A Concept of Self in EATING-DISORDERED Adolescent Girls

A Consideration of Genetic Factors

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Abstract

This article reviews some characteristics of anorexia and bulimia nervosa, as well as some widely held beliefs about the theoretical concepts of the self with particular reference to adolescent girls who struggle with self-starvation and compulsive bingeing and purging. A review of the literature suggests that as the knowledge base on infant psychology developed, evidence supported the idea that the infant was not the passive recipient of nurturing and drive reduction by the mother, but made an active contribution to the bonding process that greatly affected the child's subsequent development. A contemporary possibility is that the child is not only actively involved, but may be responding to internally driven biological factors that have little to do with the quality of the environment. A case is made for the fact that, despite "good enough" mothering, something can go awry in the maternal-child interaction process which is determined by genetic factors, resulting in a problematic influence on selfhood. Such biologically based disabilities, such as autism spectrum disorders, particularly Asperger's syndrome, may be associated with the emergence of an eating disorder in adolescence. Some guidelines for treatment are presented.

The alleged dramatic emergence of anorexia and bulimia nervosa in adolescence has been of compelling interest to researchers and clinicians and has led to theoretical and empirical analyses among all the mental-health disciplines. While there is consensus about the multi-factorial nature of these illnesses, the diversity of opinions about their etiology is widespread. This has led to speculation that the roots of eating-disorder disturbances are largely embedded in factors that long predate the onset of puberty and may be related to a dysfunction in the early mother-child relationship. This article lends some historical perspective to this traditionally held belief, accepting some inevitable sequelae of the maternal-child dyad but suggesting that despite adequate, even ideal mothering, certain personality and genetic factors hardwired into the child may lay the foundation for eating-disorder vulnerability in adolescence. Some guidelines for treatments that take these biological factors into account will be considered.

The first outpatient clinic designed exclusively for the physical and mental health care of adolescents was established at Boston Children's Hospital in 1951. Previously, the medical needs of young people between 12 and 21 years were incorporated into the practices of pediatricians, internists, and gynecologists. This last group gradually preempted maternal authority in the realm of educating girls about their bodily functions. Pubertal development, once marked by traditional adolescent rites of passage, no longer included introspective examination of the inner self of character and the "protective umbrella" offered by female mentors. Good works and preparation for the adult feminine role were replaced by an emphasis on good looks. Today, for example, instruction by elders about menstruation emphasizes sanitary protection rather than introduction into adult womanhood (Brumberg, 1997).

Against the backdrop of changing social and sexual mores, the generations of the 1950s and 1960s emerged as the largest group of adolescents in American history. Their issues became harder to ignore and too complex to be absorbed into other medical specialties. Since then, the practice of adolescent/young-adult medicine has flourished and is now, under the auspices of the Society for Adolescent Medicine, a fully fledged medical subspecialty devoted to the unique biological and psychological needs of adolescents.

A significant portion of these issues emanate from the predominantly female preoccupation with body shape and the desire for a strikingly slender, tubular form (Becker, 1995). The body, according to Brumberg (1997), is now the central personal project of American females and has become the ultimate expression of the self.

A plethora of research and literature continues to document the pursuit of an idealized, perfectly toned and molded body in Westernized societies (Becker, 1995). This, in turn, has led to an ongoing debate over the possible association between an intense preoccupation with dieting and body shape and the prevalence of eating disorders (Bruch, 1973; Brumberg, 1988). Some research suggests that it is both normal and socially adaptive for girls to diet, regardless of an objective or health-related need to lose weight (Bruch, 1978). Becker (1995) argues that "dieting and the cultivation of the body have evolved as legitimate social pursuits as well as lucrative industries" (p. 29). Nonetheless, whether the quest for a perfect body represents a cultural preference or a distinct psychopathology, most clinicians would

agree that consumerism, driven by the media and the evolving attitude that the body needs to be managed and manipulated rather than used as a means for improvement or identity, has resulted in growing numbers of adolescents with disordered eating (Brumberg, 1997). One is reminded by Kilbourne (2002) that the obsession with food and weight control that grips many American women not only supports a $60 billion diet industry, but sabotages women's health and self-esteem as well.

Adolescence is a time of explosive physical, intellectual, and emotional change and growth. Adolescence taxes stability in each of these areas, and challenges successful negotiation of developmental tasks by the teenager who, given sufficient protection and good fortune, can usually achieve them. It is a time fraught with choices that are replete with both danger and opportunity and that demand the best of the adolescent's inner resources, slowly evolved over time in tune with the maturation of the frontal cortex of the brain. Central among these internal states is the construction of an abstract notion of self. The developmental stages from incorporative to inter-individual, described by Kegan (1982) as "a helix of evolutionary truces" (p. 109), emerge in infancy and must be renegotiated during adolescence. This process is transformed into an essence of "self" which endures over the life cycle. But for the adolescent who has primarily genetic as well as environmental and psychosocial influences, the journey into and through adolescence holds considerable danger. The child's hardwiring may make at least an equal, and in some cases, dominant contribution toward a predisposition for disordered eating in adolescence. In fact, 50% of the incidence of anorexia nervosa may be genetic, according to Berrittini (2002). Although Berrittini stresses that increased vulnerability does not imply causation, he does suggest that there is a substantial hereditary risk for anorexia. By the same token, De Castro (2002) reiterates that heredity is the major determinant of weight, although it is tempered by such cultural factors as inactivity, palatability of food, and lifestyle. Similarly, the onset of eating disorders in adolescent girls may be rooted in genetic wiring rather than in a paucity of Winnicott's "good enough" mothering (1965), which is still the wisdom held true by some.

Historical Perspective

As the knowledge base has expanded, useful descriptions and diagnostic assumptions about eating disorders have been drawn. One example is a spectrum model that designated four categories of eating-disorder severity (Swift & Stern, 1982). This model estimated that half of young females in affluent industrialized societies had some transient preoccupations about weight and body image beginning in the adolescent years. Another 25%, the "identity-conflicted" or "restrained-eaters" group (Herman & Polivy, 1980) presented with similar but more troubling and persistent symptoms. The third (15%) and fourth (10%) groups, called by Lacey (1985) the "false self" and "borderline" eating-disordered patients, represented the most severe forms of these illnesses, necessitating and sometimes defying vigorous treatment intervention. This article focuses on the "false self" and "borderline" groups.

Lacey's (1985) "false self" concept draws from Winnicott's (1975) observations that deficits in the self emerged either as an adaptation to a lack of empathic encouragement from the primary caretaker, or as an unintended consequence of miscuing between mother and child. Such a disruption might go on to cause problems in introspective awareness, or inadequate consolidation of self-regulatory skills. Later, the adolescent eating-disordered girl might present with an undemanding, compliant personality that is sensitive to outer, but not inner, cues, since there is a lack of inner awareness. She might tend to be a "people pleaser" whose pseudo-maturity and psychic autonomy are part of the false facade. The therapeutic task was to make possible a discovery or restoration of the girl's selfhood.

The so-called "borderline" patients comprised the most seriously ill group and still do to this day. They perceive themselves as overwhelmed, always in danger, worthless, and unlovable. They see others as punitive, controlling, and harshly critical. Their fragmented sense of self and fragile ego boundaries often result in poor impulse control and a frantic search for external tension regulation. Behaviors that are exhibited in order to mitigate a sense of internal emptiness and despair cause these patients to be poly-symptomatic and extremely difficult to help.

These theories that inform the contemporary understanding of anorexia and bulimia nervosa have proliferated at a rapid pace; however, an extensive survey is not the aim of this article. The focus is to discuss some ideas about the self and its role in the possible emergence of disordered eating. This aspect of the eating-disorders knowledge base has also been considered by scholars in the field, particularly because interest in

early self-object relations was rekindled by advances in research on infant psychology (Kohut, 1971, 1977; Sameroff, 1975; Sheaffer, 1977; Stroufe, 1981; Call, Galenson, & Tyson, 1982; Basch, 1983; Stern, 1985). The subsequent and ongoing development of selfhood, especially feminine selfhood, is of particular interest to contemporary clinicians and researchers who recognize gender differences in self-differentiation within the context of relationships (Gilligan, 1982; Steiner-Adair, 1990).

Eating disorders are multi-factorial, but there are three examples of factors that may particularly predispose young people to develop anorexia or bulimia nervosa. These include socio-cultural forces, family problems, and individual vulnerability as a result of trauma or things that might have gone awry in the intricate early mother-child relationship.

Socio-cultural Forces

The present-day societal and culture-bound obsession to be thin, where food is plentiful but rejected, is both a result of and a protest against the cultural mandate that women must be beautiful in order to be valued (Pipher, 1994; Russell, 1986). Indeed, Bruch (1978) identified the "unrelenting pursuit of thinness" as a primary symptom of anorexia nervosa, and Steiner-Adair (1990) adds that the self-destructive dieting behavior so characteristic of this disorder is culturally supported. Steiner-Adair (1990) agrees with Wooley and Wooley (1980) that girls have been socialized at an early age to hate obesity and to have an internalized acceptance of a dangerously extreme standard for thinness.

But this illusory beauty can only be achieved by being thin, ideally thinner, and ultimately thinnest. Failure in this endeavor may lead to a mind-body dualism in which the anorectic person experiences her body as alien or even as an enemy (Bordo, 1993). The stereotypical concept that a slender female body is equated with social success, greater self-esteem and sexual appeal has been amplified by the mass media and has likely contributed greatly to the increase in anorexia and bulimia nervosa, although Hornbacher (1998) reminds us that this latter group of patients do not bear the stigmata of a skeletal body. The pain of the bulimic is more secret and guilt-ridden than that of anorectics, "whose whittled bodies are admired as the epitome of feminine beauty" (Hornbacher, p. 153).

Family Problems

Parents have been cast as central players in the dramatis personae of families whose dysfunction is believed to be a major causative factor in the illness of the "identified patient" (Bruch, 1973; Minuchin, Baker & Rosman, 1975; Kalucy, Crisp & Harding, 1977; Palazzoli, 1978; Crisp, 1980; Sours, 1980). More recently, there has been a retreat from this stance toward a growing consensus that family members are more accurately regarded as enabling rather than causing these disorders (Hsu, 1990). Evidence is lacking to confirm whether certain interactional patterns exist as a necessary precondition for emergence of an eating disorder, or if they evolve as a consequence of anorexia or bulimia. In either case, present thinking deems it essential to actively engage the family, respecting the importance of its members as collaborators in the treatment process and joining with them so that recovery is not undermined by old or newly surfaced conflict (Eliot, 1990; Hsu, 1990; Eliot & Baker, 2000).

Individual Vulnerability

The above discussion suggests that it may not be known precisely what eating disorders are. However, we can say something about what they might be about. They might be about control and communication of, and by, the self. These two directions of thought lead to ways of conceptualizing and treating anorexia and bulimia nervosa.

Geist (1985), a self-psychologist, applies this theory to long-term psychotherapy with eating-disordered patients. He believes that multidimensional theory, which is reflected in disparate treatment modalities, is less beneficial to patients than a unified framework. The framework he proposes is founded on the premise that anorexia is a form of self-pathology emanating from a chronic disturbance in the empathic connectedness between parent and child. The essence of therapy is to use the method of empathy to reconstitute a cohesive self. Others, including the present author, are more in concurrence with the part of this theory that addresses the cohesiveness of the self rather than defects in connectedness. Although there is acknowledgment that the disconnectedness or deficit in bonding is not necessarily corroborated by objective fact, but is informed by the subjective history of the patient's own perception of reality, Geist's implication points toward failures in parental mirroring and empathy. The false self of the compliant, sensitive child is silently accumulated and created over time because those specific parts valued by others, or that are perceived to be valued, are emphasized as special and worthy and are reinforced. These, however, may not be aspects of the self that are internally valued. The self object, therefore, is not of the child's own making and becomes less and less known or experienced. It is a creation of the external figures, to which the child must carefully attend in order to derive value and self-esteem.

Orbach (1986) provides an example that allows us to track the mismatched transmission of physical cues. A mother who relies greatly upon the bonding that the breast or bottle symbolizes may offer this means of comfort to the baby when the child actually seeks soothing in another form. Repeated misinterpretation of the child's internal cues may result in confusion between the physical and psychological states of being hungry and receiving other kinds of comfort and feelings of satisfaction. The thwarting of these cues within the child's evolving self develops into a heightened receptivity to search outside him or herself for information about hunger, satisfaction, and a general sense of well-being. The false self of the anorectic finally loses touch with the weakened or silent voice of the inner self.

Failure of the primary caretaker to understand and mirror the child's needs is one of the classical views of anorexia which has its roots in the not-so-distant past when mothers were felt to be responsible for this fundamental problem. At an International Psychoanalytic Congress held in Paris, Sours (1973) offered the following clinical vignette describing a patient.

> **The girl's early years are said to have been blissful and idyllic. The baby is remembered as healthy, chubby, pink cheeked, rather placid, accepting, and responsive to the mother's wishes. The baby's eating patterns were ideal. She was not anxious or tense and showed no anxiety at separation or with strangers ... the mother rarely recalls signs of the child's pushing away in terms of exploration and curiosity ... and none of the oppositional behavior and negativism so commonly seen in normal children 2-3 years old (p. 2).**

Sours went on to depict, "the best little girl in the world" (Levenkron, 1978) as she emerged into a full-blown adolescent anorectic. Drs. Mahler and Kramer, (Sours, 1973) as discussants of Sour's paper, presented ideas that have since been more fully developed in the field of infant psychology. Kramer cited Mahler's research and her own belief that too much emphasis had been placed on pathologic mothering and too little on the child's own contributions to the mother-child relationship, which might result in illness despite "good enough" mothering (Winnicott, 1965). She queried whether normal aggression could be truncated by an overbearing mother, or if, in fact, it could be an intra-psychic, experiential, or constitutional problem within the child that generated the dependency and compliance. This active, generative role of the infant suggested in the field of infant theory, especially the child's eagerness and ability to learn and its early readiness to attach and develop social awareness, was an exciting new concept proposed by object relationists. It radically changed previously held Freudian drive theory and oedipal-phase development to a much earlier stage, where wholeness of the human organism superseded structural splitting of the mind and body.

Winnicott (1965) differentiated between a true self and a false self. The former was defined as that part of the infant's psychic apparatus that felt internal and spontaneous and generated feelings of being alive and real; the latter, the socialized aspects of the self which were presented to the outside world, or that which the Greeks and later the Jungian analysts referred to as the persona. Winnicott felt that submergence of the self led to feelings of emptiness (primal hunger) and unreality. In keeping with prevailing analytic theory, he concurred that a split between the true and false selves was a result of the mother's failure to respond to the cues of the infant. What is of interest here is less that it is another example of responsibility placed upon the primary caretaker, or external life events beyond anyone's control, but

that it again calls attention to the innate capacity and need for active meaning-making on the part of the infant, seen now as a dynamic, initiating force rather than a passive receptacle of instinctual drives seeking tension-reduction (Hamilton, 1982). Kohut (1971, 1972, 1977) theorized that an empathic environment was necessary for the very survival of the infant in order to foster an internal psychic structure that could facilitate the establishment of narcissistic equilibrium. He was less inclined to emphasize the circular aspects of this empathic process than the unidirectional one; that is, Kohut spoke of the necessity for the mother to create such an environment through mirroring and responsiveness, but not of the necessity of the child to express his or her particular needs and the consequences of not being able to do so.

Miller (1979) also addressed the self in terms of the true or "authentic" part that is shunned by gifted youngsters in favor of the idealized false self. It is unclear whether she espoused a constitutional or an environmental etiology of self-development. At one point she states that therapeutic intervention must help the patient regain a long-lost authentic self in order to feel alive, but in the same piece she alludes to that which is "missing" in all of her patients who were seriously impaired in their ability to experience true feelings. This does not imply faulty parenting as much as it suggests parenting in less-than-optimal conditions.

The Concept of the Self and Its Relationship to Eating Disorders

Critiques of the theories that optimal infant development is solely associated with neutralizing instinctual drives, or that defective mothering is the primary causative agent in eating disorders, are germane to contemporary understanding of the self and its relationship to eating disorders, particularly anorexia nervosa. Regarding eating-disordered patients, Bruch (1973, 1979) spoke of the importance of responding to physical and emotional cues originating in the child, which were just as essential as stimulation from the environment. She felt that a paucity of confirmation of child-initiated gestures and emotions often led to fundamental difficulties in articulating inner states (alexthymia), which she had observed in her anorectic adolescent patients. These problems may have developed from maternal misinterpretation of the child's internal cues (Orbach, 1986) or the child's inability to discover or refine signals that deliver a successful message to the mother.

Reflecting upon these authors, as well as other theorists who have dealt with this subject, this author suggests that it is not necessarily poor bonding between the child and its mother, or something inherently defective within the cybernetic reframing of the interaction between the two, but instead poor bonding of the child with its own self due to some fundamental and inherent genetic alteration in self-definition and expression. As hinted by Kramer (1973), and substantiated by Berrettini (2002), this might represent not a paucity of maternal response to cues emanating from the child, but a constitutional deficiency within the inner realm of the child which makes it difficult to organize cues into an expressible form on any level. It is this psychic state which silently accumulates and is eventually manifested through deviant and maladaptive efforts to establish control and communication with one's self and ultimately with others, usually at critical junctures during the course of the life cycle. The failure in "mirroring" emanates from the self of the child, rather than from failure of the mothering figure to respond accurately to the feelings, needs, and desires that are held by the child. This seems to be because the child cannot give the necessary cues in sufficient quality or intensity for the maternal figure to accurately decode. For the mother, this feels like a rejection of empathic reaching-out. Henceforth, as with most repeated rejections and miscues, the gulf widens and becomes filled with feelings of alienation, loneliness, and even the rage to which Klein (1975) alludes, where there is a desire to have needs met that are not or cannot be met. These affective states are bound together with a brittle rigidity that puts the individual at risk for fragmentation of the self. The panic that this arouses stimulates the defensive postures of anorectic behavior or the attempts of the bulimic to regulate inner tension.

Anorexia, then, as characterized by Goodsitt (1985), is a disorder of the self and of selfhood. It is also about control and communication. But one cannot communicate that which does not exist or exists in a biologically maladaptive way. The self must be developed, discovered, and regulated in satisfying ways so that its essence can be communicated when its bearer is ready and able to share this selfhood with the external world. An example of a disorder that impairs this ability is Asperger's syndrome. This is a neurological disorder named for a Viennese pediatrician, Hans Asperger, who authored a paper on the subject in 1944 (Bashe & Kirby, 2001). It is characterized by problems in social interaction, communication, and imagination, accompanied by a narrow, rigidly repetitive pattern of activities (Wing, 1998). It

is unlikely that anyone familiar with the isolation, verbal taciturness, and obsessive behaviors of an eating-disordered girl who may have metaphorically lost her voice at the onset of puberty (Gilligan & Brown, 1992) will not recognize similarities between anorexia nervosa in its more severe form and Asperger's syndrome. The DSM-IV-TR (2000) definition of Asperger's syndrome includes impairment in social interaction and isolation from peers, and restrictive and repetitive patterns of behavior, interests, and activities. However, there is no great delay in cognitive development.

The concept of a self which is constitutionally fragile, or at least at war with and a stranger to itself and struggling for rapprochement, gives no ready answers, but does provide a framework from which to consider the psychological treatment which must go hand-in-hand with medical management and whatever other kinds of treatment modalities one selects. The patient's attempts to search for, defend, and come to peace with her tenuous self-cohesion form the cornerstone of recovery, and the therapeutic space becomes an arena that potentially facilitates or undermines the emergence of the anorectic patient's self-structure (Geist, 1985). The goal of the therapeutic work is for the young female to develop a sense of self through attunement to psychic, physical, and social self-experience (Reindl, 2001).

The Therapeutic Space and the Treatment Process

What goes on in the "safe place" (Havens, 1989), the therapeutic space where healing can begin? The subtle, almost inscrutable nature of the therapy process makes it perennially difficult to convey to others, even to other therapists. Yet there are some demystifying guidelines with reference to the treatment of people with anorexia and bulimia nervosa that can be outlined.

It is a new kind of relationship. The need to build a new personality after so many years of stressed existence requires new rules which did not apply in the traditional definition of psychotherapy, where people sought help because various feelings, cognitions, and behaviors had become troublesome to themselves or their significant others. This is less of a factor among bulimics, because their behavior is more ego-dystonic than that of the rigidly defended restricting anorectic. But denial is pervasive within this group in the same insidious way as it is among other patients suffering from addictive disorders. The desire for change does not come from within as much as from without, from the person's family, friends, and employers. People with bulimia are inclined in the same way as substance abusers to minimize the extent of their problem and to externalize its causes.

"These patients resist treatment because they genuinely feel they have found a perfect strategy, a compromise-formation, if you will, to express their need for rebellion and accommodation in a spectacular way. What is seen by the therapist as a problem to solve is perceived by the patient as a solution to be cherished."

The adolescent with anorexia nervosa comes prepared to fight, although her experience with superficial compliance and middle-class mores may mask this in a cloak of cold courtesy. These patients resist treatment because they genuinely feel they have found a perfect strategy, a compromise-formation, if you will, to express their need for rebellion and accommodation in a spectacular way. What is seen by the therapist as a problem to solve is perceived by the patient as a solution to be cherished. Any attempts to change this will be perceived as an attack against the integrity of the self (Kohut, 1977). Resistance is reinforced by the fear of self-fragmentation. This helps explain the extraordinary diversion of energy that the person with anorexia devotes toward the maintenance of her behavioral structure, just as someone with Asperger's syndrome clings tenaciously to special, even bizarre interests concerning objects, persons, events, or abstract concepts (Bashe & Kirby, 2001). Avoidance of food, excessive exercise, obsessive-compulsive behavior, a dichotomous attitude, and so forth all serve to keep the tension attached to the image of thinness containable. The delusion must be maintained in order to provide sufficient motivation for the continuation of unnatural behaviors. It is essential that the therapist convey the sense that the patient's feelings are respected and will not to be dismissed as bizarre, but are part of the problem that needs to be worked out together. Freud expected his patients to be equal partners with him in the treatment process in order to make sense of their feelings and symptoms (Basch, 1983). In work with both anorectics and those with biologically determined disorders, this involves empathy; that is, the capacity to position oneself inside the other person's psychic reality (Schwaber, 1979). It goes beyond, and should not be confused with, the other basic ingredients necessary for establishing a "good enough" therapeutic relationship (Winnicott, 1971).

It should be clarified as soon as possible that the patient's thinness or preoccupation with food as a way of answering needs besides those of biological hunger is a metaphor for other doubts about the self. The grandiosity associated with the illusory ability to remain emaciated in the midst of unlimited amounts of food is an attempt to compensate for inner inadequacy and the need for self-sacrifice (Chernin, 1985; Orbach, 1986). Most of all, what occurs in anorexia nervosa is the "excruciating spectacle of women actually transform-

ing their bodies in an attempt to deal with the contradictory requirements of their role in the late twentieth-century" (Orbach, 1986, p. 24). These requirements are voluminously explicated in contemporary feminist literature, and suggest the deep conflict between autonomy demands and attachment needs (Gilligan, 1982; Steiner-Adair, 1984).

In the role of external ego, the therapist must be prepared to take over when the patient's inner resources are not sufficient to keep her alive and safe. This may sound contradictory to the principle of preserving the anorectic's integrity of self. But it does, in fact, represent survival and conveys the central nature of the problem; that is, that one is faced with basic deficits in the self, not merely distortions and defenses that can be analyzed. An alliance is formed by freeing the patient from having to try to fill these defects by herself, because she can learn to rely upon external support systems (Goodsitt, 1985).

Neither starvation nor daredevil, impulse-ridden behavior is compatible with life. The therapist must assist the reality-testing and management techniques deployed by the patient's family and enter into discussions about the cause and effect of such actions. The wish to remain emaciated and get well, to be invisible and be noticed, reflects an impossible ambivalence that must be confronted with sensitivity, clinical understanding, and proper timing, but it must be confronted.

The "emptiness" that the eating-disordered person brings to the therapeutic space is real for all the reasons discussed above and does not constitute resistance. An important milestone in the therapeutic process is conveying that it is "Ok to have nothing to say" (Levenkron, 1983). This implies a tolerance for silence on both sides. Eliciting authentic thoughts requires a "constructive use of ignorance" (Bruch, 1985). These young women simply do not have a language for talking about themselves (Levenkron, 1983), precisely because there is an inherent deficit in affective expression and understanding of core experience. Similarly, Bashe and Kirby (2001) note that children and adolescents with Asperger's syndrome lack the innate capacity to understand that other people can have ideas and feelings that are different from their own. Their "mind blindness" is not lack of emotional empathy, but rather a lack of the ability to express it appropriately. This awareness is of great help in resolving counter-transferential feelings of frustration and anger. Pressure for expression of affect and insight in order to fill the silence or please the therapist can result in intellectualization and oppositional gamesmanship that will not facilitate recovery in these challenging patients.

Conclusion

The treatment of disordered eating involves discovering, listening to, and really hearing the voices of the inner self, which may not have found expression before, or may have become derailed by genetic abnormalities. This concept must include the conviction that the human organism has tremendous plasticity and actively participates in its own growth and healing. Despite obstacles, and given a favorable environment, the young person can engage in attempts to organize and structure her world. The infant is endowed with a host of abilities, which, according to Kegan (1982), are designed to seductively beguile and win-over the mother. The case made in this article is in agreement with Kegan's thesis that when something goes awry in the attachment process, it may be that the baby lacks the "sending power" or "hooking ability" to accomplish this monumental but necessary task. Contemporary contributions to the proverbial nature-versus-nurture controversy are the beneficiaries of earlier scholarly wisdom and recent technological advances in medicine, physiology, and psychology, such as magnetic resonance imaging. The critical evolutionary process is not only part of Kegan's "embeddedness culture," but is also rooted in the mutual interactions, more infant-initiated and biologically determined than previously thought. The process continues along the life cycle through childhood, adolescence, and maturing adulthood: a true life's work in progress between and among individuals whose lives touch upon each other and interweave in poignant, infinitely varied, and creative ways.

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