Section of Psychiatry

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Anorexia Nervosa

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Diagnosis and Outcome of Anorexia Nervosa: the St George's View

In the field of psychosomatic enquiry one believes one can sometimes detect endless interplay between the mind and the rest of the body on the basis of predominant and primary or 'necessary' pathological triggering mechanisms or morbid states in one or the other. Such thinking encourages and seems to endorse Cartesian dualistic ideas. Anorexia nervosa readily allows another understanding of both the machinery of the mind and to some extent also the basis of mental content as part of both the individual's body and his social experience.

Thus it is rooted in the full spectrum of human experience, in growth, individuation, reproduction and decay, and in the parallel needs for security and sufficient self-esteem. The time when these experiences first converge and demand incorporation (and this word's Latin roots have particular relevance for anorexia nervosa) is adolescence.

Lewis (1958), in his 1957 Bradshaw lecture, states that mental illnesses appear to contain and to be distinguished by an element of gain. Others have unequivocally seen them as primarily adaptive and defensive in their purpose. Certainly anorexia nervosa has been construed as reflecting the adaptive needs of the individual and as having arisen on this basis (Crisp 1967*a*,*b*). The search for security and self-esteem has proved incompatible with growth, which has therefore come to be stifled and avoided. Indeed the disorder has often been subsumed under the category of hysterical disorders. Without doubt the state reflects an avoidance posture and also profound primary gain, but with concrete rather than symbolic significance in terms of the precipitating maturational problems. The rest of the body has joined the mind in a single biological protective stance.

Many have commented on the apparent role of sexual trauma in precipitating the disorder. Some have seen food intake as variously symbolizing the mother or the oral sexual impulse, and hence the food being symbolically rejected on this basis; others have emphasized the complementary view that the posture of starvation, stemming from the context of more normal adolescent female dieting patterns, was the means by which, biologically speaking, the individual's sexuality was dramatically and necessarily quelled (Crisp 1962, Crisp & Roberts 1962). Evidence to support this mechanism could be culled from studies in starvation (Crisp 1965*a*). This effect, it has been argued, is the over-determining or rewarding influence, intensifying the dieting behaviour. Food is still seen to be equated to sex but a biological mechanism is intervening. In harmony with this it has been proposed that the unique posture of carbohydrate starvation generated in the initial stages of this condition is also a major influence determining the early amenorrhœa (Crisp 1965*b*, 1967*a*, Crisp & Stonehill 1971).

This hypothesis generated a treatment programme (Crisp 1965*c*, 1967*b*) involving restoration of body weight to matched population mean levels as a means of re-exposure of the patient to the feared situation. This provides a realistic basis for psychotherapy and it focuses attention on the 'threshold' phenomenon which was initially identified in terms of body temperature and BMR changes studied during full weight restoration. Patients gaining weight often appeared to change abruptly in these and other clinical respects (acne, blushing, coyness) at a body weight around 47 kilograms and, sometimes, menstruation would resume shortly thereafter. These pubertal threshold considerations and related notions concerning the

psychobiological and social maturational tasks of adolescence have influenced much subsequent research in the department. Much of this work is interwoven with ongoing clinical experience in the unit and it is the latter which is the topic of the present paper. The observations are based on a series of 350 patients documented since 1960.

Diagnostic Issues

The various descriptive terms applied to the disorder in the English language literature are of some interest. It has variously been called *anorexia nervosa* (Gull 1868), implying a nervously determined absence of appetite; *primary* anorexia nervosa, to distinguish it from secondary anorexia nervosa, concepts generated (Dally & Sargant 1960) in an attempt to respond to the oversimplification of the issues involved by the introduction of the term *nervous malnutrition* (Bliss & Branch 1960); and *weight phobia*, an attempt by Crisp (1965*b*, 1967*b*, 1973) to focus on the central psychological issue of body weight and its significance for the adolescent and especially for the fearful anorectic, and on the avoidance mechanism involved.

Thus the diagnostic process involves assessment at four levels. The first of these is central to the psychophathology. All of them can be significant for treatment.

Level 1: This feature is always present (although difficult to detect), it is exclusive to the condition and its particular qualities and factors directly related to it determine the evolution of the illness. It is the central preoccupation of the anorectic with maintaining a low subpubertal body weight and of avoiding any weight gain. The immediate experiential and behavioural content is the commonplace adolescent female's wish to slim by dieting. Within the potential anorectic there emerges the increasing conviction that her body shape and volume is governing her destiny. The need to become thinner is increasingly construed also in terms of body weight – all is eventually condensed into a feared avoidance of normal adolescent weight as the biological status, pivoting in reverse around the pubertal process, regresses to being prepubertal in association with a body weight somewhere usually between 30 and 40 kilograms (Crisp 1977*a*).

Mature biological sexuality is eliminated from the system, childhood is biologically reestablished and the attendant starvation ensures an exclusive restless preoccupation with food and foraging. For the anorectic, who wishes nothing other than to be able to forget about food, this is the ultimate irony and the ever-present temptation – that she can think of nothing else but food and seeking it and that she is in the presence of plenty. She must be constantly alert and often defend her position desperately.

This central mechanism then generates the symptomatology, the manifest syndrome; is governed by a number of factors, biological and experiential within the individual and her family; can exist in borderline forms, blending with the normal, as is the case with most diseases; is often desperately concealed (Crisp 1977*b*) and may only be revealed, especially amongst those who binge and vomit as a means of weight control, in the treatment situation within which restoration of normal body weight is intended.

Level 2: The symptoms are a product of the individual's ever-present need to retain control over her impulse to eat (or where decompensation has occurred, then to vomit, exercise, purge or ingest other relevant drugs following eating); her starved state; and her biologically regressed state.

Her secretiveness, hostility, moments of elation and despair, regular weighing of herself, ritualistic behaviour, and desperate commitment to schoolwork are amongst the symptoms that reflect her terror of weight gain. Her restlessness, hoarding, preoccupation with food and cooking and her impaired metabolic status, and her isolation from her peers, are amongst the symptoms that reflect her starved and regressed states.

Even these various symptoms, not pathognomonic of the condition although always suggestive of it, may not be easily detected since the individual has no wish to change and will attempt to conceal any aspects of her behaviour that she judges may lead to significant intrusions by others into her control mechanisms.

It is perhaps useful to re-state the view that the basic psychopathology involves shape and weight, the symptomatology involves food and feeding. Any anorectic would eat hugely, and of course may do so as long as weight gain does not follow. It is adolescence which has conferred a new meaning for body shape and weight on the individual's life. Food only symbolizes sex via the process of consequent growth and the body weight precipitating mechanisms of puberty. In looking then for the meaning of food for the anorectic we have to look at the meaning of adolescent body weight and shape, including its sexual aspects for the individual and her family, rather than specifically the nature of her relationship with her mother as is perhaps more valid in, say, the feeding disorders of childhood.

Level 3: The context within which the weight or volume phobia arises. The factors converging to precipitate anorexia nervosa are: the presence of a concern about shape and wish to slim and a determination to diet; and the coexistence of major

adolescent maturational conflict and the absence of ways of coping or other ways of defending against it both within the individual and within her family system.

A wish to slim: The concern about shape, especially fatness and the wish to reduce it is characteristic of adolescent females. This is in sharp contrast to the attitude of adolescent males to their body shape. The disposition of female fatness is hormone dependent and conferred at puberty. It is importantly related to both biological and social aspects of adolescent sexuality. The pubertal female becomes sensitive to her fatness, often specifically her breast development and the fatness of her thighs but also often her waist and hips; less often her lower legs. The majority attempt to slim by restricting their carbohydrate intake. By the age of 17 years, 70–80% of females are behaving in this way, obviously not all of them obese. Very few males except the massively obese and perhaps some with more profound gender identity problems are doing the same. The majority of adolescent males are more likely to wish that they were larger. Such dieting in the female reflects more than current fashion although there are epidemic qualities to it. It has, in my view, also to do with such issues as the search for confidence and self-esteem stemming from the experience of successful impulse control (the impulse to eat) on the one hand, which the adolescent female construes as evident to others in terms of her manifest capacity to control her shape, and the hope of appearing more attractive on the other hand – two aims that can come into conflict when the need for control over other and related impulsivity, sexual and social, become important within adolescence. The adolescent female in general appears to be programmed to construe her adolescent tasks in terms of her body shape.

The anorectic-to-be stems from this population. Her initial concerns about her shape are of the same kind as those of her peers; but she is more likely than them to have come from a background emphasizing such factors. These other risk factors concerning shape (an aspect of the fourth level of diagnosis) include: a greater tendency to have been immediately premorbidly obese (Crisp & Stonehill 1971); childhood overnutrition, fast growth and early puberty (Crisp 1970); a tendency for her family to show an excess of both obesity and anorexia nervosa and/or to be greatly concerned about weight control, to be involved in the food business and to construe secure family structure and personal stability in such terms as good nutrition or physical fitness (Crisp 1967*a*, 1970, Kalucy *et al.* 1978). None of these factors, of course, is necessary for the condition to develop but statistically, along with other influences, they bear on it.

The immediate adolescent turmoil: Adolescence is or should be, a time of turmoil. It requires the individual to come to terms with her genital sexuality and to integrate it into her ways of relating to her adolescent peers, male and female; to differentiate herself from her family – to what extent is she destined to be like her mother, her father, to what extent is she distinct – to renegotiate her relationship with them. It requires her family to cope with and support her in this transition; to tolerate the experience of their own adolescent adjustments being brought into question. It may in many ways challenge the basis and balance of their marriage and other institutionalized adjustments such as their philosophy of life, their moral attitudes and their careers, and thus pose a major threat to one or other or both of them. As the adolescent warms to her tasks, trying out new roles, hopefully not lingering too long in insubstantial postures that merely reflect reaction formations to parental attitudes, at times distancing herself seemingly beyond reach, the demands on the parents to understand themselves better than ever before will grow. Otherwise, if the adolescent is still to flourish, then conflict and parental rejection are likely and must be lived with (Crisp 1974).

In the families studied in the present series no conflicts specific to anorexia nervosa have been found. A few examples are cited here:

(*a*) A precariously balanced marriage, the father elderly, obsessional and authoritarian, the mother ambivalent but secure within the marriage though potentially much more extrovert and impulsive. The proband construed as being like her father and close to him as a child (recapitulating themes within the parental marriage) but like the mother since puberty and up until the start of the illness. The mother during this period living vicariously through the proband's expanding adolescent adventures and testing out of the family. Mounting conflict in the marriage and threatened rejection of the proband via the father. Proband, sensitive about her shape, overeats whilst away on holiday, looks pregnant, is teased by her friends and condemned by her father. Developing anorexia nervosa in the proband resolves this and the related and larger family problem. As a variant of this, of course, there is the parent whose own adjustments and identity are challenged so much by his adolescent child, who is in many ways so similar to him but acting out, that he becomes directly repressive and potentially rejecting.

(*b*) The proband, now aged 16, the last of three siblings, conceived in an attempt by the mother to bind together a foundering marriage. The father stays but with inner reservations that he will leave

when the proband is old enough to cope with life. Mother overprotective and fearful but hoping that time is on her side. In his early 40s the father embarks on an affair – mother miserable, proband, now a teenager sensitive about her shape, seeking friendships, sexually aware, striving to cope, but the more she demonstrates her independence the more her family threatens to disintegrate. With her childlike regression within the supervening anorexia nervosa, the family finds that it once again has a child and is locked together.

(*c*) Adoptive parents with an unconsummated marriage have an idealized family life with their adopted illegitimately born child. In adolescence, as she begins to explore her newfound life and reveal her likeness to her attractive, promiscuous and real mother, the adoptive parents are confronted not only by their own impotence and frigidity, but their own adolescent conflicts which determined these qualities, and which are now re-illuminated by the proband's behaviour. Threatened rejection follows. Resolution for the entire family is by the evolution of anorexia nervosa in the proband.

(*d*) Strict, religious, ambitious parents have been dismayed by the promiscuity, pregnancy and life style of their long-favoured and, to them, always their most promising eldest daughter. Now living elsewhere with her boyfriend, she is ignored by the family, especially by her father. The mother's favourite is the son, who now has a girlfriend and is about to leave home. The proband, the third child, always the least favoured of the siblings in her own view, now finds herself effectively the only offspring and the focus of new affection and emotional investment by the parents. Her own tentative and desperately secret first adolescent flirtation has filled her with fear of suffering a similar fate to her sister. Her concurrent sensitivity about her shape intensifies and anorexia nervosa supervenes as she secures her position in the family.

These typical family conflicts reflect the mid-life crises of the parents concerning their identities and their relationship, provoked by their adolescent children and in this instance coming to be resolved by the proband's 'illness'. As previously stated, such challenges characterize most families at this stage in their life. Some survive them because all members are tough enough and flexible enough. In other families the adolescent does fall ill but with some other disorder to which she is predisposed by her environment and her constitution, including her personality. These latter illnesses, whilst responses to some extent to this conflict and sometimes serving to resolve it in various ways, do not produce a 'solution' to the problem in the way that anorexia nervosa does. Often for the entire family there is some primary gain within the proband's anorexia nervosa, characterized as it is by her total reversion to a childlike posture. The parents' evident distress and guilt at presentation is the explicit price of this solution and is paid in terms of their helpless witness to their daughter's evident ill health, bizarre social behaviour, and restricted and at times hostile, though dependent, relationship with them, and the specific and new conflicts generated within the family by this. In other families the adolescent survives but the parent falls ill instead; depression is of course common.

What then are the other factors (again at the fourth level of diagnosis) that can determine the evolution of anorexia nervosa rather than some other disorder?

Level 4: The proband appears singularly ill-equipped to cope in any other way. She will often have been a singularly good compliant child, explicitly never wishing to grow up. She may have been a tomboy, liked by her father with whom her relationship was very close, unable to cope with the impact of her puberty. She will often have been characterized in early adolescence by being sensitive, cautious and with a sense of low self-esteem; just occasionally with some individuals there has been a phase of impulsive behaviour causing panic within the family. She is likely to be increasingly ascribing her difficulties to her shape at this stage.

She is more likely to be in a social class I or II family, with its middle-class value systems concerning conformity, achievement and the need for an extended dependent adolescence. In our present-day society she will find little in the way of institutionalized support of a social kind for her in her adolescence. Her parents' attitudes may clash hopelessly with the prospect before her now as an adolescent, of the permissive society within which she will be expected to 'do her own thing'. Unfortunately for her the only thing she is equipped to do is to develop anorexia nervosa as a means of surviving this system. Meanwhile the parents between them are likely to reveal (or conceal) a history of neurotic social avoidance behaviour (often the mother) and depression (often the father).

Treatment

What then are the implications of such formulations for the treatment?

The striking thing, at presentation, is that there is no family conflict of the kind described above. It is 'solved'. Moreover, the individual does not want treatment. She does not see herself as a patient but as someone trapped, and she is already beginning to work out ways of negotiating her disengagement from the treatment situation. The prospects for

transference entanglements with the doctor are legion and their existence and control immediately paramount for meaningful evaluation and care.

Treatment therefore starts at the very first encounter. I find this is often a crucial event and we, a social worker and myself, allocate two-and-a-half to three hours to it. In the first instance both of us meet with the parents and/or whoever else is relevant, e.g. siblings, spouse. After a preliminary discussion of the proband's illness we begin to thrust them into the patient role – seeking to learn about them as individuals, as a family and about their marriage. In our experience denial of relevant problems by them is commonplace; such denial has probably always characterized their lifestyle. One or other parent may be deeply embarrassed and hesitant at revealing secrets; they fear recrimination and a breakdown of the present adjustment. Such parents need to be gently but firmly supported through such interviews in a non-judgmental way with a clear emphasis on their own involvement and an expectant understanding that crises occur in many families and marriages. After an hour or so of interview the parents go off with the social worker for further investigation. Gaps in the histories are filled at this stage and sensitive areas further explored. Meanwhile I will see the proband for an hour or so. Typically she will appear fearful, wary, resentful and sullen. The task is to attempt to help her to see the possibility, however remote, of change; of developing some alternative ways of coping. She will certainly need to know that her parents are also expected to change. She should clearly learn what the persistence of the illness holds in store for her. She should know that treatment will probably require both short-term and long-term intervention and care and will take two or three years as a minimum. The bare bones of the specific family psychopathology so far as they have been revealed should be put before the patient and her family at this stage.

The inpatient treatment programme has been described elsewhere in detail (Crisp 1967*b*, 1970, 1974). It is usual to recommend admission to hospital on the basis, not negotiable, of restoring weight to a matched population mean level (the weight of the average person of the patient's sex, height and age at onset of her illness, i.e. she is expected to pick up in adult life in terms of body weight at the chronological age at which she left off), within the context of eating normal amounts of food including normal amounts of carbohydrate. No one is allowed to bring in extra food. She is allowed to visit the unit beforehand and meet the other patients if she wishes. Until target weight is reached the patient is in bed. She welcomes the apparent understanding that she has the same tendencies, unpredictable in their expression, as say an addict to protect her situation and that she needs, if she is to be helped, to surrender control over her body weight and her shape to others. She will only do this if she is confident that the outside agencies will protect her from overeating and stabilize her at the target weight. A specifically trained and experienced nursing team is essential.

She understands that the purpose of restoring her weight is merely to restore her to the reality of the phobic situation, her normal adolescent biological self, so that meaningful psychotherapy can be done with both her and her family. Unless she believes this latter prospect is real she will reject the treatment programme. In addition she can be expected to be involved in social skills training and the therapeutic community activities within our inpatient unit. Such a treatment programme, with its behavioural and psychotherapeutic elements is reminiscent of Freud's view that agoraphobics must first be exposed to the feared situation before psychotherapy can be usefully done.

Of such patients seen in the outpatient clinic 80–90% will accept hospital admission on these terms and then find themselves in a unit containing a total of 8 anorectic patients at various stages of treatment. Putting an anorectic to bed and feeding her is not encouraging her to regress – to believe that is to confound the disorder with the feeding disorders of childhood once again – it is instead removing her profoundly regressed status from her and confronting her, through her restored weight, with reality and with the need for progression.

Individual psychotherapy by the registrar, senior registrar or social worker is planned on a weekly or twice-weekly basis and supervised. Psychotherapy with the parents involves fortnightly conjoint meetings into which the patient is introduced once her weight is normal. The patient must be helped to understand early on that recovery from anorexia nervosa is only the beginning of her and sometimes also her family's problems.

Outcome

What is the outcome and what are the factors bearing on it? First, one is always operating within the context of a disorder wherein many individuals sooner or later recover spontaneously. The ultimate extinction of family and marital conflicts with the passage of time or their resolution by other means, the natural human impulse to eat and to live are all on the side of the natural recovery.

The first two-and-a-half-year follow-up study (Crisp 1965*a,b*) showed a 50% recovery rate after two years but with some patients now ill in other ways, e.g. socially phobic, depressed, suffering severe dermatitis. A more recent follow-up study shows a 60% recovery rate four to seven years later (Stonehill & Crisp 1977); 5% had died.

Following discharge from inpatient treatment

some degree of initial relapse is not uncommon. Subsequent recovery, however, is often seen by the patient as having been helped by the original inpatient experience.

As patients achieve target weight, parents as a group get significantly more depressed and more anxious, despite their earlier despair, irritation and shame, which had ultimately driven them to seek help for their daughter.

The following are factors that in our experience influence outcome (Crisp *et al.* 1977, Kalucy *et al.* 1978):

(1) Males are resistant to developing anorexia nervosa and those who do, either in association with premorbid massive obesity and/or major gender identity problems, do less well.

(2) Working-class families (social classes IV and V) are less likely to generate anorexia nervosa than families from within the professional and managerial classes. When it does arise within them it is signficantly often more severe and chronic.

(3) The presence within the anorectic's family of major nutritional disorder and excessive concern with weight control worsen prognosis.

(4) Premorbid obesity with the attendant greater than usual (and in many ways realistic) fear of reversion to a state of excessive fatness, and an ultimate propensity for bingeing and vomiting to evolve as a means of weight control, worsens prognosis.

(5) Marriage institutionalizes the disorder.

(6) Duration of illness: the disorder serves to divorce the individual from any further biological maturity and growth and any meaningful contact with her potential peers. They grow steadily away from her and as time passes the gulf widens. The task of spanning it after ten or more years of illness is daunting, although, with the kind of treatment programme described above, it can sometimes be achieved.

(7) Personality: undue compliance and passivity as a child revealing itself as a major psychological developmental defect in the early teens.

Our follow-up study at four to seven years of 46 patients screened with the Middlesex Hospital Questionnaire at presentation shows no difference in outcome on anxiety, obsessional or depression scales. Those who have a high measured level of somatic complaint at presentation, however, have a worse prognosis. The subgroup of bingers and vomiters, characterized by fathers with high obsessional scores and by low obsessional scores themselves, also do less well. The majority, recovered from their anorexia nervosa four to seven years later, now show pathologically high social phobic scores whereas previously, with their all-protective posture of anorexia nervosa, such scores had been very low. This symptom shift reflects, in my view, considerable underlying maturation and highlights the difference between the outstanding primitive psychobiological defence mechanism of anorexia nervosa and the less primitive one of social phobic avoidance behaviour uncomplicated by anorexia nervosa or obesity.

(8) Family psychopathology: we have shown that high levels of anxiety and depression in the parents and high levels of marital discord at the time of presentation are associated with poor immediate outcome following inpatient treatment (Crisp *et al.* 1974).

(9) Dietary pattern: those who binge/vomit/purge (a feature of the more chronically ill anyway) do less well.

(10) Those who do not embark upon or sustain themselves in the initial treatment programme – who are poorly motivated to tackle the adolescent maturational problems underlying their disorder – do less well.

In summary, anorexia nervosa has been viewed here as a defensive biologically regressed posture pivoting around the events of puberty and reflecting primary gain. There is rarely any secondary gain – on the contrary life is miserable though still usually possible. The disorder is rooted in psychobiological mechanisms within the individual and in individual and family psychopathology concerning the meaning of body weight and fatness, evoked by the proband's adolescence and its maturational challenges. There are many identifiable 'risk factors' that can influence the evolution of the condition. Treatment requires a combined behavioural and psychotherapeutic approach involving special medical and nursing and psychotherapeutic skills.

REFERENCES

Bliss E L & Branch C H
(1960) Anorexia Nervosa. Hoeber, New York
Crisp A H
(1962) *Middlesex Hospital Journal* **62**, 112–117
(1965*a*) *Journal of Psychosomatic Research* **9**, 67–68
(1965*b*) *Proceedings of the Royal Society of Medicine* **58**, 814–820
(1965*c*) *British Journal of Psychiatry* **112**, 505–512
(1967*a*) *Journal of Psychosomatic Research* **11**, 117–131
(1967*b*) *Hospital Medicine* May, 713–718
(1970) *World Review of Nutrition and Dietetics* **12**, 452–504
(1973) The Nature of Primary Anorexia Nervosa. Royal College of Physicians, Edinburgh; No. 42, pp 18–30
(1974) *Practitioner* **212**, 525–535
(1977*a*) *International Journal of Obesity* (in press)
(1977*b*) *Proceedings of the Royal Society of Medicine* **70** (in press)
Crisp A H, Harding B & McGuinness B
(1974) *Journal of Psychosomatic Research* **18**, 167–173
Crisp A H, Kalucy R S, Lacey J H & Harding B
(1977) In: Anorexia Nervosa. Ed. R A Vigersky. Raven Press, New York (in press)
Crisp A H & Roberts F J
(1962) *Postgraduate Medical Journal* **38**, 350–353

Crisp A H & Stonehill E
(1971) *British Medical Journal* iii, 149–151
Dally P J & Sargant W
(1960) *British Medical Journal* i, 1770–1773
Gull W W
(1868) *Lancet* ii, 171
Kalucy R S, Crisp A H & Harding B
(1978) *British Journal of Medical Psychology* (in press)
Lewis A
(1958) *Lancet* i, 171–175, 227–230
Stonehill E & Crisp A H
(1977) *Journal of Psychosomatic Research* **21**, 187–193

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Anorexia Nervosa: Do We Need a Scapegoat?

The Old Testament scapegoat had to accept people's sins, and was then sent out into the wilderness, presumably to die sooner or later of starvation. The idea of the patient with anorexia nervosa being seen as the scapegoat bearing away her family's sins, being despatched to starve in the desert, may be macabre but is of course by no means absurd. It is not uncommon for parents to displace resentments felt for one another on to their anorexic child (and for marriages to break up when the child recovers and refuses to be the family scapegoat).

In anorexia nervosa the traditional scapegoat is the mother. Mothers are blamed, without any substantial evidence, by husbands, doctors, and even by patients, although fathers, siblings, grandmothers and other relatives are occasionally held responsible. I hope to show here that it is helpful for the doctor to identify the family scapegoat; to seek to find out whether the patient agrees or not; and not to get drawn into the scapegoat idea himself.

Anorexia nervosa is a neurotic disorder (Dally 1969), mainly of adolescence. This paper is based on 120 new female patients and their relatives seen separately by myself and a social worker, Greta Godfrey, over the last seven years (Table 1). All these patients had that primary disturbance of eating behaviour, originally described by Gull (1888): they had lost weight because of active refusal to eat. All women who had started to menstruate developed amenorrhoea, but 8 (25% of the age group 11–14 years) had not reached their menarche when they began to diet. Males can also develop anorexia nervosa, although they are outnumbered by at least 10 to 1. I have omitted 12 males seen and treated during this time (*see* Table 1) in order not to complicate the series any more than necessary.

There are subgroups of primary anorexia nervosa with their particular clinical colouring and outcome, such as primary and secondary, or atypical (Bruch 1974), those who vomit and purge (Beaumont *et al.* 1976), or those who swing between eating binges and dieting. I have not tried to separate these patients into such groups. Rather, I have been interested in examining the effect of age and stage of maturation reached by the patient when she first developed anorexia nervosa. I have therefore divided them into three groups based on age at onset (11–14, 15–18, 19 onwards), and subdivided each into the following categories:

Recovered: Weight has returned to 90% or more of pre-onset or standard weight, whichever is lower, and has been stable for at least nine months. Preoccupation with thinness or eating is minimal or absent. Menstruation has resumed (in all but 3 cases).

Improved: Weight is consistently above 90% of pre-onset or standard weight, but may fluctuate, sometimes considerably, because of eating 'binges'. Preoccupation with weight and eating is still strong. Menstruation has returned in 50%. 'Neurotic depression' occurs from time to time.

Unchanged
The causes of anorexia nervosa are complex, but two aspects stand out: the patient's fears of growing up and facing the physical and psychological changes of adolescence; the patient's difficulties in communicating and expressing her new feelings within the family. Refusal to eat with the family symbolizes in a sense refusal to communicate. It is also an effective way of dominating the family scene. When the patient and her family are first

Table 1

Numbers and ages of new patients (120 females, 12 males), 1970–76

Age (years)	*No. of new patients Females*	*Males*
11	2	–
12	3	1
13	15	–
14	12	1
15	12	2
16	19	4
17	19	2
18	8	–
19	6	–
20	8	–
21	7	–
22	3	–
23		–
24	1	–
25	1	–
26+	4	2