

# Survivor Guilt in the Pathogenesis of Anorexia Nervosa

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THE purposes of this paper are (1) to contribute to an understanding of the crucial role of unconscious guilt in the pathogenesis of anorexia nervosa and (2) to contribute to an appreciation of the importance of the concept of survivor guilt by demonstrating its usefulness in describing and explaining aspects of the pathogenesis, psychopathology and psychotherapy of anorexia.

## BACKGROUND

In the voluminous literature on the psychology of anorexia, guilt is rarely mentioned and then only in a peripheral way. When it is mentioned, it is usually conceptualized as a form of oedipal guilt. Early formulations emphasized conflicts over sexuality and fantasies such as oral impregnation (Waller, Kaufman, and Deutsch 1940; Lorand 1943). Other psychoanalytic theories have focused on pathological defenses against oral-aggressive drives (Thoma 1967). Object-relations formulations describe the anorectic as projecting onto her body the image of a rejecting, sadistic mother, explaining self-starvation as an attempt to control or destroy the introjected "bad" object (Selvini-Palazzoli 1978; Sours 1980; Kernberg 1980). None of these theories emphasize the role of unconscious guilt in the pathogenesis of anorexia.

Guilt does not appear in the subject index of the 1981 NIMH literature survey on anorexia. Garfinkel and Garner (1982), in their encyclopedic volume on anorexia, place virtually no emphasis on guilt. A recent anthology on anorexia (Wilson, Ho-

gan, and Mintz 1983), which represents the conclusions of a group of analysts who have studied anorexia for over two decades, does contain some clinical discussion of guilt; however, unconscious guilt does not enter prominently into their theoretical formulations.

There are several current theories of the etiology of anorexia which see separation and the struggle for autonomy as central. One is found in *The Golden Cage* by Hilde Bruch (1978). Another is the family therapy theory of Salvador Minuchin (1978). A third is James Masterson's (1977) theory about anorexia and the borderline adolescent.

Although none of these theories place guilt in a central theoretical position, they are, nevertheless, close enough to the theory I shall present to warrant discussion. I shall postpone this discussion until after I have presented my ideas. These ideas are based to a considerable extent on a particular psychoanalytic theory of psychopathology and therapy developed by Joseph Weiss and tested clinically and in formal research by Weiss and Sampson. I have found their theory useful in analyzing my

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clinical experience of the past ten years in the treatment of anorectic patients in long-term psychoanalytic psychotherapy and in family therapy.

### SURVIVOR GUILT

The concept of survivor guilt was introduced into contemporary psychiatric literature by Niederland (1961), who wrote of a "severe and persevering guilt complex" affecting the survivors of the Holocaust. After a symptom-free interval characterized by the initial hardships of adjustments to beginning a new life and the lingering hope that some of their missing family were still alive, these people succumbed to a variety of symptoms such as depression, anhedonia, anxiety, hypermnnesia and psychosomatic conditions (Niederland 1981). They often appeared and felt as if they were living dead. Niederland believed that these symptoms were identifications with the loved ones who had not survived and ascribed them to a deep and pervasive sense of guilt, which he called survivor guilt. The survivors carried with them "the ever present feeling of guilt, accompanied by conscious or unconscious dread of punishment, for having survived the very calamity to which their loved ones succumbed" (1961, p. 238). He concluded that the pathology of these patients was due not to prior unconscious hostile wishes toward the loved ones but rather to the terrible fate that befell them and to the patients' unconscious feelings that merely remaining alive was a betrayal of the dead.

Modell (1965, 1971) has broadened the concept of survivor guilt. He writes of more subtle forms of survival accompanied by unconscious guilt that motivates a person to undo success in life and therapy. For example, one of his patients was a talented, wealthy woman with a good job and a good marriage, who had risen far above the accomplishments of her parents. She undid her success by experiencing it as unreal, as only acting. Moreover, she provoked fights with her husband which eroded her marital happiness, and she allowed herself little

pleasure in any of her activities. "Her deepest conviction was that she had no right to a life better than that of her mother, which was perceived by her as a life of hardship and degradation" (1965, p. 326).

Another patient, a woman whose sister was trapped in an unhappy marriage and whose mother had divorced her father and was never able to love a man, experienced guilt over being "the lone survivor of this family in the sense of being the only one who still had the opportunity to love" (1971, p. 340). Her guilt impeded her ability to use psychoanalysis to free herself to have a better life. A third patient described by Modell was a successful man whose sister was chronically schizophrenic. He punished himself for being better off than his sister by deadening his own feeling for people and by drinking excessively (1971).

Modell describes two kinds of survivor guilt. One is separation guilt, founded on the belief that growing up and separating from mother will damage or even destroy her. The other is guilt based on the belief that taking is at someone else's expense:

There is a common fantasy that is observed in psychoanalysis, that is: love is a concrete substance in limited supply within a given family—as if all of the family are obtaining nourishment from a closed container. The subsequent belief is: if one has something good, it is at the expense of someone else being deprived. [1971, p. 342]

In this paper I will call this second kind of guilt depletion guilt. Separation guilt and depletion guilt have in common the belief that one's own welfare is at the expense of another's—that one is a survivor at someone else's expense. My classification of survivor guilt into depletion and separation guilt is meant as provisional, helpful to the exposition that follows. Survivor guilt may take many different forms, each related to a belief about the way in which the pursuit of normal developmental goals will harm significant others (Weiss, Sampson, and Modell 1983). Even oedipal guilt has a survivor component: it is a form of guilt over winning in competition.

Modell believes that the phenomenon of

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survivor guilt is of universal significance, that it is "not confined to a particular diagnostic group, but represents a fundamental human conflict" (1971, p. 340). He believes that survivor guilt stems from a biologically based concern for and sensitivity to the pain of significant others, making it difficult for a person to be comfortable or successful if these others are not. Such a concern would, according to Modell, have survival value for the individual via survival value for the group and would be selected for over time.

There have been, of course, many others who have viewed guilt, particularly kinds of guilt which conform to Modell's description of survivor guilt, as having a more pervasive role in mental life than traditional psychoanalytic theory usually attributes to it. It may be helpful to mention a few contributions. Melanie Klein (1937) recognized the child's worry about hurting his mother and his urge, out of love, to repair the damage he believes he has done. Searles (1958, 1964) has written of the schizophrenic patient's love for and loyalty to his mother as an important motivating force in the development of his illness. Searles sees guilt over abandoning his loyalty as a major impediment to the patient's recovery. The patient's love for and worry about his mother leads him to make a "loving sacrifice of his very individuality" for her welfare. "He cannot bear to grow out of the relationship and leave her there, tragically crippled" (Searles 1958, p. 231). In other articles, Searles writes of the patient's attempt to cure the therapist as a transference manifestation of his worry about his mother.

Asch (1976), writing about the negative therapeutic reaction, sees loyalties to psychologically ill mothers and guilt over abandoning these loyalties as the central motivation in the negative therapeutic reaction of several of his patients. Loewald has proposed a broadened conceptualization of oedipal guilt to include separation guilt:

It is no exaggeration to say that the assumption of responsibility for one's own life and its con-

duct is in psychic reality tantamount to the murder of the parents, to the crime of parricide, and involves dealing with the guilt incurred thereby. . . .

In an important sense, by evolving our own autonomy, our own superego, and by engaging in nonincestuous object relations, we are killing our parents. . . . [1979, pp. 757-58]

In their 1982 and 1983 papers, Weiss and his colleagues have emphasized the role of unconscious guilt in the failure of patients to separate from infantile objects and to relinquish infantile gratifications. They stress the important role survivor guilt plays in a wide range of masochistic psychopathology. According to Weiss, the patient may, in order to avoid intense feelings of guilt, identify with a suffering parent or comply with what he perceives to be the parent's expectation that the patient suffer, fail, remain dependent, and so forth.

One of Weiss's patients illustrates some of the varied clinical manifestations of separation guilt:

A patient in his thirties would often torment himself by an obsessive rumination about a high-school girlfriend, whom he glamorized and who ultimately rejected him. He would, in his ruminations, long for the girl and tell himself that by losing her he had lost a great opportunity for happiness. It turned out that this man had felt quite guilty about leaving his mother, whom he perceived as possessive and whom he believed had lived mainly for him. He had, in his high-school romance, unconsciously experienced the girl's rejection of him (which in retrospect he seemed to have provoked) as a fitting punishment for his rejection of his mother. [1983, pp. 73-74]

I have reviewed the concept of survivor guilt in some detail because I believe that it is not entirely consonant with the traditional psychoanalytic concept of guilt and that it raises questions about the causes of, and even the very meaning of, guilt. Guilt is usually conceptualized as an internalized fear of *being harmed* by the object through loss of love and the consequent loss of protection from a variety of dangers (Freud 1930). The phenomenon of survivor guilt

demonstrates the importance of the fear of *harming* the object in the genesis of what we usually understand as guilt. Modell is suggesting that survivor guilt and the fear of harming the object may have a biological basis, aiding in the preservation of the group, if not the individual. The implication is that fear of harming the object is not reducible to fear of being harmed by the object but represents a different, and relatively neglected, line of motivation in human life. This is a very interesting hypothesis which deserves careful thought and investigation.<sup>1</sup>

I am not unaware of the *logical* possibility of reducing fear of harming the object to fear of being harmed by the object. If one harms the object, one risks losing a needed relationship and exposes one's self to a variety of dangers. The younger the child is, the more the distinction between harming and being harmed is blurred; guilt presupposes a degree of self-object differentiation and at least a rudimentary notion of causality. To make such a conceptual reduction would be consistent with Freud's tendency to reduce the number of basic motivations to as few as possible and, in particular, to see all supposedly "altruistic" motivations, such as maternal instinct, as deriving from "egoistic" motivations, such as a revival of maternal narcissism.

It is beyond the scope of my paper to address this question adequately. What I wish to emphasize is that at a *clinical level*, it is useful to distinguish between fear of harming and fear of being harmed by the object. In particular, this distinction helps one to notice important elements in the pathogenesis and psychotherapy of anorexia that are often missed. Anorectic patients seem to be much more concerned with harming than they are with being harmed, an idea I will develop more fully in the section on separation anxiety versus separation guilt.

A second theoretical issue raised by the concept of survivor guilt, particularly as

applied to anorexia, is the relative pathogenic roles of instinctual endowment and experience. Melanie Klein paid little attention to the child's experience in his family and saw the phenomena of guilt and reparation as deriving from instinctual processes, largely independent of environmental factors. Even Modell, who recognizes the importance of experiences in the family in contributing to the intensity of unconscious guilt, believes that some people "suffer from a particularly intense form of envy and greed," i.e., that innate oral sadism plays an important role in the genesis of guilt. This issue is very important in treating anorectic patients, because they often present themselves as greedy and invite the therapist to see them in such a way. If one believes that these patients really are greedy, one's interpretations will differ from what they would be if one thought, for example, that the patients' mothers may have led them to believe that their normal needs for support and nourishment were excessive.

While quantitative differences in original instinctual endowment are difficult to assess, the role of differences in experience in determining the strength and nature of unconscious guilt may be directly observed. The difficulties that parents or other family members have in their lives and the child's beliefs about his role in causing these difficulties or his ability to ameliorate them can be readily observed to play an important role in the genesis of survivor guilt. Often parents contribute to these beliefs by conveying to their child, through praise or blame, an inaccurate sense of his or her ability to bring them pleasure or pain.

In sum, unconscious survivor guilt is a major motivating force in a wide range of masochistic psychopathology. It is guilt based on a belief that the pursuit of a normal developmental goal is harmful to one's parents or significant others. It may stem from an innate concern for and sensitivity to the pain of one's parents and from beliefs about one's role in causing this pain or one's ability to ameliorate it. Typically, these beliefs are encouraged by par-

<sup>1</sup> Significant research in this area is currently being done. See, for example, Zahn-Waxler, Radke-Yarrow, and King (1983).

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ents who convey to their children an inaccurate sense of their ability to affect the quality of their parents' lives.

Survivor guilt in the form of separation or depletion guilt has played a central role in the psychopathology of the twelve anorectic patients I have treated. Depletion guilt was experienced typically toward the mother. Separation guilt, while usually experienced toward the mother, occasionally extended to both parents. It was by focusing on these two forms of survivor guilt that I was able to be of most help to my patients. It is my intention to describe not *the* cause of anorexia but rather a highly orienting point of view with therapeutic implications. In the next section I shall present several brief clinical vignettes which show the role of experience in producing the intense guilt felt by my anorectic patients, and document the family contexts in which this guilt arose. In general, parental neediness, vulnerability and, at times, implicit or explicit blaming led my patients to infer that their survival had damaged or would damage their parents.

### CLINICAL EXAMPLES

#### *Polly*

Polly suffered from separation guilt. She believed that she would hurt her parents by having values different from theirs and by leading an independent life. The youngest child and only daughter of a prominent physician, Polly was called by her father the "jewel in the family crown." This was a close-knit family in which both sons went to medical school and joined the father's clinic. Father was a moody, often depressed, and blaming person, who was unable to enjoy his professional and financial success. He saw himself as unappreciated and could tolerate little in the way of criticism. Differences of opinion and style were seen as disloyalties and ingratitude. His wife tiptoed around him and encouraged the children to do the same. She shared his ideas about the importance of a close family and the threat that differences and separations

posed. Polly was her confidante and companion. They had many conversations about the troubles other family members were causing by their selfishness and disloyalty.

Polly remembered many times in grade school when she would complain to the school nurse of some vague discomfort. Her mother would be called, Polly would go home, and the two of them would spend the afternoon reading, playing games together, or even going shopping. Polly sensed her mother's pleasure in her company. Polly's closeness to her mother and her "school phobia" proved in therapy to be based not on separation anxiety but on an unconscious compliance and what she perceived as her mother's wish for her to remain close.

Polly was expected to finish college and then get married to a respectable professional man, to settle down with husband and children close to where her family lived, to continue to partake in the many extended family activities, and to remain as mother's confidante. Instead, at the age of 19 she went to an Eastern drama school, partly supported herself, and even got small parts in several summer productions. She remained in the East for a year, continually barraged by letters and phone calls asking her to return from what was called her "interlude."

An excerpt from one of her mother's letters illustrates one way her parents conveyed to her the belief that because they had sacrificed and given her so much, she had no right to separate from them—separation was a selfish and harmful act:

It's hard to believe that just nineteen years ago you were in my tummy next to my heart. Although you are no longer in my tummy you will always remain next to my heart. . . . Your father misses you very much, too, and wonders about your unconcern for him. He worked so hard to provide us with the material comforts we all enjoy and which, I might add, have enabled you to have this extended vacation in B. He too would have loved to take a vacation. I wish he had—then there would not have been the money to support your extensive absence and I would

not have to write this painful letter. . . . Let us know what your plans are and when we can expect you home.

Hugs and hugs,  
Mommy

Polly returned home shortly after the summer and never went East again. She moved back into her parents' house and had a series of unsuccessful jobs and relationships. She began to starve herself after about two years of living at home.

### *Karen*

This vignette is intended to illustrate the extent to which a child may be called upon to comfort a distressed parent and the difficulty the child can have in entertaining thoughts of separation under such conditions. When Karen, an only child, was 13 her father, a corporate lawyer, began to take longer and more frequent business trips. It soon became apparent that he was romantically involved with his secretary, and shortly after he got a separate apartment in town. Karen's mother became severely depressed and had frequent outbursts of sobbing and rage. This was a conflict-avoiding family, which in mother's words, had had "no fights in 27 years of marriage." Mother couldn't understand how her husband could consider a divorce. "I gave my life for him and expected a lot in return."

To comfort herself, Karen's mother went to Europe for the summer, taking Karen with her. There were many long, tearful evenings in strange hotels when mother would cry on Karen's shoulder and Karen would try to comfort her. It was in Europe that Karen began to diet. By the time they returned to the United States, she was 20 pounds underweight and still losing. At home mother's attention turned from fury and grief over her impending divorce to intense worry about her starving daughter. She did a lot of research on nutrition and tried to buy all the right foods. Mother and daughter became an inseparable pair. Mother worried about Karen's anorexia, and Karen worried about mother's loneli-

ness. Both, according to mother, deeply resented father for abandoning "them."

During the first conjoint family interview, Karen's mother spoke for her, answered questions addressed to Karen and maintained physical contact with her most of the time. She implied that Karen would speak more freely if her father left the room and sobbed uncontrollably, as though I had wounded her terribly, when I pointed out that she was speaking for her daughter.

### *Susan*

This vignette is intended to show the way in which a family can contribute to a child's belief that she is responsible for family fate. Susan was an only child. Her mother, who had grown up in a fatherless home, described her own mother, Susan's grandmother, as an unaffectionate woman who was resentful of having children and so depressed that she would often lock herself in a closet, threatening suicide. Susan's mother was equally depressed. She often took to her bed for long periods and was hospitalized several times for psychotic depression. Susan's father was a fairly successful lawyer, who frequently was absent on business and political trips. Both parents doted on Susan, whose moods, successes and failures were the center of family interaction. Susan's grade school reports became family projects, father helping with the research, mother typing the paper. Susan remembered that at age 5, she had selected the location and length of stay for the family vacation, because her parents could not agree. Her successes in school became occasions for family rejoicing and her failures, even minor ones, occasions for intense worry, resulting in school conferences and psychiatric consultations.

Susan remembered that at age 10 she was dropped off at a slumber party with the suggestion that if she should feel at all anxious during the night not to hesitate to call home. At about 3 in the morning, although she was not anxious, the thought occurred to her that she should call. Her parents drove over right away and brought her home.

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Susan's parents called her their joy and hope, and her mother said several times that Susan was her only reason for living. Susan's major recollection of her mother was of her long, frequent, incapacitating depressions. Susan herself felt depressed, inadequate and unworthy for not being able to help her mother. She felt enormously responsible for the moods of her husband, a depressed and discouraged man who could do little more than earn a living. Susan remained in the marriage because she thought it would devastate her husband if she left and jeopardize the financial security of her daughter. Whenever she hinted to her parents that she was considering a divorce, they reminded her of her duty to her daughter and expressed their belief that life is inherently disappointing and that one must make compromises.

Prior to treatment Susan had had anorectic episodes during which she lost a large portion of her body weight. The first occurred in college, the last one when she separated briefly from her husband. These episodes were characterized initially by an increase in pleasurable and selfish activity and in productivity; they ended in hospitalization. Susan described her self-starvation as the only way she had of maintaining a mood separate from that of her mother.

### *Shirley*

This vignette illustrates an extreme form of survivor guilt, including elements both of depletion and of separation guilt. Shirley was 16 when her father divorced her mother and moved to another state. Her older sister chose to go with her father, and Shirley remained behind with her mother, who was having increasing problems with alcohol and depression. Over the course of the next year, Shirley's mother was frequently drunk and unable to obtain employment. Shirley responded by graduating from high school early by passing an equivalency test and then finding a full-time job. She supported her mother and also saved enough money to go to nursing school. While in nursing school she worked nights, both to meet her and mother's expenses and to

avoid coming home to an inebriated, overweight, tearful, chain-smoking woman sitting in front of the television.

Shirley's mother often reminded her that "one's family is all one has" and that it was the "duty of the strong to care for the weak." She promised Shirley repeatedly that she would stop drinking but was not able to do so. She made frequent suicide threats while drunk, and she had tearful, violent outbursts when Shirley refused to give her money for liquor.

Shirley's mother failed to appear at her graduation from nursing school. When Shirley returned home late that night, she found her mother dead of an alcohol and barbiturate overdose. The mother's mother came for the funeral and berated Shirley for not taking better care of her daughter. Shirley believed that if she had not stayed out late that night, she might have come home in time to save her mother.

Shirley's anorectic symptoms began the year her father left and gradually worsened until they underwent a severe exacerbation after her mother's suicide. At the time she entered treatment at the insistence of her head nurse she was working double shifts, allowed herself no friends, no pleasure, little food and little sleep. In the course of therapy, whenever Shirley began to allow herself some pleasure, such as a quiet evening at a friend's house, she would immediately be troubled by thoughts or dreams about her mother's pathetic life. She once told me in tears that it sometimes seemed as if she were waiting for her mother to recover so that she herself might also recover.

### *Rachel*

The following is an example of a patient who in addition to separation guilt suffered severely from depletion guilt. In Rachel's family there was never enough to go around. She believed that her normal needs for nourishment, tenderness and attention were depleting her mother. Rachel was 19 when she first entered treatment. Five and a half feet tall, she weighed 70 pounds. The youngest of 8 children born into a midwest

farm family, she had come to California to visit one of her sisters; the sister, shocked at her appearance and state of mind, brought her to see me.

Rachel was not a wanted child. Maternal physical illness and postpartum depression resulted in her being cared for by an unwilling aunt for her first 6 months. Her father was a depressed, withdrawn man who tried to ignore his own problems and those of his children. Her mother was a depressed, critical woman who had some paranoid ideas of being robbed and depleted. This attitude was embodied in her way of dealing with food, which was hidden from the children and parceled out grudgingly, even though there was never any actual shortage. Attention and care were also in short supply, parceled out only *in extremis*. Rachel remembered throwing herself out of bed as a young child in the hope that her mother would come. This was the only way she could get tucked in and kissed goodnight. Rachel's mother often made generous offers and promises to her children only to become anxious at the possibility of being depleted or taken advantage of. She would then withdraw these offers, accusing her children of greed and ingratitude.

Rachel had bulimic symptoms: frequent gorging followed by vomiting. One of the first times she remembers vomiting was when her mother caught her eating some cheese she had stolen from one of her mother's secret food-hiding places. After being scolded for being sneaky and greedy, she went outside and threw up. Bulimia was one of Rachel's most refractory symptoms. The foods she gorged on were milk products such as cheese and ice cream, and sweets—foods which she felt she was not entitled to eat. She would eat enormous quantities with the knowledge that she would not keep them down.

The following dream, which Rachel had early in treatment, illustrates her belief in the theory of limited supply described by Modell.

Mom and Dad and I in the car. Mom told me that during her first pregnancy they had no

money so she got an abortion. They saved money while Sally [the oldest] was a baby in order to pay for the rest of us. The feeling was that they saved up, all at one time, love, money to spend for the rest of their lives, never being able to replenish it, hoping the supply would last.

The next dream illustrates Rachel's belief that she was depleting her mother.

I'm lost in a snow storm, starving. I find my old house, pound on the door, no answer. I look in a window and see Mom, pretending not to hear me. I continue pounding, extremely tired and frustrated. She leans out a side window and yells, "Can't you see no one's home, I'm not here!" I say, "What is this? I can see and hear you, let me in!" She reluctantly comes to the door, lets me in. I say that I'm so hungry, cold. She flings open the refrigerator door and kitchen cupboards to reveal barren shelves. "Don't tell me you're hungry, I'm hungry, too. There's nothing here; you ate it all!"

Her mother's cruelty, capriciousness, blaming and rejection conveyed to Rachel a sense of fragility which Rachel perceived unconsciously. It was this perception and her worry about her mother that made it difficult for Rachel to fight back and to separate. The following dream, which occurred in the second year of therapy, illustrates Rachel's perception of the fragility underlying her mother's cruelty, her belief in her ability to hurt her mother, and her consequent guilt over fighting back.

I'm returning from therapy carrying my dream journal. Mom won't let me in the house. She grabs my book. She takes my dreams away. I ask for them, she refuses. I'm so angry at her. I yell, "I hate you!" Then I start to hit her repeatedly with all my strength, until I lift my hand up to slap her face and finish her off. I see her eyes for the first time, so full of hurt, and my hand trembles and falls to my side. I'm really shaken and confused. She changes into a snowman, crying. Her tears turn to icicles. I try to hug her; she's too cold for me. I have to get away.

#### PSYCHOPATHOLOGY

Many of the symptoms that constitute the syndrome of anorexia nervosa are



explainable, at least in part, by the motivating force of unconscious guilt. Anorectics are typically "premorbidly" compliant girls who fulfill parental expectations. The onset of anorectic symptoms often coincides with increased need to differentiate themselves from their parents, to express hitherto repressed feelings, to take their own needs into account, and to reject certain parental styles and values. They experience these needs as disloyal and damaging to their parents. Once they begin to starve themselves they may become defiant and oppositional. It is as if they feel that since they are no longer "taking," they owe less compliance. The self-starvation is thus both a justification for wishes for independence or noncompliance and a punishment for such wishes.

Anorectic symptoms occur frequently during adolescence not so much because of conflicts over sexuality but because adolescence is a time when separation and loyalty issues are in the forefront. Even when an anorectic's conflicts seem explicitly sexual, they may represent deeper and earlier conflicts about separation. Guilt over sexual fantasies and impulses may represent guilt over harming one's parents by having separate pleasures and establishing more important loyalties (Jackson 1958; Loewald 1979).

Self-starvation is also a hunger strike, an implicit accusation: "I'm not doing well and it's your fault." Again, the punishment is contained in the crime—starvation is the punishment for the disloyalty of accusing the parents of having acted wrongly. The accusation is also, and perhaps more importantly, a turning of passive into active, in that it is a reversal of what the anorectic fears: "You are not doing well (mother) and it's my fault." In rendering her parents helpless (nothing they do is any good), the patient reverses her feeling that *she* is helpless to alleviate her parents' suffering.

Anorectics with depletion guilt occasionally have kleptomaniac tendencies. While this symptom often represents a defense against feeling "ripped-off" by the blaming, depriving mother, it may also be a compliance with the mother's view of her child as

a "rip-off." These patients take in a way that is proof of their greed and a confirmation of the mother's message that their taking was a harmful act. They also place themselves in great jeopardy of punishment. (Just recently there appeared in the local papers a story about a successful high public official, an anorectic, who was caught stealing candy from a blind vendor.)

Much of the masochistic self-denial of certain anorectic patients is an identification with a masochistic self-denying mother, about whom the patient is extremely worried and toward whom she feels very guilty. One patient, for example, managed to obtain daily passes to leave the hospital for a few hours. She used this time to go home and clean her parents' house. Her mother, who worked hard all week as a secretary, was a compulsive cleaner and would spend the entire weekend cleaning her house, leaving little time for anything else. The common phenomenon of an anorectic preparing an elaborate meal for others and eating nothing herself can be seen as an identification with and a caricature of a self-denying mother, who gives to others, including the patient, but, although needy, takes nothing for herself. Through her self-denial, the anorectic changes from a guilty worrier to a not-guilty, and implicitly reproachful, person who is worried about by others.

Some anorectics are very guilty and worried about being envied by their mothers. One patient told me that her mother felt inferior to almost everyone, especially anyone with an education. This patient had dropped out of college shortly before she was to obtain her degree. Her self-starvation and general masochistic behavior made her an object of her mother's pity and insured that she would not become one more person whom her mother would envy.

The psychological mechanism of denial, so prevalent among anorectic patients—i.e., the patient denies that she is thin—is seen by some as an example of primary cognitive dysfunction. It can also be explained in part by unconscious identifications based on guilt. The families of anorectic patients are well known for their use

of denial. They frequently describe themselves as ideal families and the patient as a perfect child until the onset of symptoms. By identifying with this denial, the patient is protecting her parents' view of self and family.

Some anorectics have mothers who have little control over certain areas of their lives. They may be overweight, alcoholic, subject to extreme mood changes, and so forth. For these patients, the self-control required in self-starvation is both proof of their separateness from their mothers and punishment for this separateness. The ability to exercise such enormous control over their own appetites is also a source of reassurance and self-esteem for those anorectics who, incapacitated by guilt, are afraid to exercise control in interpersonal relationships for fear of provoking conflict and upsetting others.

#### SEPARATION ANXIETY VERSUS SEPARATION GUILT

The concept of survivor guilt discussed earlier implies a set of motivations—fears of hurting the object—that are of central importance, and are not, at least at the clinical level, the same as, nor are they simply defenses against, the more generally understood motivations—fears of being hurt by the object. For example, separation guilt is not the same as, nor is it ordinarily a defense against, separation anxiety. It is experienced differently; its manifestations in the transference are different; nor will it yield ordinarily to interpretations of separation anxiety.

The difference between separation anxiety and separation guilt is illustrated by the following case (not of anorexia) reported from the Hampstead Clinic. Novick and Kelly (1970) describe an 11-year-old boy, Tommy, who saw himself as a "damaged, messy, stupid child" out of compliance with his mother's need to externalize unacceptable aspects of her own self-image. Novick and Kelly present the traditional explanation of Tommy's reasons for experiencing himself as stupid, messy and damaged:

The main reason for accepting the mother's externalization lay in the realization, at some level, that despite the mother's distancing maneuvers she needed such a devalued object and that failure to comply with her need would leave him prey to the primitive terror of abandonment.

However, after Tommy worked through this primitive terror of abandonment, an entirely different kind of motivation began to emerge:

His material centered mainly on the sadness of the mother, the chaos in the home, the madness of the family members, and, related to this, his own intense feelings of guilt. It should be noted that he was guilty not about the newly attained level of functioning per se, but about having deprived the family of a needed vehicle for externalization. To a certain extent this material related to Tommy's own feelings, fears and fantasies, but to a marked degree it also reflected the reality. [pp. 89-90]

The distinction made by Novick and Kelly between separation anxiety and separation guilt is not typical in the psychoanalytic literature. More commonly, no clear distinction is made between fear of being hurt by the object and fear of hurting the object. In the absence of a generally accepted alternative way of conceptualizing the motivation for the maintenance of pathological compliances and identifications, much rich data are forced into the procrustean bed of separation anxiety. The failure to make or to maintain the distinction between separation anxiety and separation guilt is characteristic of a number of important contemporary studies of anorexia, particularly those of Bruch and of Masterson.

Of all the writers on anorexia with whom I am familiar, Hilde Bruch (1978) comes closest to recognizing the central importance of separation guilt. Her sensitive volume, *The Golden Cage*, is replete with examples of young girls burdened by guilt over separating from clinging, fragile mothers. In fact, *The Golden Cage* could serve as a case book of material supporting my position. But Bruch does not draw the same

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conclusion as I have. For example, Kathy, one of her patients, is first described as wanting:

to be a child again in relation to her parents . . . she felt an overpowering desire to be little so that she could rely completely on her parents and have them take care of her. [Then it comes out that] before she left home she was keeping her parents together. She worried that they might separate if she did not help her mother with her problems. Now she felt that her illness would keep them together. [1977, pp. 66-67]

Bruch concludes that by keeping her parents together, Kathy was ensuring external love and care *from* them. She does not note that Kathy's expressed need to be taken care of *by* her parents was motivated by concern *for* her parents.

Bruch is occasionally quite explicit about the importance of guilt:

In three families the mothers underwent a mastectomy, several years before their daughters' anorexia developed. Mother had thus become someone to whom one had to be especially considerate. This led to a renewed clinging closeness, in one case directly demanded by the mother but also precipitated by the daughter's sense of guilt. It happened at an age when under normal circumstances the process of emancipation would begin to take place, finding closeness and friendship outside the home. Instead, these girls felt duty bound to be helpful to mother, to stay and provide the enjoyment and protection they feared she was deprived of. [p. 68]

Bruch's conclusion, however, about why separation is difficult is that the anorectic is anxious about losing her parents' love. "The patient herself lives in continuous fear of not being loved and acknowledged."

A similar point of view is central to Masterson's position. In an attempt to provide what he calls an "intrapsychic dimension" to Bruch's work based on his version of object-relations theory, he minimizes the important material on guilt in *The Golden Cage*. He sees the mothers of anorectics as offering "approval, support, and supplies for regressive and clinging behavior," but as "attacking, critical, hostile, angry, with-

drawing supplies and approval in the face of assertiveness or other efforts toward separation-individuation" (p. 479). The underlying dynamic, according to Masterson, is the anorectic's "separation anxiety and abandonment depression." This is similar to the viewpoint of Sours, who, in the novel which forms the preface to his survey of the literature on anorexia, portrays a self-absorbed, callous, rejecting mother.

There are, of course, rejecting mothers and patients who suffer from separation anxiety and abandonment depression, some of whom are, no doubt, anorectic. However, the anorectics I have seen were primarily burdened by unconscious guilt over hurting somewhat fragile mothers by having depleted them or by separating from them. The mothers of my patients were not usually the attacking, critical, hostile, angry mothers that Masterson describes, nor the rejecting, self-absorbed, successful mother portrayed by Sours, but, with a few exceptions, fragile, depressed, dependent, often devoted women, who looked to their daughters to supply much of what they lacked. Even when an anorectic's mother is rejecting, as Rachel's mother was, the patient's unconscious perception of and consequent worry about her mother's underlying fragility may be the major motivation in her failure to separate. My patients were not motivated as much by their need for maternal care and love as by their need to protect their mothers from real or imagined harm, depression, loneliness, envy, disintegration, and so forth.

I would like to emphasize that anorectic patients often do *experience* separation anxiety and fears of abandonment. However, the patient's conscious experience often is not a reliable guide to her underlying conflicts. The patient's conscious experience may represent a compliance with parental wishes or expectations; for example, separation anxiety may be a way of protecting the mother by professing intense need for her. Separation anxiety may also result from an identification with the parent whom the patient fears she is hurting by her wishes to separate. The patient be-

comes the victim rather than the offender. Separation anxiety becomes for these patients a defense against separation guilt.

The distinction between whether the anorectic patient is suffering from separation anxiety or separation guilt has important implications for understanding certain transference phenomena. For example, anorectic patients often become oppositional, uncooperative and even hostile during treatment. Masterson sees this aggressive negativism as:

an expression of the rage at the demand that the self be given up to obtain supplies; the rage is projected onto all expectations and expressed by opposition. The negativism to psychotherapy is more specific. Psychotherapy symbolizes separation-individuation and as such triggers the withdrawing object-relations part unit which is projected onto the psychotherapy which is then resisted. [p. 491]

In my experience this oppositional behavior is often an attempt by the patient to master her guilt over becoming more assertive and noncompliant. The patient attempts, in the relative safety of the therapeutic situation, to try out a range of oppositional, aggressive behavior, taking the risk that the therapist will know how to handle it and will not be as upset by it as her parents would be. The extreme nature of her assertiveness results in part because of its newness and a long overdue self-indulgence and abandon, and in part out of guilt; in other words, assertiveness is expressed in extreme ways in a manner which invites disapproval and punishment. The patient unconsciously observes the therapist's reaction. If the therapist is not upset by such behavior, he will help to disconfirm the patient's belief in the destructiveness of self-assertive, non-compliant behavior and diminish her separation guilt. (See Weiss and colleagues 1982 and 1983 papers for a general theory of the therapeutic process, of which this is an illustration.)

Another example: Patients' reports of separation anxiety and abandonment depression can have a blaming quality. This occurs typically around the therapist's va-

cation. The therapist will be blamed for abandoning them in a time of need and causing great distress. Masterson's patient complained "I did trust you. I don't trust you any more. You turned against me just when I needed you." Masterson saw this as an experience of retraumatization, a reactivation of the "withdrawing object-relations part unit."

In my experience, such reproaches by the patient are often attempts to find out whether the therapist feels guilty about separating, as the patient does when trying to separate from mother. The patient is watching to see how the therapist will handle blame—will he succumb to guilt and become defensive or will he proceed comfortably with his life (the separation and vacation) and with the therapy? The patient is also watching to see how *she* will react if he does not succumb to guilt. It is helpful for her to realize that his refusal to be guilty is not really as upsetting to her as she imagined it would be and that, in fact, she does not suffer inordinately from his proceeding with his vacation. The implication for the patient is that her mother also will not be as hurt (as mother implies) by the patient's proceeding with *her* life. All this, of course, takes place unconsciously and is an example of what Weiss (1983) calls turning passive into active. The patient is attempting "by reproducing them actively, to master traumas . . . which he once experienced passively. He does to the analyst what, as he experienced it, a parent had done to him" (Weiss 1983, p. 182).

#### SURVIVOR GUILT, PSYCHOANALYSIS AND FAMILY THERAPY

Modell correctly sees that his ideas about survivor guilt move toward a theory that bridges intrapsychic and interpersonal processes. It is not surprising, then, that some of Modell's ideas are similar to those central to the family therapy movement, which grew out of Harry Stack Sullivan's interpersonal theory of psychiatry and more generally out of a discontent with psychoanalysis' relative lack of interest in

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interpersonal process and the way in which the specificities of family life shape and maintain psychopathology.

From its inception the family therapy movement has dealt with issues pertinent to survivor guilt. For example, it put forth the idea that children's symptoms are often born out of loyalties to parents and are attempts to help them. Separation guilt was seen as underlying the inhibition of sexual and other pleasurable activity (Jackson). Delinquency, school phobias, suicide, psychosis, negative therapeutic reaction, failed marriages, failed careers and many other self-destructive forms of behavior were seen as motivated by unconscious guilt over disloyalty to one's family of origin (Boszormenyi-Nagy and Spark 1973).

However, not finding in formal psychoanalytic theory a place for their observations, nor a guide to the techniques they found to be useful, family therapists have tended increasingly to turn away from psychoanalysis. Some have attempted to construct their own theory of the individual (see Boszormenyi-Nagy's ethical-existential approach), while others (Haley 1963, 1976; Minuchin 1974) have almost eschewed *any* use of an intrapsychic vocabulary. Neglecting the vast corpus of knowledge gained through empathy and introspection, they proceed to accumulate important observations of interpersonal process and develop effective techniques for treating certain symptoms. Anorexia is one of these symptoms. There is a proven family therapy approach to the treatment of anorexia, the underlying theory of which makes no explicit use of intrapsychic terminology (Minuchin 1978).

Minuchin's theory is that anorexia arises in an enmeshed, overprotective, conflict-avoiding, rigid family having a preoccupation with food. Therapy consists in challenging these family styles. The therapist, sitting with the entire family, creates boundaries, blocks overprotection, and stirs up conflict. The patients, usually young teenage girls, recently ill, often improve. Minuchin's theory stops at this point. Obviously these patients have learned some-

thing from the family treatment, and something has been internalized. Often these patients remain symptom free after leaving the family. Minuchin makes no attempt, however, to describe what they have learned or how it has changed them as individuals. This is not an oversight but a deliberate omission of the intrapsychic point of view—a "polarization of paradigms," as Minuchin calls it.

In my view, Minuchin's patients are anorectics with separation guilt. In treating these patients Minuchin creates separations (boundaries and conflicts) in the family. Is it evident from his transcripts that he and his colleagues titrate very carefully the tension level in the family, watching to see that family members can tolerate the process. The patients see their families survive, and even enjoy the therapy. Minuchin tells his anorectic patients that it is appropriate to individuate and demonstrates to them that their parents can survive their individuation. He disconfirms his patients' belief that they will harm their parents by separating, and diminishes their guilt.

It is interesting to note that Charcot (1889) treated an anorectic patient in much the same way. With great difficulty he managed to persuade the clinging, worried parents of a young anorectic girl to leave her to his care. He virtually ordered them to separate from her and leave the city, threatening not to treat her otherwise. The girl recovered in several months and told Charcot how much it meant to her that he had been able to send her parents away. Charcot recommended "parentectomy" as the first step in the treatment of anorexia, which is, of course, what Minuchin accomplished in a more subtle, effective way.

Minuchin's patients are not the most severely ill anorectics. I doubt if his technique would be effective with patients such as Rachel, who suffer from depletion guilt. Family therapy would be difficult with Rachel's family because her parents are so ill that they would feel too threatened by family sessions to help diminish the patient's depletion guilt. Family therapy provides no guidelines for the individual treat-

ment of anorexia in cases in which this is preferable or necessary, nor is Minuchin particularly concerned with anything besides the alleviation of anorectic symptoms. For these reasons, his theoretical framework, although imaginative and powerful, is incomplete. His polarization of paradigms and exclusion of the intrapsychic does provide a bold and commendable approach. The oversimplification it requires may, as he says, eventually serve to clarify the issues. However, a psychiatric theory cannot ultimately dispense with a theory of the individual. If one has no explicit theory, one ends up with a collection of possibly contradictory, or inadequate, implicit theories. What is needed is a theory of the individual that can mesh with a theory of the family.

One way of bridging the intrapsychic and the interpersonal traditions in psychiatry would be the construction of an adequate psychoanalytic object-relations theory. Such a theory would have to correct at least two of the inadequacies of classical psychoanalytic theory: (1) It would have to pay adequate attention to what a child learns in his family and have a language for describing the internalization of the specificities and subtleties of this experience. (2) It would have to include a theory of moti-

vation that recognized in some way the importance of a child's loyalty to his parents. A child's ties to his parents do not consist simply in his attempt to use them as a means whereby his instinctual aims can be achieved (the original meaning of "object"). Contemporary object-relations theories, which would seem to be likely candidates for just such a bridging theory, have failed on both counts. They seem much more interested in describing the *structure* of internalization than the *content* (see, for example, Kernberg 1976). Objects are often described as good and bad, gratifying and frustrating, exciting and rejecting, rewarding and withdrawing. These descriptions offer little improvement over classical psychoanalytic theory, and reflect the acceptance or influence of drive theory.

I believe that the expanded concept of survivor guilt described in this paper is a significant contribution to an adequate psychoanalytic object-relations theory of motivation. I believe I have demonstrated that by including the various forms of survivor guilt among the basic sources of motivation, psychoanalytic theory becomes better able to describe and explain not only the intrapsychic but also the interpersonal aspects of the etiology, psychopathology and psychotherapy of anorexia nervosa.

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