

ence. It is questionable whether an interpretation of the unconscious fantasies contained in the observations would have had the same effect. Would such an interpretation not instead have contributed to raising doubts about the patient's capacity for perception, as if the analyst had not been tired at all and was therefore vulnerable?

In the second episode it was another realistic observation that offered her the chance to overcome the polarization of idealization and disparagement and that led her to approve my having – the previously denied – masculine qualities and to integrate her projected parts into her self-conception.

### *Epicrisis*

Some three years after the termination of therapy Dorothea X wrote in a supplement to a questionnaire specifically designed to examine the consequences of interruptions during therapy:

I answered all the questions immediately after receiving the questionnaire, for me a sure sign of how much I still felt a close tie to psychotherapy and to my psychotherapist. The greater the distance to the last session, the more benefit I can derive from the treatment. For example, I've just now come to understand many of the therapist's ideas from that period and know how to handle them. I am thankful for every session of therapy in which I learned to live a bit more light-heartedly and happier.

Some time before the termination of my psychotherapy I rehearsed, laughing and crying, all by myself for the hour of separation. This game became so unbearable for me that I requested that the therapist announce the last session as quickly as possible. And I also clearly felt that the time was ripe. Afterwards I felt free – not happy and not sad – just waiting. I continued to live as before and had many mental conversations with my ex-therapist. I have never considered returning to therapy. The circle had closed. I knew that it was a good and productive period for me. In therapy and from the therapist I studied how to live better and more freely and rehearsed it. I then had the firm will and fairly secure feeling of being able to master life outside.

## 9.5 Anorexia Nervosa

### *Reconstructing Its Genesis*

We have taken the following reconstruction of the origin of anorexia nervosa from a case history that has already been published in full (see Thomä 1967a, 1981). Although it is not a trivial matter that this reconstruction of a psychogenesis still retains such vitality after almost 30 years and that the problems posed by identification and identity in anorexia nervosa which are the focus of this reconstruction have in the meantime been acknowledged by all the schools of psychotherapy, we would like to emphasize something else. We want to familiarize the reader with the termination phase of a psychoanalysis, because in the eighth and ninth phases of this treatment there are hidden signs that in hindsight turned out to be significant regarding symptom substitution.

Henriette X's symptoms first appeared when she was 16. Her premorbid body weight of 50–52 kg (110–115 lb) fell to about 40 kg (88 lb). At the beginning of psychoanalysis three years later she weighed 46.3 kg (102 lb). Amenorrhea and ob-

stipation had been present since the beginning of the illness. During the psychoanalysis, a total of 289 sessions in two years, the patient's weight increased to 55 kg (121 lb), her period returned spontaneously after an absence of nearly four years, and her obstipation improved.

In order to provide insight into several important psychodynamic processes in this case we proceed from the precipitating situation, which is intimately related to an asceticism of puberty as it has been described by A. Freud (1937).

Henriette X used to blush when boys looked at her or when a subject related in any way with love was mentioned at school. The developing erythrophobia was a symptom that tormented her. She had had the feeling that she was the master of the house (see Freud 1916/17, p. 285) until something happened that was beyond her control. She discovered that she could make her blushing anxiety disappear by fasting in the morning. The blushing ceased with her loss of weight. In the course of the psychoanalysis this process was reversed. Her recovery of her ability to blush was accompanied by the old conflicts that had previously led to her asceticism and by the fact that she recognized them and was able to overcome most of them.

It turned out that Henriette X blushed because she was embarrassed when someone looked at her as a girl. This summary focusses on the anxiety that accompanied this involuntary act and her ego's defense mechanisms. The important question is why her erythrophobia was so intense that it caused her to limit her nutrition for years and to reject her body, which was accompanied by isolation. In the following we give the analyst's attempt to provide a survey of this patient's psychodynamics.

1. The description that the patient had felt like the master in the house prior to the blushing refers to a peculiarly structured ego ideal. She wanted to be a boy, not be looked at as a girl. This desire to be a boy had been anchored in her particularly firmly by elements of her environment. She had grown up without a father, an only child, together with her mother. Her mother was a widow who projected her image of her husband onto her daughter, who was intellectually precocious and acted as an advisor and partner to her mother. In other words, the patient was forced into a "masculine" role. The family circumstances strengthened those features in the patient that are not inherently masculine or feminine but are primarily exhibited in Western society by men, such as independence, firmness, and vigor. She set the tone and was accustomed to her mother doing as she wanted. This circumstance was partially responsible for the fact that the patient hung on to the misapprehension of an "omnipotence of ideas" (Freud 1916/17, p. 285).

The patient was also the active person in her long friendship with another girl. As long as she could play the role of the boy and succeeded in everything – she was an excellent athlete and pupil without having to work hard – her ego ideal was unimpaired. Her inner balance was disturbed until she reached puberty.

2. In the conflict between *not being able* to be a boy and *not wanting* to be a girl (in accordance with her ego ideal that was by now anchored in her unconscious), she reestablished a sense of security by adopting an asexual ideal. This is an example of the undifferentiated, primitive animosity between ego and libido or instinctual nature that A. Freud referred to in connection with the asceticism of puberty. The consequences of this patient's general rejection of libidinal wishes can be seen in her behavioral modifications in general and her disturbed eating behavior in particular. The

- patient achieved an anxiety-free ego by denying dangerous aspects of external reality and repressing her own libidinal nature.
3. Hunger became the prototype of her bodily needs, and asceticism helped her to overcome her anxiety about the intensity of her drives.
  4. Upon closer consideration, I differentiated this anxiety into its unconscious components, whose repression disturbed and inhibited the patient's thoughts and behavior. This led to, first, a limitation of the patient's capacity to enter interpersonal relations, second a disturbance of her capacity to work and concentrate and, third, functional disturbances. These consequences resulted from the different fates of the affect and mental representations of her unconscious impulses. The repressions were secured by means of anticathexes and alterations of her ego, as could be discerned in her behavior.
  5. The following psychogenetic processes can be distinguished:
    - (a) The avoidance of real satisfaction, retreat of the drive from the object, and satisfaction of desires in fantasy (daydreams about eating). This is already an attempt to avoid a danger that would be posed given an unrestricted and real satisfaction of drives.
    - (b) It turned out that the patient's amazon behavior in general and the anorexia in particular were the result of the receptivity she warded off ("something comes in me") because food was unconsciously linked with fertilization. Revulsion and vomiting were related to sexual defense.
    - (c) Oral gratification was unconsciously linked with destruction and killing. Her experiencing of eating was therefore restricted or burdened with guilt.
  6. Her anxiety that the borders might be destroyed points to a longing for a relationship that is all-encompassing or transcends all differences. Since she felt anxiety about her ambivalence and destructive oral claim to totality, she repressed this longing and satisfied it in a regressive manner. From an economic perspective, the tension from the restricted nutritional intake was discharged in her urge to be active (excessive walks). The urge to move and be active also helped to purify her body and were thus a part of her defense.

### *Biography*

Henriette X grew up as an only child and without a father. Two much older siblings had almost left home when she was born at the beginning of the war, in which her father died. It should be emphasized that a very close tie developed between her and her mother; her mother loved her more than anything else and let her sleep in her bed because the child otherwise fell into states of anxiety at night. From the perspective of the mother and other family members (a distant uncle who had a large family of his own took on an idealized father role), Henriette was a completely normal, happy, yet often difficult child who preferred to play outside than with dolls. She was intelligent and had a vivid fantasy. From early childhood she and Gusti were close friends, each of them playing a gamut of different roles. Of course, Henriette was not only the more inventive, but also frequently the active one, playing the "masculine" role.

School continued to pose no difficulty to her, and she continued to be one of the best in her class. Everything seemed to come easily for her. She was an excellent athlete, played piano well, and was gifted in learning languages. She was also one of the boyish leaders in her coed class, setting a tomboyish tone. She found

complete satisfaction in her friendship with Gusti, which protected her against having to keep closer contact with the others in her class. Her relationship to the others consisted almost solely of competing in gym class. Henriette frantically attempted to maintain this constellation and detested her periods, which forced her to abstain from competition for days.

With the changes that took place in the class during puberty she gradually lost her position of leadership and changed her behavior, becoming quiet, fragile of character, and losing her desire to roam around. In contrast to earlier, when she enjoyed eating, just like Gusti, she now reduced her food intake and occasionally vomited. Her declining athletic prowess kept her from taking part in competition. At the age of 16 she had to change schools, taking a bus to one further away. This meant a separation from Gusti. The physical and psychopathological manifestations of her illness, which arose when she was 15, did not change during the following two years at the new school, at which point she came for treatment.

### *The Terminal Phase of Therapy*

#### *Eighth Phase of Treatment: Sessions 215–254*

It was with some concern and also pleasure that Henriette X commented that the increase in her weight that she had achieved some time ago was accompanied by a change in her body feeling, adding that her muscles had become softer. Her concern resulted from sensations from her body, such as the pressure on her stomach when she wore a narrow skirt or belt. We were unable to understand a number of other, peculiar body sensations, but they appeared to us to be of significance for understanding the relationship between function and form, i. e., her disturbed nutrition and body image. The remarkable fact that many anorexics can maintain their body weights constant for years with only minimal fluctuations leads one to assume that food intake is automatically regulated by unconsciously signaled bodily perceptions.

Henriette X was just as moved by agitation that drove her to eat as by her perception of her body forms. In her states of anxiety she feared being overcome both from inside, by unknown instinctual dangers, and from outside. The unification of inside and outside, such as during eating and sexual intercourse, was the subject of the following dreams.

In the 237th session Henriette X mentioned a dream in which she had at first sought protection with her mother and then lay in bed with her analyst. There was a struggle, an injury, and bleeding. The important dream element in this context was that Henriette X was suffocated by the heavy beams in the ceiling of the room, which in the dream were actually cookies. In further dreams (240th session) she once again had the sensation of suffocating, and in one of them had her period. Finally in the 245th session she dreamed about having had her period, which was partly white. In the dream the blood from her period, including the white parts, were mixed with food that she ate. Later in the dream she lay under a particularly beautiful girl and had intercourse with her. She did not have a sensation of a penis, but did feel the girl's beautiful body and see her well formed breasts.

Now it became clearer what the phrase “being married with food” meant; Henriette X occasionally used these words to describe her current condition. Her dream about the white color of some of her period and the mixture of her menstrual blood with her food depicted an unconscious fantasy that refers to self-sufficiency, parthenogenesis, and oral fertilization. The analyst interpreted the dream at two levels and – to be brief – in the psychic context viewed the white component in the one case as semen and in the other as milk. It was now also possible to better comprehend an earlier dream, in which a baby sucked at her genitals; she had unconsciously equated her excrements with food. The analyst referred to the narcissistic nature of the dream, in the sense that “I am strong and can do everything, both procreate and live from my own substance.”

This autarky refers on the one hand to an anxiety about loss and death (nothing should be lost), and on the other to an attempt to overcome this anxiety. If this process is not restricted to the dream level but also governs behavior, then a situation develops that is apparently characteristic of many of those who refuse to eat. As a result of the maximal isolation caused by defense processes, nothing changes any more and the patient – even to the extreme of losing her life – retains her belief in her immortality, in a delusional manner. This paradox can be described by the following set phrases: “I live from my own inexhaustible substance and am thus not exposed to all of the dangers of an exchange that ultimately lead to death. I am from nothing, and therefore not threatened by death.” This denial enables the anorexic to be free of a fear of death. (Unconsciously, the person’s own substance is identical with her mother’s, so that the unconscious symbiosis appears eternalized in death.)

Fortunately Henriette X did not live in such autarky in reality, and with the help of other dreams we are also able to understand why she had been thrown back to its narcissistic nature. She had to ward off dangerous relationships, such as being overcome orally by cookies (displacement from bottom to top) and homosexual contacts, and the accompanying instinctual impulses. The object displacement of the dream image – e.g., the suffocating on the cookies – also corresponded to a peculiar body perception during association. Henriette X had the sensation that her tongue was swollen, and she reproduced the feeling of suffocation she experienced in the dream. The analyst took the swelling of her tongue to represent a displacement of excitation, and Henriette X feared that she might not be able to speak normally any more and would stutter. This fear disappeared immediately after the analyst interpreted the displacement as libidinal tendencies related to the mouth as the organ of articulation; in this regard he referred among other things to a homosexual dream. The patient commented that at this point she would have broken off the treatment if the analyst had been a woman because she would have been unable to speak with a woman about her needs for tenderness.

It is amazing that Henriette X managed to comprehend the analyst’s interpretations, to place her initially seemingly unmotivated states of anxiety in the context of her experiencing, and to integrate them. She was particularly tormented by her aggression directed against her mother, which on the one hand helped her to ward off her desires to lean on somebody, and on the other was the result of frustration. Her feelings of guilt occasionally led her to be careless and get into very dangerous situations in traffic; also involved in this was the aspect of testing her skill.

To her own surprise the quality of her work at school improved, even in the sciences, even though she had little endurance – but when, then with great intensity – and in comparison to the others in her class she still did not work enough. Her choice of a profession created more difficulties. She wanted to keep all her options open and, moreover, as she ultimately realized, find a profession that would serve as a substitute for marriage and family. At a job counselling session she was characterized as being of above average intelligence overall. She made good for her lack of persistence with her great agility. She herself had already considered becoming an interpreter, and with her continued progress this choice of a career seemed to come naturally.

### *Ninth Phase: Sessions 255–289*

Henriette X wanted to take advantage of the Christmas holidays to study hard, but it did not work out that way. For the first time she had fun at a party that she had organized together with her girlfriend Gusti. She was relaxed, enjoyed herself, and did not need to control herself. She was successful, admired by the boys, and courted in a friendly manner. She was not tormented by impulses to kill. Yet she did not dare to go for a walk alone and occasionally had the feeling of suffocating.

Her relation to her mother had changed, and Henriette X regretted that she innerly was more separated from home. It was also obvious that she continued to ward off strong needs to lean on somebody, which had a peculiar effect on her dealings with children. Although she enjoyed playing with her nieces and nephew, she suffered from the impression of innerly not being free and uninhibited and of not having any real contact to children. In her words, “I could have feelings toward children after all, now that I don’t have any feelings toward my mother anymore.” The only desire that seemed natural to her was to once have an intimate relationship, inconceivable in contrast the thought of bearing, feeding, and raising children. The analyst based his interpretations on the assumption that she could not have any feelings toward children because she would then partly identify with them, and precisely in identification with a child of her own she would experience infantile dependence. The interpretations were extended with reference to the above-mentioned dream about sucking and licking. The real problem expressed by both the patient’s and the analyst’s words was that of the interwoven nature of self- and object representation.

In the final phase of treatment Henriette X dreamed about suffocating her doctor. The dream contained some talk about love and lust. She associated a fantastic dream about a devil who waited for his victims before greedily devouring them. She also recalled that her 4-year-old nephew had once whispered to her while playing, “I want to tell you something very beautiful: I want to make you dead.” The destructive force of her claim to love led the patient to ward off her desire to lean on somebody because in such a circumstance she would have been helpless against her own impulses.

Another fact that deserves mention is that on the weekend between the 258th and 259th sessions Henriette went dancing and fell intensely in love for the first time. A girlfriend commented, with satisfaction, “You’re becoming normal.”

The patient passed her final examinations at school without experiencing any anxiety or agitation. She also did not miss an opportunity to celebrate fasching (Mardi Gras). Her first intense love was replaced by a new fascination. One night she became enthusiastic about an "existentialist" boy, in whom she in many respects saw an image of herself. They discussed good and evil half the night, denying the existence of the latter. They also decided in favor of highly ascetic ideals and called every form of dependence on the body inhumane. These arguments did not, however, keep them from caressing passionately. During the brief period of sleep that followed, Henriette X dreamed about lying in bed with a young man and hiding him under the blankets from her mother. She subsequently had difficulty falling asleep, which resulted in part from the sexual arousal she felt every evening. Henriette then recalled that she had used to feel sexually aroused, but had rejected the feeling and had not masturbated.

The patient's experiences during fasching precipitated a dream which revealed one important root of her feelings of inferiority as a woman. Henriette X dreamed that a large number of small black bugs came out of her full and swollen breasts. This dream was motivated by her sensation of the boys' sexual arousal while dancing, which was autoplastically represented in the equation of breast and penis. The black bugs symbolized semen, making it something repulsive. The patient came to this interpretation practically on her own, especially since it now became clearer that she considered herself for ever unable to fulfill the role of a mother: breasts were supposed to procreate, not nurse.

The patient was excessively disturbed by a renewed difficulty to fall asleep that manifested itself during the final phase of treatment. Previously she would have resorted to a fantasy that worked promptly, but which was now ineffective. This was the idea of falling in a deep well. The explanation for this difficulty was that she experienced this "falling" to sleep both as something that overpowered her and as a regression into the security she longed for. It was characteristic that the patient now felt the anxiety about falling asleep during a session. That this letting herself fall was still burdened, via an unconscious linkage, with an aggressive and dangerous act was shown by a dream in which the patient fell over, paralyzed by a man's poison-filled pistol. A significant improvement in these symptoms was reached by a continued working through.

Henriette's treatment came to an end after she had finished school and was in good condition. Her period had come regularly for months. Her weight was 55 kg (121 lb) and the obstipation was significantly improved. Overall she showed a positive development. Yet with regard to her symptoms, it must be added that the patient still did not feel completely uninhibited while eating and took special pleasure in the last bite.

The analyst now felt justified to leave the rest to the *vis medicatrix naturae*, the healing power of nature, and to terminate the treatment. The patient wanted to pursue her education in another city. Arrangements were made for another 15 sessions, held some months later. Overall the patient's development had been positive.

### *The Problem of Symptom Substitution*

Almost thirty years have passed since the termination of Henriette X's psychoanalysis, which provided important insights into the pathogenesis of anorexia nervosa. Her treatment produced lasting changes. We are completely justified in speaking about a cure because Henriette X has led a successful and full life, both privately and professionally, since completing treatment and because she has not exhibited any residual symptoms of anorexia nervosa. After graduating from college and starting a career that led her to spend some time abroad, Henriette X married the friend she had been living with for a long time.

Some twenty years ago she had a disturbing symptom, which led her to consult her analyst once again. She had rejected the intense desire that she and her husband had for children because of her neurotic anxiety that something might happen to their helpless children, and that she herself might do something to them. The patient, who had retained a vivid memory of her analyst, traced this symptom to the fact that in her psychoanalysis she had been separated from her mother too abruptly. Although she was completely happy with her husband and was grateful to psychoanalysis for her being at all able to establish a heterosexual relationship, among many other positive changes, she criticized the intensity of the treatment and the far-reaching changes, referring in particular to the abrupt resolution of her close relationship to her mother. She then went on to complain about another restriction of her otherwise active life – a light flight phobia – that she attributed to the changes caused by her treatment. In order to fly alone, she had to overcome her anxiety. She also blamed this inhibition on the analyst because he had contributed to her recognizing her dependence and thus losing the self-security she had had in her illness.

By acknowledging her complaints and thematizing them both at the relationship and transference levels, the analyst made it possible for the patient to undergo an intensive focal therapy, which for external reasons consisted of numerous sessions in a brief period of time. In the transference analysis the imaginative patient was able to relive her very aggressive feelings toward her mother and critically reflect on them. Since these aggressive feelings were manifested in a relationship she unconsciously experienced to be distinctly symbiotic, the patient could not be sure whether she was not referring to herself when she thought of her mother and any children she might have. She was anxious about the children she might have because the problems of a symbiotic relationship might be repeated for them. It was not difficult for the analyst to include her anxiety about flying alone in the focus of treatment, especially since the transference aspect was quite obvious. She could not face empty space without feeling anxiety because she still had an old bill to pay; having great trust in someone also means being very dependent and experiencing the related disappointments. The wide spaces represented a transference object whose reliability was cast in doubt by her own unconscious aggressions.

The patient's longing for an omniscient and omnipotent mother inevitably led to disappointments and aggressions that undermined the security she sought. Ultimately it was the unconscious process by means of which the symptom motivated the anxiety – as can be regularly observed with such symptoms – and was perpetu-

ated by “external” confirmation, which has the effect of reinforcement. The symptoms improved in a short time as a result of the intensity of her experiencing in transference and of her insight.

Henriette X is now the mother of several children and has written her analyst about her family several times.

Several interviews were conducted about ten years ago in the course of a follow-up survey conducted by the analyst. They helped the patient to cope with a momentary stress situation. She had a particularly close relationship to her children, which made it difficult for her to bear the steps they took toward autonomy before and during puberty.

The issue of symptom substitution is raised by the phobic symptoms mentioned above which appeared some twenty years after the termination of Henriette X’s treatment. The stumbling block is a comment referred to above that might be related thematically with the patient’s later symptom. At the time the patient had said that it might be possible for her to have some feelings for children since she did not have any feelings left for her mother, but that bearing, feeding, and raising children was inconceivable to her. Based on our knowledge of the later course, we can now state that an unconscious constellation had remained that later brought forth a thematically related symptom.

Such observations contributed to the formation of the theory of symptom substitution and symptom displacement, which Freud (1937c) discussed in his late work *Analysis Terminable and Interminable*. The issue of symptom change is connected with a controversy between the psychodynamic schools of treatment and behavior therapy (Perrez and Otto 1978). Several comments about this are appropriate at this point in consideration of the course of Henriette X’s illness. Taking into account the effects of so-called nonspecific factors in psychotherapy inevitably leads one to question the hypothesis that a treatment can be effective solely at the symptomatic level, because the motivations emitted by the symptom in a self-reinforcing manner remain linked with the earlier pathogenetic conditions. For this reason these conditions can be affected in some way even by treatment that is symptomatic and seemingly noncausal. Psychoanalysis has in practice neglected the dimension that consists of the course and secondary gain from illness, together with its repercussions on the underlying primary condition. It is not only with regard to the transference neurosis that the illness “is not something which has been rounded off and become rigid but that it is still growing and developing like a living organism” (Freud 1916/17, p. 444). A symptom displacement is only to be expected, on the basis of psychoanalytic theory, if important conditions of the origin of the symptom cannot be overcome by psychotherapy and continue to exert an influence. In the case of Henriette X an unconscious configuration survived, whose revival was precipitated in a particular situation and which became active again. A latent condition became manifest, precipitated by a thematically appropriate factor.

Since all neurotic symptoms are overdetermined, it is often sufficient to remove one of several conditions. The problem of symptom change thus amounts to the question of whether it is empirically possible to predict the conditions under which a configuration shifts from a latent to an active state, or to determine when the relevant links in a chain of conditions are actually interrupted.

The not insignificant difficulties involved in specifying the connections between latent dispositions and the probable future conditions of their manifestation seem to have contributed to the striving for a utopian solution, namely the destruction of all the pathogenic constellations that might become active in the future. Although Freud (1937c) demonstrated that such a goal is infinite, such utopias exert a great attraction. Paul Ehrlich's idea of one day developing a *therapia magna sterilisans*, i. e., a chemotherapy able to cure all infectious diseases with a single dose, corresponds to the utopia of resolving the disposition for psychopathological reactions by means of an interminable analysis.

We would now like to turn to the question of whether the *familial constellation* might have contributed to the origin of Henriette X's anorexia nervosa. This discussion will be exemplary in nature, providing a basis for different practical applications.

We will now summarize several of the peculiarities in Henriette X's family that had an effect on the formation of her inner world. Above we mentioned that in a certain sense Henriette X took the place of her father at her mother's side. This resulted in a very close tie between mother and child, the mother being able in her loneliness to find consolation in her daughter's company, which must have given Henriette X the feeling that she was very important to her mother. In the literature on family dynamics, the term "parentification" is used to refer to a situation in which a child takes on such a parental role (Boszormenyi-Nagy 1965). This is a kind of reversal of roles in which the mother or father directs desires to the child that were not satisfied in their relations to their parents or partner. They demand too much of a "parentified" child, forcing it prematurely into an adult role. Henriette replaced her father. We have described the difficulties this caused her in finding her sexual identity.

When Henriette X felt the desire to have children, she developed a neurotic anxiety that was rooted deep in her symbiosis. Later she actually sensed how her children's autonomy was a burden on her. The therapeutic work at this juncture was directed at resolving the parentification of her own children. In her close relationship to her children she attempted to satisfy her own childhood desires to lean on somebody that she had not been able to satisfy with her mother. This had been thwarted by her efforts to find autonomy and by her precociousness.

As the analytic treatment helped Henriette X to increasingly separate herself from her mother and to recognize her longings for dependence, and as she became careless in traffic because of her feelings of guilt about her aggression, Henriette's mother turned to the analyst. She was concerned that her daughter might do something to herself. In terms of family dynamics, the therapist was assigned the role of the father, which visibly relieved the patient. Henriette could transfer her worries about her mother to the therapist. At the same time the analyst was able to work out with the mother how the patient unconsciously attempted to assure herself her mother's attention in order to control her own strong desires for autonomy.

The family dynamics must be taken into consideration especially if a circular process cannot be interrupted by a change made by the patient. However we do not share Petzold's (1979) view that anorexia nervosa is the symptom of a family neurosis. The assumption that there are pathologic familial constellations which

are specific for the origin of anorexia nervosa, other psychosomatic illnesses, schizophrenia, or cyclothymia may well prove just as illusory as the assumption of specific causes of psychosomatic illnesses (see Sect. 9.7). The adverse consequences of such a misjudgment are well known since the invention of the “schizophrenogenic” mother. Moreover, in an individual’s experiencing the sense of cause is easily linked with guilt or at least with responsibility, which impedes or even obstructs any attempt to involve family members in the therapy because they feel misunderstood and perhaps withdraw completely.

The study of family diagnosis is still in its infancy. Research into the typology of psychosomatic, schizophrenic, and manic-depressive families (Wirsching and Stierlin 1982; Stierlin 1975; Stierlin et al. 1986) is burdened by so many methodological shortcomings that any assertion of causal relationships is dubious. Anderson (1986) has, for example, discussed such methodological problems with regard to the model of “psychotic family games” designed by Palazzoli Selvini (1986). We believe that a more modest goal is called for, also for reasons of theoretical plausibility; such a goal is for the family crisis precipitated by any chronic illness to be registered and included in the therapeutic scheme. Although Henriette X’s family has to be considered incomplete, due to the death of her father, it still clearly demonstrates the “entanglement” between mother and child described by Minuchin (1977). This word refers to an extremely close and intensive form of interaction. Other descriptions of “typical families of anorexics” (Sperling and Massing 1972) also point to specific structural features in familial relations that appear to be typical. Meant are patterns of interaction that are identified *after* the manifestation of the illness. The approach of family therapy constitutes a supplement to individual treatment if it provides the patient the freedom to leave home and attain the necessary autonomy (Gurman et al. 1986).

It is misleading to act as if a child has no innate dispositions, space for individual freedom and decisions, or active participation. Despite a child’s dependence, it does not simply react passively to its environment, but takes an active part in constructing it. This is particularly true of anorexics in puberty, who truly have a mind of their own.

## 9.6 Neurodermatitis

The repertoire of different types of somatic treatment for a chronic illness has usually been exhausted when a patient comes for psychotherapy. This fact, together with the study of changes during the analytic process, facilitates a *comparison of the case with itself* and thus the evaluation of the therapeutic efficacy of the new procedures, i. e., the psychotherapeutic ones. This constitutes a valid basis for single case study design, given that the only new factor is psychoanalytic therapy and that all the other conditions, particularly the patient’s living conditions, are constant. This is a fruitful application of J.S. Mill’s classical differential method in clinical research (see Eimer 1987).

First, it is necessary to name a few of the criteria that have to be taken into account in single case studies of this kind. The comparison of a case with itself is the most important basis for therapy research (Martini 1953; Schaumburg et al. 1974).