constantly thinking about food as they restricted. Rae and Ellen West enjoyed watching others eat food they had prepared, acting as if they could gain nourishment just in the viewing process. Marya states that she wanted to talk about food all the time, while Lucy would follow recipes to

feel a sense of accomplishment and success. Lori “ate” through her eyes and obsessively poured over diet books, identifying the empty feeling in her stomach as pleasurable.

Jena, Marya, and Lucy also report great satisfaction in the physical results of their starvation by viewing and feeling their bones. Each describe in detail the ways in which they explored their bodies both visually and by touch, counting bones, pushing on bones, and grabbing bones that jutted out of their skin. They note their pleasure at seeing and feeling the great valleys of negative space on their bodies where flesh used to be. Many of these women also describe a sense of euphoria and enjoyment that took place in their minds as their bodies began to starve, providing them with a belief that they could keep on fumes and willpower alone.

For the schizoid, whether the self is unembodiment (Laing) or weak (Guntrip), she is left feeling insubstantial, like there is nothing complete or full within her. At the same time, the schizoid experiences great fear of the devouring and impinging nature of the others that may “shove” and “force” something down her throat, which would leave her overwhelmed where she is most vulnerable: her true inner self. As a result, the schizoid believes she must remain empty to stay safe. However, as Guntrip notes, depersonalization can occur in the face of complete emptiness, which the schizoid also must defend against to remain in existence. Thus, she must keep a tension between remaining alive enough to exist while not being too open and vulnerable to others, leaving her to find fuel and energy without taking in from the outside.

Laing describes that the schizoid feels that she embodies a sense of emptiness, using a metaphor of a vacuum to capture the anxiety around implosion (a fear of being filled up and destroyed from within.) Laing writes that the schizoid comes to develop an

identity around this emptiness. She becomes someone who lives “without,” which is difficult to maintain in light of the body’s inherent desire to “take in.” Thus, she fears filling up with anything external, whether food, emotions, or the thoughts and worries of others, will result in her suffocating from the inside out. As a defense, she completely avoids being filled.

Through the perspectives of Laing and Guntrip, this empty fullness in anorexia can be seen as the person’s solution to remaining alive yet empty and holding a balance between depersonalization and implosion. Each of these women studied found a way to become satisfied while remaining empty, whether it is cooking for others, watching others eat, or even thinking and dreaming of food. In anorexia, these women were able to avoid the physical (food), and the psychic (emotions), to prevent an unbearable “overstuffedness” and internal suffocation

Success that Can Never be Reached

Sella (2003) describes that many of her anorectic patients were praised and rewarded for what they accomplished and produced growing up, not for who they were as individuals. This focus on production, paired with an internalized sense of inadequacy, can lead the anorectic to constantly strive for success and perfection to prove her worth. In anorexia however, perfection cannot be attained, which leads the sufferer into the seventh paradox of this illness: *success that can never be reached*.

For the women in this study, anorexia became a way to measure their success on a moment-to-moment basis, as each mealtime and each goal weight was an opportunity to prove their abilities. Rae describes that in her family, the focus was on a person’s

actions, not their feelings. Lori and Ellen West report that success in academics was a way to showcase their perfectionism, finding only the top possible grades acceptable. Lucy believed it was her destiny to do something profound and life changing for those in need, which she felt required her to perform to the best of her ability at all time. Rae found that in anorexia, any task could be a measure of her success or failure, a chance to prove to herself and others how she measured up. The specialness that each of these women felt in their weight loss and restricting goals became a source of pride, even though each victory was short-lived. What these women soon learned, was that the perfectionism in anorexia pulls the sufferer into a downward spiral, where the goal becomes one that cannot be attained.

Ultimate success in anorexia, that is becoming “the best anorectic,” is only awarded to the sufferer when she is six-feet under, as stated by Ata at the Renfrew Center, which captures the dangerousness of this illness: a constant striving for a desire despite (un)conscious knowledge that it can never be reached. However, as described by these women in the data, this “knowing” is not in the forefront of their minds. In anorexia, they continued to build upon what they had already achieved, in the hopes of someday accomplishing a sense of satisfaction and satiation. The alluring trap into which the anorectic falls, will be further discussed in the following sections.

Becoming a Person Without Needs . . . Without a Body

The women studied describe that by hiding their inherent inadequacies, they constantly feared being discovered, which would jeopardize the image of control and perfection they were trying so hard to cultivate. Through starvation, these women

believed that they could be rid of this fear by reducing the body to “nothingness.”

Coupled with this fear also seemed to be an emotional wish to be the least imposing on the environment. By reducing the body to something insignificant, they would also become the least bothersome to others. The desire to no longer live within a physical form highlights the eighth paradox of anorexia, *becoming a person without needs and without a body*.

As discussed earlier, Laing describes that the schizoid feels detached from her body to protect against three anxieties that have the potential to threaten her low threshold of security. These include: engulfment by another (a fear of being swallowed and eaten), implosion (a fear of suffocation from within), and petrification (a fear of being rendered inanimate by another). The schizoid develops defenses against these anxieties that lead her to further distance and detach from her body self. In the schizoid defensive fantasy, there is a wish to be rid of any connection with the outside world, which can only interact with the body. Thus, getting rid of the body self becomes the safest way to prevent these fears from being realized. Laing describes that the person with schizophrenia who breaks completely with reality, this ridding of the body takes place through psychosis.

In anorexia, the sufferer does not psychotically break with her body, but instead engages in a “delusional” endeavor of trying to reduce it to its most least possible form, ideally to complete nothingness. The sufferer sets out not to “kill herself,” as is addressed in later section, but to solve the issue of the badness and danger in her physical being. She appears to, at least consciously, disregard the biological fact that she cannot exist in this world without a body. Therefore, in the hope of becoming “no body,” the

anorectic may “know” that she will not reach this goal, and instead settles for becoming as small and inconsequential as possible. In this fantasy, the anorectic is in the perfect position to be the least imposing on others. Lastly, she is left without a “receptacle” or container that can be filled, whether it is literally with food, or psychically with the concerns and feelings of others. The clear and acute problem with this strategy is that the anorectic often continues to reduce her body when her physical health is compromised. Without outside intervention, the sufferer often seems set on a path that will result in death.

For the women in this study, they felt a deep desire to be rid of any needs. Jena believed that having to ask for anything was too much, while Rae and Lucy describe the process of acting “as if” they did not have needs, which ultimately led them to believe this was the case. Marya wrote of her multiple fears around neediness and others, and found anorexia as a way to avoid all of these fears at once.

Laing also describes that for the schizoid, there is a “compulsive preoccupation with being seen, or simply with being visible,” which he states suggests an “underlying phantasies of not being seen, [or] of being invisible” (p.113). Within their illness, each of these women also spoke of a desire to not be seen by others. Lucy, Lori, Jena, Morgan, Rae, and Marya all describe starvation as a way for them to literally become less visible and thus less vulnerable to scrutiny and judgment. In the process of taking up less space they also reduced their capacity for emotional experiences. It seemed that as each of them literally became smaller, they were left with less room in which to hold and process their feelings, a desirable state for each of them.

Self-Annihilating Narcissism

This leads to the ninth paradox of anorexia, a self-annihilating narcissism, in which the sufferer holds a need to be preoccupied with the self, while also detesting the self. Laing describes that out of this unembodied insecurity, the schizoid becomes “preoccupied with preserving rather than gratifying himself” (p.42). This distinction is important because this narcissistic scrutiny and constant keeping in mind does not result from self-love and arrogance, but out of intense anxiety and fear that the person may cease to exist at any moment. Laing further describes that the dilemma for the schizoid because she is unable to “sustain a sense of [her]self as a person with the other” (p.52) and or when she is alone.

Guntrip writes that a narcissistic self-preoccupation in the schizoid is “enforced by [her] fears for the stability of [her] ego” (p.89). The schizoid feels that she must “hold onto” herself from “minute to minute” to keep herself alive, “daring not to let up for a moment” (p.91). Furthermore, Guntrip describes that in the schizoid, an experience of superiority is only a defense against deep feelings of inferiority.

For the anorectic, it can be understood that she experiences this same preoccupation that stems from a belief that she must be vigilant and alert at all times. She finds that she must constantly think of herself and her actions to create a sense of continuity and movement forward. In this perpetual self-examination, the anorectic is also hostile and critical towards herself and her behaviors, always feeling inadequate compared to her goals. Many sufferers speak of “the voice” of anorexia as an internal tyrant or dictator that constantly points out their shortcomings, flaws, and perceived lack of results.

Rae describes in the same paragraph both feeling like the strongest person on earth for denying herself food, yet also feeling like she did not deserve to eat like everyone else. Marya states that the constant vigilance and attention towards herself was out of a need to know that she still existed. She also describes a loathing of the self while being stuck in “arrogant self-absorption,” as well as a splitting between her “weak” body and her “powerful” mind. Lucy wanted to be both fragile and powerful at once, while Jena writes of her low self-esteem and her “Messiah complex” occurring at the same time. Lori and Ellen West both discuss a level of obsession within themselves that they felt was required to maintain their restricting goals.

In trying to understand this duality within each of these sufferers, the anxiety of petrification by Laing appears relevant. In this fear the schizoid worries that the other can “steal her soul” and render her inanimate and statue-like. In defense, the schizoid takes an offensive strategy of first turning herself “into stone,” which prevents others from doing it to her. Laing describes that “to forgo one’s autonomy becomes the means of secretly safeguarding it; to play possum, to feign death, becomes a means of preserving one’s aliveness” (p.51). He also writes: “to consume oneself by one’s own love prevents the possibility of being consumed by another” (p.51).

Thus, the state of starvation achieved by all of these women can be viewed as playing out this defensive strategy discussed by Laing. In detail, each of these women describe how severe weight loss resulted in a deadened pallor and a loss of color and vibrancy in their appearance. As their bodies became that of skin covering bones, they wandered around as someone who was not quite living, yet still present in some capacity. In this state, they each appeared to have petrified themselves, losing the energy and the

ability to use their mind and body for everyday tasks. While this state allowed them to feel less vulnerable to others, these women failed to realize that in the process, they were forfeiting the sense of self that they had created.

The Illogical Logic of Anorexia

Once the person is embedded in the process of restricting, anorexia encourages complete isolation from others, resulting in a solipsistic experience that gives her illness unlimited power and control. As family and friends become more worried, a battle ensues around the sufferer's health. For each of these women, they experienced care and concern from others as controlling and destructive. Because they could not "see" their sickness, they were not able to recognize that these comments came out of concern.

As Laing describes, the schizoid anxiety of engulfment is a fear of being swallowed or eaten up through contact with another. To find safety from this fear, the person must isolate and find all that she needs from within herself. Laing also points out the importance of understanding the source of threatening feelings in the schizoid, to make sense of the person's seemingly bizarre behavior. The fragmentation of the self in anorexia becomes exacerbated by the deficits that occur in the brain in starvation. From these physical deficits, the already present obsessions and fears in the anorectic become morphed into bizarre and psychotic-like experiences. It is in these distortions that a tenth paradox of anorexia was found, *the illogical logic of anorexia*.

Through Laing, we can find an understanding of the anorectic's distortion within herself. In this state, concerns of further dissolving and turning lifeless are very real and present for the sufferer, as all of these women describe disordered thought processes in

starvation. Rae and Lucy write of feeling that their thoughts and behaviors in their illness seemed perfectly normal and logically, even as those around them said the opposite. While sick, Jena believed that the concern from her family was their way of overtaking her, and she unable to recognize her own state of mind as illogical. Lori described her pervasive fear of vicarious calorie absorption in the hospital, whether because the windows did not open, or because she could always smell food on the breath of her doctor.

Along with this inability to recognize a shift in their logic, they each developed fears and anxieties about food that were not rooted in biology and physics. They believed that by touching, smelling, and sometimes even viewing fattening foods, they would be taking in calories. Marya, Lucy, and Lori all describe moments of fear in which they believed they consumed calories through other sensory organs besides the mouth. Jena writes of the food nightmares she would have in which she consumed massive amounts in her dreams, waking up panicked and covered in sweat because she could not tell what was real. Morgan describes a bizarre and gruesome image she had upon hearing her grandmother use the expression “we need to put some meat on her bones.”

Guntrip writes that a sense of temporality is important for meaning making in one’s existence, which comes from the need to “mentally internalize everything.” Without a sense of time connecting “isolated memories and objects, no meaning can be derived, leaving a sense of emptiness and lack” (p.21). Rae and Marya stopped using the first person when referring to themselves, while Jena and Lucy had moments in which they got “stuck” in time, not realizing that they had stopped all movement. Jena and Lucy also describe moments of visual distortions as they believed their bodies had suddenly

become larger, even as they tried to reason that this was not possible. Lori was unable to make sense of the fact that she had become much thinner than her “idealized” friend, even with the evidence that this person’s pants fell down to her ankles after putting them on. All of these women state that they could not see the faultiness in their logic and thinking in the moment, thus any attempts at reason and logic employed by their families and doctors were not effective in bringing about their recovery.

Suicide, Anorexia, and the Pain of Recovery

The difficulty in recovery from anorexia was attested to by all of these women, as they saw treatment as taking away their external organizing and regulating system. In treatment, the removal of anorectic behaviors can feel annihilating and destructive because the sufferer loses her way of coping, as well as her identity.

As a result, many of these women felt suicidal in the beginning of treatment, which captures the eleventh paradox, *anorectic death vs. suicide*. Rae, Marya, Lucy, Lori, and Jena all describes suicidal urges that arose in treatment, and for some, it was their first experience with feeling suicidal. This is important to note to dispel the myth that anorexia is always a form of slow-suicide. While there are many sufferers who are both anorectic and suicidal, none of these women consciously connected their anorectic thoughts and behaviors with a suicidal wish. As Lucy describes, “the desire isn’t always to die; it’s to disappear.” Jena explains that with anorexia, she was desperately trying to live, despite the physically destructive ramifications of her restricting behaviors.

As already discussed, the state mind in anorexia allows the sufferer to exist between a full life and a complete death, providing her with a place to figure out what she

wants and who she would like to become. Only in recovery could each of these women fully acknowledge the contradictory nature of their illness that hurled them towards death as they were trying to assert themselves. In the midst of anorexia, they could not gain access to this awareness, even if they caught glimpses of this understanding from time to time. While it can be argued that these women on some level were “wishing” for death, it is very clear that when each of them started treatment, they overtly expressed a desire to die rather than suffer through the experience of regaining their body, their feelings, and their pain.

The slow and excruciating process of recovery requires the sufferer to build and internalize new methods of coping long after they were “supposed” to be created. The person in recovery must start with the basics, learning to self soothe and tolerate intense emotions like that of a young child. The person, often a teenager or an adult, has to simultaneously regress and learn these methods, while continue to “function” as someone competent in the world. In this process lies the twelfth paradox of anorexia, *recovery as torture*.

As described earlier, the defensive strategies in anorexia allow the person to stave off overwhelming emotions and fears, that lead her to feel contained, empty, and in control. In treatment, she is asked to open herself up to the very things she has been keeping at bay, food and emotions, which flood her body and mind and leave her in physical and psychic pain. In this refilling, she experiences an intense and uncomfortable pressure that she immediately wants to “evacuate” and “avoid.” In this process, she pines for the return of her illness or death. Through Laing, the taking away of a person’s

anorectic behaviors can be seen as a simultaneous loss of her defenses against engulfment, implosion, and petrification.

In treatment, these women describe that their difficulties were exacerbated by the fact that as they gained weight and appeared “normal,” the world started treating them as such. They no longer looked sick, in need, or special. As they each lost their anorectic body, they lost their ability to communicate to others that something very basic was missing. Lucy, Rae, Marya, Jena, & Lori experienced intense feelings of shame and embarrassment when they were told they did not “look anorexic,” or as they were expected to already “know” how to function like an ordinary person. Rae describes that while in anorexia she knew how to punish herself, it was in recovery that she “learned how to truly hate” herself. Lucy also describes a self-hatred in treatment, which left her feeling inadequate even for death, because she would not be thin enough in her coffin.

As Lori and Marya discovered in recovery, the awareness that someone cared about them was invasive and terrifying, something with which they did not know what to do. In recovery, Marya and Lucy aptly describe how the process of giving up the only way they knew how to exist in the world, left them with overwhelming fear that without their illness, they would suffer complete annihilation.

In Recovery, Not Recovered

Lastly, for these women they describe that the slow and cumbersome process of recreating and building a sense of self without physical destruction remains in constant motion. Thus, they each describe themselves as being *in recovery, not recovered*, which encompasses the thirteenth and final paradox found in the data.

Marya describes that she has reached a place of “alright,” while Jena believes that treatment made a “small crack” in the barrier that stands between her and the world.

Lucy discusses her commitment to helping those who also suffer, having had her anorexia and depression described as “the best thing that could have happened to her or any person,” in that it allowed her the opportunity to find herself. Rae believes that while the process of finding herself began in anorexia, it was ultimately through recovery that she found her own voice and a true sense of self.

The Paradoxical Nature of Anorexia

The allure of anorexia is great for a person who is already concerned and confused about levels of enoughness, fullness, and the potential devouring nature of her desires. Anorexia promises to transform her into “just the right amount” on a physical and psychic level, yet the tragedy of this illness is that this notion of what is right and appropriate is illusion that is never specified or anchored in reality. The nature of striving for a goal that is elusively defined inevitably leaves the sufferer in a constant state of anxiety, because she will always find herself just out of reach from what she believes is acceptable and worthwhile. The desire for fulfilling her wish to become someone without needs and without a body cannot be translated into something tangible, and as her physical and cognitive functioning deteriorate, the sufferer often loses the ability to make this distinction.

In anorexia, the culmination of the sufferer’s fears and anxieties takes places deep within a state of starvation. As she has transformed her internal fear into something external, she is able to focus on reducing her problem “of the body” to attain her wish of

perfection. In the beginning of her illness, the sufferer feels invigorated, satisfied, and in control of her actions, often for the first time. However, as the control and power slowly shifts from the sufferer to anorexia itself, the person becomes trapped in this fantasy that without her body, all of her problems will be solved.

The resulting anxiety and emptiness of this predicament presents the sufferer with a new fear, that of total annihilation at any moment. In defense, she must spend all of her time and energy keeping herself in mind and maintaining her eating disorder. At this point in her illness, she has lost the autonomy she had originally gained, and enters a state of existence that leaves her in limbo between life and death. Because of the destructiveness of this method of self-preservation, anorexia ultimately fails the person by making an empty promise of protection and salvation.

The dilemma around emptiness that exists on both a psychic and physical level for the person leading up to and during anorexia captures the overall paradoxical nature of this illness. Anorexia encourages the sufferer to give up her needs and desires in the hopes of achieving something greater and more profound. Like the schizoid, she believes developing an identity of someone who lives without will fulfill and sustain her. Unfortunately, in the end this may come at too great a cost: her life.

Limitations of the Current Study and Ideas for Future Research

While the sources of this data, published memoirs, provided rich and detailed information, I was limited as the researcher by the information presented by each author, and I did not have the ability to facilitate discussions on particular topics, as is the case when interviewing live research participants. As a result, I was unable to discuss a component of this investigation that was put forth in the literature review, the role culture played in the development and manifestation of anorexia for these women.

Rae did provide some commentary about her views on America's culture and anorexia, describing a cultural attitude personified, as a "highly self-conscious person who is preoccupied with being independent," who is really dying on the inside from loneliness. However, she was the only one of the six that engaged in this discussion. While Lucy did briefly describe how society can "ignore the ugly reflection of itself," in anorexia, she and the other four authors did not provide enough information to allow an interpretation of the role of culture in their internal meaning-making experiences.

It should also be noted that of the six memoirs, one of them took place in the United Kingdom (Lucy), while the rest took place in the United States, as did the interviews at the Renfrew Center. Also, for Jena and Morgan, Christianity was a part of their identity, though they did not specify how their spiritual beliefs directly related to their experience with anorexia. Lastly, Ellen West, who lived in Victorian time, offered a case study that lent support for the origins of anorexia put forth by Brumberg (1988). As expected though, this presented inadequate information to make a comparison between restricting behaviors from this period and modern times.

Lastly, several differences among the memoirs should be noted. As mentioned, Morgan's writings are a fictionalized version of her experiences with anorexia, which may include dialogue and experiences that were not "from" her life. However, as discussed in the methods section, all narrative stories are in part "new" in that the person is recreating her experience after they had already been lived. The concept of truth thus becomes not what is most "factually" true in the moment, but what the truth was for each author through their meaning making processes when writing their narratives. In this light, Morgan's writing did not seem to present as qualitatively different from the other authors.

Also, Lori was the only one of the six whose experience with anorexia took place over approximately one year, at the age of eleven. For the rest, the journey into and out of anorexia spanned many years and recovery took place in their late teens or early 20's. However, the experiences and details of Lori's illness did not appear drastically different than the others and instead followed a similar pattern on a condensed timeline. Therefore, this difference did not seem to affect the eligibility of Lori's experience for comparison and interpretation.

Methodological limitations of narrative inquiry should also be discussed, as there are benefits and disadvantages to any method of study. In utilizing narrative inquiry to analyze these texts, one limitation already discussed in the methods section is the assumption that each of these women meant the same thing when using similar words to describe their experiences. While this assumption had to take place to conduct a thematic analysis, there can never be a certainty that each of these women held the same meaning for the words that they chose. As the researcher, great effort was made to pay particular

attention to the context of which similar words were used to formulate what seemed most likely or accurate, given the overall words and writing style of a particular author.

However, this does not guarantee that this assumption was completely resolved.

Secondly, given the small number of research participants in this research design, there is less power to demonstrate a generalizability of these results to all sufferers of anorexia. It is possible that there may be something particular and unique about each of these women who chose to write about their struggle with anorexia, versus women who do not write and publish their story. Also, all of the six women were in various stages of recovery, which allowed them a certain perspective of their present functioning, as well as their experiences throughout their illness. It is possible that sufferers still in the midst of anorexia may find these ideas and themes do not resonate with their current experiences, which may or may not change in the stages of recovery.

This notion of meaning also raises a critique of narrative inquiry methods, in that the conclusions reached in this research are not one of certainty, but of possibility. The strength of likelihood is held in part by the success of the interpretation of the data. However, even the most eloquent of interpretations cannot achieve an absolute in knowing. Again, the more conceivable and likely it seems that the argument being made is, the more justifiable becomes the claim that these interpretations approach the concept of knowing. With this in mind, it is valuable to also think of the results of this narrative investigation as containing various starting point for a multitude of future research

The goal of this research was to explore the meaning-making process of the entire experience of anorexia, which presented a large amount of material to cover and interpret. As discussed, the idea of narrative inquiry opens up a greater possibility of

knowing, which cannot only enhance theories and ideas that already exist, but also create new trajectories for study to be explored with other methodologies. Any one of the themes discussed, including the five paradoxes, may lead to more specific and more narrowly focused quantitative studies. Other methods of research can further investigate these elements of the internal experience of anorexia, which will help discern if these themes are applicable to all sufferers of the illness, or just a particular subset.

Additionally, similar research should be conducted with male participants to explore the similarities and differences of their internal experiences to that of female anorectics.

Finally, other research designs can accommodate a larger number of participants, which can increase generalizability of their results on the experience of anorexia in general.

Conclusion

It was found in this research that the internal experiences of anorexia, when viewed through a schizoid object-relations lens, originally serve to create and affirm a sense of self and purpose for the sufferer. This was illustrated by applying the theories of Guntrip and Laing of the schizoid to the contradictory and paradoxical aspects of anorexia. Through the data, it was demonstrated that the anorectic operates under a unique logic, in which she believes she can preserve something vital and important by breaking ties and destroying her body. In this process, the sufferer sets out to become a completely internal and authentic self, where she can be free from the restraints and dangers of her corporeality. It was also illustrated that this attempt at preservation ultimately leads to great destruction on a physical and psychic level and results in the

sufferer inhabiting a space between living and death. Despite the risk to her physical health, the anorectic finds that this deadened state in starvation allows her to escape the intensity of her emotions and creates distance from others, all the while communicating her disavowed yet still very real needs in a non-verbal manner. However, she also finds herself with new and terrifying fears of dissolving and disappearing if she does not constantly keep herself in mind.

It is here that she continues to believe that striving towards this desired physical destruction will allow her to become free, despite the biological evidence that she cannot reach her goal without taking her life in the process. As her loved ones try to make her understand the seriousness of her predicament, she remains embedded in the illogical logic of anorexia. She is unable to make sense of their words of concern within her anorectic understanding that operates without the physical constraints and laws of the external world. She cannot recognize that those who are expressing their concern may be wishing for her the same goal that she holds: to develop a sense of esteem and separateness from others to live and flourish as her true authentic self.

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