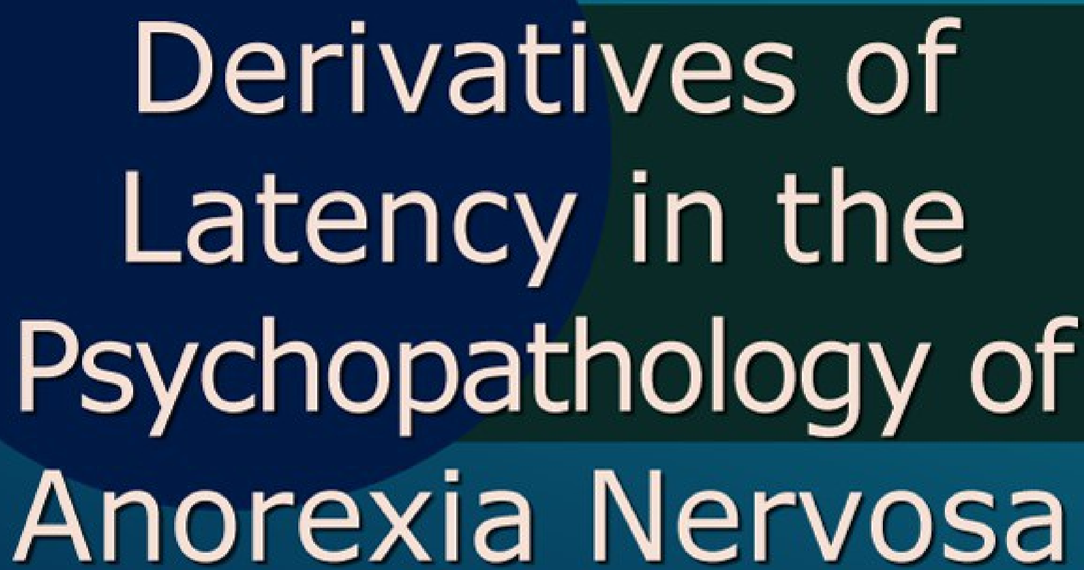

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Derivatives of Latency in the Psychopathology of Anorexia Nervosa

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e-Book 2016 International Psychotherapy Institute

From *Psychotherapeutic Strategies in Late Latency through Early Adolescence* by Charles A. Sarnoff, M.D.

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Derivatives of Latency in the Psychopathology of Anorexia Nervosa

There is a point during emergence from latency when a maturational process involving a burgeoning of physical secondary sexual characteristics, and a shift in primary love attachment from parents to peers is to be expected. In some young people, this expectation is interdicted by a cessation and regression in normal development; in effect, these young people make time stand still, or even turn back. Physical maturation slows; weight is lost; in girls menses ceases, and the figure recedes. Emotionally, involvement with the family intensifies, and involvement with friends becomes secondary. Usually, a strongly ambivalent quality invades peer ties. Peers are viewed as externalized rejecting and condemning superego figures. Therefore, the anger laden passivity relationship to the mother is intensified for lack of peers to relate to and to trust.

The emotional configuration consists of a cessation of the process of removal (disengagement of drive-discharge functions from the parent) and a regression from the task of developing the capacity to relate sexually to a peer. The process described is *anorexia nervosa.* The cessation and regression in the normal developmental process is the result of a configuration of defenses that takes the place of adolescence. We are not dealing so much with a disease or a syndrome as with an alternative organization of the ego that is chosen over the often chaotic, but always challenging and sometimes frightening, variations available to the young teenager trying to find the best way to master the challenge of adolescent sexuality. Of the normally negotiated types of adjustment usually seen in adolescence, the ones most closely allied to anorexia nervosa are the withdrawn and the ascetic. In both, the child shies away from intense sexualized socialization; and in both, parents remain more important than peers in the area of close personal relationships. In all three adjustments (asceticism, withdrawal, anorexia nervosa), the pattern of reaction may be transient in the sexual adaptation of the child, in which case it gives way to a more mature experiencing of life. For many, though, the pattern may persist to become the basis upon which is built their future adjustment and character.

All three adjustments have in common disengagement from sexual encounters. The withdrawn has

no contact with potential sexual partners; therefore, one so afflicted remains without skills for dealing with sexuality, nor has the opportunity to develop some. The ascetic confronts social situations and partners and learns personality skills to cope with sexual feelings through techniques of repression and denial. The anorectic changes bodily configuration to that of a younger child, seeking disqualification as an object of approach. For the anorectic, the primary mechanisms for dealing with sexuality entail withdrawing from peers and extinguishing, through starvation, the physical traits and configurations that announce sexuality and invite a sexual approach. The development of personality skills to deal with these is thus obviated.

Essentially, our purpose will be exploration of the characteristics of the phase of late latency-early adolescence, which persist in these youngsters and contribute elements to the disorders (such as anorexia), which make their first appearance during this phase (see Sarnoff 1976, Chapter 8). The other conditions that emerge at this time are depression with adult affect; adult-form paranoid schizophrenia; organized and repeated delinquent acts involving the property of others, and perversions without partners.

In my experience, female anorexia nervosa patients universally have a fantasy involving their psychic body image. The nonscaphoid abdomen is a sign of pregnancy. Manipulation of the true image of the body through starvation supports denial of sexuality from within at the same time that it fends off sexual approach by others. Both as a child psychiatrist doing consultation in a major hospital and as a practicing psychoanalyst, I have had the opportunity of seeing a wide spectrum of anorectics, ranging from those whose anorexia cleared after a few sessions of psychotherapy to others whose anorexia was intransigent and persisted through many years—and many therapists. In all cases, behavior and defenses were organized around specific fantasies involving body image, which are responded to by self-starvation.

The easily reachable, transient anorectic adjustment is associated with a discrete, thinly repressed, and well-organized body image fantasy in the context of a competent ego organization. The intransigent anorectic, on the other hand, has a bizarre, poorly organized body image fantasy, filled with contradictions. These, however, do not appear so to the child, since they exist in the context of an ego organization that shows impairment in reality testing, narcissistic deformations that caricature the

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expected deformations for the age, and the impress of the mother in both ego-ideal content and the interactions of object relations. All three of these elements carry the characteristics of latency ego states into the organization of the personality mobilized to confront the challenges of adolescence.

The reason for the imprint of latency on regressed adolescent adjustment is obvious: when the intensifications of sexuality that accompany puberty appear, the defenses of latency are near at hand, familiar, and made up of practiced skills. For those who are reticent to follow the direction of their drives to seek gratification in the world, the defenses of latency are available to help counter and stifle the drives through mediating their discharge with justification in fantasy, discharge of drive energies through regressed and sadistic, cruel interactions with parents who remain the center of interest in their lives, and a narcissistic deformation of object relations, which causes fantasies about people to seem more real than the people themselves.

When confronted with insights into these patterns, the intransigent anorectic readily agrees, but sees no reason to change her ways. The regression is conscious and felt to be justified; and as a result of support from the mother, it often provides secondary gains that entice the child to remain as she is.

The Transient Anorectic

The transient anorectic, on the other hand, finds insight a help. Much of her fantasy activity is repressed, leaving her bewildered at her state and unaware of her reasons for starving herself. The intransigent early adolescent anorectic is aware of what she is doing; her refusal to eat is a form of impulse disorder with an emphasis on overcontrol. The pathology of the transient anorectic is related to repression. In essence, she is food-phobic, with anxiety associated with eating and little understanding of what causes the fear.

> Millie was such a child. She was 13 years old when I was called to see her in the hospital, to which she had been sent by her pediatrician for evaluation of her refusal to eat. She sat by her bed reading, and was wearing street clothes. She appeared to be of normal weight, and her development was that of early puberty. She told me that she had lost 15 pounds in the last few weeks; she had been much heavier before that. At *5'3"*, her 110 pounds did not make her appear overly thin or in need of hospitalization from a life-threatening condition. However, Millie's pediatrician felt that the rate of weight loss was a cause for alarm. He had admitted her for a general work-up for the causes (organic or functional) of sudden weight loss. Uncovering no positive organic findings, he attributed her starvation diet and weight loss to anorexia nervosa, and thus called for a psychiatric consultation.

Millie's mother had called attention to the weight loss and the starvation diet. She was cooperative with the hospital, but not overly involved in the treatment. Many "get well" cards from friends were observed in Millie's room. The child was somewhat impatient with my presence, because she was expecting a visit from some of her friends.

In the course of the consultation, I asked a question which has been routine for me in dealing with anorectic youngsters: Dr. Mellita Sperling[1] had pointed out that a characteristic of all anorectic girls is a preoccupation with keeping the stomach flat. No matter how thin they are, the girls will intensify their self-starvation if the abdomen protrudes in any way. Behind this preoccupation is the fantasy that the protuberant abdomen is a sign of pregnancy. Starvation keeps the abdomen flat and hides from the world the sexual fantasies and preoccupations that gave rise to the psychic transmutation of a protuberant abdomen into a pregnant one. Therefore, I inquired whether she was worried about her stomach—does it bother her if it protrudes? She associated to my question with a recollection of her concern during a party at which she wore a tight dress that someone would think she was pregnant. I posited a relationship between her fear about eating and her concern lest her figure take on the configuration of a pregnant woman. "I think that's it," she said. "I probably could eat now." She did, and soon went home. There were only a few sessions, and these were related to her concern about how to behave with boys. I never saw her again. Her pediatrician reported nothing unusual for the rest of her adolescence.

The case of this child is remarkable in that she was brought to someone's attention. Transient anorectic adjustments to the sexual challenges of adolescence are more frequent than the number detected by physicians. The episodes are often masked as ordinary dieting. It is obvious in these cases that body-image-oriented fantasy made a decisive difference in choosing the particular avoidance technique for use in coping with the pubertal intensification of sexual drive energies. For all intents and purposes, I could detect no involvement, or even awareness, on the part of the mother of the true nature of Millie's condition. Loss of appetite and weight loss were the mother's reason for taking the child to the doctor for a work-up. Her cognition was normal for her age. She could apply abstract thinking to free standing ideas. She could grasp abstractions. She could remember them and apply her grasp to new situations in such a way that she could see them in a new light. As a result, she could differentiate the words of fantasy from the false reality that the words created when her situation was described for her. I am sure that these skills made it possible to set aside the latency style of functioning through fantasy that had reassumed dominance at the time of her anorexia.

The capacity to differentiate reality from fantasy, when confronted with the difference, necessitated the use of repression. Without repression to mask the fantasy from rational challenge, she could not have acted on the basis of an untenable hypothesis. In brief, she had a characterological *neurotic* cognitive style of ego organization. Thus, her condition was amenable to uncovering therapy, and consisted of a food phobia. When the irrational fantasy was stumbled upon and exposed by me, her rational faculties were

brought to bear on it. Then, like ancient cities exposed to the light and air, it crumbled.

The Intransigent Anorectic

It was quite different with Myra. She was 16 years old and quite a beauty, if one could judge from pictures, her mother's descriptions, and the time or two that she gained weight. In latency she had been the ideal child for her mother. Her latency-age fantasy life had been rich. However, when she reached puberty, the cognitive changes that are part of maturation wrought havoc with the effectiveness of fantasy as a discharge pathway. The population of symbols of her persecutory fantasies ceased to be fantasy figures. In their place, other teenagers became her persecutory protagonists. Myra placed herself in the role of the persecuted. She could not make friends or go to parties. She feared that she would be considered dull or boring, or that she would be ignored. In actuality, she could not differentiate herself from the internalized "bad mother imago" of her childhood, and had projected this confusion into the thinking of her peers. This was intensified by the ambivalent relationship with her mother.

Myra's father had disengaged himself from the family and had devoted himself exclusively to his business at the first sign of a crisis. As the result of the loss of accessibility to others, her mother became her main—in fact, only—object tie. Although her mother often spoke of the burden of her constant contact with the girl, she did little to separate from her. She felt relief whenever her daughter was hospitalized, but never actively initiated separation. The closeness of the two intensified the child's ambivalence towards her mother. This, in turn, reinforced the negative aspects of the internalized maternal imago.

As a result, her misinterpretations of her peers' behavior were magnified. The more time she spent with her mother, the more she railed at the passivity she experienced as a pubertal child in contact with her mother. Constant attendance, and constant advice, by the mother stirred up rage in the child, but the negative feelings were projected onto peers. Thus, fighting with the mother resulted in an intensification of the bond with her.

Of course, much of this situation with her mother had been present before the age of 12. At that time, the relationship with the mother and her peers had been preserved by the ability to project the conflict into a fantasy, which was clinically manifest in the form of night fears.

That is the way a latency-age child manages to be "perfect." The depressive affect that accompanies such a situation is also dealt with within the personality. The affect of depression is rare when the mechanism of projection is actively involved in fantasy formations containing fantastic symbols. In that circumstance, anger or anxiety is the manifest affect. When real people are used to populate the fantasies, depression surfaces. Actualization through the fancied detection of feared situations in the reactions of peers justifies depressive affects.

At 12 ½ years, Myra experienced a marked manifest depression coupled with a feeling that she could not make friends and was disliked by her peers. Myra's parents decided to get psychotherapeutic help for her. Although the family had sufficient money, her father, who put little stock in psychotherapy, asked her pediatrician to make the lowest possible fee a prerequisite. They were referred to a Mr. M., whose office was many miles from their home. The office consisted of a desk and chairs set in the garage of his house. No attempt had been made to alter its appearance from that of a garage, and it was never cleaned. The mother mentioned cleaning her

> clothes after each visit. His abilities as a therapist were reported by the child to be as dilapidated as the setting. Mr. M. spent the time (18 months, two sessions a week) telling Myra about himself, and offered her rewards if she would go to parties. She tried. Her interpretations of the reactions of peers continued to have a quality of rejection.
>
> In the meantime, Myra's figure matured and she began to attract the attention of young men. One day she decided that she was unliked because she was fat. She went on a diet. Her mother was delighted by her "fashion model" appearance. The child had mixed feelings about the whole situation. She liked her slimness; however, she did not like the feeling of hunger that went with starvation, the empty-space feeling inside her stomach, or the constipation and interference with bowel habits that accompanied it. Myra especially disliked giving up her favorite food, which was chocolate cookies. She hit upon a compromise. She would eat all she wanted of cookies and candies and then either spit out what was chewed or vomit what was swallowed.
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> In this way the impulse to eat could be responded to at will, while the feeling of emptiness within could be considered a product of her own design. Myra had a true disorganization and disorder in impulse control. She over-controlled and under-controlled her eating with little pattern or reason other than the urge to eat and the need to stay thin. Her mother considered the vomitus and the packages of spat-out food to be disgusting; but the girl considered her actions justified since, in her own mind, the chocolate tinge that pervaded it all made it look "just like shit," with the implication that the food had been digested. She began to lose weight rapidly. Her therapist declared the situation beyond his control. By this time she was 5'4" and weighed 68 pounds. Her appearance was gaunt and skeletal. Her skin took on a yellowish cast. People who met her casually became fearful and withdrew, reinforcing her own fears.
>
> There followed a series of hospitalizations, during which Myra was threatened with intravenous feeding. In response to these threats, she agreed to eat, and gained sufficiently to be able to go home. Her mother was quite fearful during this period; she appeared not to know what to do. Her response to the situation consisted of placating her daughter while begging for her cooperation. This was certainly a mixed message, and the girl followed her impulse of the moment. This is what appeared on the surface.

The problem occurred too close to late latency not to have implications in terms of the influence on behavior of the object relations of late latency. At that time, children (after 9 years of age) are beginning to look beyond their parents for superego contents. Peers and social influences, such as magazines, television, and films, provide children with notions that can be called upon to challenge parental guidance and fuel rebellion against passivity. As often as not, parents themselves, seeing the child's potential in terms of new levels of maturation, encourage development in areas, especially sexual, that they formerly forbade. In essence, the child finds herself in conflict with old parental imagoes, sometimes even with the current parent as an ally.

These are internal conflicts the resolution of which results in some of the more disquieting, though transient, psychopathological symptoms of late latency. Obsessional symptoms, paranoid reactions, hives, and gastrointestinal symptoms are common (for more on this, see Sarnoff 1976). The point is that, specifically at this age, internal conflicts between oneself and parental imagoes stir guilt, which may be

dealt with through the use of body functions as primitive symbolic forms. Thus, the children withdraw from the conflict on a verbal level and occupy themselves with cathexes turned toward the self. In the process, the world is devalued and the form and functions of the body become more important than relations with others.

> Even Myra's thoughts about her body changed as the process of turning inward of her attention progressed. She ceased to worry about weight as a deterrent to other's esteem, and began instead to seek the perfection of a personal ideal filtered through an immature and distorting cognition. All of this was conscious. She accepted without a qualm the contradictions between the reality of her thinness and her interpretation of what she saw in the mirror. Conscious contradiction formed a part of a new form of "rationalism" that she had coined for her own use (e.g., "No matter what you see in the mirror, I see the same thing and to me it is fat."). Myra was anxious and fearful when forced to eat. At one time she was enrolled in a program of voluntary hospitalization that placed little faith in a search for insight. Instead, there were rules about eating which emphasized discipline in eating and punished weight loss, which was measured on a scale and responded to with loss of privilege. She became quite anxious under this regimen and asked her mother to give her another chance with psychotherapy. That was when I first saw Myra; she was then 16.
>
> She explained her rejection of the program on the basis of the fact that she felt fat if her abdomen protruded at all. She was so thin, that any food ingested, and at the time in the process of digestion, was perceivable as a distortion of her scaphoid abdomen. In her intuitive response, this little part seen as fat stood for a whole body that was fat and pregnant. Myra's cognition in the area of perception of her body was so distorted that all input was shaped to support her delusion. Since it was conscious and rationalized, interpretation could not avail her of new insight nor confrontation diminish her invariable response to all she heard or saw. She unquestionably loved the power she had over those who loved her or wanted to help her. Her power was the result of her personal, irrational, and unassailable logical system.
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> There was more than a touch of sadism exercised in Myra's refusal to yield to the logic of sound minds. She was the center of attraction in an adult world. The alternative, in her mind's eye, was to become a wallflower in a world of young teenagers. Narcissistic overcathexis of her own ideas, fantasies, and distorting cognition helped her to preserve her self-created world. In this way she was able to select a moment in her life and stop time at that moment. It was a moment when, as she recalled, she was praised for asexuality and was free of the roundings of the body and the menstrual period which led her towards adult sexuality. It was a moment when, as Wilson (1979) says, the anorectic has "the capacity to live in fantasy and to avoid reality." It was a moment from a time when all one had to do in order to learn was to memorize words, instead of having to understand, challenge, and catch the intrinsic essence of a process.

Myra had stopped time in latency. Wilson[2] in his extensive experience, has found that parents encourage this.

> The parents, because of their character structure, admire their children most in the latency phase, and do not accept the aggressive and sexual changes of adolescence. The parents unconsciously like the latency figure and are repelled by the roundings of the female figure.

In addition, the parents engage in fighting with the children. The children respond in kind. This

interferes with removal and the establishment of relationships with peers. There is a mutual interplay aimed at keeping the child forever young.

Myra's cognition interfered with interpretation. She could not learn from psychotherapeutic work in those areas involved in her complex. She had withdrawn from reality object ties. She learned by memorizing words and phrases by rote, so that her only exercise of logic consisted of twisting words to fit her needs rather than engaging in the search for new meanings. Her long thin arms and legs gave one the impression of a spider. Indeed, spiderlike, she had woven about herself a web of words through which she would not see, and it soon became her world. No matter how I tried to free her, she would not leave the safety of her web. It tangled close about her; reality receded, as the predator became prey to her own device. Her web of words served both as hiding place and prison. Although her loneliness was devastating, she reveled in her ability to outsmart others and to twist reality to suit her needs in a contest of wills, with herself the sole judge.

> Within four months Myra had worked through her use of projection to fend off peers and had reestablished contact with old friends. She began to feel anxious in the treatment, and told her mother that she thought therapy put too much burden on her. She demanded to be allowed to drop out of therapy and return to the program that offered external controls. When her mother called to tell me what was afoot, she explained that she could not argue with her daughter. She feared the rage of the child should she defy her wishes. I met them four years later. They were shopping. Myra appeared to be essentially unchanged except that her affect was flatter.

Summary

We have delineated the person who develops anorexia during the period of emergence from latency. The residua of the latency state are present to be used by any child who wishes to turn from the sexual demands of puberty instead of exploring sexuality. Withdrawal and asceticism are other common examples of such a response. In essence, these people return to a world of fantasy in continued exercise of well- tried latency techniques of adjustment. For those who entangled their image of their bodies with fantasy, anorexia as a transient adjustment to sexuality becomes a means of causing the body, with the menstrual function, to regress to the form and function of the latency child. For those with neurotic character defenses, this condition is temporary. The fantasy (i.e., fat means pregnancy) is unconscious and can be dispelled when the unconscious fantasy is interpreted. At the other end of the spectrum are the intransigent anorectics. These children, too, wish to withdraw from sexuality through regression to

fantasy and unraveling the process of puberty. Their heightened narcissistic cathexes of fantasy at the expense of reality, and their primitive cognition and understanding of causality allow them to establish a cognitive style that permits an indefinite continuation of this state. Since the illogic and contradictions are conscious and accepted by the child without challenge, the process of interpretation offers no new insight and, consequently, only slow progress in psychotherapy.

The occurrence of anorectic symptoms during the period of emergence from latency is a common event. Anorexia most often makes its appearance at this time. Skills exercised during the latency phase that make it possible to live without surrendering to reality, as well as the undemanding nature of the latency-age bodily configuration, make regression to the latency state a sanctuary from adolescent turmoil. Hypercathexis of fantasy as in latency and return to the latency-phase bodily configuration provide a potential agenda of responses which rivals asceticism and withdrawal as a technique for dealing with increased sexual and aggressive drives during puberty.

I have presented examples of the extremes of the spectrum of anorexia. The external characteristics of anorexia nervosa do not define a disease entity; rather, they are the products of a reaction pattern. The underlying psychiatric diagnosis depends on the status and nature of ego functions, not the manifest symptom. The more pathological the cognitive impairments, the more likely is the child to become involved in an intransigent form of anorexia.

The more severe forms of anorexia involve intense aggressive interaction with parents. This encourages regression in physical form and interferes with removal. The emotionality and high noise level of the verbal interactions give the parents no time to convey the need for and encourage the development of more mature levels of abstraction and other logical processes. Failure to achieve some mastery of sexuality leaves the child without the personality skills acquired through gradual exposure. Thus, the longer anorexia lasts as a defensive configuration during emergence from latency, the more entrenched and necessary does the reaction become. For this reason, early psychotherapeutic intervention is indicated.

Notes

1 Mellita Sperling, *Personal Communication* (1965).

2 C. P. Wilson, Personal Communication (1979).