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Psychosomatic Disorders in General Practice

Aspects of eating behaviour

1. Nutrition

Eating habits mirror one's affective needs and current state of mental health, while exerting in turn their influence on these psychic aspects. Nor should it be overlooked that nourishment is often identified with love, as exemplified by numerous colloquial expressions. There is a kernel of truth in the saying 'the way to a man's heart is through his stomach', while 'I could eat you' is an expression of great affection. We also speak of being 'hungry for love', and our mouths remain in the service of tenderness and love throughout our lives. This link between the tender passions and nourishment goes back to an early phase in our development.

Nutrition as a primary experience

In the initial stages of life no other vital function plays such an important part in development as eating. The satisfaction of hunger produces a feeling of security and well-being. The child experiences the first relief from physical discomfort during nursing, and contact with the smooth, maternal skin gives him the feeling of being loved. The infant also experiences the pleasurable sensations in the mouth, lips and tongue while being breast fed and tries to reproduce them later by thumb-sucking. It is thus that feelings of satiation, security and being loved are inseparable in the infant's early experience.

It is advisable to comply with a baby's tastes and needs as far as is possible in order to make feeding a pleasurable experience and thus ensure the absence of lasting tensions between mother and child. This is the basis of what is known as free-demand feeding. It is recommended by the Aldriches, a medically qualified married couple in the USA. They opposed primarily the kind of infant feeding having a prematurely educational approach. Free-demand feeding involves giving the infant a large measure of freedom in choosing his mealtimes during the first months of life. When the baby is hungry and cries it should immediately be breast fed or given the bottle. The child should also determine the quantity of food; no attempt should be made to force food on him, and it should be withheld only on the doctor's instructions.

The child should never be woken up to be fed. Washing should then be carried out when the child is satisfied and, more often than not, sleepy after being fed. Children fed in this manner fall of their own accord into a rhythm of dozing and sleeping as has been observed among primitive peoples.

In the fourth month the child can be made to wait a short while. He plays by himself, listens and watches, and this is the safest and most suitable time to adapt him to a time schedule.

The opponents of this method stress in particular that the strain on the mother would be unbearable if she had to listen for her child's every cry and be completely at his beck and call. She would become a slave to her child and find it impossible to take into account her own interests or those of other members of the family. The sheer physical and mental strain on the young mother would become a burden and be of no benefit to the newborn baby.

The weakness of this argument is that - as previously stated - children fed on demand fall into their own sleep-wake rhythm, thus enabling the mother to obtain necessary rest. Another point that the opponents of free-demand feeding overlook is that unfulfilled wishes on the part of the child for the food and protection afforded by the mother lead to discomfort that may find expression in paroxysmal weeping, tantrums, sleep disturbances, unrest and digestive disturbances. Infants, whose elementary needs for food and the maternal care accompanying it have been too early frustrated, will in the end make more demands on the mother's attention than those whose cries received timely response and satisfaction.

There is also the danger of lasting developmental disturbances occurring in infants whose vital needs were prematurely thwarted in a manner they cannot possibly grasp at such an early age. When such children are fed they tend to drink hastily and desire large quantities, being seemingly never satisfied. This behavioural pattern is the infant's answer to an insecure and disturbed mother-child relationship. It has been put forward that in such a situation the seeds are sown for later tendencies towards greed, envy and jealousy.

As Freud pointed out, the mother-child relationship is even more important than the method of feeding. Such factors as insufficient love and attention, absentmindedness and hasty or rushed feeding give rise to the first feeling of aggression towards the mother, which the child can neither express nor overcome but only repress. This evokes ambivalent studies to the mother. Such conflicting emotions cause various autonomic reactions. On the one hand, the child's body is in a state of readiness for food, on the other, the mother is unconsciously rejected. The sequelae are counterinnervation, stomach cramps and vomiting, which can be the first psychosomatic manifestation of a later neurotic development.

'Three-month colic' is another example we could mention. Insecure, anxious mothers transfer their concern to their child. The insecurity produces increased tension in the infant, together with colicky pains and sudden bouts of crying. The mother thinks her child is hungry, gives it food and thereby increases the tension already present, which again produces colic.

Investigations carried out by Spitz provided striking evidence that adequate feeding of infants, strictly adhering to hygienic principles, but given without manifest loving care fell short of the mark. He made a study of infants brought up in a home where the shortage of nurses resulted in a lack of love and attention, although everything needed from the hygienic and biological points of view was regularly and adequately supplied. A quarter of the children who remained in this situation for more than five months died of nutritional diseases. The remainder exhibited severe mental and physical damage which in a large number of cases remained in evidence for many years. Spitz made the interesting discovery that if the number of nurses was

increased to that each child could be picked up while being fed from the bottle, and if the nurses smiled at the children, such disturbances did not occur and those already present disappeared again providing they had not been in existence for longer than five months.

Hufeland had made a similar observation as early as 1798. In his book *Die Künste, das menschliche Leben zu verlängern* (The Art of Prolonging Human Life) he wrote that out of the 7.000 children who were brought to the Foundlings Home in Paris each year only 180 were still alive then years later. He recognized that the reason for this high mortality rate lay partly in the separation of the children from their mothers and the loveless treatment they received in the home.

Anxious parents often complain to their doctor that their child 'doesn't eat anything'. To such parents the 'care' of the child does not go beyond seeing that he eats enough and empties his bowels regularly. In return they expect rosy cheeks. Coercion and appears to reason or volition tend to dull the appetite rather than sharpen it. Such children, who really feel neglected and lonely, tend to regard the parents' persuasions as merely a means of achieving their own peace of mind and experience them as subliminal threats of further withdrawal of affection. Children react in extremely varied ways to such parental blackmail. They may eat only when told to do so and then only piecemeal, refuse food in defiance or passively tolerate overfeeding to the point of becoming obese. Effective treatment is only possible once the disturbed relationship underlying the nutritional disorder has been revealed.

Nutrition as a communicative experience

We have seen that infant feeding is not merely a matter of metabolism but that it is inseparably linked with feelings of security, of being loved and cared for, or with feelings of a totally opposed kind. Such experience in early life is never completely effaced. Goethe aptly stated in his *Wilhelm Meister* that no-one could escape from the first impressions of his childhood. Symbolic hunger for security, love or recognition can influence the stomach in such a manner that one may experience a longing for food that appears very real. Such hunger frequently results in overeating to the point of phagomania. In his investigations into the etiology of obesity Cremerius found that this association of symbols was a deciding factor.

Mitscherlich has stated that the tea-breaks taken in offices and other places of work are not really for the purpose of satisfying a calorie need but rather for relieving the listlessness connected with the given situation, just as the infant related the experience of feeding to relief from discomfort.

Eating is indeed eminently suited to reviving moods and feelings experienced in the past and in a similar setting. An excellent an observer as Proust analysed his own feelings on enjoying a cup of tea and a biscuit. In *A la recherche du temps perdu* he wrote: 'I lifted the spoon to my lips having previously put a piece of biscuit into my mouth. The instant the liquid and the biscuit touched my palate I trembled with the extraordinary sensation that overcame me. As if out of the blue a feeling of enchanting bliss took hold of me, and I was completely unaware of its origin'.

Proust's previous feeling of wretchedness had disappeared and he wondered from where his new happiness had come. He concentrated on searching for its origin and finally he saw once more a happy picture from his early youth: a Sunday morning when his aunt had brought him tea and biscuits. Everything was there again - the summer house, the neighbour's garden and Combray; the delightful picture unfolded before his eyes like a Japanese paper flower in a glass of water.

Owing to the close connection between food and mood, mealtimes are the most unsuitable occasions for arguments, correcting children or giving them severe lectures. For the annoyance evoked not only ruins the appetite but impedes the process of revitalization that should accompany every meal.

Healthy eating involves more than just healthy food; a friendly atmosphere at the table and food that we like are equally important.

An experiment carried out at the Bethesda Institute near Washington, DC, to test certain psychic influences on appetite and digestibility proved extremely revealing. Several men who were accustomed to plenty of good food volunteered to take part in the experiment. They were given meals consisting of anything they wanted but had to eat the food in pulp form through a tube in a small bare room. The experiment soon had to be abandoned since all the volunteers lost their usual appetite, found the meals disagreeable and lost a considerable amount of weight.

An experiment of this type naturally reflects extremes. Nevertheless, for everyday purposes it can be concluded that the way meals are presented and the external circumstances that determine our mealtimes are matters of no mean importance. An attractively laid table and food served in an appetizing way do more than merely satisfy our aesthetic sensibilities. When heightened rather than diminished by outward appearances, the enjoyment of food is also beneficial to health. Because eating is associated in our subconscious with the need for care and affection, loveless 'feeding' signifies a disappointment which if continually repeated can damage our health.

It is not generally known that our psychological needs are reflected in our eating habits. In a fundamental study Kaufmann classified foods according to their psychological implications; positive foods include those with 'safety components' that produce a feeling of security, such as milk, foods that signify thanks or a reward (sweets), foods with a magical action that give strength (beefsteak, black pudding), foods that reflect social standing (caviar and other delicacies), 'adult' refreshments that are forbidden to children (coffee, beer, wine), etc.

Accordingly, the craving for sweetmeats frequently constitutes a form of self-reward when there is a background of boredom and lack of love. Müller-Eckhard aptly commented that many women seek the sweetness at the confectioners that they miss in their love life.

Practical conclusions

Eating is not only closely related to the need for affectionate attention; indeed, it is even more of a communicative event. Such expression becomes immediately clear when we consider that meals frequently require the work of other people. Moreover, most of us prefer to eat in company with others. A doctor has to take this into consideration when he requests the patient to give some of his eating habits, which may be one of the few pleasures in his life. A person who has to cut down on his meals or follow a particular diet often feels 'reduced' and deprived of a full life. Without psychological help, therefore, even the right diet could have an unfavourable effect.

For this reason it is essential to give the patient a thorough explanation as to why he is being asked to make such sacrifices. The best results are obtained by arousing the patient's enthusiasm for the desired objective. In prescribing a diet, the doctor must of course consider the patient's financial situation and occupation. Instructions should be precise and easy to understand. Experience has shown that they are most effective when written, provided with the name of the patient, and contain remarks tailored to his individual needs.

It is moreover always advisable to enquire into the eating habits of patients presenting with alimentary disturbances or gastrointestinal disorders. They can provide invaluable clues as to the origin of the patient's abdominal discomfort, loss of appetite or bulimia.

2. Overnutrition and obesity

Basic aspects

Despite all the question that are still open in the problem of obesity, it is at least generally agreed that a positive energy balance lies at the root of the trouble. The food intake of obese patients is more than they actually need.

In the overweight, there is a disturbance of the normal satiety control. Pudel is of the opinion that obese patients are influenced more by external stimuli in their craving for food than they are by physiological internal stimuli. Such patients just do not know when they are hungry. Instead, their appetite is triggered off by external stimuli and various forms of discomfort and uneasiness.

The perpetual desire to eat or sudden bulimia are thus not an expression of an increased need for food on the part of the organism. It is rather that when confronted by conflicts and personal problems these patients regress to infantile patterns in attempting to overcome their feelings of discomfort and displeasure. Food then becomes a consolation for satisfying other, unfulfilled emotional needs.

Adiposity and anorexia have a common tangent in the sense that in both there is a dependence on the satisfaction of oral needs. In the former, the fixation is expressed in the form

of positive dependence as compulsive overeating, and in the latter in that of negative dependence as a refusal to eat.

Freyberger and Struwe classify the obese according to eating habits into four main groups:

1. The binge-eater. He is suddenly overcome by a voracious appetite. His ecstatic craving becomes uncontrollable and he consumes enormous quantities of food before he is finally satisfied. One even speaks of an 'oral orgasm'.

2. The continual eater. Appetite occurs on getting up in the morning and persists throughout the day. This type of patient can and will eat at any time, being incapable of limiting himself to the main meals of the day. Yet he does not appear to suffer from his compulsion; on the contrary, he feels quite well.

3. The insatiable. Unlike his fellow sufferers in the other groups, appetite does not drive him to a well-laid table. But once he starts to eat, his hunger knows no bounds.

4. The night-eater. This type of patient is most common in the USA and is afflicted by hunger only after nightfall. No matter how much he eats, his hunger remains unsatisfied. His sleep is troubled or he frequently awakes and eats, then goes to bed again and suffers from reduced appetite on the following morning. From this shift in the polarity between hunger and satisfaction, Freberger concludes that there is a defect in the structure or function of the ventromedial nucleus. But this has so far not been proved.

Personality profile

Bruch showed how obesity can be triggered by parents if they respond systematically to the child's every need by offering him something to eat and make their attention dependent on his acceptance. Such behavioural patterns lead to lack of ego strength, so that frustrations can be neither coped with nor worked through but must be compensated by 'reinforcement'. A strong mother fixation is frequently encountered in obese patients.

From the psychosomatic point of view the excessive caloric intake may be explained as a form of defence against emotional tensions, dissatisfactions and anxiety states, particularly those having a depressive undertone. Many members of the lay public are quite aware that excessive weight gain may result from overeating caused by worry.

Yet it is impossible to describe a standard type of obese patient. We encounter traits of inner compulsion, apathetic, gloomy resignation and signs of a flight into isolation. The act of eating shifts the unpleasant affects - even if only briefly - into a depression-free phase.

The patients feel incomplete, vulnerable and inadequate. Hyperphagia, reduced activity and the resultant excess weight provide a certain amount of protection against this deep-seated sense of inadequacy: being large and imposing makes the obese person feel stronger and safer.

In isolated cases the bulimia either appears or is reinforced as an obvious result of frustration.

Regressing to the infantile pattern of equating food with love, the obese person often seeks consolation in eating for the affection he lacks.

Treatment

Slimming cures are usually ineffective unless it is possible to change the patient's instinctual-affective behaviour in such a way that he no longer feels that he has to overeat and so become overweight.

On the whole, the results of treatment in general practice have been bad because the pleasure-pain balance is ignored. It is thus repeatedly pointed out that during dieting over half the patients exhibit symptoms of nervousness, irritability, fatigue and depression in the broader sense. All of these may find expression in the patient's increased anxiety.

Reasons for the frequent failure in the treatment of obesity are as follows:

1. In both diagnosis and treatment, the organic approach to medicine tends to concentrate on alterations in physical structures and their functions. The problem of the obese patient has no place in such a concept. In a moral sense he is frequently regarded as being 'foolish' rather than 'ill', the inference being that he himself is responsible for his condition. Emotionally, he is frequently rejected.

2. Careful analysis of the particular behavioural pattern along with its implications and motivations is indispensable for treating a disorder of this kind. For such an undertaking, the doctor frequently has neither adequate training nor time enough at his disposal. It is moreover difficult to offer the patient satisfactory compensation for the loss of pleasure he obtains in eating.

3. Sociological factors also play an important role in epidemiological considerations. We are thinking here of the stimulus and temptation offered by the display and availability of traditional high-calorie foods, against which our treatment is largely powerless.

4. Patients deviate far more frequently from their doctor's instructions than one would like to believe. Such behaviour is a particular source of annoyance to the doctor since he assumes that a patient who does not follow his instructions is not prepared to cooperate. Many investigations have however shown that patients often fail to understand or remember the instructions because they are too complicated. They are also extremely reluctant to ask the doctor to explain or repeat his instructions.

How can patient compliance be motivated? Most important is the patient's *active* participation in the treatment. In order to do this the doctor must first of all establish a good contact with the patient. The better this sympathetic understanding develops, the easier will be

his task. Of prime importance is it to form a picture of how deeply the patient is affected in his personality by being deprived of a means of overcoming his conflicts and of obtaining pleasure.

The next step is to draw up an individual plan for treatment together with the patient, taking into account his personal situation and occupation. The reader is here referred to the remarks in the *practical conclusions* in the section on *Nutrition* (page 71). The patient should be offered the possibility of practising and controlling what is for him an unfamiliar eating behaviour. How extremely important this is has been shown in a study carried out by Balabanski and Tashev, according to which, patients who had lost 17 kg should only keep their weight normal if they were given regular weekly consultations by their doctor. Follow-up studies on a group of patients who had broken off contact with their doctor after treatment showed that they had very quickly put on weight again. The application of behaviour therapy techniques and specifically oriented group therapy may also be of help to such patients. Treatment employing exclusively appetite suppressants has, on the other hand, proved of little value.

3. Anorexia nervosa

Basic aspects

Anorexia nervosa is encountered with marked frequency and constitutes a typical example of a somatic disorder of psychic origin. It is most common in young women in the years following puberty. Nevertheless, it is not unknown for young men and older women to suffer from this disease. The sex distribution ratio usually quoted is 10:1.

The prime characteristic of anorexia nervosa is a *refusal to eat.* Food intake is reduced so drastically that it is not uncommon for the disorder to endanger the life of the patient. The case fatality rate is about 10%. In general the weight loss amounts to 20-40% of the body weight at the onset of the disorder. In advanced stages of the disease patients usually weigh no more than 30 kg. Particularly in the early stages, however, this refusal to eat is interrupted by bouts of bulimia, which the patients satisfy mostly in secret. Vomiting is also induced in secret, so that with time and training the emptying of the stomach may be achieved almost spontaneously.

The clinical picture is frequently characterized by amenorrhea, usually secondary, and chronic constipation with subsequent laxative abuse. Severe cases may be accompanied by hydremia, hypoproteinemia, electrolyte shifts and the formation of edema.

A conspicuous feature of these patients is their erratic restlessness. There is a curious discrepancy between the cachectic state of the body and the patient's lively mental and psychomotor behaviour - something which is never observed in other disorders resulting in such severe cachexia. A further major symptom is a disturbance of body concept.

The historical development of this disease concept can be divided into four periods. The first of these covers the early attempts to relate the disorder to some kind of suggestive process. During the second period the symptoms and pathogenesis of the syndrome were more clearly

defined. The third phase began in 1914 with Simmonds' discovery of hypophyseal cachexia and the fourth is distinguished by psychoanalytical and phenomenological investigation.

The first paper on anorexia nervosa was published by Porta, a Neapolitan physician practising in the sixteenth century. His monograph bore the title *Reflection of the prominent philosopher Simone Porta of Naples on the case of the young daughter della Magna who lived for two years without eating or drinking* and was translated into the Florentine language by Giovanbattista Galli.

In 1689, in his treatise on phthisis, the English physician Richard Morton described, under the heading 'atrophy or nervous consumption', a loss of body tissue which occurs in the absence of fever, cough or dyspnea but which is accompanied by loss of appetite and marked disturbances of the digestive tract such as achylia and dyspepsia. In Paris in 1873, Lasègue published a fundamental study of anorexia hysterica in which he attributed the disorder to a particular state of mind, in other words to a mental perversion due to the admitted or hidden emotions of the patients.

In the same year William Gull, a Londoner, called the syndrome apepsia hysterica, believing that it was caused by functional impairment of the gastric branches of the vagus nerve in patients with a hysterical dysposition. He later used the expression anorexia nervosa.

Owing to Simmonds' description in 1914 of a case of cachexia involving atrophy of the anterior lobe of the pituitary gland, a connection was for many years thought to exist between hypophyseal cachexia and anorexia nervosa, with the result that the latter was treated with pituitary extracts or transplants.

In recent years, however, anorexia nervosa has become more a problem for psychiatrists, who have turned their attention to a phenomenological understanding and interpretation of the disorder. Zutt has put forward that a cardinal symptom of anorexia is the inability of the patients to eat together with others. This he regards as a communicative disorder underlying the disturbed eating pattern. According to this, the somatic dysregulation results from impaired communication, which finds expression in eating since meals are a social phenomenon of the first order.

Personality profile

The patient usually comes from a middle-class family and is often an only child. If she has brothers, she almost invariably complains of being regarded as inferior to them. The patient's family is generally dominated by a female authority figure, which may be the mother or a grandmother. The father is excluded from the child's emotional sphere, being outmanoeuvred and belittle by the mother, either openly or otherwise.

The general attitude to life prevailing in the patient's family is strongly orientated towards achievement. Emotional conflicts are stubbornly disclaimed since the members of the family see no possibility of working out adequate solutions to them. The atmosphere in the home is

constantly tense and gives rise to heated discussions on the most trivial of subjects, which are in some measure a surrogate for venting feelings.

The family itself gives the impression of a closed system that gives no latitude to any of its members. The symbiotic, close-knit interplay of the individual members is very marked. This is expressed in that it is not uncommon for another member of the family to fall seriously ill when the patient suffering from anorexia nervosa succeeds in departing from her course of self-destruction.

Most patients give the impression of being extremely well-adjusted, conscientious and obedient to the point of docility. They are usually of high intelligence and make brilliant scholars. Their interests are centred around intellectual subjects and their ideals are ascetic. A normal body concept seems to have been lacking since early childhood. They bear frank contempt for everything sensual and instinctual, and girls tend to be troubled at puberty by the development of secondary sex characteristics. The situation triggering off the disturbed eating behaviour is not uncommonly the first erotic experience, which the patients cannot work through and find threatening. Other precipitating factors may be intense rivalry between the patients and their brothers and sisters, separation anxiety from travel, grown-up children leaving the family circle and divorce.

The patients transfer their struggle against instinctual drives, particularly against those of a sexual nature, to an oral plane by refusing to eat. It must be admitted that they thereby achieve physically the desired result in that the development of characteristically feminine curves or rounded forms is halted. In this context it is interesting to observe that many patients state the reason for their behaviour as the wish to avoid at any price getting a fat belly. Looked at in this way, the refusal to eat represents a defence against vague fears of pregnancy.

The rejection of food does not however constitute solely a struggle against the maturing of feminine sexuality. It is also an attempt to resist becoming adult, backed by a feeling of helplessness at the thought of the increasing demands of reality.

At the centre of the psychodynamic pattern of forces is a symbiotic bondage to the mother coupled with a strong, ambivalent desire for separation. In this conflict, the proximity of the mother is sought and yet feared, and in this sense, the refusal to eat is also a rejection of such proximity. On the one hand, the patients turn their self-destroying aggression against themselves as punishment for their 'betrayal' in desiring to be separated from the mother. On the other hand, they attempt to use their rejection of food in order to gain loving care or, if this fails, at least to annoy the other members of the family, particularly the mother, and exercise control over them by such behaviour. In many of these families, the dominant topic giving rise to vexatious reactions is in fact the patient's eating behaviour. When under treatment, the patients attempt to transfer this scheme of reference to the hospital staff.

The same ambivalence becomes apparent if the refusal to eat is regarded as an oral protest. This is primarily directed against the mother, who is not really nurturing the child but

at the same time is not prepared to give her the freedom she requires. The purpose of the protest is equally ambivalent: on the one hand it is an attempt to extort affectionate care, while on the other, food is rejected in an effort to gain independence. It is precisely this striving for self-sufficiency that paradoxically leads to self-destruction when taken to its logical conclusion.

In anorexia nervosa it is thus not simply oral aggression that is suppressed - the negation relates to all oral needs and the ego attempts to assert and revalorize itself by rejecting all oral stimuli.

Whereas neuroses involve a battle between the ego and the symptom, it seems that in anorexia nervosa the idea of 'having to lose weight' constitutes an immutable component of the personality right from the outset. This peculiarity is only found in symptoms that are triggered off by psychotic processes. Even in severe forms of anorexia nervosa the ego does not fight against the idea by which it is dominated; this also explains the lack of awareness of the disorder and the refusal of all help. Anorexia nervosa cannot therefore be regarded as an ordinary neurosis.

Palazzoli-Selvini accordingly speaks of a monosymptomatic psychosis restricted to the dominating idea that the body must be destroyed by the denial of all oral tendencies. Clauser has described anorexia nervosa as a chronic form of suicide.

Treatment

The general practitioner's first duty is to make sure there is no organic cause for the disorder. When making a differential diagnosis particular attention should be paid to wasting diseases such as tuberculosis, malignant tumours and hyperthyroidism, and also to chronic enteritis and juvenile diabetes.

A disorder which for many years was often confused with anorexia nervosa is Simmonds' hypophyseal cachexia.

Anorexia nervosa should then be distinguished from symptomatic anorexia occurring in cases of depression or schizophrenia where sitophobia could, for example, be due to fear of poisoning. A finer distinction must also be made between reactive anorexia from psychogenic inhibition and vomiting neurosis due to emotional trauma resulting from mechanical function disorders of the digestive tract and leading to an involuntary weight loss (esophagospasm, functional dysphagia, intractable vomiting, etc).

Early diagnosis is of prime importance since the prospects of successful treatment diminish as the disease progresses.

The initial contact is rendered difficult by the patients' cool, passive and often mistrustful attitude. Freud refused to give treatment on an outpatient basis. He considered that these patients, who were so near to death, had the ability to gain such a mastery over their analyst that it was

impossible for him to overcome their resistance.

The patients' lack of insight into their illness makes it particularly difficult for the treatment to take shape. Ziolko spoke of an 'exchange of blows' with the doctor that can end in the patient's favour by her achieving a minimal weight. Kütemeyer reported that more effort and attention had to be devoted to one patient's problems with other patients, other doctors and the hospital staff in general than to the patient herself. With the passage of time these problems increased in such measure that the growing conflict of opposing impulses gave an impression of whimsicality and extreme malice.

A vast range of therapeutic measures have been suggested by various authors over the past thirty years. The sheer weight of numbers and the frequent contradictions between the individual recommendations are indicative of the uncertainty of the results and the lack of specific remedies.

In recent years there has been an increasing tendency to recommend treatment employing a combined approach carried out by well-coordinated teams in special centres. The initial phase of treatment consists of feeding up the patient. Should behaviour therapy fail to bring about a change for the better, the nasogastric tube must be resorted to in order to avert the progressive threat to the patient's life. Feeding by intubation is then replaced at a later phase by measures involving behavioural therapy. The treatment is based on the principle of operant conditioning. The patients are isolated but the situation is improved by the presence of the therapist at mealtimes. During the initial stages of treatment the patient is rewarded for every increase in weight, while at a later stage the reward is given for maintaining what is considered as a normal weight.

The problem for the doctor handling such cases is to avoid giving the impression of forcing the patient to eat or allowing the symptoms of the disease to become the focal topic of the treatment. Indeed, the aim is to break any tendency on the part of the patient to restrict her perceptions to purely physiological aspects.

Various psychotherapeutic techniques have been employed. One that has proved of great value in recent years is that of 'family confrontation'. The patient's family is included in the therapeutic setting from the very outset. Its members are confronted with the grave consequences of the illness in the presence of the patient as soon as she is admitted. The essential nature of their participation can be gleaned from a report by Petzold and coworkers who stated that successful treatment was impossible when other members of the family were not prepared to take part.

As a modification of J. M. Charcot's words in describing anorexia nervosa as a *perversion du système nerveux*, Petzold called the disorder a *perversion du système familial* and defined it as a symptom of a family neurosis.

The use of family therapy has brought about surprisingly good results, even in cases proving resistant to other forms of psychotherapy. Before these dynamic components of family

life were taken into account in therapy, one could say that roughly 10% of all cases had a fatal outcome; one third of the patients remained anorectic and the disorder assumed a chronic character; another third developed severe emotional, even psychotic symptoms after losing those of anorexia nervosa, while only the remainder showed a change for the better.

Petzold attaches great importance to general medical care. He sees its primary task as being that of no more but no less than to conserve what remains. A frequent problem is to keep informed about the patient's weight and nutritional state without oppressing her with too many check-ups since the disorder represents in the first place a protest against excessive family control.

It is also common for young married women to become anorectic, their attitude to pregnancy being at the centre of the conflict situation (Willi). They nevertheless seem capable of overcoming their - albeit unwanted - sterility, which has a favourable influence on the prognosis.