

Bruch Revisited and Revised[†]

Abstract

The aim of this text is to remind the clinical and scientific field of eating disorders of the seminal figure Hilde Bruch. Her work is highly original, but is it sinking into the mists of oblivion? The contemporary overemphasis on cognitive behavioural therapy may indicate that. Hilde Bruch's contribution was a descriptive and theoretical model defining anorexia nervosa and severe eating disorders as self-disorders, with emphasis on developmental deficits in the organisation of the psychological self. A limited focus on cognitions may undermine both the awareness of central aspects of the psychopathology of eating disorders, as well as the relevance of sensitively regulating the psychotherapeutic stance. Copyright © 2009 John Wiley & Sons, Ltd and Eating Disorders Association.

Keywords

anorexia nervosa; eating disorders; Hilde Bruch; mentalisation; psychotherapy

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Introduction

As a psychiatrist and psychoanalyst with an extensive authorship on eating disorders, particularly anorexia nervosa, Hilde Bruch is probably the most influential figure in our field the last 50 years, developing new vistas in the understandings and conceptualisations of the particular psychopathology (1970, 1973, 1988). Her work is a demonstration of a willingness to experiment, to challenge established truths, and to develop new knowledge and practices. Hilde Bruch was a pioneer in developing the psychotherapeutic approach towards such disorders, with emphasis on curiosity and a not-knowing stance (1970). As a psychotherapist, she is described as meticulous in her avoidance of jargon. She was immensely productive, and a prolific author, both for a scientific and a popular audience (Bruch, 1996; Lidz, 1988). Her book 'The golden cage' (1978) is still, 25 years after her death, an inspiring reading for many persons with anorexia nervosa.

The history of psychiatry and psychotherapy is interesting in itself, but the motivation for revisiting the works of Hilde Bruch here, is primarily not of such a kind. Rather, it is based on the self-critical premise that the state of art for anorexia and eating disorders, and that goes for both theoretical understanding and therapeutic approaches, is far from satisfactory. In a special issue on anorexia nervosa in *International Journal of Eating Disorders*, Fairburn (2005, p. S29) is asked to answer the question 'Is evidence-based treatment of anorexia nervosa possible?' His disquieting conclusion is 'barely', based on both weaknesses of scientific trials and that treatment programs are not good enough. In the same issue Woodside (2005, p. S41) comments on a series of comprehensive overviews on therapy and therapeutic organisation, that there are 'more questions than answers', and that 'there are more weaknesses than strengths in our understanding of the treatment of individuals with anorexia nervosa'. Problems of understanding the disorder may provoke overreactions due to intense emotional reactions in the therapists, lack of commitment and patience; or worse to aggression and rejection.

[†]Have we forgotten the fundamental insights of the pioneer Hilde Bruch (1904–1984)?

Hilde Bruch's contribution was a descriptive and theoretical model defining anorexia nervosa and severe eating disorders as *self-disorders*, with emphasis on developmental deficits in the organisation of the psychological self. Or as Bruch writes herself (1988, p. 4): 'Expressions of the deficiency in overall development are manifested by inaccuracy in perception and control of bodily sensations, confusion of emotional states, inaccuracy in language and concept development, and great fear of social disapproval. The relentless pursuit of thinness can be conceived of as an effort to camouflage these underlying problems'.

In the field of eating disorders today there is the hegemony of the cognitive behavioural therapy traditions. And, given the lack of effective treatment, it is both an intellectual and practical obligation to raise criticism. The strengths of such approaches in many clinical areas are their practicability, not at least due to the manualisation of treatment. A major weakness is theory. That again may represent the risk of 'practicism', in the sense of working on without sufficient conceptual tools to guide the specific therapeutic encounters. Many of the cognitive behavioural therapy traditions refer to dysfunctional schemes of self-evaluation, but actually they do lack a concept about the development of the personality and the psychological self in general, and more specifically about the different phenotypes of disorders of the self. A rather limited focus on cognitions may undermine a language for and awareness for central aspects of the phenomenology in severe eating disorders. And correspondingly, a key focus on changing dysfunctional cognitions may represent limitations with regard to emphasise vital aspects of effective therapeutic stance. An adequate theoretical and practical focus on sensitive attunement in the therapeutic interactions is one of the least developed aspects in the treatment manuals.

As stated by Vanderlinden (2008) in his Viewpoint in this journal, limitations in the cognitive approaches are too little focus on emotional life, and too much focus on contents of cognition. There is a main focus on *what*. Hilde Bruch was deeply engaged in developing this *what*, in the sense of elaborating *meanings* of symptoms together with her patients. But she was not at least a pioneer through her original capacities to describe and conceptualise *how* the anorectic self works.

The hegemony of the cognitive behavioural traditions may undervalue the severity of serious eating disorders, in the sense that it is a hazardous reductionism to limit

major psychopathology to mainly cognitive dysfunctions. Yes, it is regularly so, as Vitousek and Ewalt (1993, p. 221) write, that 'the lives of anorexics are progressively dominated by a central, overdetermined idea about one aspect of the self: that the self's worth is represented in – or at least delimited by – the weight and shape of the body'. But, in Bruch's perspective, this *idea* would rather be understood as a manifestation of an underlying self-disorder, and these underlying deficiencies should be the central focus for psychotherapy.

Therefore, the rhetoric question in the title: Have we forgotten the fundamental insights of Hilde Bruch?

Biographical Sketch

Hilde Bruch was born in Germany in 1904, and graduated from the medical school in Freiburg in 1929. As a Jew she left Germany in 1933 to escape from the Nazi pogroms, firstly for 1 year in London and from there to the USA. She had started on a career in paediatric physiology before she left her native Germany. In USA she took her psychiatric training under Adolf Meyer who was a pioneer in the new field of psychosomatic medicine. She entered psychoanalytic training, and had the fortune or good sense to have as her analyst Frieda Fromm-Reichmann, who was also an émigré from Hitler's Germany and could well understand Bruch's trauma of leaving and losing most of her family (Bruch, 1996; Lidz, 1988).

It is highly relevant for Bruch's later work with anorexia nervosa that her training milieu consisted of analysts, amongst them Harry Stack Sullivan, with a dominant interest in the analysis of schizophrenic patients. The challenges were how to modify psychoanalytic techniques to suit the needs of these patients. Here, Bruch learned that working psychotherapeutically with schizophrenic patients could lead to insights into fundamental problems of human existence and of psychopathology not readily gained from neurotic patients.

In 1964 Hilde Bruch accepted an invitation to move to Houston to become Professor of psychiatry at Baylor University College of Medicine. And here she developed further her work on obesity and anorexia nervosa, and published numerous scientific texts. Over the years she had observed a number of developmental themes and personality characteristics common to many persons suffering from anorexia nervosa as well as idiosyncrasies of their families that contributed to the patients' eating

problems. She published the book 'Eating disorders. Obesity, anorexia and the persons within' in 1973, and this was immediately considered as one of the most insightful and significant work on these topics. Despite her virtual immobilisation from Parkinson's disease and considerable pain from various infirmities during her last years, she managed to dictate her final work, 'Conversations with anorexics', which was first published in 1988, after her death.

Bruch Revisited

Noting that treatment results from traditional insight-oriented psychotherapy were rather poor, possibly harmful, Hilde Bruch concluded that the classical psychoanalytic formulations of anorexia nervosa were based mainly on atypical cases suffering from conversion hysteria. Bruch regarded (1982/1983, 1985) the psychopathology of primary anorexia as different from the Freudian understanding of psychoneurosis, and more akin to what we today would describe as narcissistic, borderline and schizoid personality disorders. It was her opinion that the core problem lies in a deficient sense of self and involves a wide range of deficits in conceptual developments, body image and awareness, and individuation (Taylor, Bagby, & Parker, 1997).

Bruch (1962) observed that anorexic patients manifest difficulties in accurately perceiving or interpreting stimuli arising in their bodies, such as hunger and satiety, and also fatigue and weakness as the physiological signs of malnutrition. In addition, she observed that patients with anorexia experience their emotions in a bewildering way and are often unable to describe them. Such disconnections between physiological and subjective feeling components of emotion are commonly termed as *alexithymia*. The concept originates from Greek and literally means 'no-words-for-feelings'. The lack of awareness of inner experiences and failure to rely on feelings, thoughts, and bodily sensations to guide behaviour, may contribute to an overwhelming sense of *ineffectiveness* and an overall lack of awareness of living one's own life (Bruch, 1962, 1973). The clinical picture presented is the patient's effort to compensate for these underlying deficits. Bruch (1973, p. 24) defines anorexia nervosa as a 'struggle for control, for a sense of identity, competence and effectiveness'.

For Bruch the person with anorexia is therefore *one who does not know*, because he/she is a *person who has not learned to distinguish*. The relationship between experience

and category has not been established in a valid manner. Experiences with the body are *mis-categorised*, and for Bruch this is understood as a *cognitive* and *perceptual* disorder. When the child or patient do not know *what* they feel and need, they are close to experiencing loss of own reality. The child does not *know*, and can be close to what is called impaired reality testing.

With respect to psychotherapy, Bruch (1973, p. 336) eschewed interpretations in favour of what she called a 'fact finding, noninterpretive approach'. She writes in her posthumously published book 'Conversations with anorexics' (1988, p. 8) that the 'therapeutic task is to help the anorexic patient in her search for autonomy and self-directed identity by evoking awareness of impulses, feelings, and needs that originate within herself. The therapeutic focus needs to be on her failure in self-experience, on her defective tools and concepts for organising and expressing needs, and on her bewilderment when dealing with others. Therapy represents an attempt to repair the conceptual defects and distortions, the deep-seated sense of dissatisfaction and helplessness, and the conviction that her own self is empty and incomplete and that therefore she is condemned to compliance out of helplessness'.

In sum, Hilde Bruch counselled a 'naive' stance which emphasises listening to the patient and stimulating curiosity and sensitivity towards oneself. She (1970, 1973) warned against telling the patient what to feel and think, confirming their sense of inadequacy and thus interfering with the development of a true self-awareness and trust in their own psychological abilities.

She often stated that the leit motif of her work was to accept the fertility of insecurity. A favourite quote of her was one of Maimonides, the great physician-philosopher: 'Teach thy tongue to say I do not know and thou shalt progress'. She stated how one of the most important tools of the therapist is his or hers continuous curiosity, and the willingness to admit errors. Late in her life she appropriately entitled an autobiographical sketch, 'The constructive use of ignorance' (1975).

It is relevant to ask: To what extent does such an epistemological and therapeutic position possibly diverge from traditional clinical approaches, both psychodynamically and CBT-motivated?

Bruch Revised

Hilde Bruch's major works on anorexia nervosa are almost half a century old. Accepting the originality of

Hilde Bruch's intellectual and clinical project, how are, or how could, her positions be integrated in contemporary theory and practice?

While much of the therapeutic enterprises dealing with eating disorders, are centred on the cognitive behavioural traditions, theoretical models have tended to move in other directions. In general psychology and psychiatry, advances in developmental psychology, infant development research, trauma research, attachment, new concepts of personality development, and newer concepts in psychoanalysis have all contributed to the evolution of a new and distinct entity, that of *self-regulation* in general and of *affect regulation* in particular. Such superior concepts are rather consistent with Bruch's original concepts of *interoceptive confusion* (1973) and self-deficits, being experienced as affective dysregulation and lack of control. Since Bruch, there is rich empirical evidence for the association between alexithymia and eating disorders in general, and not only for anorexia nervosa. For a review of the scientific literature, see Taylor et al. (1997).

Skårderud (2007a,b,c) has applied the concept of impaired *mentalisation* (Bateman and Fonagy, 2006) as updated conceptualisations of what Bruch originally described as deficiencies in mental processing. Mentalisation is defined as the ability to understand feelings, cognitions, intentions and meaning in oneself and in others. With regard to eating disorders impaired mentalising is used both with regard to understanding other people's mind, one's own mind and also minding one's own body. The essence of such descriptions could be stated as such: When psychic reality is poorly integrated, the body may take on an excessively central role for the continuity of the sense of self, literally being a body of evidence. Not being able to feel themselves from within, the patients are forced to experience the self from without. The concrete symptoms essentially serve the function of maintaining the cohesion and stability of a tenuous sense of self. As one of Bruch's patients described: 'Anorexia is a way of bringing order to one's universe, and attempt to freeze time and relationships' (Bruch, 1988, p. xvi).

One of the important advances since Bruch's heyday is the progress of neuropsychology and new neuroimaging technology. Today the biology of mental processing is among the most notable conundrums faced by scientists. Recognising the mind as a sequence of functions performed by the brain, neuroscientists are increasingly joining forces with mental health prac-

tioners to rid us of the Cartesian dualistic conception of mind-body (Oppenheimer, 2005). With reference to the concepts above, self- and affect regulation, Allan Schore (1994) has produced impressive scientific work on the neurobiology of regulation and dysregulation.

The specific neuropsychology and neurobiology of eating disorders is only in its childhood. There is fragmented knowledge of irregularities and dysfunctions, and therefore a need to develop conceptual models. For a review, see, for example Tchanturia, Campbell, Morris, and Treasure (2005). Tchanturia is a prominent researcher in describing deficiencies in cognitive and perceptual functions, see, for example Tchanturia, Morris, and Brecelj (2004), and Tchanturia, Serpell, Troop, and Treasure (2001). Of particular interest in the context of Hilde Bruch is new empirical studies on eating disorders that describe *theory of mind* (Tchanturia, Happé, et al., 2004), *reflective self-functioning* (Ward, Ramsay, Turnbull, Steele, Steele, & Treasure, 2001) and *reflective function* as a an operationalisation of the model on mentalisation (Fonagy et al., 1996). According to this model, mentalisation as the capacity to understand oneself and others is a key determinant of self-organisation and affect regulation, and is acquired in early attachment relationships. There is a growing body of neurological evidence for the importance of secure attachment for mentalizing capacity (Slade, Belsky, Aber, & Phelps, 1999; van Ijzendoorn, Moran, Belsky, Pederson, Bakermans-Kranenburg, & Kneppers, 2000).

The focus on attachment is congruent with Hilde Bruch's (1973) developmental model of impaired attunement between the innate needs of the child and the responses of the caregivers in the environment. In the terminology of contemporary developmental psychology and psychoanalysis, this could be described as *incongruent mirroring* (Gergely & Watson, 1996).

Conclusion

The ethos of Hilde Bruch's work on psychotherapy for anorexia nervosa and eating disorders is that interventions should be tailored directly to psychopathological processes. To follow such a motto, Bruch should be used today as an inspiration for a stronger focus on theory and conceptual models. And we need to look beyond the limited concept of cognitive dysfunctions. But where to search? Bruch had her background in clinical and theoretical work with schizophrenia. With

the notion of severe eating disorders as self-disorders, partly expressed as affective dysregulation, a highly relevant field of reciprocal fertilising today are personality disorders. The reference to common traits in psychological functioning in severe eating disorders and personality disorder, to search *transdiagnostically*, may contribute to concepts promoting such tailoring of psychotherapeutic interventions.

Disturbed self-organisation is partly based in genetics and biology, and partly based in milieu factors, with particular reference to attachment bonds. The therapeutic relation is also an attachment bond. Hence, with Hilde Bruch as a model, there is the inspiration for a stronger focus on therapeutic stance and the therapeutic relation as such.

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