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BODY IMAGE OF MALES WITH EATING DISORDERS. A CASE STUDY[1]

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Summary

A closer look into the psychodynamic understanding and treating of the eating disorders of men in the hospital ward environment. Brief discussion of selected publications pertaining to the differences in the course of eating disorders between women and men.

Case description. On the basis of the available documentation, medical interviews, summaries of the patients' illnesses, records of individual psychotherapy sessions, therapeutic process supervisions and reconstructions of the patients functioning in the therapeutic institution department, the authors provide a more detailed discussion of treatment in a form of 2 continuous hospitalisations lasting several months in the Eating Disorder Subdepartment of the Adult Psychiatry Clinic. With a particular emphasis on the phenomena occurring during intensive individual psychotherapy received by the patient while staying in the clinica.

Results: etiopathologic and diagnostic hypotheses concerning the development of the psychopathologic syndrome. Description of selected aspects of unconscious dynamics of the time-limited complex treatment in the clinical department.

On the basis of the case analysis and in connection with the modern theories describing the therapeutic relation, certain assumptions were formulated which might help in organizing other centers where adult men with symptoms from the eating disorder spectrum could undertake treatment adapted to their needs. An attempt was made to formulate some hypotheses about the differences and similarities between men and women with severe symptoms of eating disorders, with respect to the course of their condition and treatment.

1. Introduction

There is currently an increase in the incidence of eating disorders, which pose a serious problem. It is assumed that 8-9% of the general population suffers from anorexia or bulimia [1]. Primarily women suffer from these diseases. The ratio of the number of women to the number of men with this disorder is approximately 10 to 1 [1]. Because of this, in the

[1] The author would like to thank his co-workers and interns of the Psychodynamic Psychiatry Department for their assistance in collecting data about the patient and the management team of the Krakow Psychodynamic Centre for facilitating access to the subject literature he was using.

subject literature the diagnosis and clinical characteristics of females are described, the models of their development are analysed, and also mostly cases of women suffering from the two basic forms of eating disorders are investigated. In the psychiatry textbook, which was published in 2016, and edited by Marek Jarema, in the chapter on eating disorders all latest reports describing the role of neuropeptides inhibiting and stimulating appetite as well as the meaning of the part of the brain which is called nutrostat and is responsible for the regulation of the feeling of hunger and satiety, are based on the study of young women. Similarly, while discussing factors other than biological, the influence of social and cultural factors on the way of experiencing one's body and silhouette is analysed on the example of women [1].

In *Treating of Eating Disorders*, in the chapter devoted to eating disorders in males, Douglas W. Bunnell refers to basic differences in the brain structure, distinct biological conditions and the course of mental development of the two sexes, and briefly describes the specificity of the clinical picture of eating disorders in males. One of the characteristic aspects of these differences is a distinct process of frontal cortex and limbic areas of temporal lobes maturation in males [2]. In this work Bunnell also focuses on the fact that both restrictive and bulimic symptoms are more harmful to the somatic state of males, simultaneously, emphasising the need of more decisive actions aiming to regaining correct body weight and normalisation of the eating behaviours [2].

What is noticeable is lack of reports, research and case reports explaining the subject matter and the specificity of eating disorders in males, and providing a more in-depth knowledge on their treatment. A brief review of the latest reports and articles on this subject reveals a similar proportion to the one describing the way in which the groups of symptoms occurring in females and males are laid out. For example, out of 60 articles on diverse subject matter connected to the entry of eating disorders in PubMed database 5 focus on males.

To fill the gap, which has been mentioned in numerous scientific publications and discussions among psychotherapists, in this article I have analysed the course of an illness and treatment of a young male with intensified clinical symptoms of anorexia, who was treated in a stationary ward, as a case study.

The case study includes data from an interview, disease history, the course of hospitalisation and therapy. The data has been processed in such a way that prospective recognition is impossible.

2. Case study

W., a 21-year-old patient, started slimming down about three years before his first hospitalisation. At that time, he weighed 90 kg, which with the height of 1.80 m gave the BMI of 27.5, a state described as obesity. The patient started to reduce the caloricity of meals and provoke vomiting. In about two years, he reduced his body weight by 46 kg, to 44.200 kg, which amounted to the BMI of 13.8. Before his admission to the ward, the patient had been hospitalised in an internal medicine ward due to two episodes of collapse. He had been discharged on his own request before the diagnostics was finished. He was almost uncritical towards the symptoms of the disease and the severity of his condition.

Biographical data

The patient had a sister older by four years, who had got married not so long before he was admitted to the ward. He used to say that he always had a close relationship with her. Already during the introductory interview, he disclosed that they had an alliance: if one of them died, she or he would take the other with her or him. W's parents graduated from vocational schools. His mother stopped working when he was 5 years old due to his illness. He suffered from underweight, at night apnoea occurred, and there was a suspicion of asthma. As a result of steroids therapy he started to put on weight. At that time, his father used to spend long periods abroad where he worked for many years. The patient recalls being mocked, maliciously laughed at and ridiculed by his peers in primary school. The motivation for their behaviour was patient's appearance, i.e. his visible overweight and little physical agility.

The beginning of the disease is chronologically connected with an overlap of several crucial events from patient's life. They are arranged in line with the order in which he related them. The first conscious impulse for slimming down was connected with gynecomastia. The patient spoke about terror and shame at the thought of how his peers would have reacted. Secondly, for the first time in his life the patient engaged into a relationship with a woman. It happened shortly after his closest friend, described as the best friend, fell in love with a girl. At that point W. started to meet her friend, as he told me, in order not to feel worse. Their relationship ended soon. The patient attributed it to his appearance, and assumed that the girl parted with him because he was too fat. More or less at that point in time he started to restrict eating drastically. He used an Internet website featuring nutritional values of products and he controlled them. He believed that the data concerning the serving size of 100 grams applied to the caloricity of one unit of a product. His weight started to drop rapidly. A couple of months later his sister met a boyfriend, got married and become pregnant. The patient was the first to found out, when he saw a positive pregnancy test result.

In a very close time, two events, which had an immense influence on the emotional state of the patient, took place. His friend told him that the girl he had been meeting was pregnant with another man. Almost at the same time it turned out that his sister had a miscarriage. The patient was present when it happened and called the ambulance. He made a comment that his illness killed the unborn child, because very often miscarriage is caused by stress.

After these events, the symptoms of the disease worsened drastically and the man started to abuse alcohol. The atmosphere at home became stifling and his parents were helpless. W. was forced to treatment when he experienced circulatory collapse for the first time. Shortly after he regained consciousness, he was discharged from the internal medicine ward on his request after one night of hospitalisation. He began the treatment under the influence of his parents, who intended to incapacitate him and treat him against his will.

Treatment

The patient came to the ward and was qualified for treatment. He stayed there from February to June. During hospitalisation he participated in individual therapy supervised by a male physician on an internship – a student of the second year of psychotherapy course. He was also a participant of the therapeutic group in the ward, where 90-minute sessions took

place thrice a week and were led by a female therapist with a certificate of a psychotherapist of the Polish Psychiatric Association. What stands out in the notes from the session is patient's significant verbal activity showing his deep fear of being reliant on a man. W. was alternately active aggressive or very submissive, even seductive. The male therapist had an impression that he wants to endear himself. Over the course of therapy, the patient was involved in an incident resembling a psychotic episode, when he convincingly accused the medical personnel who provided him with the information on his loss of weight of plotting with the therapist in order to test his strength. From the present perspective, i.e. after the end of therapy, it is very interesting that the therapist was convinced that patient's IQ level was not very high or even within the norm. At the same time, the patient displayed acute, deep anxiety, which could be noticed on the symptomatic plane. It was manifested in both a very concrete and symbolic way: patient's weight stopped on the level slightly below the BMI of 16, which in his case translated into a very significant amount of 50 kg. The BMI index which equals to 16 is also the borderline between the first and second stage of the treatment (one of the most important in the behavioural program logics). During the first stage it is impossible to obtain passes, and during the second, there is such a possibility. The second stage of the program enables also family visits in hospital. On the weekly clinical meeting, where the course of treatment of respective patients is discussed, with the elements of supervisory discussion, it was decided that the functioning of the therapist must be modified, and it should take the direction of more confronting interventions also with an aim of diagnosing the status and value of the alleged intellectual limitations of the patient. A couple of weeks afterwards, the patient was discharged on his own request, despite numerous cases of talks, persuasion and comments on the destructive character of his decision. At the moment of the discharge, his weight amounted to 52 kg, i.e. the BMI of 16.2.

After three months, the patient, in a state of severe emotional tension, called the ward and in tears confessed that he led himself to devastation again. He disclosed that he had experienced collapses and had been hospitalised in a neurological ward, where he had been diagnosed with an acquired epilepsy. He asked, or even begged, for a possibility of readmission to the ward. There we had a discussion in a therapeutic team and decided to hospitalise W.

The patient was readmitted after three and a half months from his discharge. He weighed 42.200, and his BMI index equalled 13.2 and was lower than the one from the beginning of the first hospitalisation. At that time, he lost 10 kg. After the admission, the symptoms of extreme cachexia, lanugo, ischaemia of lower limbs and mottled skin could be noticed. Before the admission, he had had a biweekly episode of binge drinking (he would drink several bottles of beer a day). In the second day of the hospitalisation he had two episodes of collapse and a very brief cardiac arrest. As a result of a 2-minute advanced cardiac life support, the patient regained his vital functions. At that time, he suffered from head and left knee injuries and was transferred to the internal medicine clinic for the sake of vital parameters stabilisation. After a short-term stay in the internal medicine ward, he renewed therapy. He was hospitalised for four months and it is not the only similarity between his former stay at hospital and the one that is discussed currently. Again, there was a change in the somatic state of the patient: initially quite quick gain of weight, and then its losses and fluctuation. Eventually, for the last 8 weeks during the weekly summary of the average body

weights, there were measures of about 50 kg, i.e. similar to those during his first hospitalisation. Over the course of four months the patient increased his weight by 8 kg.

During the first three months of his stay in the ward, the patient remained in therapeutic contact with an experienced therapist twice a week. She was a psychologist on an internship, and a graduate of a course on psychodynamic psychotherapy. Once a week, during a supervisory meeting she discussed the course of therapy with me. After she finished the internship, the patient kept attending the therapeutic group in the ward, and also art therapy group. He also started therapeutic meetings with me. In the last month of his stay, when his weight gain stopped, just like during his last stay in hospital. Thereby, the patient stopped fulfilling one of the conditions of the contract, namely, the obligatory gain of 0.5 kg a week. During a weekly clinical meeting the therapeutic team created an individualised contract for him. The modification consisted in a threat of being discharged from the ward in the case of no further growth of body weight. After having introduced this condition, the patient started to struggle with the ward more and more. During individual and group sessions he described problems connected with both the current situation on the ward and the relationship with his sister and mother. The figure of his father was not spontaneously mentioned in the therapeutic dialogue, despite the fact, that it was his father who was by his side when the patient had been admitted to the ward twice. In his daily conduct, the patient seemed conforming to the external requirements of the contract: he would come for meals and eat them up (the total nutritional value of the meals amounted to 2.5-3k calories). His BMI index fluctuated between 15.2 and 15.5 during these two months.

The patient presumably transposed the entire threat connected with being better-nourished and physically stronger and, as a result, capable of experiencing impulses and desires, on the ward. In the two next weeks of his hospitalisation, the therapeutic team started to be more and more convinced that patient's further stay in hospital was not beneficial to him, and then, he was discharged upon their decision. The patient consciously experienced the discharge as being unfairly ejected and a way of countering his plans. It turned out he had an intension of being discharged on his request three weeks later. He was planning to resume his university education, which he had started a year before. He was supposed to be the one who had been rejecting, and not subconsciously repeating the pattern of being the rejected one by an object which he cherished. Three weeks later he called the ward, asking for a possibility of continuing therapy in outpatient care conditions, however, he heard that he would have to meet the condition of maintaining his weight from the moment of discharge. However, he had not fulfilled it, and I had not heard from him for a couple of years. After about three years, W. called me to tell me that he passed his driving licence exam, became a BA and maintained a safe body weight. After two more years, he unexpectedly knocked at the door of my office. He just popped in to tell me that he had just graduated and was now a MA. His appearance did not show any symptoms of gauntness.

3. Thoughts and conclusions

Etiology of the patient's eating disorder

Most probably, the primary cause of symptoms of the disease lie in the past of the patient. In the period when, in accord with the psychoanalytical concept, the bodily self is shaped. This process is described by such authors as Frosch, Lichtenberd, Mahler and McDevitt as well as Merleau-Ponty [3]. Hoffer, Sendler and Rosenblatt emphasise the importance of the ability of perceiving and being perceived simultaneously [after: 4]. This ability uncovers two sensations of the same value, and leads to a distinction between self and not-self, between body and what becomes the environment, the surroundings. Such an approach would suggest an occurrence and temporary domination of defensive mechanisms described as psychotic. Both the clinical episode of symptoms which had a character of ethereal delusions as well as temporary behaviour of the patient when he had just regained his consciousness carried connotations with a very strong, almost psychotic loss of contact with the reality. Also the way of treating one's body, associated with extrapsychicintracorporeal projection, suggests that the patient was using the mechanism of psychotic projection for defence. And even the behaviour of the patient during the session, revealing contradictory aspects of his ego, based on the split of the session, confirm the hypothesis on the existence of lack of sufficient separation of the representation of self from the representation of object. Brytek-Matera in her studies describes this phenomenon from the perspective of cognitive difficulties of identifying own emotions [5]. Bąk puts forward similar hypotheses of coexistence of eating disorders with oral features of character [6]. Asthma, following psychopathological mechanisms described by Katarzyna Schier, reveals a deathly fear of breath, taking in the air as a synonym for autonomous life, a separation from the maternal object. The author suggests directly that there is a similarity in the area of psychological mechanisms conditioning the emergence of anorexia and asthma [7]. It is possible thatthe medications inhibiting activation of inflammatory processes and contraction of the smooth muscles of lower respiratory tract caused the activation of other psychosomatic mechanisms. The patient had been overweight since early childhood and it was possibly the result of iatrogenesis. The phenomenon of realistic overweight or pathological obesity, according to our observations on a group of males treated on the ward, very often precedes the occurrence of strengthened symptoms of anorexia. Initially, for a very short period of time, patient's slimming down was partially pro-health, beneficial from the medical point of view, because he fought his pathological obesity. However, the way in which he was losing subsequent kilograms, namely, the pace, as well as the nature and mode of slimming down, were not that beneficial. Namely, extremely rigorous limitation of meals and fast catabolism, which on the pathophysiological level could also contribute, through ketonaemia, to the toxic state of specific stupor, i.e. a state of partially distorted consciousness and clarity of mind with lowered criticism. Positive reactions on the part of family and peers (finally achieved or regained narcissistic reflection) could be a very strong reinforcement of own self-esteem based on the feeling of effectualness and efficient control of one's body, contrary to earlier, traumatic experiences of loss of control over the breath. The beginning of pathological slimming down could be connected with an entire range of subconscious tendencies, factors,

motives and impulses, overlapping in a longer period of time, and through synergistic reinforcement, leading to setting vicious circle into motion, which revealed itself in the form of utter devastation.

The set of symptoms which consisted in: 1) considerable limitation of nutritional value of meals, 2) periodic binge eating and then provoking vomiting, 3) episodes of alcohol abuse were most probably a pathological effort of the patient to neutralise his high level of anxiety resulting from at least two areas of conflict: 1) Separation anxiety formulated by immature or pathologically shaped personality with an unfinished period of adolescence, 2) fears of the Oedipal stage

The primal source of an increased anxiety level could be the dysfunction of early childhood development in the stage of second approaching of the separation-individuation process, which earlier on had been neutralised by psychosomatic solutions and using food consumption as a way of calming oneself. In subsequent stages of development these ways were no longer enough. It could be connected both with the requirements of biological development in the adolescence period as well as specific events from W.'s life, preceding the beginning of slimming down and reinforcing eating symptomatology.

I shall enumerate them in order, emphasising, at the same time, that it is impossible to indicate the factor which was crucial or decisive, because they were all interconnected. It seems unachievable to recreate the complete image of complicated interconnections and, out of necessity, I shall limit myself to the creation of a brief list of these aspects of illness, which I managed to reconstruct during both hospitalisations of the patient.

1. The relationship with patient's sister: emotions connected with a very strong relationship which demonstrate associations with incest. What seems a crucial moment is when the sister of the patient entered into a relationship with a man. W. recounted this event as an experience of traumatic abandonment by the most important person in his life, and in a way, a betrayal. He indiscriminately repeated that family is most important and all of its members should be together. It sounded(it still does) desperately and terrifyingly, because it is filled with masked hostility and contradicts any sense of autonomy.
2. The parting with a close friend, who entered into a relationship with a girlfriend. The experience of another abandonment by two important people. Possibly the patient was deprived of self-objects, which were specific to him at that time, and as a consequence he lost cohesion and integrity. From another alternative perspective, he was bereaved of "substitute parental couple". With the two of them W. remained in a relationship resembling Oedipal triangle. The relationship of the patient with his friend showed associations with an activation of unconscious desires and fears of homoerotic nature.
3. Attempts of initiation and engaging with a woman other than his mother or sister, i.e. the intensification of separation and castration anxiety simultaneously.
4. Traumatic and dramatic situation of his sister's pregnancy and miscarriage, triggering unconscious guilt as a derivative of the expression of castration anxiety for an imaginary, unconscious, fulfilled relationship with a forbidden woman. Possibly he could also felt guilt for the unconscious fantasies of aggressive content towards the unborn child. The guilt, which partially entered theawareness of the patient was expressed in his words.

5. Activation of a partially conscious guilt as a reaction to his feelings towards parents, which were filled with anger, wrath and injustice for loneliness which was a result of constant quarrels between them, taking care of the home and themselves. The illustration of the very specific recreation, in relation to the relocation ward, of the relationship with parents was an increase in negative therapeutic reactions over the course of treatment. A huge improvement at the beginning of his hospitalisation and stabilisation of the body weight on the pathological level of significant underweight.

6. The long-term factor which was present in the preadolescent period was the frequent, extended absence of the father. The consequences of this absence could be metaphorically formulated as leaving the patient in symbolic and literal embraces of women, mostly his mother, sister and grandmother.

7. Cultural factors specific for the development of boys, who were bullied and mortified by their peers, is that they learn to avoid dependence and lose the ability to engage into interpersonal relationships and maintain them [2].

8. Approaching secondary school final examinations, which provide the perspective of adulthood, perceived by W. as threatening.

The aforementioned hypotheses formulate the multifactorial concept of emergence and rapid development of restrictive symptoms in the patient in an approximated way. A part of them seems to indicate similarities to symptoms displayed by women, however, another part is more specific for males, and yet another part is connected with the individual life story of the patient.

Selected phenomena during the course of treatment in the ward

The patient was treated in the ward in a complex way, which involved elements of behavioural interactions and psychotherapy based on psychodynamic paradigm. Behavioural treatment programme (contract, being watched during meals, enhancing the gain of body weight) represents a symbolic paternal function, described by such characteristics, as well as a system of rules and specific consequences if the rules are not obeyed. Therapeutic relationship, due to its properties, symbolises a maternal role: understanding, "containing" and reshaping the "beta elements into alpha elements" in the patient, thinking in Bion's terms [8], creating an intermediary space, as Winnicott would say [9].

What is the way in which we can we understand the difference between the image of intellectual functioning of the patient in contact with the first therapist and the impression that the patient created during his second hospitalisation? First of all, in the ward we often see a connection between the behaviour which seems very infantile on the one hand, and the degree of utter cachexia (below the BMI index of 12 in women and 14 in men) on the other, and the level of intellectual functioning, which sometimes holds associations with the bordering on the level of norm. Therefore, it seems justified that in states of cachexia, the brain, possibly the specific cortex areas, is also subject to a temporary damage. It may be visible both in the psychotic psychopathology (at that point understood as having partially somatic conditioning), as well as in the aspect of intellectual functioning. Such conclusions are proven by brain neuroimaging examinations in the states of significant cachexia. It should be pointed

out at once that in the reception of the female therapist who treated the patient during his second hospitalisation, he appeared as a very intelligent man, also in the period when he remained in the state of extreme devastation.

Another hypothesis which can shed some light on the background of the described phenomenon is a presumption that the therapist processed a deeply unconscious, countertransferential hostility, which may have appeared in his mentality through the work of the mechanism of projective identification. The deeper the level of pathology in terms of personality the patient presents, the more intensely this mechanism appears [10]. The processing of the unconscious hostility would involve a strong tendency of the therapist to interpret the periods of massive resilience of the patient, which is expressed in the form of silence or a specific way of talking, words selection as a derivative of low levels of cognition and not as an expression of defensive hostility and fear in a situation of emotional dependence on a man. On the basis of supervisory meetings, the therapeutic process supervised by the female therapist, emerges an image of a very intelligent patient, which, nevertheless, is deeply unsettled in terms of personality – whose personality is organised in a way strongly resembling the one described by Otto Kernberg and commonly known as borderline personality organisation with changeable, alternately appearing conflicting identifications of ego [11], with an active inclusion of the therapist through her identification with an aggressor in a role play of seducing and seduced boy. Over the course of our supervisory discussions it turned out that the sessions were often very difficult for the therapist, as the patient was seducing in order to destroy and abandon in the act of unconscious revenge for the initial abandonment. An unfavourable situation connected partially with a lengthening hospitalisation was an experience of the end of another relationship with someone whom he found important, i.e. his therapist, who ended a three-month internship in the ward. W. still participated in group therapy there, and also in art therapy group and started therapeutic meetings with me.

Now I shall present a brief scheme of the course of individual sessions, which were repetitive, we may even dare say ritualistic. They were organised in such a way that the patient tended to speak in a voice trembling with tension incessantly for 30 minutes or so. Listening to what he was saying and the way in which he spoke, I had an impression that he was neutralising the tension. It can be said that he was separating from it in a symbolic way, simultaneously, trying to create a distance between me and himself and to contradict the existence of an emotional link (which emerged at the moment of initiation of the direct contact). It is possible that he was denying his desires, which created this subconscious link. Maybe he was protecting himself from creating a new bond with another therapist, which would entail an inevitable experience of another loss. And at the same time, on a much superficial level, he talked about how healthy he was. It was true that he still had minor problems, but one could not achieve everything at once. In the further part of his soliloquy he told me that he had already understood everything and former therapy seemed worthless to him. The new one was completely different. It was, as I thought, as if he was saying at the same time that: “See and appreciate what a good patient, son and partner I am”. And by means of the same words: “Feel how much I don’t need you, that you have nothing to offer me. Just seat there, listen and feel helpless”. My comments, in which I tried to show him the outlines of what I had described just a moment before, were encountered with quite rapid

verbal attacks, massive denial and desperate defence of the status quo. It is the one of his utterances that stands out in my memory. He expressed it about the second month of our meetings. He said it in a loud voice, filled with tension, bearing the mark of wrath and fear: "No! The disease is not the part of me!". He reacted in such a way when I told him that his self-destructive impulses could result from the fact that he had been punishing himself for his desires, not allowing them to be heard. It could have seemed that due to its general character, the comment was not a very threatening one. But then I understood what massive fear and successive attack on himself, his thinking and rationality was hidden in the reaction of the patient. Most probably he reacted in such a way to even smallest signal or announcement or emergence of desires in his consciousness or emotions which would be expressed in the presence of another man. It may be because they were directed towards that man or because he was afraid that they may have been directed to him. What appeared to me then was Fairbarn's concept of antilibidinal object and persecuting and rejecting ego [12]. I had an impression that this concept described this phenomenon quite accurate way. A hostile attack of the rejecting ego on any pleasant excitement in its second part. Maybe for that reason the patient had to deny, with such a wrath, underlain with fear, that he had such a cruel, sadistic part in him. And in my mind I connected the reasons why W. maintained his body in the state of cachexia. It was because only in such a state his body, yoked by physical weakness, was unable to generate, create and combine desires, impulses and passions, and the patient remained the "tormentor and victim" for himself. Many publications emphasise the importance of cachexia in the context of the lowering of the level of testosterone and the way it affects loss of sexual interests [2]. When I was listening to W., I had an overpowering impression that he had no awareness of himself. He was unable to tell me in an understandable and clear way how he was feeling or why he had started binge eating or he kept losing weight. In the literature on that subject the importance of "lack of introceptive awareness" is emphasised [13] as well as the connection between this deficit and the development of addiction [13]. Because if you say something, it means that you cut this thing out. You separate it from the remaining part, and show, where its semantic, aural and emotional borders are located. Because through the tone of voice, sonority, resonance and emotional modulation you express the crucial aspects of what in the psychology of self and attachment theory with the object is described as bodily self. The patient displayed extremely strong level of fear and shame of revealing his thoughts and emotions, which is hard to explain only as the cultural proofs of learning in men, which is described by Bunnell [2]. When I was searching for theoretical descriptions of therapeutic relationships that would encompass the character and meaning of the aforementioned situation of emotional exchange between me and the patient in literature, what seemed especially useful for me was the concept of "words which were touching the patient". Danielle Quinodoz, evoked in the position edited by Cierpiałkowska, writes about a problem with which contemporary analytics are confronted, namely, treating patients with disorders consisting in two coexisting levels: neurotic and psychotic. She develops a concept of dynamic alternative functioning of a patient in a split order and projective identification and a skilful use of symbolisation. She stipulates a constant creation of a language which would be common for these two levels. An analytic can use the words which appeal to the patient and words which touched her or him [14]. Based on that supposition the words I used might have affected W. very much, maybe, in a way similar

to how hurt he felt by cutting remarks and aggressive jokes of his peers. The mental functioning of the patient presented above can be described, following Winnicott's concept, by means of the notion of false self [15] created for the purpose of survival in a life-threatening environment, the environment which was deeply disadaptive during the subsequent stages of development. Then the symptoms would be a pathological attempt to preserve the status quo, and another pattern of an ideal, dependent, asexual child was recreated in a transference. Another regularity, which drew my attention, was, in the simplest terms, the type of reaction to treatment. The stop of the weight-gain on the level of about the BMI of 16. This phenomenon reveals that apart from the fear of returning to the state from before the illness, he felt an unconscious desire to stay within the hospital structures forever and in such a way to recreate the uninterrupted relationship with the object associated with the ward through transference. The fact that he kept in touch with me via the telephone or would come to the ward in person, makes this fantasy a little more justified. However, it also allows for a verification of the diagnostic dilemma which has been expressed explicitly above. On the basis of very specific premises, i.e. a possible disappearance of symptoms in the patient, one may put forward a hypothesis that a dramatic and grave clinical image of eating disorders was rather a sign of massive destabilisation of patient's functioning in the course of developmental crisis, with psychophysiological complications resulting from cachexia, rather than incorrectly shaped personality.

It makes one think of several conclusions and reflections regarding the legitimacy of treating patients with severe cases of eating disorders in the way described above. It seems that only by providing this patient with a relatively intense form of therapeutic interplay (2 or 3 sessions per week with a requirement of maintaining one therapist), with a simultaneous creation of conditions that would stimulate a recovery of a physical state, provided him with a possibility to initiate the process of change. A change, which most possibly consisted, first and foremost, in releasing the process of development which was stopped in adolescence. The release of increased anxiety of various character, especially the separation and castration fears, led to a situation in which the patient centred his entire activity on pathological attempts and striving for neutralising unconscious fears. It seems that only such a course of treatment with an intensive therapeutic relationship, which is currently impossible to provide in the conditions of outpatient medical care, created an optimal space in which the phenomenon of common *reverie* of the patient and therapists [14], finding touching words [14] and distribution of the containment function on the therapeutic team, the group and the ward was possible. At the same time, considering all possible factors leading to the patient's illness, and then affecting the course of the treatment, simply forced the entire medical personnel of the ward to constant modification of their therapeutic proceedings. One of them was the decision of readmission of the patient to the ward. It happened only three months after he had been discharged on his own request. Usually such a discharge is considered a violation of the therapeutic relationship with the ward and a possibility of restoring the bond and renewing the treatment is assigned within the next six months. From the time perspective, it is certain that the decision of the team was correct and that it saved patient's life.

One of the basic differences between females and males suffering from eating disorders is that the course of the disease is more serious andcomplex in terms of somatic complications in men. All authors providing comparative analysis emphasise this fact, basing

it both on literature on this subject as well as their own experience [2]. Through his fears and their consequences which were life-threatening, the patient seemingly blasted the basic, psychiatric and psychotherapeutic frames of the ward. For a couple of days, when he was staying in the internal medicine ward, he expressed his deep fear that he would not be readmitted. His rehospitalisation and renewal of group and individual therapy were important to him as a corrective emotional experience. It may have been one of the factors which underlay of his further symbolic returns, which revealed the preserved bond with the ward.

On the example of W's treatment, some fundamental differences as well as numerous similarities in the image of female and male disease can be signalled. One of those has been provided above. Males suffering from eating disorders are subject to the control of biochemical parameters more often. The programme of behavioural treatment is adjusted to an increased nutritional value of meals, and the crossing of respective stages requires a higher BMI index than in the case of women. The patient, just like other men treated in the ward, generally complied with the rules of behavioural contract better than women. In the course of the interview and therapeutic sessions the subject of fear of obesity was practically absent. The patient displayed some associations connected with the requirements of the contract regarding rivalry, struggle and orientation of the goal, namely, recovery of health and the end of hospitalisation. Another meaningful factor was alcohol abuse. The frequency of co-occurrence of symptoms connected with the abuse of psychoactive drugs, especially alcohol, seems to be greater in males [2]. The history of patient's disease illustrates another commonly noticed aspect which is characteristic of men suffering not only from eating disorders, namely, great difficulties and strong emotional resistance towards receiving psychiatric and psychotherapeutic treatment. Social and cultural factors shaping the identity of males remain in strong conflict with the proposal of treatment which is based on the focus on emotions and reflection, and not on acting. A separate realm is conscious and unconscious significance of being ill with disorders typical for women. The patient, who for a long time was the only man in the therapeutic group consisting solely of women, and which was led by a female therapist, was experiencing especially strong and difficult emotional reactions, which were often connected with the fact that he was the addressee of specific transferred emotions and defence. His reaction towards the expectations of the group took various forms: taking on the role of an expert providing pieces of advice, attacking the group, its significance and the therapeutic dialogue or complete withdrawal from any verbal activity. It surely must have reinforced the unconscious dilemmas of the patient: masculinity and femininity, dependence on women, activeness and passiveness, dominance and subjection. Also the reactions of the patient to the comments regarding the importance of emotional relationships, including the relationships with the therapists. Possibly a little safer and less harmful for him were the techniques of intervention based on metaphors and symbolic stories. The patient revealed slightly different reactions during group meetings involving elements of drama therapy and systems therapy comprising family sculpting. These observations are consistent with the recommendations which can be found in some publications dealing with the issues discussed [2].

What was similar to the analogical organisation of personality in women were the pathological eating behaviours, unconscious attitude to the body, great difficulties in identification and verbalisation of affective states and bodily emotions, obsessive-compulsive

forms of defence together with the clinical phenomena derived from dissociation (patient's withdrawal and stupor). The latter ones suggested the presence of non-overworked traumas, preserved in the right hemisphere, in accord with determining of neurobiology [16]. Similar symptoms and behaviours can be noticed in many women with eating disorders who are treated in the ward. As a result of a more in-depth interview over the course of subsequent therapeutic sessions they disclosed the experiences of relational, sexual traumas as well as these resulting from verbal, physical aggression and neglect.

It seemed justified to provide a short comparison of the course of illness, treatment and reaction to therapy in women and men suffering from severe forms of eating disorders. The aforementioned observations and reflections are not the result of an ambition to formulate scientific statements, however, they have a strong confirmation in available publications devoted to this issue [2, 6, 17]. They are only a contribution to building hypotheses, which in the future may bear the fruits of studies searching for some regularities verified via research on a bigger group of males treated in the ward as well as in the outpatient medical care conditions.

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