

TITLE:

**INVESTIGATING DEFENSIVE ORGANISATIONS AND
PSYCHIC RETREATS IN ANOREXIA**

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DECLARATION

I declare that this is my own unaided work. It is being submitted for the degree of PhD in Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at another university.

Yael Adira Kadish

_____ day of _____, 2012.

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ABSTRACT

This psychoanalytically informed research project combines three theoretical trajectories together with illustrative clinical material to present an exploration of anorexia through a particular conceptual lens. The three theoretical areas are synthesised in an original way through the ideas and arguments presented in the thesis. The theory included: contemporary understandings of eating disorders; contemporary Kleinian literature on pathological organisations and psychic retreats (Steiner, 1982; 1987; 1992; 1993; 2011); and literature on autistic-like (autistoid) defences in non-autistic adults (S. Klein, 1980; Tustin, 1972; 1973; 1978; 1981; 1986; 1991). The research aimed to interrogate and explicate the relationship between pathological organisations of personality structure in anorexia, using case studies and vignettes to illustrate and elaborate the arguments. There was also some consideration of other types of eating disorder, similarly conceptualised. Case material from clinical work as a psychoanalytically informed psychotherapist was used as data in all but one case, in the latter instance interview material being used. The body of the thesis was structured in the form of four journal articles.

CHAPTER ONE

INTRODUCTION TO THE RESEARCH PROJECT

The research set out to interrogate and explicate the relationship between pathological organisations in personality structure, possibly including autistoid manifestations in anorexia¹, using case studies and vignettes. The term pathological organisation denotes a tightly knit, rigid assemblage of psychic defences that develop within personality as a result of psychically overwhelming events which have led to a breakdown in psychological functioning. Their purpose is to protect individuals from experiencing devastating persecutory and depressive anxieties through the avoidance of emotional contact and of internal and external reality (Spillius, Milton, Garvey, Couve & Steiner, 2011)

This thesis arose out of my work as a psychoanalytically informed clinical psychologist within the area of eating disorders. Such work has sometimes felt frustrating and the theory inadequate, regarding some of the struggles encountered with anorexic patients. In collegial discussions it became apparent that others were experiencing similar difficulties. My professional experience led me to consider that much of what ‘feeds’ or propels anorexia occurs at the level of bodily sensation, that which is felt - rather than mentalized, (symbolized and thought about). Thus it might not occur to a ‘normal eater’ that the anorexic gains intense secret satisfaction and soothing from, for instance, getting up from a chair and feeling an intense dizziness (a symptom of hypoglycaemia) which for her means she is in control, there is strength in her weakness (Bruch, 1978). As a source of constant reassurance that she is succeeding in her ‘war’ against flesh, some patients habitually and rhythmically rub protruding hip or rib bones.

As the illness progresses the anorexic typically retreats ever further into this somato-sensate world, eschewing outside relationships. Her body, its niggles and her carousel of thoughts about food become her closest companions. This intimate relationship with somatic sensation, accompanied by obsessive thoughts, is the *bare bones* of the illness. Mental life stagnates as

¹ Whenever I refer to anorexia I am including starving and purging types - unless I state otherwise - as defined in DSM-IV-TR, APA, 2000.

non-verbal sensation becomes the focus. It seems crucial to understand this if one wishes to comprehend the internal life of the anorexic. Yet, in most of the anorexic literature, the phenomenology of the regression to a sensate existence has not been emphasized. On the other hand, the body of theory which addresses autistoid phenomena (i.e. autistic-like manifestations in non-autistic adults) has emphasised sensation-based modes of self-soothing in the course of their research, and have included contributions to technique in light of this particular focus.

In the course of my work I became aware that my anorexic patients inhabited a deeply private somato-sensate world, intensely coloured by the physiological sensations of starvation. In very rare instances a patient would share these intensely private, seemingly autoerotic experiences with me. This became a stimulus for many of my questions about the disorder.

Over time I encountered a few authors who had touched upon sensation-based manifestations in anorexia but even they had not processed these with their patients therapeutically. Until I encountered Frances Tustin's (1986) work with her two anorexic patients, 'Margaret' and 'Jean', I had not been able to think of a way that the traditional 'talking cure' would be able to access the most primitive layer of the illness that sufferers themselves struggled to mentalize, much less verbalise, in therapy. In her work, Tustin did not focus particularly on eating disordered patients but on autistoid patients in general. It seemed to me that 'Margaret' and 'Jean' were not anorexics who happened also to have an autistic-like disturbance, but (based on my own observations) that their presentation seemed actually characteristic of anorexic manifestations.

Another significant aspect, more commonly disclosed by my patients, regarded the strict or harsh thoughts or internal 'voices' experienced in relation to eating and bodily form (Zerbe, 2008). Attempts to explore their harsh, punitive self-directed sadomasochism was possible, albeit superficially, because in most cases this seemed to be entirely ego syntonic (Lane, 2002; Farber, 1995; 2000; 2008). This line of disclosure appeared to provide a way to frame themselves as passive victims of the disorder rather than being able to acknowledge the

simultaneous perverse gratification their disorder gave them. It seemed essential that we begin to talk about their complicated experience of living in and acting upon their bodies.

John Steiner's (1982; 1987; 1992; 1993; 2011) work on pathological defensive organisations of the personality seemed to offer a way for me to think about and begin to work on this level of my patients' experience. Steiner discussed organisations of defences in some patients that were organised along a sadomasochistic divide. He spoke of the relief from overwhelming, annihilatory anxiety offered by this type of organisation in the form of a psychic retreat from unbearable reality.

After becoming acquainted with the literature on pathological organisations and autistoid defensive manifestations, the idea for the project began to cohere. These psychoanalytic bodies of theory both seemed to comment on similar transference tendencies— difficult patients who, to a greater or lesser extent, seem 'cut off', and who are unwilling or unable to participate creatively in psychotherapy, despite attending their sessions (Steiner, 1982; 1987; 1992; 1993; 2011; Tustin, 1978; 1981; 1986; 1991). They talk but do not communicate. Such patients manage to get their therapists to collude with their powerful non-verbal communications so that a status quo of *deadness* in the therapy prevails for long periods of time.

The autistoid literature, specifically the idea that an autistic barrier or enclave might well exist in many anorexic patients, seemed highly pertinent (S. Klein, 1980; Meltzer; 1975a; Mitrani, 1996; Tustin; 1978). Additionally, it seemed to me that these autistoid defences formed part of a greater organisation of intra-psychic defences along the lines of the pathological organisations described by Steiner (1987; 1992; 1993; 2011). He proposed pathological organisations to be the product of defensive reactions resorted to after the failure of normal splitting processes. This resulted in a pathological organisation unique in nature to each individual, which develops to 'collect the bits together' and to reconstruct the personality. Steiner proposed that there were two important ideas implicit in this. The first pertains to the inner workings of the pathological organisation and the second to the idea of a psychic retreat from anxiety as mentioned above. This will be discussed in detail further on. However, the

lived experience of an individual with a pathological organisation is that of living under an internal tyrannical dictatorship.

It should be noted that the idea itself was not entirely original insofar as a few authors had presented patients displaying both an eating disorder and a particular sort of pathological defensive organisation (Barrows, 1999; Farber, 2008; Magagna, 2009; Mitrani, 2006; Tustin, 1986). Thus this study sets out to synthesize key theoretical concepts pertaining to anorexia, pathological organisations and autistoid defences in order to present a particular lens through which anorexia, and possibly other forms of eating disorder, could be examined. It was hoped that this thesis will make a contribution at the levels of theory and of technique in work with anorexics.

The current thesis presents a particular conceptualisation of anorexia. It is offered as an invitation for the reader to think about his/her own patients with similar difficulties and psychodynamics. It does not claim to be all-encompassing but hopes to add to contemporary psychoanalytic understandings of anorexia (Greenwood and Lowenthal, 2005).

Rationale for the Research Project

This thesis was conceived of in order to address certain gaps that the researcher perceived in contemporary eating disorder literature. Firstly, although the role of sado-masochism in eating disorders had been described by others (Farber, 2008), it occurred to the researcher that sadomasochistic organisations of defences might operate in anorexic (and eating disorder) cases. This idea developed in relation to the researcher work with eating disordered patients, however in the literature this had not been comprehensively theorised or written up. The pathological organisations of Steiner (1982; 1987; 1992; 1993) seemed to comment on those phenomena. Hence some sort of synthesis was envisaged by the researcher as being able to helpfully elaborate on existing theory.

Secondly the anorexic's private experiencing of sensate impressions and auto-erotism in her starving state, as noted by Hilde Bruch (1978), had not been carried forward and elaborated on in the contemporary eating disorder literature. Frances Tustin's (1986) work with her two anorexic patients, 'Margaret' and 'Jean' was an exception. Tustin did not focus particularly on eating disordered patients but on autistoid patients in general. It seemed to the researcher that 'Margaret' and 'Jean' were not merely anorexics who happened also to have an autistic-like disturbance, but that these dynamics might actually be somewhat characteristic of anorexia. This seemed to indicate an important association between anorexia and autistoid defensive manifestations (S. Klein, 1980; Meltzer, 1975; Mitrani, 1996; Tustin; 1978; 1981; 1986; 1991). That anorexics escape to sensate, autistoid retreats seemed to be an important feature of the disorder. These ideas seemed to resonate with the idea of the psychic retreat introduced by Steiner (1982; 1987; 1992; 1993), (although his work does not emphasize sensate defenses). In her work, the researcher observed that these intrapsychic manifestations frequently arose in the material of her eating disordered patients, which she processed therapeutically with them. Because these manifestations had rarely been written about or addressed directly in the eating disorder literature, their operative synthesis appeared to be a worthy research enterprise. The researcher felt that it would be important to investigate the relationships between these psychoanalytic concepts, as seen in anorexic (and possibly also other sorts of eating disordered) patients. This quest became the research rationale.

Aims

This research project aimed to contribute to the psychoanalytic literature on anorexia; and secondarily, where applicable, to theorise about bulimia and binge eating disorder, using two specific aspects of psychoanalytic literature. Consequently, three theoretical areas were synthesised in an original way. Namely - contemporary understandings of anorexia (and eating disorders); contemporary Kleinian literature on pathological organisations and psychic retreats; and the literature on autistic-like (autistoid) defences in non-autistic adults. This was an endeavour which anticipated elucidating particular modes of defensive organisation in anorexia (and possibly in bulimia and binge eating disorder). The thesis explored the possibility that pathological organisations, including autistoid and other encapsulated phenomena, manifest within the intrapsychic structure of anorexics (and possibly other eating

disorders). It was intended that conceptual innovation would be based upon ideas that had been formulated over time through my work as a psychoanalytically informed psychotherapist. As such psychotherapy case material was used as data.

Research Questions

- 1) How do pathological defensive organisations manifest within intrapsychic structure and through the symptoms and interpersonal relationships (especially the psychotherapeutic relationship) of anorexics?
- 2) How do autistoid phenomena (including autistoid encapsulation) seem evident - based upon clinical material from anorexic patients?

Chapter Breakdown

Chapter Two is the literature review section, introducing and discussing the most important literature for the current research project.

Chapter Three is a discussion of the method as well as the ethical considerations that were important for the research.

Chapter Four is the first paper of the thesis, entitled: *Pathological Organisations and Psychic Retreats in Eating Disorders* published in *Psychoanalytic Review* (2012). This paper intends to create the broad theoretical scaffolding for the research project. It rehearses John's Steiner's (1993) conceptualisation of pathological organisations and psychic retreats in personality as they apply to the material of three eating disordered women. The paper offered a detailed examination of the particular pathological organisation and psychic retreat mechanism seemingly operative in each case and discussed these concepts in relation to the eating disorder manifestations of each participant. The paper sets up the overarching structure for the research project. A central tenet of the thesis is the idea that eating disordered patients might often have in common, a pathological organisation within personality. Hence all

subsequent papers contain this central idea while each one offers a specific development on or extension of Steiner's core conceptualisation.

Chapter Five is the second paper called *Autistoid Psychic Retreat in Anorexia*, published in *The British Journal of Psychotherapy* (2011). This paper offers an in-depth case study exploring the autistoid psychic retreat of an adolescent anorexic patient, 'Amy'. Autistoid psychic retreat is an elaboration on Steiner's notion of psychic retreats (1993). 'Amy's' early history and important relationships were described in detail, as were the transference-countertransference manifestations, crucial for the identification of autistoid states. An elaborated account was given of the two somewhat distinct phases of this psychotherapy.

Chapter Six – *Two Types of Psychic Encapsulation in Anorexia*, currently under review, carries forward the case study of the previous paper where 'Amy's' autistoid encapsulation was discussed in detail. This paper compares 'Amy's' autistoid (primary) encapsulation with a different, later developing, type of psychic encapsulation which I have termed *secondary-adjunctive* encapsulation. This second type of encapsulation is illustrated by case material from two other anorexic patients, 'Maya' and 'Jessica'. The latter two patients experienced non-penetrative sexual abuse trauma. It is suggested that either of these different types of psychic encapsulation can be found to operate within the pathological organisations of many anorexic patients.

Chapter Seven contains the last paper of the thesis, entitled: *The Role of Culture in Eating Disorders*. It has been accepted for publication by *The British Journal of Psychotherapy*. The paper provides an in-depth consideration of the potential influences of contemporary cultural trends on eating disorders. This paper considers aspects of the feminist and critical social theory literature pertaining to eating disorders, which is compared with psychoanalytic conceptualisations of the disorder. Two cases are discussed to illustrate the arguments. The paper argues that socio-cultural trends become part of the pathological organisations in eating disorders. It considers the idea that socio-cultural trends can be used by eating disorder sufferers to perform a symbolizing function by *translating* confusing internal states and organising sadomasochistic defensive structure. The argument is made that trauma underlies eating disorders, whether it be early developmental trauma, later relational trauma and/or trauma brought on by social forces espousing a particular sort of bodily ideal. This latter point is considered resonant with Straker's (2006) concept of the anti-analytic third.

Chapter Eight aims to bring the arguments presented in the papers together as a complete thesis in the Discussion and Conclusion section. The contributions to knowledge made by the research project are discussed in relation to the literature review. Additionally important areas for possible further research are highlighted and critiques of the research are acknowledged.

CHAPTER TWO

LITERATURE REVIEW

Overview

This research project has its roots in psychoanalysis, especially in contemporary Kleinian literature. However Freudian, Independent and Intersubjective theory was also pertinent. Specific authors whose work on eating disorders was essential for the thesis are: Hilde Bruch (1973; 1978), Marilyn Lawrence (1984; 1995; 2001; 2002; 2008), Janine Chasseguet-Smirgel (1995), Gianna Williams (1997b), Robert Lane (1989; 2002) and many others. The literature on autistic defensive manifestations relied largely upon the work of Frances Tustin (1972; 1973; 1978; 1981; 1986; 1991), Sydney Klein (1980), Bernd Nissen (2008) and several other writers in this field. Earl Hopper's work (1991) was used for the aspects pertaining to the broader understanding of psychic encapsulation currently found in the psychoanalytic literature. John Steiner (1982; 1987; 1992; 1993; 2011) and Herbert Rosenfeld's (1971a) writings on defensive organisations were a crucial part of the thesis and especially John Steiner's conceptualisation of pathological organisations and psychic retreats. The work of Donald Meltzer (1975) and Esther Bick (1968) on second skin formations and adhesiveness was also very important for this research project. Donald Winnicott's (1945; 1953; 1960) very important work conceptualising the earliest days of the infant were used where necessary for the thesis. Lastly, different aspects of Thomas Ogden's (1989a; 1989b) writings were incorporated in the arguments at various points in the thesis.

Psychoanalytic Understandings of Eating Disorders

This research project was intended as an exploration of anorexia and other eating problems and therefore the literary review will begin here. Indeed, if one were to go back to some sort of beginning regarding the contemporary literature on eating disorder, it seems that the pioneering work is accredited to Hilde Bruch (1973; 1978). Bruch's work marked something of a turning away from earlier psychoanalytic explanations based on overly narrow Freudian

lines which were rooted in a singular understanding of anorexia as a defence against sexual anxiety and specifically - the unconscious fear of impregnation. This theory viewed the anorexic's starvation as oral regression (Bruch, 1973). Bruch disagreed with this emphasis; her own ideas were based on extensive work with eating disordered patients. Although her theories were not purely psychoanalytic, she acknowledged its strong influence on her thinking. Bruch had begun the important work of trying to unravel the anorexia syndrome as well as other forms of eating disorder. Interestingly, it was not until the 1980s that bulimia was recognised as a separate disorder rather than a variant of anorexia (Dana & Lawrence, 1987).

Bruch (1973; 1978) believed that something significant had gone awry in the early feeding experiences of eating disordered patients. She suggested that these patients experienced hunger sensations in a distorted way; appearing to confuse hunger with various other somatic signals of internal distress or discomfort. Despite the fact that hunger is a primary need, it seemed that the recognition of it necessitates learning by the infant. Such learning is either facilitated or hindered by the mother (Brody, 2002). According to Bruch, in anorexia, bulimia and compulsive overeating this learning had been subverted (1973). She said that all who suffer from eating disorders have experienced "the absence or paucity of confirming responses to signals indicating their needs and other forms of self-expression" (p. 55). Bruch suggested that such a child, product of a mother who could not respond to her² needs appropriately, would grow up confused, unable to function autonomously and with diffuse ego boundaries. These deficits prevented the child from developing her own body identity (Brody, 2002).

Bruch (1973) noted that people with eating disturbances in general, experienced intense feelings of greed; the defining aspect was its expression. The over-eater personified the greed, the anorexic denied it and patients who binged and purged enacted it in a compromise formation. With regards to anorexia, there was often a developmental impasse at puberty which was experienced as an insurmountable obstacle. The anorexic denies hunger and the need to eat. Bruch suspected that such patients *did* in fact experience hunger but felt that its

² Although men do present with eating disorders, the overwhelming majority of sufferers are female (Bruch, 1973; 1978; Lawrence, 1984). For this reason the feminine pronoun will be used throughout.

suppression was a badge of honour. She also noted that, especially at the beginning of the disorder, over-activity (compulsive exercising) and a denial of fatigue was often present. Bruch noticed that her anorexic patients typically exhibited concreteness in their thinking and also in their relationships. As their illness progressed they became increasingly isolated. She noted that eventually at the advanced stage of the illness there was psychic disorganisation—almost to a psychotic degree, (Bruch, 1978).

In the family relationships of her patients, Bruch (1973; 1978) noted that an enmeshed mother-daughter relationship where the daughter seemed unable to function without her mother was somewhat typical. On the other hand fathers of anorexics were often under-involved, emotionally absent or seductive. Such daughters felt a crippling sense of helplessness and inadequacy. They had no faith in their ability to function independently. They were generally over-submissive and lacked a sense of autonomy. From the earliest days, she noted that these mothers seemed not to have been attuned to their infant daughters' needs and emotions and rather to have projected their own needs and anxieties into them. These daughters were left with a sense that they had not been *seen* and understood. Parents generally reported that they had been very 'good girls' never having given any trouble until their illness. They worked hard at school and were high achievers who tended to learn by rote (Bruch, 1978).

Bruch (1973; 1978) carefully documented the characteristics she observed in her anorexic patients. Over time in therapy these patients became able to communicate deeper layers of internal experience. Of particular relevance for the current research was Bruch's observation that many of her patients reported hyper-acuity of their senses due to their starving state. She understood that they were preoccupied with their inner experiences and felt themselves to be superhuman. This seemed to be linked with their ability to dissociate themselves from the sensations of weakness and malaise usually experienced in the advanced stages of starvation. These observations seemed highly significant to the researcher, as applied to her own patients. Therefore this became something of a theoretical departure point for the thesis.

Another important writer on anorexia, psychoanalyst and psychiatric social worker Marilyn Lawrence (1987; 2001; 2002), seems to concur with many of Bruch's observations. She went on to significantly extend these understandings using predominantly Kleinian theory. In her earlier writing she contributed the idea that anorexia was not a problem but the *solution* to a terrible impasse. She stated that anorexia offered a sense of safety for sufferers. It was something to shelter behind, concealing the vulnerable true self from the conflicts they are afraid to face. Indeed an important intention of this thesis was to try to gain a deeper understanding of the sufferer's paradoxical perception of this life-threatening disorder as a 'safe shelter'.

In her important paper, *Loving them to Death: The Anorexic and her Objects*, Lawrence (2001) posited that the anorexic's primary motivation is to exercise absolute control over her internal objects. It was vital that the oedipal couple were kept apart. The anorexic did this by bringing on a 'white out' state in her mind³. This generalised sort of fantasy was experienced in a particular way by one of her patients i.e. that there was a sort of heavy obscuring snowfall that wiped everything out, in this way she 'murdered' her objects. On the other hand Lawrence understands the bulimic to be more of a 'serial killer' i.e. because she was relatively healthier (she was not starving to death, notwithstanding her very disturbed relationship with food), her objects did not *stay* dead. The bulimic felt an overwhelming need for her objects (so she must eat and eat - binge) but once they were inside her she felt panicked and disgusted and 'killed them off' so to speak (purge) only to need them again later (Lawrence, 2001).

In another paper, *Body, mother, mind: Anorexia, femininity and the intrusive object*, Lawrence (2002) proposed a genetic, unconscious intrusive object as pivotal for understanding anorexia. The pre-anorexic daughter harbours envious, hostile and aggressive feelings and wishes towards her mother. Her attacking projective-introjective processes result in extreme fears about retaliatory attacks by an angry intrusive object (Lawrence, 2002). The infant is thereafter unable (due to massive anxieties) to reach for mother to mediate her struggles. The controversial point in this rich and detailed paper is that the impact of the actual mother is understated in contrast to the conceptualisations of other authors. In her other papers mentioned above, Lawrence had not made her position as explicit (i.e. the primacy of

³ The white-out state can be compared with Meltzer's (1975) 'dismantling' concept.

innate temperament in relation to aetiology) though undeniably the role of external objects had never been emphasized in her work. The majority of authors do not echo Lawrence's rather rigid reading of Klein with her strong emphasis on the subject. Most contemporary Kleinian authors acknowledge the interpersonal context in the evolution of envy (Gilhar & Ivey, 2008). For example, Spillius' (1993) paper highlights the role of emotional deprivation in fuelling and exacerbating envy.

Certainly the role of envy, greed and manic defence cannot be ignored (Klein, 1930; 1935; 1940; 1946). Contemporary Kleinians acknowledge that the greedy infant who is frustrated by the (frustrating) maternal breast envies it and wishes to possess it (Shipton, 2004). The infant then employs a narcissistic defence, i.e. fusion with the maternal object rather than facing the depressive reality that the mother is the possessor of all the milk and goodness. Hence there is a complete denial of separation. The infant can then magically possess the mother and all mother's valuable attributes in omnipotent phantasy (Klein, 1957; Rosenfeld, 1971; Segal, 1983). In this way the anorexic symptom can be understood as a dramatic, manic defence against the pain of the depressive position.

It should come as no surprise that most authors note the anorexic's struggle to move from pre-oedipal (dyadic) relating, to oedipal (triadic) relations (Freud, 1897; 1925). Or in Kleinian terms, the anorexic's struggle to move beyond the early oedipal phase (1923; 1928; 1933; 1945; 1952; 1957). On this note, many authors have emphasized the meaning conveyed by the anorexic's physical appearance which is gaunt and apparently asexual (Bruch, 1973; 1978; Lawrence, 1984). Many agree that the anorexic's emaciated body communicates to the world that she is an eternal child rather than an adult. In this way she attempts to avoid what is for her the overwhelming pressure of full genitality, i.e. adult relationships including a sexual relationship (Lawrence, 2001; Sours, 1974, Magagna, 2009; Williams, 1997). The anorexic's denial of sexuality and her retreat inwards, away from relationships in the outside world, indicate serious pre-oedipal/early oedipal difficulties (Barrows, 1999; Boris, 1984; Lawrence, 2001 Sours, 1974; Swift, 1991; Williams, 1997; Wilson, Hogan & Mintz, 1992).

Lawrence (2001) makes an important connection between this inability to resolve the oedipal situation and what has already been referred to as the anorexic ‘white out’ - a state where time is felt to be frozen and objects are killed off inside her. She sees the retreat in the ‘white out’ as a withdrawal to an objectless world. The anorexic retreats to this internal pure white world where she can ‘kill off’ any knowledge of the parental couple in her mind. Anorexics cut themselves off from relationships and seclude themselves in a two dimensional retreat in which there is a denial of the temporal dimension and thus of separation (Lawrence, 2001; Nissen, 2008; Williams, 1997b), but which lacks the feeling of *being* (De Cesarei, 2005). Lawrence (2001) concludes that the anorexic’s fear of loss of the object is so severe she would rather kill off the object inside herself than wait for the unbearable, and in her mind inevitable, separation and loss.

Such patients turn inward and take their own bodies as their object - one which they tyrannically control by starving and/or purging. The control gives them extreme pleasure (Barrows, 1999; Boris, 1984; Lawrence, 2001 Williams, 1997). The role of sadomasochistic elements in anorexia has been noted by several writers; this is another point of emphasis for the current study (Chasseguet-Smirgel, 1995; Farber, 2008; Lane, 2002; Magagna, 2009; Sacksteder, 1989). These authors note that anorexics experience “estrangement and alienation” between psyche and soma. The mind/self and body/self are experienced as distinctly separate entities rather than a psychosomatic unity (Lane, 2002). Anorexics appear not to have libidinally cathected their bodies. But quite the contrary; their anorexic behaviour displays a striking need for absolute bodily control and a disturbing level of cruelty. The idea that anorexics experience sadistic, persecutory internal voices, different from psychotic voices that propel the sadomasochism of anorexia, has also been suggested by a few writers (Tierney and Fox, 2010).

This is a total subversion of normal development and normal physiological impulses and processes. It is a retreat from the demands of life and living “an encapsulated piece of madness” (Bloom and Kogel, 1994, p. 58). In Lawrence’s (2001) words:

“Whenever one meets a patient in the grips of anorexia nervosa, one knows that some kind of catastrophe has taken place. Without knowing how or why, it seems that

psychically the patient has given up on the idea of relationships and crucially on any possibility of development. It is as though some kind of decision has been made. All sense of relatedness to an object is lost” (p. 43).

Autistoid phenomena in neurotic functioning patients

The discussion now turns to the body of psychoanalytic literature that considers the role of autistic-like (autistoid) phenomena in patients who do not suffer from autism proper. This concept has been very important for the ideas presented in this thesis. A brief history of the theoretical background preceding the conceptualisation of autistoid phenomena reflects that Winnicott’s (1945; 1960) writing on the early needs of the infant, and Bick (1968) and Meltzer’s (1975) on secondary skin formations, had done significant preparatory conceptual work some years before the notion of autistic enclaves/pockets/barriers in non-autistic adults appeared in the psychoanalytic literature. Winnicott (1960) discussed the necessity of ‘finding’ a boundary for the self in the neonate, which she can internalise. This internalised limit would allow the development of an ‘internal space’ inside the self. Bick (1968) and Meltzer (1975) also spoke of the need for an internalised boundary, calling it a ‘psychic skin’. These writers contributed much to the understanding of autistoid phenomena and a perusal of their contributions follows shortly.

However, the initial assertion that autistic phenomena could be found in non-autistic patients must be attributed to Frances Tustin (1972; 1973; 1978; 1981; 1986; 1991), a child psychotherapist renowned for her work with autism. She first noted the existence of a capsule or ‘pocket’ of autism in neurotic functioning children which she described in her 1978 paper - *Autistic elements in neurotic disorders of childhood*. Tustin’s discovery was followed by Sydney Klein’s (1980) highly significant and influential paper which took her discovery further, stating that an enclosed autistic nucleus could be found within the personality structures of various adult patients including neurotics. S. Klein acknowledged the pioneering work of Bion, (1957) on psychotic parts of the self, and Rosenfeld (1978) with his discussion of ‘psychotic islands’. S. Klein’s called this sort of closed off part of the personality - an

autistic enclave and described it as “an almost impenetrable cystic encapsulation which cuts the patient off from the rest of his personality and the analyst” (S. Klein, 1980, p. 395).

A few years later, in a paper prepared for the California Institute for the Arts, Tustin made an important link between autistic patients and those who are neurotic functioning with a ‘capsule of autism.’ She theorised that both these patient groups suffered the ‘dread of dissolution’ – the fear of spilling away and dissolving. In this paper, as an example of an articulate neurotic patient, she presented ‘Jean’ a patient with a severe case of anorexia. The following year the paper was published in her book entitled *Autistic Barriers in Neurotic Patients* (1986). By this stage the existence of autistic enclaves/barriers in adult patients with various (apsychotic) pathologies had been established within the psychoanalytic literature. The assertion that certain neurotic patients concealed a ‘capsule of madness’ within was highly significant. Neurotics had been regarded, by definition, as devoid of psychosis. This idea took root within the psychoanalytic community and many authors continue to develop it (Innes-Smith, 1987; Gomberoff et al., 1990; Mitrani, 1996; Nissen, 2008). The current research project is an attempt to contribute to this body of work.

Any real understanding of autistoid manifestations must begin with the foetus’ pre-natal experience. Gaddini (1987) traces the origin of the infant’s fundamental need for a containing ‘psychic skin’ in utero. As previously noted, this idea is rooted in the child work of Bick (1968) and Meltzer (1975) although these authors do not emphasize the prenatal environment. From the first stirrings of awareness inside the womb the infant begins to perceive that he has a border or perimeter. The prenatal environment defines as it contains. In so doing it provides a perfectly circumscribed area within which the baby can develop. Unsurprisingly then, the infant is born with an urgent need to recapture a sense of having a boundary in the earliest post-natal period (Anzieu, 1993; Bick, 1968; Gaddini, 1987; Meltzer, 1975; Winnicott, 1960). After the dramatic caesura of birth however (Freud, 1926), the infant’s world ceases to be defined by the amniotic sac and she requires (without *knowing* that she does) the mother to set up as gentle a transition as possible. This is so because all that the infant encounters in her earliest days is not experienced as outside herself but as the boundary of herself (Winnicott, 1960). The absence of the secure boundary after birth leads to the infant’s other primary need - and that is for ‘holding’. The infant needs this phase of holding to achieve the primary

integration of *indwelling of the psyche in the soma* (Winnicott, 1949). The post natal infant idyll is the nipple in the mouth accompanied by the sounds and smells of mother (Bick, 1968; Gaddini, 1987; Mitrani, 1996; Ogden, 1990; Tustin, 1986).

If this situation is sustained and continues along optimal lines, the baby will, in due course, internalise a feeling of a sort of an *amniotic sac inside* - a secure boundary or 'psychic skin' that separates self and other, inside and outside (Bick, 1968; Meltzer, 1975; Mitrani, 2001; Shipton, 2004; Winnicott, 1960). This psychic skin is a projection that correlates with the infant's actual skin. It is something which Freud (1923) described when he proposed that..."the ego is first and foremost a bodily ego; it is not merely a surface entity, but it itself the projection of a surface" (p. 26). Whether the infant is able to introject and identify with this internally binding state depends on whether there has been an external object that was able to initially fulfil this function for the baby (Winnicott, 1960). Of course by definition, the external object of this period must never be felt to be external.

When the psychic skin has been successfully internalised, it allows for the conception of a space inside the self (Winnicott, 1960). This, in turn, allows for the perception of boundaries - between inside and outside, me and not-me - which supplants the earlier unintegrated state. It is this internal space that is the necessary precursor to normal adaptive splitting and projection required for idealisation and separation (Bick, 1968; Mitrani, 1996).

Unfortunately this optimal situation is not the lot of all infants. Bick (1968) warned that if it transpired that the containing function could not be introjected, there could be no space felt inside the self. This would result in a highly adverse scenario - the lack of a containing object inside. The infant then embarks on a desperate search for a containing substitute fragment-object. This could be a light, the mothers voice, her smell - a sensual object to cohere her fragile state - if only briefly. This is known as a 'secondary skin' formation; it is a pathological yet essential substitute (Symington, 1985). Following from this regrettable circumstance would be two dimensional object relations. Meltzer (1975) describes its manifestation in adulthood "[such individuals are always] looking in the mirror of other

people's eyes all the time, copying other people, imitating" (p. 296). The sense of having an internal authentic self is grossly compromised.

Various authors have considered the reasons for this sort of developmental catastrophe. Inevitably there is a premature confrontation with that which is undeniably outside the self. (De Cesare, 2005; Gomberoff et al., 1990; Innes-Smith, 1987; Mitrani, 1996, 2001; Tustin, 1986). The infant is woefully unprepared for such impingement, and so it is experienced as a massive, overwhelming trauma (Winnicott, 1960). The primordial sense of self is grossly subverted by the trespass. It is against this apocalyptic landscape that an autistic barrier or enclave may develop as a defensive shield against that which threatens to destroy the infant's psyche. This survival crisis arises out of a premature confrontation between subject and object at a time when the former has no knowledge of the latter. Tustin called this event a premature psychological birth (Tustin, 1981). Tustin revised her ideas on autism (1994) over time, and her ultimate thoughts were that there was no normal-autistic phase in development in the way that Mahler (1958) proposed, ie in normal development there is an awareness of the object from birth. This revision led her to propose autism as a 'two-stage' illness. That what had looked like a 'normal' autistic phase was actually a prolonging of an over-close mother-infant sense of merging, so that when the infant was eventually confronted with mother-as-object, this was experienced as a trauma (1944).

This trauma leads to 'unthinkable anxieties' - Bion's "nameless dread", associated with feelings of unintegration (Bick, 1968; Meltzer, 1975; Mitrani, 1996). Unintegration must be contrasted with disintegration. The latter can be employed as a defence but presupposes a measure of ego integration not associated with the inchoate unintegrated state. This unintegrated state is then defensively encapsulated, forming an autistic nucleus (Nissen, 2008). These autistic manoeuvres serve as a protective shell against the horrifying awareness of separateness described by Tustin as 'the terror of two-ness' which is synonymous with a terrifying sense of dissolving into nothing, spilling, falling forever. Autistoid shapes, hard objects and delusions operate to enclose the unmentalized experience of devastating loss and unbearable longing for the object (Mitrani, 1996, 2001). Tustin revised her ideas on autism (1994) over time, and her ultimate thoughts were that there was no normal-autistic phase in development in the way that Mahler (1958) proposed.

This autistic unintegrated state has much in common with traumatic encapsulations discussed by authors such as Earl Hopper (1991; 2003). Hopper does not write in the autistoid tradition but approaches encapsulation from the departure point of the general psychoanalytic trauma literature. This importance of this distinction was highlighted in this thesis. It seems that both of these bodies of theory have psychic unintegration as their core (Nissen, 2008). However, the individuals Hopper describes have generally suffered massive later-stage traumas; this leads to the complete breakdown of that which was once integrated. On the other hand in autistic encapsulations the infant's state of primary unintegration is encapsulated (Tustin, 1986). In both cases authors comment on the fact that symbolization is impaired, that time has no meaning and that somatic and sensory impressions dominate (Mitrani, 1992). The important distinguishing characteristic separating these bodies of literature seemed to be that in autistic formations early developmental trauma at the hands of the primary object is always the cause (Nissen, 2008). In encapsulation this is not the etiological basis. However the task of comparing and differentiating between these two bodies of psychoanalytic literature had not been accomplished; therefore this was attempted in the current thesis.

This very early traumatic impingement occurs in the period before Melanie Klein's 'paranoid schizoid position' and has been called the *autistic contiguous position* by Ogden (1989) and *auto-sensuousness* by Tustin (1981), in agreement with Freud's (1914) *auto-eroticism*. This developmental period is thought to precede narcissism. In this auto-sensual stage hard and soft objects prevail (Tustin, 1980: 1986). Soft objects are regarded to be pleasant sensational experiences whereas hard objects are the reverse; they seem to represent hard edges and sensations (Tustin, 1980: 1986). The traumatised baby turns away from the mother and retreats to sensorially imbued autistic shapes and objects and self-generated sensations for comfort - rather than to the mother and normal transitional objects (Mitrani, 1996; Alvarez & Reid, 1999; Tustin, 1980; Ogden, 1990; Winnicott, 1962). This temporarily "holds the parts of the personality together" (Bick, 1968, p. 484). These self-generated sensations give the infant some comfort from terrors that are preverbal, pre-imaginal and preconceptual (Tustin, 1986).

Bick (1968), Gaddini (1969) and Meltzer (1975) originally noted the characteristic defences of this period that are more primitive than projective identification. Such defences see the

infant's adhesiveness to the object, imitative of it desperately defending itself against any awareness of separation (Anzieu, 1993; Bick, 1968; Gaddini, 1967; Jessner & Abse, 1960; Meltzer, 1975; Meyer & Weinroth, 1957; Shipton, 2004; Tustin, 1981). An illustration of this can be seen in Deutsch's (1942) description of the 'as-if' personality. She saw these individuals living as if they themselves were their loved objects, existing in a state of fusion. Adhesiveness is one of the only available defences when there is no sense of a boundary, no internal space between subject and object (Bruch, 1973; Birksted-Breen, 1989). The infant's capacity to make use of projective identification would develop after this period because it requires some rudimentary recognition of the separateness of the object (Gomberoff et al., 1990; Cohen and Jay, 1996). Adhesiveness is thought to be characterised by adhesive pseudo-object relations rather than normal or narcissistic object relations (Mitrani, 2001).

A comprehensive, although not all-inclusive review of the work in this area to date was presented by Bernd Nissen in his recent paper, *On the Determination of Autistoid Organisations in Non-Autistic Adults* (2008). After a critical discussion of the literature, he concluded that autistic structures are to be found in many fields of psychopathology and that this knowledge has made some contributions to specific pathologies such as eating disorders, hypochondrias and obsessional neurosis.

It was my contention, influenced by authors such as Tustin (1986), Barrows (1999), Mitrani (2007) and Farber (2008), that in the case of anorexic patients autistoid phenomena might well be more prevalent than previously thought due to some sort of association (although psychotherapy case study research cannot speak to issues of prevalence, and this is not my aim here). It was the intention of this thesis to make these structural manifestations explicit.

However, I wished to extend this work further by making the argument that in anorexia, sadomasochistic pathological organisations of the personality also exist – as over-arching defensive structures within which autistoid encapsulation is a component. Thus the literature on pathological organisations and psychic retreats was the essential foundation of the thesis.

Pathological organisations and psychic retreats

John Steiner (1982; 1987; 1992; 1993; 2011) developed his theory of psychic retreats and pathological organizations in an attempt to understand the dynamics of patients who are not merely resistant in the usual way but who are, for all intents and purposes, unreachable to the analyst for shorter or more extended periods in treatment. Such patients seem also to display the intrapsychic structure of a highly organized and often sadomasochistic nature. Such powerful resistance had been first described by Freud (1909; 1910; 1914), who noted in the case of 'The Rat Man' (1909), a patient who felt compelled to commit a crime under the influence of internal "agents provocateurs" (p. 261). Abraham (1919; 1924) contributed to the ideas on defensive organisations, as did Reich (1933) in adding his notion of "character armour." While Riviere (1936) presented her significant paper addressing negative therapeutic reaction, Klein (1958) made the important distinction that unconscious destructive parts of the self were not part of the superego but were split off, remaining separate from both ego and superego. Thereafter, Joseph contributed two influential papers, "*The Patient Who is Difficult to Reach* (1975), as well as, *Addiction to Near Death* (1982), while Rosenfeld (1971b) presented an incorporative theory to try to explain these sorts of resistances, which he termed 'destructive narcissism', and introduced the term 'narcissistic organisations'. His conceptualisation was a significant precursor to Steiner's pathological organizations. Steiner's theory attempted an even broader reach than Rosenfeld's, as reflected by his use of *pathological* rather than *narcissistic* to describe the organizations that he believed could occur with a wide range of patients, including certain types of neurotic patients as well as those who are narcissistic, borderline and perverse - even psychotic patients who are accessible to psychoanalytic treatment (Steiner, 1993). In fact, Steiner asserted that all individuals may, under conditions of extreme anxiety, withdraw to a psychic retreat. A psycho-diagnostic distinction can be made regarding the duration of said retreat (the shorter, the healthier) and the extent of the pathology inherent in the organization (Steiner, 1993; 2011).

According to Steiner's theory, the patient who has withdrawn from meaningful contact into a psychic retreat in analysis may relate in a number of ways (O'Shaughnessy, 1981). She may present with an aloof superiority, with a shallow, "as if" sort of cooperation, or with a dishonest manner of engagement. In response to these particular sorts of contact, the analyst

may feel frustrated, shut out, and/or pressured to behave in a superficial, corrupt, colluding, or perverse manner (Steiner, 1982). Steiner proposes that these particular sorts of defensive manoeuvres are undertaken behind the protective armoury of a rigid pathological defensive organization of the personality, which functions as a safe haven that can be retreated to at any time in order to avoid the menace of seemingly unbearable anxieties. Steiner co-opted Meltzer's (1968) and Rosenfeld's (1971b) notion of the internal 'mafia' or 'gang' that offers protection to the vulnerable part of the self so long as there is complete deference shown to the ruthless, terrorizing 'regime'. In certain cases there are strong sadomasochistic components; this becomes evident in a transference-countertransference wherein the patient derives sadistic pleasure from, for instance, opposing the analyst's wish to be helpful, as well as masochistic pleasure in remaining "sick" rather than improving.

Psychic retreats

The psychic retreat, which becomes available only under the auspices of a pathological organization, is conceptualized structurally (Steiner, 1993) as a latent and expedient third position, located *outside* of Klein's (1946; 1952) two other developmental positions. In times of overwhelming anxiety of a paranoid-schizoid or depressive nature, the pathological organization is *activated* and the psychic retreat becomes available as a refuge. The individual's typical psychodynamics are then partially restructured and absorbed into this new structure that has arisen to *take over* psychological functioning (Steiner, 1993). The reign of the new state might be short-lived or continuous. Psychic retreats take different forms; they can be undertaken during anxiety-provoking periods in therapy, but are also accessible outside of analysis in everyday life when an individual is faced with the threat of unbearable anxiety.

Steiner (1993) proposed pathological organisations to be the end result of various defensive manoeuvres resorted to by the individual after the failure of normal splitting processes has occurred. He cites Klein's (1952) formulation that the individual, under the weight of severe anxiety, has defensive recourse first to normal splitting processes, which implies the splitting of the object with its resulting splitting of the self/ego (Klein, 1957; Rosenfeld, 1950).

Healthy splitting entails a good object in a relationship with the good part of the self/ego kept separate from a bad object in relation to the bad part of the self/ego. In a situation where this sort of splitting fails to bring about equilibrium, the individual may then turn to the good object and good parts of the self to combat the bad object and bad parts of the self. If this defensive strategy also proves insufficient, a violent and archaic form of projective identification occurs, which entails the expulsion of the self and the object now fragmented in bits (Bion, 1957). A pathological organisation, different in its exact form in each individual, may then develop to “collect the pieces” and reconstitute the personality (Steiner, 1993). However, it is a contaminated conglomeration – in that good and bad bits of the self, projected into objects, have become inextricably mixed up together. The new structure, comprised therefore of impure ‘building blocks’, is an attempt to restore the former good/bad split within, but this task is impossible; instead a complex, ‘Frankensteinian’ structure emerges - the pathological organisation. This hybridized personality structure, the pathological organisation, *presents* itself as good and protective by *offering* the weak libidinal self/ego a place of safety against attack (Steiner, 1993).

Due to its above-mentioned origins, the pathological organisation is constituted by mixed-up bits, and nothing is as it seems. The organisation appears to seduce and mislead the weak libidinal ego; however there is always some degree of collusion (Steiner, 1993). Tyranny and sadism are allowed to dominate the weak, dependent libidinal self/ego that both knows and does not know the nature of the *unholy* bargain that has been struck, which thus by definition is a perverse engagement. Unwavering compliance is demanded and obtained because safety against overwhelming anxiety is offered in return. Hence a rigid, often idealized, sadomasochistic structure becomes entrenched. Steiner’s (1993) description seemed to me to have powerful resonance with my understandings of especially my anorexic (but also my bulimic and binge eating disordered) patients’ internal sadomasochism. It seems that the eating disordered individual takes her body concretely and sadistically as an object to be cruelly controlled by another part of the self.

Steiner (1993) holds that if the omnipotent protection of the organisation is excessively relied upon, healthy growth is arrested. This is because psychological development relies upon the flexible use of projective identification as an object relational tool. Since pathological

organisations are comprised of multiple split-off, disowned parts of the self in complex formation, no one element can be separated out and identified as being part of the self - mourned (which would allow the withdrawal of projections) and then internalized, as is necessary for depressive functioning. Thus, in cases where these organisations are entrenched, there can be no healthy flexibility of projective identifications, and development is frozen (Steiner, 1993).

It seemed to me that this stagnant situation might be found with eating-disordered patients where sadistic “mafia boss,” aspects might function as a conduit for projections of harsh, punitive ideology regarding ‘fatness’ and greed is *engaged in a relationship* with a masochistic part containing loathed, disavowed parts of the self. At first glance this situation seemed most apparent in anorexia, where sadomasochism seemingly manifests in the symptom and in the transference-countertransference (Bach, 1997; Lane, 2002; Risen, 1982). Indeed Steiner (1993) posits that it is not only the building blocks of a pathological organisation that must be comprehended but also the particular way in which they are placed and held together. This is vital, because the analyst might well become an element in the organisation, enacting either or both the oppressive and malevolent part or the passive and compliant part.

A consideration of common theoretical ground

It can be seen from the second and third sections of this chapter that much of the eating disorder literature echoes autistoid theory, in regards to early beginnings i.e. that the infancies of such individuals are understood to have been anything but a smooth transition from womb to world (Bachar, Latzer, Canetti, Gur, Berry & Bonne, 2002; Cohen and Jay, 1996; Klein & Walsh, 2003; Lawrence, 2001; 2002; Mitrani, 1996; Tustin, 1991; 1993; Williams, 1997a). Certain writers on these bodies of work draw upon common ideas such as those of Winnicott (1949; 1960), Bick (1968), Meltzer (1975) and Bion (1962b; 1970).

As mentioned, in both the autistoid and the eating disorder literature certain ideas consistently co-occur. Firstly, regarding etiology - both bodies of theory it is suggested that the infant suffers damage to her inchoate ego due to a traumatic intrusion (De Cesarei, 2005; Grotstein, 1983; Innes-Smith, 1987; Lawrence, 2001; Nissen, 2008; D. Rosenfeld, 1984; Tustin; 1972; 1981; 1986; 1990). Such infants are left to deal with their primitive terrors alone (Cohen and Jay, 1996; De Cesarei, 2005; Green, 2001; S. Klein, 1980; Nissen, 2008; Rey, 1979; Tustin, 1991; 1993). There is either the absence of a maternal containing function or a reversal of the container-contained relationship (Bion, 1962b; 1970). The devastating intrusion of the *not-me*, caused by a disruption to the mother-infant bond, makes the infant prematurely aware of her separateness from the object. Such a disruption may be due to maternal depression, psychosis, serious illness or some other significant internal event that leads to maternal disinvestment. The father, for whatever reason, does not support the mother-infant pair in the crisis. This is mentioned as a feature in both the autistoid and anorexic literature (Bruch, 1973; 1978; Nissen, 2008)

A second important resonance between these two bodies of literature is in their descriptions of the psychic structural aftermath – resulting from the abovementioned traumatic impingement. De Cesarei (2005), although only writing about autistoid patients, envisaged a post-traumatic structural aftermath that she called the narcissism-autism bipolarity. This conceptualisation seemed to offer a promising explanation about how anorexia and autistoid phenomena might function. The structure, born of necessity, maintains the split between a petrified world (with the illusion of being immobile, unchangeable and without need) and a glittering mental world which develops precociously (De Cesarei, 2005). She saw the forming of a hard autistic shell to be an attempt by the traumatised infant to move backwards and to close off against anything new or unexpected which could threaten the precarious system again. This rigid defensive ‘throwing the baby out with the bath water’ manoeuvre also prevents growth, fantasy and thought (Cohen and Jay, 1996; Gomberoff et al., 1990; Tustin, 1972; 1981; 1986; 1990). There is a repetition compulsion between the sadistic armour which covers the fragile emotional world and the mind which takes over as organising the system towards survival and then a largely intellectualised development. The narcissism-autism bipolarity is able to allow the system to survive disintegration but it is restored as a two dimensional structure which lacks the feeling of *being*. The very early trauma that threatened the vulnerable nucleus becomes a violating element that must be preserved (Winnicott, 1965).

Betty Joseph (1982) conceives of her patients (not specifically eating disordered) with this preserved violating element as having an ‘addiction to near death’. This conceptualisation may not pertain to all patients with autistic enclaves but has definite resonance with anorexia and bulimia. Joseph (1982) speaks of one part of the self that is actively sadistic towards another part of the self, that is in turn masochistically caught up in this process, and that this has become addictive (p. 450). Anzieu (1993) describes this *negative attachment* - the attachment instinct becomes associated with the self-destructive, rather than the self-preservative instinct. Joseph (1982) cites Freud’s (1924) elaboration of the workings of the death instinct in masochism with his enlightening conclusion “even the subject’s destruction of himself cannot take place without libidinal satisfaction” (p. 170). This has such obvious significance regarding the ego syntonic and apparently self-directed, sadomasochistic nature of the anorexic and the bulimic. Joseph (1982) regards such patients as being “in thrall to a part of the self that dominates and imprisons them and will not let them escape, even though they see life beckoning outside” (p. 450).

This explanatory system has been employed by authors who explain the infant’s survival via the employment of autistoid defences and the encapsulation of the early intrusion. It can be deduced then that anorexics suffering early trauma might defensively develop a cystic structure to *insulate or split off* traumatic early memory traces. This autistoid structure must be acknowledged and worked with in treatment.

Existing work associating eating disorders with either pathological organisations and psychic retreats, and/or autistoid phenomena

This section presents existing work where authors have associated anorexia (or other eating disorders) with pathological organisations and psychic retreats, and/or autistoid manifestations.

The first noted cases where eating disorders and autistoid phenomena were directly linked are Tustin's 'Margaret' and 'Jean' (Tustin, 1986). 'Margaret' was seen by Tustin at age thirteen, in 1955. At this stage of her professional life, Tustin had not yet realised that there could be a connection between anorexia and psychogenic autistic states. 'Margaret' had been hospitalized due to the severe, almost terminal nature of her anorexia. Her mother had become depressed when 'Margaret' was four months old and her milk had dried up. This withdrawal was caused by the news that her husband's naval ship was feared lost at sea. She subsequently discovered, three months later, that he was alive and well. 'Margaret' did not take well to the bottle and was always a very fussy eater who then went on to become severely anorexic (Tustin, 1986). This case highlighted the importance of the early disruption to the mother-infant relationship, which has been emphasized as very important with regards to the etiologies of both anorexia and autistoid phenomena.

Tustin (1986) described 'Margaret's' illness as being obsessive, compulsive and having depressive features. Also, that it was neurotic in that the psychic was expressed somatically. From the start of the analysis 'Margaret's' weight fluctuated in response to a feeling of hope (gain) or despair (loss). Tustin noted penis envy, greed and a rivalrous envy towards her mother. The importance of these psychodynamics have been commented on by the authors who have described either anorexic or autistoid cases. Hearteningly, as a result of the analysis 'Margaret' went on to make a full recovery and even married and even had children.

'Jean' also presented for psychoanalysis as a thirteen year old with a severe case of anorexia. She was helped by the intensive treatment but terminated two years later (in order to go to boarding school), before the analysis had run its course. She returned as a twenty one year old suffering fits of depression. Some very important descriptions of 'Jean's' experience were included in this case study. She experienced terror about 'spilling away'; during the second period of analysis, "the Pandora's Box of her autistic enclave was opened" (Tustin, 1986, p. 198). This exposed the terrors that had been shut away inside. The fears about falling away into a bottomless abyss had resonance with her anorexic phase when the cessation of menses gave her relief from her terrible fear of bleeding to death.

Tustin (1986) highlighted an area often commented on in the anorexic literature, namely the enmeshed quality of the mother-daughter relationship (Shipton, 2004). ‘Jean’ and her mother had an un-naturally close relationship where a sense of bodily separateness and a toleration of absence had not been established. Her developing sense of self had been significantly impinged upon, even blighted. The containing aspect of the relationship was not adequate and thus an autistic encapsulation arose as a defence against the fears of dissolving away (Tustin, 1986). Tustin noted the fluidity of the primitive proprioceptive body image and how these sensations are intrinsic to the establishment of the feeling of being alive. If there are traumas in infancy, the sense of fluidity can translate into a bodily sense of instability and impermanence. ‘Jean’ had fantasies that she could cease to exist at any time, her sense of I-ness was severely impaired. ‘Jean’ too underwent a successful course of treatment.

More recently Barrows (1999) who does not usually work particularly with eating disorders, presented an anorexic, then bulimarexic, patient – ‘Miss Y’ in her paper - *Ghosts in the Swamp: Some Aspects of Splitting and their Relationship to Parental Losses*. As can be seen Barrows’ more current work has benefited from the ever richer body of contemporary psychoanalytic thought. This case is understood through the lens of both psychic retreats and autistoid phenomena.

Barrows (1999) noted three types of object relationships pertaining to her patient. Firstly, the patient’s “idealised retreat” (Barrows, 1999, p. 548) where she starved herself of food and social contact but filled herself with books and television. In this state she felt in control of her own resources. Secondly, when this patient had begun to respond to analysis and had emerged somewhat from the retreat, she clung to an idealised object, fearing its loss terribly. The third way this patient related was in response to an internal persecuting object full of ghosts. This damaged object prevented her from having her own life. This persecuting ‘ghostly’ object derived from the transmission of her parents’ un-mourned losses into her, as well as her own projections.

Barrows (1999) drew on different aspects of psychoanalytic theory to understand her patient. She employed Fraiberg, Adelson and Shapiro’s (1975) paper – *Ghosts in the Nursery* – which

discusses the effects for children of their parents' unmourned losses and un-mentalized, frightening figures. Barrows also noted a reversal in the Bion (1962) container/contained relationship. She looked at 'Miss Y's' splits between idealised and persecutory objects as well as between psychical satisfaction and material functions as described by Bion (1962). Of relevance to this thesis is Barrows' (1999) observation that particularly in the first year of the analysis, 'Miss Y's' retreat had a "very autistic quality to it" (p. 550). 'Miss Y' was "entrenched in a retreat she was afraid of leaving and that at times she felt to be far superior to other modes of existence" (p. 551). 'Miss Y' displayed sensory anomalies in that she struggled to process and integrate sensorial impressions. She also had autistoid fantasies of bleeding out, having an essential bit missing, being like a tortoise without a shell, and living at the bottom of a dark well. She displayed adhesiveness in her clinging to the analyst, regurgitating her interpretations without metabolizing them – a defence against loss.

Mitrani (2007), in her article *Bodily centred protections in adolescence*, examines the way that patients who had been unable to introject a containing object in infancy experienced a resurgence of anxieties in adolescence. Such individuals are once again overwhelmed by nameless dreads and resort to using body and bodily sensation as container because they are unable to mentalize intra-psychic experience. She regards this defensive manoeuvre as simultaneously destructive and lifesaving. She links these somato-sensual phenomena as belonging to autistoid protections.

Mitrani (2007) proposes that the infant is prematurely aware of maternal emotional unavailability. Such an infant then relies on its mother's physical presence only as a sensation-based container. This is a default scenario and is inadequate to contain infantile anxieties. This maternal failure renders separation from her actual physical presence very traumatic because a 'good enough' container has not been introjected or assimilated by the infant. Therefore embodiment-the feeling of living harmoniously in one's body cannot occur in such cases. Mitrani illustrates her points using Tustin's (1986) patients, 'Margaret' and 'Jean'.

Mitrani (2007) also presents her own patient 'Cathy'. 'Cathy's' eating disordered symptoms included binge-purge as well as starvation. She struggled to mentalize and integrate difficult emotional experiences in adolescence. She 'froze' the therapeutic relationship so it became static and controllable and in this way preserved against the threat of loss. She feared that analyst and analysand 'might melt' if warmth or spontaneity was felt between them. This 'icy barrier' prevented a healing therapeutic experience. Eventually 'Cathy' was able to renounce her autistoid defences and move towards a greater tolerance and mentalization of her exquisitely painful infantile feelings. Mitrani advises analysts to be alert to auto-sensual defences (such as bingeing, purging and starving), adhesive object relations and isolated encapsulations as well as concreteness rather than metaphor in their patient's communications. This would allow the analyst to know that she was in the presence of autistoid phenomena and thus be able to intervene appropriately.

Farber (2008), in her article *Autistic and Dissociative Features in Eating Disorders and Self-Mutilation*, believes that self-harming behaviours are a way that certain individuals act out mental pain on the body, as a defence against feeling such pain emotionally. Moreover, that the physical pain is in some manner pleasurable. This subversion of psychic onto somatic gives the individual a sense of omnipotence and self-sufficiency. In Farber's words, "When suffering the pain of anxious hyperarousal, gliding a razor blade across the skin and/or violently purging themselves of food can produce a release that is as close to joy as they will get" (Farber, 2008 p. 24). Farber includes a biological argument with her psychoanalytic understandings, citing studies that have linked bulimic, self-starvation and self-mutilating behaviours to reduced serotonergic functioning and increased impulsivity. These phenomena, in turn, have been linked to childhood trauma (Fessler, 2002; van der Kolk, Perry & Herman, 1991; van der Kolk, 1994; Winchel & Stanley, 1991).

Farber (1995; 1997; 2000; 2008) views self-harm as a product of both dissociative and autistic processes. These manoeuvres are employed defensively against the feelings associated with traumatic experience. Both of these processes help create an unconscious scenario where traumatic events are correctively re-experienced in a dissociated way and re-enacted on the body. Such individuals' parents had become their 'predators' in childhood- emotionally, physically or sexually (Farber, 1995; 1997; 2000). These patients withdraw into a capsule of

autism, they become the predator, attacking their own bodies: “in an omnipotent feat of destructive narcissism in which they become prey and predator, masochist and sadist all at the same time” (Farber 2008, p. 32). Both dissociative and autistoid protections are understood to be self-preserving in the most primitive way, they are a defence against a descent into madness.

Of relevance to the current research was ‘Kathleen’ (Farber, 2008) a research subject, not a patient, who had a tumultuous childhood and adolescence that included family violence and countless episodes of physical and sexual abuse. She had anorexia in childhood and was bulimic in adolescence. She often used self-mutilation as well. ‘Kathleen’ would write down her thoughts before she would self-mutilate and her disorganization is manifest in her narratives.

In terms of the proposed research, it is significant that all Farber’s (2008) subjects were sexually abused as well as having traumatic childhoods and infancies. This does not in any way negate the link between eating disorders and self-mutilating behaviours but may imply that her work is based on a different sub-population within the same general area as the current research. It is possible that these individuals have defensive organisations that contain autistoid as well as later encapsulations due to later trauma. This distinction will be discussed in detail further on. However the association between anorexia and both early damage and sexual abuse is very significant for this research. These aspects are sensitively discussed in Magana’s (2009) in-depth case study of an anorexic adolescent.

In an important paper Magagna (2009) considered how her dangerously emaciated patient ‘Grazia’ used her anorexia defensively to afford her feelings of omnipotent control in light of both early dyadic and oedipal difficulties. This patient experienced profoundly challenging life circumstances that included her father’s abandonment of the family and her mother’s mental illness. Grazia took over caring for her mother and younger brothers via the development of “a hard masculine self ” (p. 72). After some time in therapy ‘Grazia’ disclosed that she was being raped on a regular basis by two boys in her neighbourhood. Unsurprisingly this patient struggled to develop a healthy female sexual identity. Magagna

explored the ways in which 'Grazia's' "protective psychic retreat" had enabled her to just barely 'survive' but that the cost was the abandonment of her libidinal (baby) self (p. 72).

Conclusion

The abovementioned authors suggested that in the particular eating disorder cases they presented, there were links with pathological organisations and/or autistoid phenomena. This research project aimed to investigate these ideas in greater depth. Although a qualitative project can never comment on prevalence, it was my hope that this thesis would emphasize these phenomena and elaborate upon them in order to potentially assist clinicians working with such patients.

CHAPTER THREE

RESEARCH METHOD AND RESEARCH DESIGN

Qualitative research

Various types of research methods fall within the qualitative ambit - it is used across various paradigms, disciplines and methodologies (Willig & Stainton-Rogers, 2008). Fundamentally, qualitative research operates in a natural setting (in this case the psychotherapy treatment setting) as opposed to an experimental one. It seeks to explore the psychological significance and personal interpretations of individuals within social situations. Qualitative research is particularly interested in how individuals make meaning in various situations and life circumstances (Denzin & Lincoln, 1998). Qualitative research findings provide a way to appreciate complex processes that have many different layers of meaning and understandings that are sometimes contradictory. The aim of such research is deep, 'thick' descriptions of experience in context.

Due to the research's focus, the research design comprised of the qualitative, clinical case study, and more specifically, the psychoanalytic research method known as the psychotherapy case study (Dreher, 2000). This method implies that case material generated from patient psychotherapies and supervision becomes the body of data (Spence, 1993). In this project, this was so in all but one case where interview data was used. In that particular instance, 'Sarah's' verbatim account (See Appendix E), originating from the researcher's honours project (Kadish, 2000), became a source of data for the paper – *Pathological Organisations and Psychic Retreats in Eating Disorders* (Kadish, 2012). For this reason the qualitative interview method will be briefly introduced, followed by a much longer discussion of the psychotherapy case study method.

The qualitative research interview

When an investigator attributes to research participants, the language and experience necessary to describe their own actions and reactions, the interview method may be employed. The purpose of the qualitative research interview is to gather worthwhile information from the subject that is a product of her lived experience (Kvale, 1996; Molyneaux & Lane, 1982). It is hoped that such experience tallies with, and elucidates, the research topic. Interviews are characterised by verbal exchange between investigator and subject on a topic that is of interest to both (Kvale, 1996; Rosenthal & Rosnow, 1991).

Qualitative research interviews are theme orientated, concerned with the subjective meaning of the central themes generated by participants (Kvale, 1996). They permit the exploration of issues that may be too complex to explore quantitatively (Molyneaux & Lane, 1982). The qualitative research interview seeks nuanced descriptions of the relevant themes. Precise descriptions and a strict interpretation of meaning in qualitative interviewing corresponds to the exactness inherent in quantitative measurements (Kvale, 1996; Rosenthal & Rosnow, 1991). In a qualitative interview the researcher asks direct questions. In the honours project that elicited the interview data also used in the current project, one projective question was posed. The question was intended as a projective device intended to elicit detailed material about the topic of interest - binge in bulimia. The question was: "Describe in as much detail as possible, your experience of a binge focusing on your thoughts, feelings and behaviour at the time; your story should have a beginning, a middle and an end" (Kadish, 2000, p. 31). 'Sarah's' response to this question, her narrative was used in the current study too. Although this piece of data had different origins from the rest of the body of data, the analysis of 'Sarah's' narrative was just as rigorous – undertaken by the researcher and her supervisors – before it was included into the body of data. The researcher had been struck by the way that 'Sarah's' narrative, although not generated in a psychotherapy, resonated with the area of interest for the research. Additionally the therapist-researcher had not been able to ask any of her bulimic patients to become participants, for various ethical reasons as will be discussed further on. Therefore the decision was taken to use 'Sarah's' interview material. The different origin of this data was noted in the paper for which it was used.

The discussion now turns to a consideration of the case study method.

The case study method

The case study is a method of enquiry that predates the scientific method itself. It is essentially a qualitative account of an individual in a situation that is regarded as worthy of research (Edwards, 1998). Case studies have played an essential role in the growth and progression of humanistic and transpersonal clinical methods of which psychology is one. However, once quantitative methodologies gained popularity in social science research, its use declined (Wallerstein, 1993). It endured almost exclusively in psychoanalysis and anthropology. However, this trend seems, if not to have reversed, at least to have become more balanced – with a return to an inclusion of case studies in general psychology once again (Edwards, 1998). The value of a case study is that the research focus is narrow and deep; it explores the experiences of a very limited number of individuals, often a single research subject (Dreher, 2000; Edwards, 1998; 2004; Stake, 1995; Willig & Stainton, Rogers, 2008). Due to the inherent narrow-ness of an individual case study it is not a method one would employ to prove or disprove something in a definitive way. Rather, a case study is heuristic, that is, a device which allows the researcher to make discoveries, to consider the plausibility of a theory (Bromley, 1986; Edwards, 1998).

Different branches of scientific enquiry have adapted the case study method to suit their own needs. In medicine it is synonymous with the clinical method and allowed medicine to develop into a universally applicable, sophisticated science (Bromley, 1986). Medicine's building blocks have always been the detailed case studies of individual patients. The grouping together of very large numbers of similar case studies led to the development of objective tests that could be used for diagnostic purposes. Therefore in medicine, multiple clinical case studies have allowed for the development of general treatments for physical illness and injury (Bromley, 1986).

Psychotherapy case studies have been essential in the development of psychoanalysis and later clinical psychology, where it is necessary to study single cases or a series of cases (Edwards, 1998). The quest is for individual meaning rather than universal truth (Bromley, 1986; Denzin & Lincoln, 1998; Dreher, 2000; 1998; Guba & Lincoln, 1989; Spence, 1993). Both the theory and the practice of psychotherapy involve hypothesis testing, and accordingly this is the basis for the clinical case study method (Spence, 1993). The revolutionary contributions arising from this method include, for example, Freud's famous psychological formulations of the unconscious mind and the Oedipus complex (Dreher, 2000). These theoretical innovations and those that have followed constitute psychoanalytic theory. This method has made it possible for psychotherapists to understand the details of their patients' innermost psychological workings-inaccessible to positivistic research methods.

The psychotherapy case study provides a viable method for the examination of psychological constructs by using psychotherapy transcripts, process notes and supervisory input to observe and rigorously interrogate a specific psychological phenomenon. It is considered by some to be "the only possible way of obtaining the granite blocks of data on which to build a science of human nature" (Murray, 1955 as cited in Spence, 1993, p. 37). This type of research falls under the ambit of *conceptual research in psychoanalysis* (author's italics), which implies "a not exactly definable - class of research activities, the focus of which lies in the systematic clarification of psychoanalytic concepts" (Dreher, 2000, p. 3).

The phenomenological-hermeneutic psychotherapy case study

The current study, which explored the psychodynamics of anorexia, positions itself within a specific understanding of the psychotherapy case study method i.e. the phenomenological hermeneutic approach innovated by Greenwood & Loewenthal (2005). As mentioned above, this method does not differ from the psychotherapy case study as such, but signals with this semantic elaboration, a subtle but particular epistemological re-location. This epistemological re-positioning is largely a response to criticism regarding the objectivity of the psychotherapy case study.

The authors argue that the phenomenological-hermeneutic psychotherapy case study is in essence no different from the method first used by Sigmund Freud (and subsequently by analytic researchers). Freud (1915) would not have agreed. He regarded psychoanalysis as being, in and of itself, a method of research - located within scientific discourse (Greenwood & Loewenthal, 2005). This claim has attracted vociferous criticism, even within psychoanalysis itself. Fonagy & Moran (1993) argue that this method “has largely been discredited in many fields of social science” and they raise the call to “enhance the internal validity of the data gathered in the clinical setting” (p. 62-63). Although this observation cannot be dismissed out of hand, the word *discredited* implies some sort of theoretical relegation. Surely, the longevity and utility of Freud’s work a century on, provides staunch advocacy for its preservation as a sound and valuable psychotherapy research method, when it is conducted rigorously? Greenwood & Loewenthal (2005) suggest that the real problem does not lie in the method itself, but in its epistemological positioning within science as Freud saw it.

Indeed Freud located psychoanalysis within scientific discourse; he maintained that his observations – reported during the analytic hour – could be regarded as evidence (Greenberg, 1994). The scientific method proposes that an observer’s perception can indeed correspond to the reality of what has been experienced (Greenwood & Loewenthal, 2005). This philosophical position places the scientific method of observation within realism, defined by Stroud (1984) as “the view that objects exist in space and we have direct perceptual access to them” (p. 134). This position has led to an energetic critique of Freud’s case studies from various quarters (Greenberg, 1994, Spence, 1993). It implies that in theory, any trained analyst would record the same observations regarding a given patient (Greenberg, 1994). This would not be the view of contemporary psychoanalysts who acknowledge the intersubjectivity of the psychoanalytic process (Butler, Flasher & Strupp, 1993; Dreher, 2000).

For this reason, Greenwood and Loewenthal (2005) argue that the psychotherapy case study should rather be seen to fit within the philosophical tradition of idealism. This philosophical approach implies – “an acknowledgement that the world a person observes does exist but that the mind and its ideas are separate from this world” (Greenwood & Loewenthal, 2005, p. 37).

On this basis one can only ever know one's perceptions and ideas; it is not possible to objectively know the world – divorced from our thoughts and impressions (Greenwood and Loewenthal, 2005). They suggest that the case study should be understood in the way of the phenomenology of Husserl and Heidegger (1927), i.e. that it seeks to *describe* possibilities rather than to claim to be an absolute truth (Donmoyer, 2000). Thus the therapist-researcher's attempt to be mindful of her own subjectivity is not seen as a path that will ever lead to the achievement of objectivity in the positivist sense. Rather her vigilant self-reflexivity (discussed further on) is seen to be, in itself, part of the phenomenological enterprise (Greenwood & Loewenthal, 2005).

A further critique levelled at the psychotherapy case study method holds that it has a rather "closed texture" (Spence, 1993, p. 38) via the telling of a single persuasive story – in contrast to a historical archive, for example, which is open to multiple interpretations and possibilities. This opinion has no foundation if one positions the psychotherapy case study within a phenomenological-hermeneutic paradigm. Such an approach restricts its purpose to the provision of an illustration of the researcher-therapists account of what took place in a particular therapeutic moment or interaction/s (Greenwood & Loewenthal, 2005). This re-framing of the psychotherapy case study offers it as a generative heuristic, in that it offers an invitation to readers to consider the arguments presented, and to have their own ideas and draw their own conclusions.

Indeed research enterprises that rely on the generation of interpretations about patient material and pivot around meaning making surely fall comfortably under the banner of hermeneutics (Gabbard, Beck & Holms, 2005). Many have argued that this is the true locus for the psychotherapy case study (Dreher, 2000; Greenwood & Loewenthal, 2005). Hermeneutics originated out of the earliest interpretations of sacred texts and was later incorporated by philosophy (Willig & Stainton-Rogers, 2008). Contemporary hermeneutics regards human experience as not being fixed but subject to an on-going generation of meaning. It acknowledges that one cannot step outside one's own socio-cultural position, thereby obtaining *objectivity*, but that one is obliged to acknowledge and become self-consciously aware of it (Dreher, 2000). This principle has been consistently upheld in the current research both in relation to the researcher's history of anorexia, and regarding her professional role as

therapist. These two experiences ultimately led to her instigation of the current project; unquestionably, one's prior knowledge of a phenomenon guides one in deciding on the optimal angle of approach (Bromley, 1986).

It follows then that in a phenomenological-hermeneutic psychotherapy case study, the role of the researcher is acknowledged and understood to be part of the meaning-making process – in contrast to the 'invisibility' demanded by experimental quantitative methods (Bromley, 1986; Dreher, 2000; Willig & Stainton-Rogers, 2008). Thus criticism relating to the role of the researcher and her subjectivity *contaminating* the data is unfounded so long as self-reflexivity is rigorous. In the current case the researcher had to be doubly mindful of her role in the research project. Firstly, the researcher's interest in the topic was partly a result of her own battle with, and recovery from, anorexia as an adolescent. She was at all times mindful against allowing this personal history to colour or distort any part of the research process. Vigilance to personal ideas, motivations and experiences was maintained and thought through, regarding the impact upon the study.

Secondly, the researcher – in her role as psychotherapist of all but one participant – played an intrinsic part regarding the generation of the data (Talley, Strupp & Butler, 1994). Therefore the inclusion of the researcher's own role in the research process had to be properly understood and processed, and in this way became part of the research enterprise (Greenwood & Loewenthal, 2005). The researcher's self-reflexivity is considered a basic necessity in order to minimise bias and to understand how her subjectivity impacts on the research. It is accepted that the researcher has an investment in the knowledge-making process, and that therefore transparency is vital, including self-revelation where appropriate (Willig & Stainton-Rogers, 2008).

In fact psychoanalysis, and by extension psychoanalytically informed psychotherapy, is inherently a method dependent upon one's capacity to be self-reflective (Butler et al., 1993; Dreher, 2000). One of the cornerstones of psychoanalytic thinking is an examination of one's own responses i.e. countertransference in relation to the patient's transference (Joseph, 1985). Psychotherapists make reflections and interpretations in response to the patient's material as

part of the therapeutic process. After the therapist responds to the patient, the latter responds in turn by either – taking up, rejecting or ignoring what the therapist has said. Psychotherapy is therefore regarded as an inter-subjective process (Dreher, 2000; Stolorow, Brandschaft, & Atwood, 1987; Talley et al., 1994).

The four steps of the research process

The following steps aptly track and describe the phenomenological-hermeneutic psychotherapy research process as used in this project. The basic framework has been fleshed out with a description of the procedure followed in this research. The basic steps (appearing in bold to distinguish them) are based on the Bleicher's (1980) observations of the hermeneutic philosophy of Heidegger (1927) and Gadamer (1975), summarised in the following manner by Greenwood & Lowenthal (2005).

1. **“The first step begins with a hermeneutic situation”** (Greenwood & Lowenthal, 2005, p. 41). In the case of the current research, this implies the psychotherapeutic setting.
2. **“The interpreter enters a situation with a comprehensive set of pre-understandings that dictate and influence the questions that emerge in relation to the hermeneutic scene and these are the cultural norms of the understanding”** (Greenwood & Lowenthal, 2005, p. 41). This step describes the entire therapeutic environment, which includes the therapist-researcher's holding in mind her training and her theoretical knowledge. This influenced her work with her patients in that theoretical knowledge was retained whilst simultaneously openness to the patient's experiential world was maintained. When the therapist-researcher [as “investigator” (p. 41)] formulated the research questions, these were developed with the entire psychotherapeutic situation in mind. These are the cultural norms of psychotherapeutic research.
3. **“The initial response is to be determining. This is seen as a spontaneous response**

to the situation given the influence of the culturally conditioned pre-understanding” (Greenwood & Lowenthal, 2005, p. 41). Thus the therapist-researcher’s ‘initial response’ to the hermeneutic scene was recorded in verbatim transcript notes and process notes generated after each session. These initial responses “are likely to be subject to considerable influence from the pre-understanding [i.e. training and theoretical influences] inherent in any account of human observation” (p. 42). Therefore implicitly a therapist-researcher cannot objectively (i.e. without subjectivity) perceive and report on the session in light of the necessary pre-requisite that she is a trained professional. However she was always mindful of her own subjectivity and included this in her notes.

Thus step three describes data gathering with emphasis on the therapist-researcher’s self-reflexivity regarding her analytic and interpretive role in session and thereafter – when she wrote up her case notes. Such case notes form the “primary data” as defined by Dreher (2000). It is clear that this step conveys the interwoven process of data gathering and data analysis in the psychotherapy case study.

4. **“Additional reflection on preconceived understanding provides the opportunity for different meanings to emerge that have been drawn from direct contact with the immediate environment”** (Greenwood & Lowenthal, 2005, p. 41). The therapist-researcher presented her ideas, questions and notes to her three supervisors who often challenged her initial understandings, thereby adding additional depth and meanings to emerge. This sometimes led to a revision, which enriched her initial response, i.e. her understandings of all that occurred in the therapy session. In this way, supervisory input also became part of the body of data.

Step four describes the therapist-researcher’s process of further reflection on the data. This process included the therapist-researcher’s intensive consultations with her supervisors – who contributed their ideas and at times challenged hers. Dreher (2000) calls the material taken outside of the therapeutic process and presented to a third person/s such as a supervisor - “derived primary data” (p. 47). This entire process functioned as a data analytic process, but also included further data gathering in the form of the inclusion of supervisory input and the therapist-researcher’s resulting further reflections.

Below is a diagram illustrative of the research process.

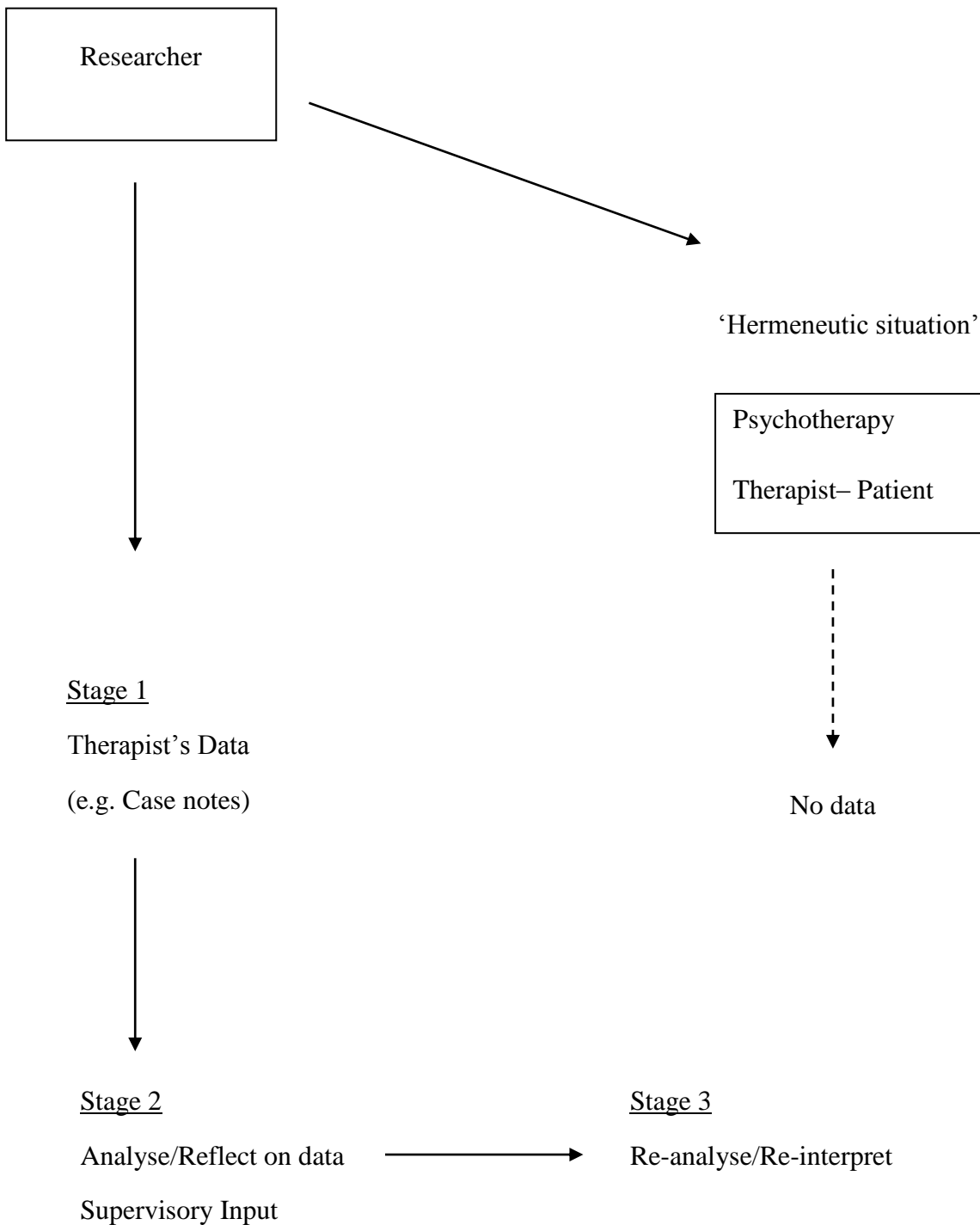


Figure 1. Adapted from Greenwood & Loewenthal (2005, p. 43).

Ultimately, it should be remembered that the primary purpose of the psychotherapy case study is clinical utility. Using the phenomenological-hermeneutic approach – a case study or case studies are offered as a possibility amongst other possibilities, rather than as ‘the truth’. This approach seeks only to invite clinicians to consider their patients through a particular lens. It seeks to stimulate thought rather than to persuade the reader of its absolute correctness (Greenwood & Loewenthal, 2005).

In regards to quality control, the dedicated self-reflexivity of the therapist-researcher was inherent from the beginning of the research process, starting with the process of data collection, i.e. clinical material from the psychotherapies of the patients who became participants. Further quality control regarding the use of the case material was provided by three senior clinicians, two of whom also acted as academic supervisors for the research. With the current PhD, peer review acts as an additional testing level. This system provides the gate-keeping function preceding publication.

The current research project is made up of four separate, conceptually interlinked articles – each of which utilizes one or a combination of the following: an extended case study, several shorter case studies, interview data and/or patient composites. Publication of these articles in accredited peer reviewed journals is a criterion for the PhD including publication. Ultimately, a therapist-researcher who manipulates case studies to impress readers while advancing flawed arguments would be discovered. This is because psychoanalytic readers are generally not a passive audience but comprise mostly of working clinicians. Thus practitioners in the field will make the final assessment regarding the value of a new theory, determining its endurance and longevity, or relegation to obscurity.

Validity and reliability in qualitative research

As previously mentioned, there have been many criticisms of the psychotherapy case study - specifically regarding lack of objectivity and generalizability (Edwards, 1998; Stake, 1995; Willig & Stainton-Rogers, 2008). The counter-argument is implicit in the section above,

namely that this sort of research wishes to investigate the specific rather than the general, and then to understand it through the lens of psychoanalytic theory, to contribute towards it. Essentially the phenomenological-hermeneutic approach, positioned within idealism - offers ideas and arguments rather than proof (Dreher, 2000; Greenwood & Loewenthal, 2005; Stake, 1993). Although the idealist position adopted by the phenomenological-hermeneutic approach should mean that realist, scientific parameters are not imposed upon it – there may in any case be a challenge of this nature. For this reason, this section has been included. Indeed qualitative methodology in general can be seen to have its own appropriate set of measures to ensure quality control and accordingly, notions of ‘validity’ and ‘reliability’ are understood differently than for quantitative research

In suggesting a basis for assessing the quality of “disciplined enquiry”, i.e. research, Cronbach and Suppes (1969) advise that “[it] has a texture that displays the raw materials entering into the arguments and the local processes by which they were compressed and rearranged to make the conclusions credible” (pp. 15-16). This implies that the research process needs to be transparent and accountable in order to allow readers to apprehend the procedures which the research goes through before it reaches its final form. Furthermore, it would seem to suggest that even in the ‘end product’ one must be able to track and understand how the theory and illustrations come together in the argument. This definition dictates important parameters utilised in this research project. Traditionally positivist research evaluation has been governed by the principles of validity (internal and external), reliability and objectivity. These principles however, are not so easily applied to the psychotherapeutic case study, nor should they be, as argued above. The adaptation of these principles for the phenomenological-hermeneutic psychotherapy case study will be briefly considered.

‘Internal validity’ implies an assessment of the accuracy one has achieved in proposing a causal relationship between two variables. Internal validity is essentially a way to evaluate whether the given research has ‘truth value’, that it in fact proves what it claims to (Guba & Lincoln, 1989, their italics). In the current psychotherapy case study, internal validity is a difficult and complex principle to establish. The nature of ‘absolute truth’ (if this ever exists) is not relevant for this type of research. As long as the research can rigorously display Cronbach and Suppes’ (1969) *raw materials* (data) and *local processes* (methodology) that

compressed and rearranged them (interpretation and analysis) that have guided the researcher's arguments and conclusions, that should suffice as internal validity. Therefore an evaluation of the quality of one's thesis is possible if there is access to the theoretical standpoint/s, data and processes that comprise it.

'External validity', on the other hand, can be understood to denote the degree to which the presumed causal relationship can be generalized across settings, persons and times (Guba & Lincoln, 1989). In a psychotherapy case study this must be adjusted to connote the correspondence between what is argued regarding the case and how that corresponds to the real world of the psychotherapeutic setting. Do the findings seem congruent with – although of course, can never be identical to – the experiences of others in similar situation in the world?

'Reliability', in empirical terms, relates to the internal coherence or consistency of the given enquiry (Bromley, 1986; Guba & Lincoln, 1989). It is a prerequisite for validity. The establishment of reliability for a given piece of research rests upon its replicability. The question is asked: will you get the same results if you repeat the same procedures with the same instruments with equivalent subjects? In qualitative research one is interested in personal experiences and meanings as a way of understanding something of the human condition. Identical replication in and of itself is not relevant. However, one must demonstrate how one came to one's findings and conclusions.

'Objectivity' is the demand for neutrality, bias free and value free research. Taken at face value, objectivity would not be applicable to the current research which is unapologetically psychoanalytic and more specifically, designed with reference to an idealist paradigm. However, the principle of objectivity can be applied to the research in a modified way, in so far as objectivity is conceptualized as being grounded (i.e. to have its assumptions rooted) in the ontological and epistemological framework of that theory or model (Guba & Lincoln, 1989). This research is grounded within contemporary, psychoanalytic theory and will have objectivity as defined by the inherent theories of the paradigm. Although psychoanalysis is not a unitary theory, as long as the thesis demonstrates its theoretical underpinnings in its

arguments, and provided there is transparency in the methodology, it can be regarded as having fulfilled the requirements for objectivity.

In qualitative research the abovementioned principles of validity, reliability and objectivity have been valuably enlarged and elaborated upon by Egon Guba and Yvonne Lincoln who have established parallel or foundational criteria for evaluation. The criteria are intended to parallel the existing traditional positivist criteria. They have been named the ‘trustworthiness’ criteria (Lincoln & Guba, 1985; Guba & Lincoln, 1989; 1994). Four criteria comprise ‘trustworthiness’. These are: ‘credibility’, ‘transferability’, ‘dependability’ and ‘confirmability’. It is important to note that the establishment of criteria for ‘trustworthiness’ is a complicated endeavour and each research project must be careful to tailor the criteria to its own specifications. These four concepts will be briefly discussed in relation to this research project.

‘Credibility’ relates to internal validity as defined above. It relates to the plausibility of the data, the findings and the interpretations of the data. It was important that the researcher took the following steps. She spent adequate time in engagement with the research subjects – in this case with each psychotherapy patient (Lincoln & Guba, 1985). In the case of the participant, ‘Sarah’, who was not a psychotherapy patient, the researcher spent, what would be regarded as ‘adequate time’ with her. This initial step allows for the second recommended step, which is persistent observation. This enables prolonged consideration of the subjects and their material.

Arguably the most important steps one should take to ensure credibility are triangulation and ‘member checks’. In this research, member checks implied checking with the patient whether she felt that what she has said had been adequately understood by the therapist via the therapist’s interpretations and clarifications. In fact, psychoanalytic therapy is a continuous backwards and forwards process of transferring meanings and understandings between patient and therapist. Triangulation on the other hand, is the way in which the sources of data are verified by different investigators who have differing perspectives in order to provide a cross check. For example, in this research triangulation was established with the assistance of the

researcher's two academic supervisors as well as her clinical supervisor who verified all aspects of the data (Guba, 1981). Professor Gavin Ivey and Dr Arlene Joffe oversaw the supervision of the entire research project while senior psychotherapist Lynn Symon supervised the clinical work. Their input became part of the body of data.

'Transferability' is associated with issues of external validity or *generalisability* to context. In the clinical case study research, the findings can only be generalized to the psychotherapy context. The therapist must supply adequate information via thick description of the research context as well as the methods and process (Kelly, 2006). The reader is then invited to consider the arguments put forward in relation to their own patients.

'Dependability' is not straightforward for the psychotherapy case study method. Like reliability, it pertains to the principle that a piece of research should be replicable by using the same research methods and instruments as the original research. In a phenomenologically and hermeneutically informed research project, such as the current one, it is understood that the same study can never be replicated exactly because 'reality' is constantly changing when one is interested in meaning making within psychotherapies. However a study such as this one can be construed as dependable if the differences inherent in subsequent replicated research projects are monitored and can be explained (Lincoln & Guba, 1985).

'Confirmability' relates to objectivity which, as mentioned above, cannot be considered identical for qualitative and quantitative research. In quantitative research if a number of people agree upon something it is regarded as objective, whereas if an individual alone experiences something, that is regarded as subjective. As mentioned previously, idealism implies that subjectivity is always part of this sort of research but that self-reflexivity, supervision (cross checking by at least three other senior clinicians), and peer review offer 'authentication'. In this way 'confirmability' can be seen to have been achieved.

'Authenticity' is an additional way in which research can be evaluated (Guba & Lincoln, 1989). Two of the suggested criteria are applicable to the current research setting, that is,

within a psychoanalytic psychotherapy. Within this context the criteria of ‘ontological authenticity’ and ‘educative authenticity’ should be met. ‘Ontological authenticity’ relates to the extent which the participants’ worldview has been extended and enhanced such that they gain a deeper and more sophisticated understanding of their own internal world. ‘Educative authenticity’ on the other hand regards insights gained regarding other people in the external world, outside the self. One would examine whether the participant’s apprehension of the differing constructions of others and of their alternative worldviews have been extended. Both of these criteria are implicit in the values of psychoanalytic psychotherapy where therapists’ reflections and interpretations often relate to what is happening inside the patient and what is external. The very idea, in psychoanalytic therapies, of working with transference and countertransference phenomena relate to an understanding of the patient’s projections onto the therapist. The patient learns to distinguish between inside and outside and in so doing takes emotional responsibility in her life, this is known within Kleinian theory as functioning in the depressive position (Klein, 1934).

Participants

There were eight participants in all: seven were either current or past patients of the researcher while the eighth participant, as mentioned previously, participated in the researcher’s honours research and her interview material was used as data (see Appendix E). The patient-participants were selected on the basis of their having had an eating disorder. The majority of participants had been anorexic but had recovered, or were in the process of recovery, at the time of the research. Other participants were, or had been, bulimic or binge eating disordered. Participants were females aged between sixteen and forty years old. Participants were selected on the basis of their appropriateness for the study. All participants were regarded by the researcher as showing evidence of the pathological organizations and psychic retreats as described by John Steiner (1982; 1987; 1992; 1993; 2011); in addition some appeared to display autistic defensive phenomena. The primary purpose of the research was to deeply interrogate the defensive structural phenomena in anorexia (including the purging subtype). However, material from participants with bulimia and binge eating disorder was also used to illustrate important conceptual aspects of the arguments.

Of the eight participants: four current patients were asked for, and gave, full signed consent via the 'Information and Consent Form' (Appendix A). These were 'Amy', 'Jenna', 'Holly' and 'Jessica'. In the case of minors, signed assent was received via the 'Information and Consent Form' (Appendix A). Consent was also obtained from their parents who were contacted telephonically and the research was explained to them and the 'Parental Information and Consent Form' was signed (Appendix B). A fifth participant, 'Maya', had been the researcher's patient at Tara H. Moross Hospital where written consent is given by patients for all research during hospital admissions at this teaching institution. The researcher obtained the status of honorary volunteer at Tara (see Appendix D) which has an inpatient eating disorder unit. The researcher worked in this unit during her internship. It was envisaged that her honorary volunteer status would allow the researcher to conduct therapies with eating disordered outpatients which could also be used as data (following the ethical principles stipulated further on). This however did not transpire. In the end the researcher was at least able to use her patient notes from her past internship as data.

In the case of the sixth and seventh participants, these were past patient composites - 'Cassie' and 'Brenda'. In those cases the researcher's own countertransference material, together with supervision notes, formed the basis of the material. Insofar as patient material was used, these were composites of a few similar cases. Therefore consent from any one patient was not mandatory. This was done in light of the complications inherent in asking for consent from patients i.e. the request for patient participation can potentially intrude upon the therapeutic enterprise. This complex matter will be discussed in detail in the Ethics section hereunder. As mentioned previously, the eighth participant, 'Sarah', was not a patient but was a participant in the researcher's honours research project. Since the completion of the honours research project in 2000, that thesis, which includes full interview transcripts, has been freely available in the Cullen Library at the University of the Witwatersrand.

Data collection

Because this research project employed the psychotherapy case study method of psychological investigation, the data was primarily generated within the context of the

therapeutic relationship. An exception was 'Sarah' who was a volunteer participant in the researchers' honours research project. Therefore psychoanalytic psychotherapies formed almost the entire basis of the research project. Material produced in a session is understood as being intersubjective which means that the relationship between patient and therapist provides the most important information (Spence, 1993). In all of the therapies, clinical supervision was sought which provided a second source of data.

In psychotherapy, the therapist immerses herself in the session but at times also distances herself from it – to think her own thoughts – moving through the hermeneutic circle to arrive at co-constructed knowledge about her patient (Kelly, 1999). Objectivity is always strived for but cannot be achieved in the absolute positivistic sense (Bruinsma & Zwanenburg, 1992). The therapist must pay attention to what is being said, what is not said, and any countertransference experiences and thoughts she has. If she feels unable to think, this is also noteworthy as she must try to understand what is happening between herself and the patient. The writing up of notes provides a further way to achieve distance and understanding (Spence, 1993). In this enterprise the therapist-researcher uses free association⁴ or reverie⁵ (Bion, 1962b).

As previously mentioned, all of the patient material was discussed in clinical supervision (Greenberg, 1994). The supervisor's 'third position' is vital in order for the psychotherapist to fully understand more difficult and elusive aspects of the countertransference. Everything that the therapist recalls was recorded in the verbatim case notes or process notes. Supervision notes—a co-creation of psychotherapist and supervisor in response to patient material—were also a source of data.

Despite arguments that audio or video taping of psychotherapy sessions are the most accurate way to objectively record the session's verbatim content, this is not how sessions were

⁴ Free association describes the mode of thinking encouraged in the patient by the analyst's injunction that she should obey the basic rule, i.e. that she should report her thoughts without censure and that she should not try to concentrate on or control her utterances (Rycroft, 1995).

⁵ Reverie is a term used by Bion to describe the abstracted musings or daydream-like receptive-translative state of mind of the mother; this maternal state enables the infant to make sense of and bear her previously unknowable internal states (Rycroft, 1995).

recorded due to the negative effects that this potentially brings (Lincoln & Guba, 1985).. In the current case, the detrimental effects on the therapy of the introduction of a taping device were considered to outweigh the benefits. The presence of a taping device is often experienced as intrusive. It alters the therapy in that the patient is at all times aware that her utterances are being recorded (Tuckett, 1993). This directly contradicts the mindset necessary to free associate, that is to say whatever is on one's mind without censorship, a basic tenet of psychoanalytic psychotherapy. Additionally tapes do not easily tap countertransference material. The introduction of a taping device suggests overtly to the patient that her psychotherapy is not only an enterprise for her well-being but will serve the purposes and ambitions of her therapist in some way (Stajner-Popovic, 2001). This point, although true, only pertained to current patients whose therapies were still in process. In those cases, the therapist-researcher was very mindful to avoid by all means her research intruding on the therapy (Gabbard, 2000). Thus although the use of a taping device would have allowed the therapist access to more of the session than her mind alone could ever retain, this would almost certainly have contaminated the therapeutic process. For this reason she continued to use the practice of writing up process notes, as well as abbreviated process notes.

Process notes are the notation of as much as possible of the session's contents (Spence, 1993). These were taken within twenty four hours after psychotherapy sessions. This included the verbatim content: what was said, but sometimes what is not said can be very significant too and was noted. The patient's non-verbal behaviours were also noted as well as her tone of voice, emotional tone, how she entered and left and of course the therapists countertransferential impressions (Greenberg, 1994).

Abbreviated process notes on the other hand, comprised of a slightly briefer account of what happened in the session rather than a verbatim account. Abbreviated process notes are sometimes taken when there is insufficient time to note down an entire session's verbatim contents. Certainly abbreviated process notes are more commonly taken because it is expedient to do so when one has many patients but wishes to record the sessions' essential content (Bromley, 1986). Process notes are a reflection of the therapists processing of the transference-countertransference manifestations in the session and whatever else seems significant (Spence, 1993). They are a subjective account of the session by the therapist.

While some might not regard abbreviated process notes as being as accurate as process notes, one achieves a faithful account of the analytic experience in the tradition of the phenomenological-hermeneutic approach (Greenwood & Lowenthal, 2005). This implies the faithful notation by the therapist-researcher of the entire session, which includes the contents (verbal and non-verbal), slightly abbreviated for length as well as the transference-countertransference dynamics as the therapist-researcher perceived them.

It should be noted that a mixture of process notes and abbreviated process notes were taken with patients (who are participants) currently in therapy. In the case of past patients, one ('Maya') was a hospital patient from the researcher's internship at an eating disorder ward. Research data in her case, mostly took the form of detailed process notes and supervisory notes with a few verbatim session transcripts. Her material was offered with relevant qualification in the paper for which it was used (*Two types of encapsulation in anorexia*).

As previously mentioned, supervisory input in response to the session notes also constituted data. This input was written down in the form of notes taken at supervision sessions where the process notes were reviewed. This further consideration by the supervisors was valuable because it constituted an additional processing of the session as well as a 'third position' to apprehend what might have been missed by the therapist due to her subjectivity, what she brings that is specific to herself, as part of the analytic couple (Dreher, 2000).

Data analysis

The psychotherapy case study is characterized by the analysis of multiple layers of subjective meaning, influenced by the patient's unconscious processes, as these find expression in the therapeutic relationship (Dreher, 2000). Hence data was interpreted through the research's psychoanalytic framework. Psychoanalytic psychotherapy is implicitly a method of collecting and interpreting data. The employment of this method draws upon both inductive and deductive thinking and application. It is inductive because the researcher is led to form hypotheses by what she observes in the cases themselves, and deductive because the

psychotherapist always uses her understandings of psychoanalytic theory to inform her understanding of the patient's material and following this, her therapeutic technique (Dreher, 2000; Edwards, 1989).

The idea that psychoanalytic psychotherapy is intersubjective has great significance for data analysis as well. The primary data for this research was analysed by the therapist-researcher and her supervisors, before the research findings were written up. As mentioned previously, this was done so that the researchers' clinical judgment was always audited by at least three senior psychotherapists (Dreher, 2000). This was necessary because the session notes were the data and so their validity needed to have been scrutinized in this way. It was anticipated that this would prevent projection of what might have been anticipated into interpretations of the data (Bromley, 1986). Past patients whose process notes appeared to display evidence of the defensive structural manifestations pertinent to the research project were included as subjects. Additionally, all current eating disordered patients seen for psychotherapy had their session notes written up as if they were to become subjects. The session notes were read and analysed on an on-going basis and if and when the researcher and her supervisors agreed that a certain patient appeared to exhibit defensive structural manifestations that were pertinent for the research project, that specific patient was included as a research subject.

Ethical Considerations

Ethics clearance for this project was obtained by the University of the Witwatersrand's Medical Ethics Committee (see Appendix C). The ethical measures taken in this research project will be outlined below.

In line with the Health Professions Council of South Africa's research stipulations, informed consent is regarded as very important if one wishes to use a patient's case notes. The ethics guidelines dictate that the practitioner: "seek the consent of patients to disclosure of information wherever possible, whether or not the patients can be identified from the disclosure" (HPCSA booklet 11, 2007, p. 3). This means that the patient must be informed

about the research in a manner that is appropriate for that particular patient and sufficient information must be provided (HPCSA, booklet 10) in order for the consent to be regarded as informed. If she is in agreement, a consent form must be provided for the patient to sign (see Appendix A). The phrase ‘wherever possible’ implies that there are cases where it might not be possible to ask for consent but where the researcher would still be able to use the (disguised) material. This should not be regarded as a loophole to avoid asking for consent but would seem to apply in the case, for instance, where the patient is deceased or if there is no way of contacting the patient despite heroic efforts. In this research, consent was granted in all cases where detailed patient material was used. In order to additionally protect patient confidentiality ‘thick’ disguise was used in all cases (Furlong, 2006). This implied that only the patient and therapist would recognize the patient in the material (Gabbard, 2000). In the cases of ‘Cassie’ and ‘Brenda’, where the data was mostly the researcher’s countertransferential responses as well as supervisory input relating to two composite cases - there wasn’t a *patient* per se to recognise *her* material.

Care was taken when choosing which facts to alter to provide the disguise so that the integrity and educational value of the material was not compromised (Gabbard, 2000). For example, besides using a pseudonym, the patients’ other identifying characteristics (such as her physical features, where she lived or her career) were altered. Obviously, if any detail would immediately identify her, this was excluded. However a ‘disguise’ such as reporting a fictitious family history would have been regarded as too extreme as this would have undermined the integrity of the material and the research. Basically the art of ‘thick disguise’ is to capture the essence of the patient’s relevant history and dynamics without exposing her.

This research project drew its participants almost entirely from the therapist-researcher’s psychotherapy practice. In addition, a past hospital patient and a past research participant became participants. Research participants were new patients (at the start of the research in 2009), current patients or those whose therapies had terminated (HPCSA, booklet 11, 2007). In the case of all consenting minors, parental consent was also obtained (see Appendix B). New patients were given the Information and Consent forms (see Appendix A) to sign at the beginning of psychotherapy. As their dynamics were at that point unknown, they were informed that not all patients would be suitable subjects and so their material might or might

not be used. The therapist-researcher did not routinely tell new patients whether or not their material had subsequently been used, unless they asked specifically. This was in order to try to minimize the impact of the research on the therapy. If a patient is not thinking about the research, the therapist-researcher's bringing it up 'out of the blue' in a therapy session might well have felt like an unwelcome intrusion. The preservation of the therapy is regarded as the most important safeguard for the patient. Although informed consent is generally required as a basic legal and ethical tenet for research participation, it is not sufficient to preclude the basic ethical premise of *primum non nocere* or 'above all do no harm' (Stajner-Popovic, 2001). The possible repercussions for a patient of being asked to participate in a psychotherapy clinical case study are complex. A universal policy of informed consent might not be the ideal (Furlong, 2006) and equally, no solution is impeccable (Goldberg, 1997). This ethical issue will be discussed in more detail further on. Selected current patients were given the Information and Consent forms (Appendix A), if they were agreed, once the research was explained to them (HPCSA, booklet 11, 2007).

Appropriate material was also used from past patients. So, as mentioned before, material for the participants 'Cassie' and 'Brenda' comprised of past patient composites - therefore no one patient was asked for permission. In the case of 'Maya' a past patient from the therapist-researchers internship, permission was granted via signed consent at Tara hospital during the admission process. Lastly, in the case of 'Sarah' her interview material from my honours research was used. Permission had been gained during that initial research enterprise.

Even when one does acquire consent, it is only the first of several protective ethical measures. Thereafter, complications may arise in the patient's thinking about, reading or hearing about herself as presented by her therapist in a presentation or publication, regardless of consent having been given (Furlong, 2006). The patient cannot know how her therapist will use her case material and will be confronted with her therapist's personal rendition of her in a different forum and format. Although it is true that the therapist should have made interpretations reflecting what she considers to be the patients key dynamics before the therapy is terminated, this may not always be entirely so. An interpretation of a specific psychodynamic made digestible for a patient in therapy might be put quite differently by the therapist when used to illustrate a theoretical point in an article (Gabbard, 2000). In the latter

case an aspect of the patient's dynamics might be emphasized for educational effect. The reading of this technically *already made* interpretation might still be wounding to a patient. In the case of patients who are currently in therapy it is possible that the therapist would use understandings of the patient that she had not yet presented to her patient. At the very least these possibilities demand that a very careful analysis be made relating to all the possible ramifications for that particular patient before participation is requested. This must be done regardless of how 'interesting' a patient is (Furlong, 2006). Additionally the therapist must always be sensitive in her use of patient material. This was upheld in light of the current research project. As yet none of the participants have asked whether they became participants or not. Two of the then current patients are still in therapy with the therapist-researcher. The therapist-researcher always wrote up patient material sensitively, considering the possible impact on patients should they read her articles.

Fundamentally, the necessity for the careful assessment of the impact on the patient occurs because of the inherent conflict of interests in such endeavours (Gabbard, 2000). Something of a philosophical impasse arises when psychotherapists wish to clinical material for professional or educational purposes, which includes publication. On the one hand, a basic precept for the psychotherapist as practitioner is to protect her patient's privacy and confidentiality (Stajner-Popovic, 2001). On the other hand, the psychotherapist as author wishes to use her patient's material to illustrate theoretical concepts and make a contribution to existing knowledge. There is no simple way to reconcile these two opposing currents (Gabbard, 2000). Various approaches have been taken to try to bridge the apparently unbridgeable divide.

As previously mentioned, new and current patients were introduced to the research when consent was asked for. However, as a protective measure, they were not told later on whether or not they had in fact become subjects. The reason for this was that telling a patient she will be appearing in a published article is more or less certain to affect her feelings about psychotherapy and her transference to the therapist and the therapeutic endeavour (Gabbard, 2000). For this reason it was decided that patients would not be informed about this unless they asked. At this stage no patient has asked whether their material was used in the project. If any participant does ask at some future time, the therapist will disclose this information to

them and in the case of current patients; attempt to work through their responses in the psychotherapy. Should patients request to read the article in which their material was used, this request would first be processed in therapy. Patient fantasies and expectations about the published article would first be explored. When it is felt that this preliminary work has been sufficient, the article will be provided, either in a session or to take home (based upon whatever the patient and therapist have agreed on as best for the specific patient). It is hoped that after reading the article, the patient will be able to use her therapy to work through her feelings about the article and all that it brings up for her.

In the case of current patients who have not asked whether they had become participants or requested to read the article, only the request to participate was processed within the therapy. This seems to have allowed for therapy to proceed as usual. It is possible that patients may have had thoughts about the research and whether they have become a participant or not for a while, without telling the therapist. However, this did not appear to be the case – the therapist-researcher was careful to be vigilant regarding direct or subtle allusions of this nature. This line of action was decided upon rather than telling each patient, unsolicited, that she had/had not become a subject in the research. It seems likely that suddenly telling a patient that she has/has not become a research subject could have had major, serious therapeutic repercussions and may well have caused an untimely end to the therapy (Gabbard, 2000). For instance, patients might wonder what it was that they were manifesting that made them eligible to be a subject, or not. This could curtail their prior feelings of being able to be completely open and trusting in therapy. They may also feel that the therapy is now a project for the benefit of the therapist (Furlong, 2006). This could cause resistance in the form of a negative transference or of over-compliance, wanting to be a ‘good’ research subject in those included. On the other hand, this could cause confusion and possibly feelings of rejection in those who are told that they were not selected. In every case it would probably become an intrusive obstacle in the therapy, subverting its course. Such an outcome is highly negative to the patient and also to the research.

CHAPTER FOUR

INTRODUCTION

The following paper – *Pathological Organisations and Psychic Retreats in Eating Disorders* – was published in *The Psychoanalytic Review*. It is re-printed here with the journal's permission. See Appendix F for published version of the paper.

This paper introduces the overarching argument of the thesis namely that pathological organisations of the personality exist in eating disordered patients, as illustrated by case material from three participants. The case material came from two psychotherapy patients, an anorexic patient 'Jenna', and a binge eating disordered patient - 'Cassie'. The third source of data came from the interview material of a bulimic woman 'Sarah' who participated in my Honours research (Kadish, 2000).

This paper was intended to answer the first research question namely: *How do pathological defensive organisations manifest within intrapsychic structure and through the symptoms and interpersonal relationships (especially the psychotherapeutic relationship) of anorexics?*

This paper discussed the pathological defensive organisations of the three participants in detail. This discussion included a theoretical exploration of the operation and meaning of the eating disorder symptoms of each participant, and the part that these behaviours played in the workings of the pathological organisation of each one.

PATHOLOGICAL ORGANISATIONS AND PSYCHIC RETREATS IN EATING DISORDERS

ABSTRACT

A set of characteristic symptoms allow for the relatively straightforward diagnosis of eating disorders. Simultaneously and paradoxically a wide variety of personality organisations/disorders underlie, stretching from the neurotic to the borderline, narcissistic, even conditions approaching psychosis. This paper will argue that the inherent commonalities can be ascribed to pathological organisations of a similar nature and quality, operational across the spectrum of eating disorders and functioning in a particular, sadomasochistic way. The typical forms that eating disorders take are based on the specific ways that food and the body are used i.e. symptom manifestation. These distinctive symptom manifestations appear to be related to Steiner's (1982; 1993) notion of a psychic retreat. Pathological organisations and psychic retreats are latent until called upon either sporadically or continuously. When activated, these defensive structures operate like a complex *psychic skeleton* around which the unique psychodynamics of each patient becomes rearranged and thereby transformed.

INTRODUCTION

Many authors have acknowledged the presence of certain common features manifested in all eating disorders while simultaneously and paradoxically documenting a broad range of underlying pathology, stretching across all variation of personality organisation and/or disorder from the neurotic to the borderline, narcissistic and even conditions approaching psychosis (Shipton, 2004; Sours, 1969; Wilson, 1983). The question of how this apparent paradox might be conceptualised has not really been convincingly addressed in the literature. This paper will argue that many of the commonalities noted despite the differing personality organisations and/or disorders can be ascribed to pathological organisations of a similar nature and quality, (Steiner, 1982; 1993) operative across the spectrum of eating disorders functioning in a particular, sadomasochistic manner.

Notwithstanding the similarity in pathological organisation, the eating disorders can be separated out into characteristic forms based on the specific way that food and the body are used i.e. symptom manifestation. It will be argued that these distinctive symptom manifestations can be directly related to Steiner's notion of a psychic retreat.

It is proposed that these pathological organisations and psychic retreats lie hidden and latent until called upon either sporadically or continuously. When activated they function defensively like a complex *psychic skeleton* around which the unique psychodynamics of each eating disordered patient becomes rearranged and thereby transformed.

The paper will begin with a consideration of some basic psychoanalytic understanding of eating disorders from the perspective of object relations, Kleinian and post-Kleinian theory in order to frame the inherent paradoxes of similarity and difference. Thereafter John Steiner's work on pathological organisations and psychic retreats (1982; 1987; 1993) will be discussed, followed by a deliberation of the role of transitional and intermediary objects in the proposed psychic retreats and pathological organisations of eating disorders. Relevant case material will then be considered to illustrate the argument.

PSYCHOANALYTIC UNDERSTANDINGS OF EATING DISORDERS

Psychoanalytic literature testifies to certain basic similarities in the conscious thoughts of eating disordered patients such as the extreme fear of fatness (Wilson, 1983), a preoccupation with food and a strict categorisation of foods into a moralistic binary of 'good' and 'bad' (Kearney-Cooke, 1991). On the other hand authors note the significant diversity in individual personality organisation (Shipton, 2004; Sours, 1969; Wilson, 1983). This has undeniable implications for the therapeutic work (Johnson, 1991) but surprisingly makes little difference to the severity of the symptoms or medical sequelae i.e. an otherwise neurotic functioning anorexic would be no less emaciated or physically ill than an anorexic with severe borderline pathology (Johnson, 1991). Through the lens of the medical model this is unusual: as a

general rule there is a direct correlation between the severity of the underlying pathology and the rate of morbidity and mortality.

One of the features common to all eating disorders is the nature of the phantasies deriving from the bodily functions of incorporation and expulsion originating from the early mother-infant feeding relationship (Gilhar & Ivey, 2009; Sugarman, 1991). The nature and quality of this relationship shapes the infant's internal world, her⁶ object relations and interactions with the external world (Wilson, Hogan & Mintz, 1992; Klein, 1963).

Eating disorders are understood to be the result of serious disruption to this early relationship. For various reasons and to different degrees such a mother has difficulty attuning herself to her baby, whether because of depression, illness or characterological disorder (Krystal, 1988; Lane, 2002). This compromised attunement, repeated empathic failure, is experienced as a series of impingements which disrupt the empathic milieu that would normally support the infant's gradually evolving awareness of self consequently ego development is impaired (Geist, 1989; Shipton, 2004). In many such cases it would seem that this sort of impairment to the inchoate ego includes the development of an enclave of autistic functioning as described by Tustin (1978) and S. Klein (1980) however a thorough investigation is beyond the scope of this paper⁷.

According to Winnicott (1960) such traumatic intrusion disrupts the development of the feeling of *going-on-being* or what Ogden (1989) has described as the sense of a bounded sensory floor. In this unstable, traumatic environment the infant is unable to internalise a definite, clear sense of what is inside and what is outside the self. This in turn impairs the development of interoceptive awareness, Bruch's (1973) term, which relates to the ability to discriminate between somatic and psychic. It is not surprising then that the development of the psychic mechanisms of introjection and projection are impaired rendering her susceptible

⁶ The feminine pronoun will be used throughout because the case material derives from female patients which is reflective of the predominance of eating disorders in the female population.

⁷ See Kadish, Y. A. (2011). Autistoid Psychic Retreat in Anorexia, *British Journal of Psychotherapy*, 27:19-36.

to depletion and fragmentation (Krystal, 1988; Stolorow, Brandschaft, & Atwood, 1987; Williams, 1997).

These developmental achievements are essential precursors for the transition from the sensory to the symbolic (Krueger, 1988). Hence the infant's developing sense of self is structurally compromised. "the interweaving of these acute and cumulative developmental empathic failures (and the resulting structural deficits) becomes the childhood anlage of eating disorders; the primordial foundation for the adolescent's later attempt to fill in the structural deficit ... by symbolically recreating within the symptoms of anorexia and bulimia both the danger to the self and the efforts at self restoration" (Geist, 1989, p. 17).

This paper seeks to identify the nature and functioning of the particular structural manifestations inherent in eating disorders, it will be argued that the interaction between the apparently *dangerous* and *self restorative* aspects are integral to the particular manner of operation of sado-masochism in the pathological organizations in eating disorders. A review of Steiner's theory follows to provide a backdrop for the argument.

INTRODUCTION TO PATHOLOGICAL ORGANISATIONS AND PSYCHIC RETREATS

John Steiner (1982; 1987; 1993) developed his theory of psychic retreats and pathological organisations in an attempt to understand the dynamics of patients who are not merely resistant in the usual way but are, for all intents and purposes, unreachable to the analyst for shorter or more extended periods in treatment. Such patients seemed also to display intrapsychic structure of a highly organised and often sado-masochistic nature. Such powerful resistance had been first described by Freud (1909; 1910; 1914) who noted in the case of 'The Rat Man' (1909) a patient who felt compelled to commit a crime under the influence of internal '*agents provocateurs*' (p. 261). Abraham (1919; 1924) contributed to these ideas in his study of narcissistic resistance as did Reich (1933) adding his notion of 'character armour' while Riviere (1936) presented her significant paper addressing negative therapeutic reaction. Klein (1958) made the important distinction that unconscious destructive parts of the self

were not part of the superego but were split off remaining separate from both ego and superego. Thereafter Joseph contributed two influential papers: 'The patient who is difficult to reach' (1975) as well as: 'Addiction to near death' (1982), while Rosenfeld (1971a) presented an incorporative theory to try to explain these sorts of resistances which he termed 'destructive narcissism' and where he spoke of 'narcissistic organisations'. His conceptualisation was a significant precursor to Steiner's 'pathological organisations.'

Steiner's theory attempted an even broader reach than Rosenfeld's reflected by his use of 'pathological' rather than 'narcissistic' to describe the organisations which he believed could occur in a wide range of patients including certain types of neurotic patients as well as those who are narcissistic, borderline, perverse and even psychotic patients who are accessible to psychoanalytic treatment (Steiner, 1993). In fact Steiner asserted that all individuals may, under conditions of extreme anxiety, withdraw to a psychic retreat; A psycho-diagnostic distinction can be made regarding the duration of said retreat (the shorter, the healthier) and the extent of the pathology inherent in the organisation (Steiner, 1993).

According to Steiner's theory the patient who has withdrawn from meaningful contact into a psychic retreat in analysis may relate in a number of ways. She may present with an aloof superiority; a shallow, 'as if' sort of cooperation; or with a dishonest manner of engagement. In response to these particular sorts of contact the analyst may feel frustrated, shut out and/or pressured to behave in a superficial, corrupt, colluding or perverse manner (Steiner, 1982). Steiner proposes that these particular sorts of defensive manoeuvres are undertaken behind the protective armoury of a rigid pathological defensive organisation of the personality which functions as a safe haven that can be retreated to at any time in order to avoid the menace of seemingly unbearable anxieties.

Steiner co-opted Meltzer (1968) and Rosenfeld's (1971a) notion of the internal 'mafia' or 'gang' which offers protection to the vulnerable part of the self so long as there is complete deference shown to the ruthless, terrorising 'regime'. In certain cases there are strong sado-masochistic components; this becomes evident in a transference-countertransference where

the patient derives sadistic pleasure from, for instance, opposing the analyst's wish to be helpful as well as masochistic pleasure of remaining 'sick' rather than improving.

PSYCHIC RETREATS

The psychic retreat, which becomes available only under the auspices of a pathological organisation, is conceptualised structurally (Steiner, 1993) as a latent and expedient third position, located between Klein's (1946; 1952) two other developmental positions. In times of overwhelming anxiety of a paranoid-schizoid or depressive nature the pathological organisation is *activated* and the psychic retreat becomes available as a refuge. Psychic retreats take different forms; they can be undertaken during anxiety provoking periods in therapy but are also accessible outside of analysis in everyday life when an individual is faced with the threat of unbearable anxiety.

It seems possible then that the sorts of psychic retreats particular to eating disorders might be a flight into certain states of bodily experience which comprise the specific form of the retreat. In other words eating disorder symptomatology: bingeing, purging and/or the changes in psychic state brought upon by severe food restriction all bring about this third position; the escape into a psychic retreat as a defence against overwhelming anxiety. This would explain why the underlying psychic structure of the individual can be neurotic, narcissistic, borderline or mildly psychotic but that under conditions where anxiety seems overwhelming the latent psychic skeleton of the pathological organisation is activated making escape into a psychic retreat possible. I have used the term psychic skeleton because the pathological organisation is a complex, powerful default defensive structure, deployed when the individual feels psychologically overwhelmed. The individual's typical psychodynamics are then partially restructured and absorbed into this new structure that has arisen to *take over* psychic functioning. The reign of the new state might be short-lived or continuous. The more severe the eating disorder the more prolonged the psychic retreat. In fact in chronic cases of anorexia the psychic retreat becomes status quo unless it is disturbed by treatment or some profoundly disruptive event.

ETIOLOGY OF A PATHOLOGICAL ORGANISATION

Steiner proposed pathological organisations to be the end result of various defensive manoeuvres resorted to by the individual after the failure of normal splitting processes has occurred. He cites Klein's (1952) formulation that the individual, under the weight of severe anxiety, has defensive recourse first to normal splitting processes which implies the splitting of the object with its resulting splitting of the self/ego (Klein, 1957; Rosenfeld, 1950). Healthy splitting entails a good object in a relationship with the good part of the self/ego kept separate from a bad object in relation to the bad part of the self/ego. In a situation where this sort of splitting fails to bring about equilibrium the individual may then turn towards to the good object and good parts of the self to combat the bad object and bad parts of the self. If this defensive strategy also proves insufficient, a violent and archaic form of projective identification occurs which entails the expulsion of the self and the object now fragmented in bits (Bion, 1957).

A pathological organisation, different in form in each individual, may then develop to 'collect the pieces' and reconstitute the personality, however it is a contaminated conglomeration in that good and bad bits of the self projected into objects have become inextricably mixed up together. The new structure, comprised therefore of impure 'building blocks', is an attempt to restore the former good/ bad split within but this is impossible and instead a complex, 'Frankensteinian' structure emerges-the pathological organisation.

This hybridised personality structure – pathological organisation – *presents* itself as good and protective, offering the weak libidinal self/ego a place of safety against attack, however this is illusory. Due to its abovementioned origins, the pathological organisation is constituted by mixed up bits and nothing is as it seems. The organisation appears to seduce and mislead the weak libidinal ego however there is always some degree of collusion (Steiner, 1993). Tyranny and sadism are allowed to dominate the weak, dependant libidinal self/ego that both knows

and does not know the nature of the *unholy* bargain that has been struck and so by definition is a perverse engagement. Unwavering compliance is demanded and obtained because safety against overwhelming anxiety is offered in return; hence a rigid, often idealised, sado-masochistic structure becomes entrenched (Steiner, 1982; 1993).

If the omnipotent protection of the organisation is relied upon excessively healthy growth is arrested. This is because psychological development relies upon the flexible use of projective identification as an object relational tool. Since pathological organisations are comprised of multiple split-off, disowned parts of the self in complex formation, no one element can be separated out and identified as being part of the self, mourned (which would allow the withdrawal of projections) and then internalised, as is necessary for depressive functioning. Thus in cases where these organisations are entrenched there can be no healthy flexibility of projective identifications and development is frozen (Steiner, 1993).

This stagnant situation can often be found with eating disordered patients. There appears to be a particular sort of pathological organisation where the sadistic ‘mafia boss’, as conduit for projections of harsh, punitive ideology regarding ‘fatness’ and greed, is *engaged in a relationship* with a masochistic part containing loathed, disavowed parts of the self. At first glance this situation seems most apparent in anorexia where sadomasochism manifests in the symptom and in the transference-countertransference (Bach, 1997; Lane, 2002; Risen, 1982). It is not only the building blocks of the organisation that must be comprehended but also the particular way in which they are placed and held together-this is vital because the analyst might well become an elements in the organisation, enacting either or both the oppressive and malevolent part or the passive and compliant component.

The discussion will now turn to the central role of intermediate and transitional objects in the pathological organisations and psychic retreats of eating disorders.

AN INTRODUCTION TO TRANSITIONAL AND INTERMEDIATE OBJECTS

As the infant moves through each developmental phase, the deep pleasures of the phase-specific zone and object are left behind. The child associates the loss of pleasure with object loss: the waning of the dominance of the organ and its product (Kestenberg, 1968). Each zone and its associated product are then psychically condensed becoming an intermediate object. An intermediate object is different from Winnicott's (1953) notion of a transitional object in that the former originates from the body, whereas the latter does not (Kestenberg, 1968; Kestenberg & Weinstein, 1988). An example of an intermediate object would be milk from the breast or bottle, vomit from the mouth, feces and urine. Intermediate objects are able to change shape and merge or separate from the individual's body; they transform and decay quickly, unlike true transitional objects.

Intermediate objects may thus be considered to be a special type of forerunner to transitional objects, an additional stage in the progression from the use of the body and its products to the use of, for instance, a piece blanket or rag doll (Kestenberg, 1968; Kestenberg & Weinstein, 1988). This additional stage occurs at a juncture where the infant has neither a secure inner representation of mother nor her own body. Thus intermediate objects typically function as a bridge to mother (Kestenberg, 1968). They are precursors to transitional objects because by they cannot last but decompose and are destructible. The 'robustness' of a transitional object, on the other hand, means it is the first object experienced psychically as having some sort of sustained existence in the space between 'me' and 'not me'. This endure-ability allows for the internalisation of a *sustainable* third area whereas intermediate objects, originally a joint possession of mother and infant, diminish in 'value' when they are detached from the body (Farrell, 1995).

THIRD AREA OF EXPERIENCING VERSUS THIRD POSITION

Winnicott's (1960) notion of a third area of experiencing must be differentiated from Steiner's (1993) notion of a 'third position' which is a psychic retreat from overwhelming anxiety originating from the first – paranoid-schizoid – or second – depressive – developmental positions. In eating disorders, psychic retreats (the third position) are used as an escape from anxiety which cannot be contained within the self due to the individual's inability to access a third area of experiencing or transitional space. These developmental

disturbances preclude the use of symbols or the tolerance of ambiguity or paradox and prohibit secure internalization of soothing and tension-regulating structures (Bach, 1997; Bruch, 1978; Geist, 1989). This renders distress incomprehensible and hence inexpressible within an object relationship (Bach, 1997; Kearney-Cooke, 1991).

The reason for these serious object relational difficulties is believed to lie in the earliest mother-infant interactions (Birksted-Breen, 1989; Bruch, 1978; Lane, 2002). Some suggest a narcissistic mother (Lane, 2002; Sours, 1974) who attempts to use her infant's body inappropriately to rid herself of unwanted feelings by way of projections into the infant. The baby's body then becomes a transitional object for mother in her attempt to reach a transitional space/third area of experiencing (Farrell, 1995; Winnicott, 1960). This is a highly toxic situation for the infant and is experienced as an impingement or series of impingements (Williams, 1997). The child is left with intrapsychic deficits. Rather than being able to contain and process their emotional experiences, eating disordered patients use food, bodily products and altered psychic states in a perverted way in order to escape from terrifying indigestible experience.

Jordá-Fahrer, Fahrer, Guinjoan, Ross, Perinot & Maritato (2001) describe the cases of two patients, an anorexic and a bulimic, attributing their progress to their utilization of transitional objects during treatment. This was possible after some therapeutic work had been done; prior to this they had starved and used food concretely. The patients' improved considerably after they were able to use transitional objects associated with their therapists to soothe themselves in-between sessions. Ultimately it is anticipated that patients become able to access an internal transitional space through their internalization of the soothing, containing qualities of the therapist and the therapeutic relationship.

Before this can be accomplished however, eating disordered patients use food and bodily products as if they are the object in the way of a symbolic equation as discussed by Segal (1957) in which the separateness of the object is denied. Food used instead of an object relationship functions to deny and substitute for said object rather than representing it. In other words, it enables the patient's feelings of omnipotence and self-reliance allowing her to

disavow the needs of her libidinal self for an object to meet the need. Hence a psychic retreat is resorted to rather than a third area/transitional space, as the latter involves a true awareness of separation between self and object (Arlene Joffe, 2010, private correspondence).

Material from three eating disordered patients will now be discussed. Although transference-countertransference manifestations are acknowledged to be crucial for the apprehension of these states, this is not the focus of the paper. Instead the clinical material has been selected in order to highlight the internal dynamics in each case. The following clinical vignette provides an illustration of the workings of a pathological organisation in an anorexic patient.

SESSION MATERIAL FROM A RESTRICTING ANOREXIC PATIENT

‘Jenna’, a recovering adolescent anorexic patient in once weekly therapy, gave an eloquent description of her struggle against opposing currents within herself, which I regard as being component parts of her sadomasochistic pathological organisation.

J: I think there is a part of me that enjoys torturing myself; I can't explain it. It's like when I was little, if I hurt my dog I would bash my head against the wall so I could feel the pain that he was feeling, that I had made him feel. And with the anorexia, if I really want a particular food and I am dying for it, another part of me enjoys saying "no you can't have it!" It likes watching me not have it. It's so weird, it's as though I like to see myself suffer.

Therapist: You feel like there is a part of you that wants things and another part that enjoys seeing you not get what you want.

J: Yes, just like that, like I get some kind of happiness from that. It's so abnormal, are other people this abnormal? I always look at people and wonder what goes on behind closed doors. Everyone else looks so perfect so normal, but maybe not...

Therapist: Maybe you are wondering if I think you are a bit crazy when you tell me about these thoughts and feelings.

*J: Sometimes I do think that, you know, I wonder if there is something really wrong with me that things never seem to go right whatever I try. Maybe I don't trust myself, maybe that's why I'm scared to give up the anorexia completely. It gives me something I can do right, I **can** lose weight when I eat less. I can rely on that.*

***Therapist:** I can see why it's so hard to give it up then because it makes you feel certain about something when other things feel out of control.*

J: Yes and I think that's why I'm feeling confused about my eating again. Part of me wants to eat less, like last night I thought I must have two crisp-breads and tea instead of the cup of Milo and two biscuits that I am supposed to have, so I would be eating less. Then another part of me feels like I don't want to go through all that again, being in hospital and everything and I know I looked terrible then, I can see that when I look at pictures now. I don't want to look like that again. I mean a normal person would know what to do. It's like a moral dilemma but what's so hard is that there isn't a right or wrong answer, neither side is completely good or bad, they both offer different things. Like if I listen to the anorexic part that makes me want to eat less then I feel like I am in control and I will never get fat again but on the other hand I wish I wasn't so rigid about food. I eat the same things all the time because I'm so scared to try new foods, like I would love to have an ice cream but I'm too scared. When I left hospital I thought I would be free from all this because in hospital it's really good the way they are all behind you and you just have to concentrate on eating properly so you can go home. You just rest on your bed and you don't have to worry about your school work or anything. And I felt positive and free for a while afterwards but now I'm stressed again: over Jamie, if he likes me, school is hard and I'm worried about the school dance. I just want to go into a chemically induced coma (laughs nervously). Ok I know that sounds bad... I want to hibernate, just to go away somewhere and hibernate, not eat, not exercise and not have to worry about anything, just sleep.

***Therapist:** So maybe it feels like the anorexia offers you a way to escape to somewhere safe where you won't have to face all this stress, it seems to offer something like a cocoon for you.*

J: Yes, then I wouldn't have to worry about all this stuff, I could just go away. But I know that won't be good, I don't want to relapse. This is so hard...

In this excerpt Jenna discusses the way that anorexia might allow her to escape from the anxiety induced by the challenges she must again face, now that she is *back in the world* and out of hospital. Some of these anxieties seem to be depressive because they demand that she grapple with issues regarding genitality, mature object relations. She is preoccupied with thoughts about whether the boy she likes, likes her back. She worries about how she will manage her school work and if she will cope socially at the school dance. These are normal adolescent concerns however the anorexic girl often develops her illness because she cannot manage these very issues. It is a time where true separation and individuation is called for and this elicits powerful depressive anxiety and the revival of earlier fixation points. This is often a stumbling block for vulnerable individuals. Obsessive thoughts and rituals function as conscious defences against physical appetite/greed and unconscious fears about separation and whole object relationships.

For patients like Jenna, anorexia seems to offer something of a solution in the face of apparently overwhelming anxiety brought about by puberty (Bruch, 1978; Lane, 2002; Shipton, 2004). In the vignette this can be seen in the way that the *mafia boss*-internal object of her pathological organisation is experienced as a voice or a part of her that demands compliance via starvation in return for ‘protection’ from anxiety. Self imposed starvation and the altered perceptual states it produces such as dizziness, light headedness or feeling ‘high’ (Jordá-Fahrer et al., 2001) offer an omnipotent escape. The psychic retreat allows her respite from overwhelming anxiety regarding object relations and her terrible struggle to cope as a separate being (Birksted-Breen, 1989; Gentile, 2006). Jenna refers to this altered mental state as a “chemically induced coma” or “hibernation”. This state is only accessible through total compliance, saint-like abstinence, which bolsters omnipotent feelings and as such comprise the psychic retreat characteristic of anorexia. Lawrence’s (2001) notion of the ‘white-out’ state of mind of the anorexic-where the oedipal⁸ couple do not exist and the world is felt to be a pure and clean-describes something of the nature of the underlying phantasy that accompanies the altered anorexic mental state. Thus her pathological organisation and accompanying psychic retreat operates like a psychic skeleton functioning as if superimposed over habitual intrapsychic mechanisms. The activation of this default structure allows entrance into a state of manic omnipotence where the realities of her life can be denied.

⁸ Oedipal concerns are highlighted in eating disorders and each case presented in this paper includes oedipal issues; however a thorough exploration is beyond the scope of this paper.

In other types of eating disorder where starvation is not a feature of the illness or is only one aspect the role of food and bodily products is central; I will now present such a case.

CASE MATERIAL FROM A BINGE EATING PATIENT

‘Cassie’, the youngest of four siblings and the “runt of the litter” was controlled by an internal object which was dominating, critical and contemptuous and which resembled her father, who was particularly disdainful of greedy girls i.e. those who ate fattening foods and of *loose women*. All evidence of physical appetite, both in relation to food and sex had to be disavowed. Cassie also had a weak and passive part of herself which seemed derived from a partial identification with her mother, who was portrayed as passive, dependent and depressive with a preoccupation with body weight.

Cassie’s binge eating symptom began when she was an adolescent, at this time her disgust at her developing body was exacerbated by her father’s disapproving comments. She felt furious with him but was unable to articulate this to anyone. In her family, father was the only one who had been permitted to express anger and as a result Cassie had found it almost impossible to confront unacceptable situations or express angry feelings instead she withdrew from such situations and then binged. She would eat low calorie foods with her family at the dinner table but then would binge secretly in her bedroom late at night. This behaviour continued into adulthood when she would eat normal meals in front of her weight-conscious husband but then on most nights she would carefully plan a secret late-night binge. Cassie was able to become aware that her binge eating was in part an angry rebellion against particularly her father’s conditional approval, now projected onto her husband. In fact her father had not commented on her weight for many years so essentially it seemed to be a revolt against the father of her youth whom I suspected personified the internal dominating critical object in her pathological organisation (Steiner, 1982).

Cassie's defensive structure seemed to comprise of this dominating critical part in close relation to a weak and passive part, this coupling seemed to function sado-masochistically in the way that Steiner (1982; 1993) described in his thesis on certain types of pathological organisation. During the course of the therapy I came to understand that there was at least one other prominent aspect in her defensive organisation, an angry, defiant third part of her that attempted to challenge the sado-masochistic pairing. However it was extremely difficult for Cassie to allow herself any appearance of anger and so it seemed that this angry, defiant third part most readily found expression in her binge eating which operated as a psychic retreat from stressful undercurrents in her life.

Cassie's binges functioned as a 'safe' way to experience inexpressible, angry feelings, but they operated in another important way as well. Cassie's interest in sex was minimal to non-existent; she communicated this to me with something akin to pious pride. Apropos, it seemed as though her libido had been prematurely 'derailed' or fixated on an oral and anal trajectory and that genital functioning in general was underdeveloped. In Kleinian terms much of her functioning was paranoid schizoid; feelings of envy and greed as well as angry anal attacks were counterbalanced by the terror of persecutory retaliation from a vengeful object. For the most part, periods of depressive whole object relations were ephemeral. Hence her binges operated orally insofar as unmitigated greed was rapturously liberated and anally in that her rage and defiance were given some sort of expression albeit in fantasy. The libidinal investment in her binges was evident in the way she described them, almost like an illicit love affair in the secretive planning and associated anticipation of some sort of perfect bliss or 'escape' to what she described as her 'food island'⁹. This oral-anal libidinal trajectory meant that her participation in her sex life was at the level of bland compliance absent of desire. This was another way which her binge 'worked.' It seemed to be a tacit reaction to the psychic conflict between her father's instruction to be *ladylike* and her anxiety provoking physical desires. Her binges 'resolved' this conflict by displacing genital desires onto oral ones where appetite could be more safely indulged in the realm of the food island/psychic retreat.

⁹ Shipton (2004) describes a similar dynamic in her patient 'Amy'.

However the dominance of sadism in her pathological organisation meant that 'positive' and 'adaptive' aspects of the psychic retreat were short lived. Some way into her binge the food ceased to functioning as a self-soothing intermediate object/psychic retreat and transformed into horror at her greed and destructiveness. She seemed to *awaken to* the perverse way she had used the food as if it were a loved object that could be devoured to her heart's content. Suddenly, like Adam and Eve, nakedness exposed, she felt she had been cast out of paradise, the mirage of the retreat exposed. Her attempt to escape from the demands of the external world via the psychic retreat/binge was short lived. Immediately post binge, her anxiety would reach a crescendo as the reality of her frenzied eating sunk in. This made her especially vulnerable to the renewed pull of the organisation. 'It' severely chastised her for her wanton greed but then offered her protection against her resulting anxiety of becoming fat and disgusting. This impure mix of soothing and destructiveness can be apprehended in a careful analysis of the stages of the binge.

STAGES OF THE BINGE

Entry into the psychic retreat appeared to begin from the planning stage, stretching over the hours before and then into the first period of the actual eating. The prolonged anticipation seemed to be a sensuous and idealised fantasy distracting her from anxiety. When she described this period, my reverie was of a little girl anticipating her birthday party where she would be made to feel special, surrounded by pretty cupcakes and confectionary. I came to understand that this state of omnipotent fantasy functioned as a defence against overwhelming mental states.

However the magical promise of the safe, self contained 'Eden' was short-lived. Once the actual eating commenced the omnipotence broke down. A growing sense of anxiety meant that her voluptuous experience with the food quickly transformed it into decaying waste in the way of an intermediate object. In her growing distress she would begin to shovel food down frenetically until she felt stuffed and ill. She feared she would be 'caught' in this disgraceful act and be punished, although she could not say how or by whom just that she knew she would feel very guilty and ashamed.

Cassie told me that after her binge, wracked with guilt and self loathing, she would feel painfully full and nauseous. The agonizing aftermath was the way she punished herself for her greedy, rebellious transgression. Harsh and critical feelings of the “now look what you have done” variety – appeared as crushing admonitions from her ‘critical father’ part in relation to her ‘passive mother’ part; she would be over taken by hopeless despair. Before the therapy she had not been able to consider her behaviour in a thoughtful way. Instead there was a desperate need to renew her compliance with the strict rules laid down by the harsh, critical part of the pathological organisation in return for protection against these unbearable feelings that she was sordid and destructive. She would recommit herself to total acquiescence-eating the bare minimum of ‘permissible’ foods and the disavowal of ‘bad’ thoughts. Predictably, when her feelings of deprivation and anger became overwhelming once again, the cycle would repeat itself.

In therapy, the processing of her binges and their underlying meaning and function lead over time to a drastic decrease in binge eating behaviour. This meant that during stressful times she was able to develop ways to work through and express her anger instead of automatically escaping via psychic retreat. She was also able to confront her disgust about sexuality and understand her unconscious linking of greed and sexual desire. She was eventually able to renounce concrete intermediate objects in return for greater reliance on object relationships.

INTERVIEW MATERIAL FROM A BULIMAREXIC PATIENT

I will now contrast the cases of Jenna and Cassie to the analysis of material derived from a journal excerpt¹⁰ from a bulimic research subject ‘Sarah’. The narrative was obtained as part of a research interview process and therefore is a different order of material from the other two. I decided to use Sarah instead of one of my bulimic patients because the material appears to allow relatively direct access to a bulimic individual’s experience of her pathological organisation. The extract is from a journal she kept during a period when she studied overseas. It was during this time that she became bulimic. This is not uncommon; going away to university is a well documented catalyst for eating disorders (Gordon, 1990). It should be

¹⁰ This journal excerpt formed part of the data for my research project entitled: ON THE RELATIONSHIP BETWEEN ANXIETY AND BINGE IN BULIMIA NERVOSA...A QUALITATIVE STUDY undertaken at the University of Witwatersrand, 2000.

noted that when Sarah referred to ‘voices’, these are different to the voices reported by psychotic patients. Sarah recognised the voices as being internal to her. In her case they seem to manifest not unlike the ‘agents provocateurs’ in the case of the ‘Rat Man’ (Freud, 1909).

She wrote:

“I should have guessed that the peace would not last, as I’d got to my block of flats and began to walk up the stairs, familiar feelings tugged at my feet. I tried hard to hang on to the joy, but it melted as quickly as the snowflakes clinging to my face. An overwhelming loneliness washed over me as I opened the door and walked into my flat. The silence was broken and the voices started again. “This is something you should only experience with Jonathan, how can you be so selfish as to enjoy this on your own, you shouldn’t even be here, you are just self-centred, egotistical...””

Sarah experienced feelings of guilt about having chosen to separate from her object, in this case her husband, to pursue her own agenda, that of studying overseas. It seems that her decision had evoked anxiety about the dangers of separation. Her joy at being able to walk in the snow to her own flat in a new city quickly turned to loneliness, as if she had been abandoned rather than having chosen to leave her home. This is then associated with the phantasy of the angry retaliation of an object scorned, embodied by her sudden awareness of the critical, cruel voices of her pathological organisation.

“I tried not to listen it was such a magical, unique experience; I didn’t want to let go of the peace and the beauty. As I took off my wet coat and gloves I realised that I was shivering. I longed for the taste of something warm and sweet in my mouth – hot milk and sugar. I hugged a smile to myself as I thought of my dad pouring out tall glasses of hot milk and ceremoniously stirring two spoons of sugar in each. The memory warmed me as the milk had

warmed our bodies... I held the milk up to my lips enjoying the sensation of the rising steam on my face. A sense of longing washed over me and was followed by a feeling of shame”.

Here, Sarah seems to try to satisfy her need for emotional nurturing with the milk that she associates with her father’s care in a concrete attempt at self soothing. A sense of shame follows one of longing for the closeness with her father. This may well be understood through the lens of oedipal and/or even pre-oedipal strivings denied, however as she was not my patient I was unable to explore this. Nevertheless, what follows is an experience somewhat similar to Cassie’s in that her attempt to use food as an intermediate object to escape her painful feelings is short lived. Feelings of shame, guilt and anxiety precede self-punitive compensatory measures.

“The voices seized the opportunity... “You greedy pig how can you have a glass of milk when you’ve had a full supper and a slice of cake?” Earlier that evening at the bible study we’d been offered cake with our coffee, I think someone was celebrating a birthday. I had tried desperately to think of an excuse not to have any but I knew that I was being carefully watched by the study leaders who were rather concerned about my diminishing appetite. After an intense inner struggle I’d accepted a small piece and eaten half of it. My fears were justified as the voices began to attack me with this latest evidence of my gluttony, my sloth. “No wonder you are so fat you are just a glutton how could you, you can’t even say no to one piece of cake and you could have left some of your supper as well. If you’d have taken the plates to the kitchen no-one would have noticed, you will just have to exercise more tomorrow or you can get rid of it now.” I tried to stop the thoughts, it was just a small piece of cake and I ate less than everyone else at supper I will get up early and do exercise, I will go for a long walk in the snow tomorrow. Please I don’t want to be sick I promised Jonathan I wouldn’t and what if I can’t. The last few times I tried it was so hard and my throat ended up bleeding and sore for days, it’s not worth it. I feel so tired and drained afterwards”.

Here the extent of the sadism of her pathological organisation is evident. It’s as if a terrified her is being persecuted by a monstrous tyrant. There is bargaining to and fro, the pathological organisation offers her chance to ‘get rid’ of the food. She seems invested in her status as

victim as a way of avoiding responsibility for her decision to purge. Possibly here is the collusion Steiner speaks of, between the weak libidinal ego/self and the pathological organisation in return for the omnipotence it brings. In Sarah's case the omnipotence comes from a perverse engagement which allows her to purge without taking responsibility for the decision. Here I think Klein's (1958) notion of a split off destructive part of the self, not belonging to either ego or superego is evident. Until the split-off destructiveness can be acknowledged integration of the self is impossible.

"I looked out at the falling snow again and again and cried. Was there no escape? I could phone someone and talk it through but who? The sense of shame and disgust at what I was contemplating prevented me from reaching out as the panic feelings rose I know that I would have to do it, if it wasn't now it would be later. There would be no rest from the voices until they were appeased, until I carried out due penance for my lack of control".

Sarah feels unable to use her relationships to mediate her painful feelings. She engages masochistically with the sadism of the voices of her pathological organisation. She calls her purging 'due penance', a biblical allusion. This is significant because she is a religious person. She appears to experience the voices as if emanating from a wrathful God demanding sacrifice. At the same time there is a denial of the knowledge that she will actually be incredibly relieved not to gain weight from her lapse of control.

"I suddenly remembered a box of chocolates that I'd been given for a Christmas gift; although it was March they were still in the cupboard sealed in the cellophane for my protection. I had known that opening the box would be fatal. I had hidden them away and tried to forget their existence but now they taunted and taunted from their hiding place. The struggle continued to rage inside me for a long time while I stared into the silently falling snow. Slowly and mechanically I walked over to the cupboard and took out the chocolates. I chose one that I liked and then closed the box and put them away- just one, just a little treat".

Interestingly Sarah narrates her experience as if she is absent of any desire for the chocolates. Her yearning for them is not mentioned but they are seen to ‘taunt’ her. She has kept them unopened for three months and now her pathological organisation offers her the opportunity to eat them because she already knows she is going to purge. Hence there is once again evidence suggesting a perverse engagement, collusion with the sadistic element. The perverse engagement entails her surrender to the ‘punishment’ of the vomiting in return for being able to eat the forbidden chocolate without admitting that she has made the decision to give herself ‘a little treat’. However, once done the internal sadism is exacerbated.

“It was a long time since I had allowed myself chocolate, it tasted so good. But the voices were having none of that “Chocolate!” “That is what fat people gorge themselves on, you have no self control, how could you open a whole box now what are you going to do with the rest?” “I suppose you intend to ration yourself to one a day, that’s a joke.” “If you eat them quickly and vomit them all up they won’t affect your weight.” The rest of the chocolates disappeared fast. I continued to watch the gently falling snow but it no longer looked white and pure. The whole world had been contaminated by my evil greed. I suffered and suffered to try to fill the gap in me that was never satisfied. Then I went and vomited until my heaving only yielded blood, I could no longer even swallow saliva through my swollen throat”.

In this final part the internal sadism provokes masochistic shame and terror at her greed; the greed is experienced as being able to destroy her whole world. However there is also the acknowledgement of an insatiable void inside herself which is a hopeful portent, a moment of insight.

In fact Sarah had already recovered from bulimia at the time of the interview. She attributed this to therapy, both individual and group, as well as the “therapeutic way” she used her diary. Gentile (2006) described a similar case in her analysis of the diaries of Hannah, a bulimic woman. The diaries were kept from early adolescence. She tracked the way that Hannah used her diaries to create an externalised space, third area of experiencing. Gradually through her writing Hannah was able to develop the capacity to discriminate between self and object and

to symbolize her traumatic experiences. This, together with therapy, led to psychological recovery.

DISCUSSION

In all three cases there is evidence to suggest the operation of sado-masochistic pathological organisations. Overwhelming anxiety instigates the activation of the latent psychic skeleton. In the three cases psychic vulnerability i.e. an impaired ability for object relations and an inability to access a third area of experiencing, appear to necessitate engagement with the organisation. In all three cases too, profound feelings of shame and guilt about greed underpinned the sado-masochistic organisation.

Regarding the use of psychic retreats in the three cases, there were notable differences. Jenna used the omnipotence afforded by her starving state as a psychic retreat from anxiety whereas Cassie and Sarah used food and/or vomit as intermediate objects, concrete props in their psychic retreats. Typical of restricting anorexics, Jenna did not use food as an intermediate object but the avoidance thereof.

If one considers the nature of the anxieties that caused the activation of the pathological organisation leading to the eating disorder, there was also some variation. Jenna's anorexia began as a result of anxiety of a paranoid schizoid and depressive nature at the time of puberty. She used her anorexia as a way of not having to attempt the challenges of genitality but rather retreated to a "chemically induced" "hibernation" state. Cassie's psychic retreat began in the period of anticipation of the binge. When she did finally allow herself to partake her omnipotence faded and overwhelming anxiety returned. As a result of this she renewed her reliance on her pathological organisation in the aftermath of the binge. Cassie's anxiety was paranoid schizoid and depressive in nature, felt in relation to her object relations and sexuality. Sarah, on the other hand, appeared to use her ritualised bouts of 'out of control' eating and vomiting as psychic retreats from her anxiety about separation and individuation as well as guilt about her greed.

CONCLUSION

This paper argued that many of the commonalities found in eating disorders can be ascribed to particular sorts of sado-masochistic pathological organisations, (Steiner, 1982; 1993) operative across the spectrum of eating disorders and functioning in a particular, manner. Case material from three women: a recovering anorexic, a binge eater and a bulimic were used to demonstrate the specific ways that food and the body are used concretely for psychic retreat from overwhelming anxiety. It was proposed that both the similar pathological organisations but different psychic retreats function as a 'psychic skeleton' around which the unique psychodynamics of each eating disordered patient becomes arranged. In eating disorders food and bodily products seem to operate as intermediate objects, concretely in the place of an object. In this way the separateness of the object is denied. Food used instead of an object relationship seems function to deny and substitute for said object rather than representing it. This enables the patient's feelings of omnipotence and self-reliance allowing her to disavow the needs of her libidinal self for an object to meet the need. Hence a psychic retreat is resorted to rather than a third area/transitional space, as the latter involves a true awareness of separation between self and object.

CHAPTER FIVE

INTRODUCTION

The following paper – *Autistoid Psychic Retreat in Anorexia* – was published in the British Journal of Psychotherapy. It is re-printed here with the journal's permission. See Appendix G for the published version of this paper.

This paper is an in-depth case study of an adolescent anorexic patient 'Amy'. The paper directly addresses both research questions. The first research question was: *How do pathological defensive organisations manifest within intrapsychic structure and through the symptoms and interpersonal relationships (especially the psychotherapeutic relationship) of anorexics?* This paper offers a detailed account of 'Amy's' pathological defensive organisation and the way that this operates in her anorexic presentation.

In answer to the second question: *How do autistoid phenomena (including autistoid encapsulation) seem evident- based upon clinical material from anorexic patients?* The paper gives a comprehensive account of the patient's history, the course of therapy, her object relationships as well as a thorough discussion of the transference-countertransference dynamic. Case material is included as well as a dream. Interestingly, since the publication of this paper Strauss (2012) has written a paper which considers a (non-eating disordered) male patient's autistic psychic retreat.

AUTISTOID PSYCHIC RETREAT IN ANOREXIA

ABSTRACT

This paper argues that anorexia may be understood to be a particular kind of autistoid psychic retreat: a defensive withdrawal to a primitive enclosed part of the self that has been damaged by early infantile trauma, the result of a disruption to the mother-infant pair. This damage can be envisaged as an enclosed ‘cyst’ or ‘tumour,’ defensively ‘sectioned off’ from the rest of the individual’s psychic life. When a patient takes refuge in an autistoid psychic retreat she is typically experienced as emotionally ‘cut off’ by others, including her psychotherapist thereby making it difficult to establish and maintain a ‘living’ therapeutic alliance. The resulting countertransference, a crucial diagnostic tool for establishing the existence of an autistoid retreat, simultaneously challenges the therapist with a range of unsettling feelings that require processing in order to access the anorexic’s inner world. The case of a female adolescent anorexic in psychodynamic psychotherapy will be presented. There were two distinct phases in this therapy, the second phase suggesting emergence from the autistoid retreat. This material will be used to illustrate autistoid dynamics and their implications for treating such patients.

INTRODUCTION

Drawing on case material from the psychotherapy of an female adolescent anorexic patient this paper suggests anorexia as a particular kind of autistoid psychic retreat (Nissen, 2008; Steiner, 1993) and seeks to examine the relationship between ‘autistic/oid states’ and anorexia in an attempt to advance understandings of autistic/oid phenomena (Tustin, 1978). Although a few authors have suggested such an overlap, presenting patients who display both an eating disorder and an ‘autistic barrier’ or ‘enclave’, none have explored how common this pathological configuration is or what the precise relationship between anorexia and autistoid psychic retreats might be (Barrows, 1999; Farber, 2008; Mitrani, 2007; Tustin, 1986). This paper is not concerned with the prevalence of autistoid retreats in anorexia but rather with the manifestation and function of these dynamics in anorexic disturbance.

An autistoid psychic retreat can be understood as a defensive withdrawal by a predisposed individual, during any stage of life and for any period of time, to a primitive, enclosed, part of the self that has been damaged as a result of early infantile trauma (Mitrani, 1992; Nissen 2008; Tustin, 1981). This damaged part of the self can be envisaged as an enclosed ‘cyst’ or ‘tumour,’ defensively ‘sectioned off’ from the rest of intrapsychic structure (S. Klein, 1980). In the psychoanalytic literature, this sort of structural manifestation is referred to as an ‘enclave of autism’ (Tustin, 1984), ‘autistic barriers’ (Golden & Hill, 1994) or ‘pockets of autistic functioning’ (Innes-Smith, 1987). These terms are used interchangeably to describe defence mechanisms, very much like those documented with ‘autism proper,’ within the personality structures of some neurotic or narcissistic adult and adolescent patients (Tustin, 1978; S. Klein, 1980). The terms ‘autistic’ and ‘autistoid’ are used synonymously (Nissen, 2008) in the case of adult and adolescent autistic/oid states (Tustin, 1978). Despite the variation in clinical picture, almost all authors agree on a common origin: autistoid pathology is the result of some traumatic impingement on the mother-infant dyad, occurring in the earliest, pre-symbolic stage of life (De Cesarei, 2005; Innes-Smith, 1987; Tustin, 1981; Mitrani, 1992), prior to Melanie Klein’s (1946) paranoid-schizoid position.

The paper begins with the case of an adolescent anorexic patient including the first phase of her therapy. This is followed by a theoretical discussion of the countertransference, origins and role of secondary skin formations in autistic/oid states. There follows a detailed consideration of the second phase of therapy including an analysis of the clinical material. The paper concludes with a discussion elaborating upon the author’s argument in relation to the relevant literature.

CASE MATERIAL

‘Amy’ has been in once weekly psychotherapy for just under two years but has recently started to come twice a week. There have been two quite distinct phases in the therapy; the first phase, spanning roughly the first year, was marked by a dyadic fusion in the transference-counter transference whereby I was drawn into an involuntary collusion with her autistoid retreat. The second phase has seen a shift towards a more triadic dynamic characterised by increasing room for each of us to think (Aron, 2006). This shift can be

mostly ascribed to two important occurrences: the patient's positive experience of hospitalization and the impact of supervisory input. Both of these have opened up a more productive therapeutic space. More will be said about this in due course.

Amy, the only daughter and second child of her unhappily married middle class parents, was born about eighteen months after her brother. Her parents were experiencing significant conflict in their marriage at this time with father often away on business leaving mother alone with their two young children. When father was home, the couple fought frequently and on occasion father had struck mother¹¹. Although the physical fighting stopped when Amy was about five years old the marriage seems always to have been marred by hostility. Recently the couple have begun divorce proceedings and Amy's father has left the parental home.

Before proceeding with the case material it is necessary to address the fact that this paper focuses more on the role of Amy's mother than on her father or the role of domestic violence due to the pre-oedipal nature of Amy's disturbance. This does not imply that I regard mother as the sole cause of Amy's anorexia, certainly many factors were significant. Unfortunately it is impossible to fully interrogate all the contributing aspects in one paper.

Amy began to develop anorexia towards the end of her first year of high school. She had, as usual, excelled academically but a quarrel and subsequent betrayal by her best friend caused her to become withdrawn. Although not overweight, she gradually reduced her food intake, while exercising compulsively. She had the idea that she was "chubby" and if she lost weight things would be better. She did this to the extreme and was briefly hospitalised a year later at a very low weight. She stayed for only a week because her tearful pleas convinced her parents to take her home against medical advice. Amy's parents agreed to take her home on condition that she promised to cooperate and get well. Mother kept her out of school for three months and the pair seemed to resume a quasi mother-infant nursing relationship in that Amy was mostly on bed rest with mother at her side, making sure she ate each carefully measured

¹¹ Unfortunately the issue of domestic violence cannot be explored due to spatial constraints. However, it is my belief that Amy's early exposure to her father's physical abuse of her mother as well as the ongoing tension between her parents contributed significantly to the development of Amy's anorexia.

morsel. From the accounts of both, this regressive ‘honeymoon period’ was mutually satisfying. Amy felt secure that she had her mother hovering over her attentively and her mother was gratified by her seeming ability to restore her daughter to health. However, after gaining some weight, mother’s careful ministrations eased off and Amy returned to school. Quite soon after, the anorexia waxed again.

A few months into the relapse, mother had to acknowledge that help was needed and Amy was brought to me for therapy. Amy’s mother was able to tolerate my having a special relationship with her daughter as long as she was able to have access to me as well. This access took the form of periodic phone calls and text messages, usually to ‘tell on’ Amy - “she wasn’t trying hard enough” or she “was being difficult and hostile.” I think she imagined I would admonish Amy in our next session. These communications were met with my polite but consistent refusal to talk about Amy which decreased but did not prevent mother’s attempts to make contact with me. Notably, Amy’s mother was steadfast in her commitment to her daughter’s therapy and would be quite put out by my infrequent breaks. While I was away during the first such break of three weeks, towards the end of the first year of therapy, Amy’s weight dropped to a predetermined level which all had agreed would necessitate re-hospitalisation. On my return I was informed that she had been hospitalised in the eating disorder unit of a psychiatric hospital. Mother’s curt, accusing tone seemed to convey that my ‘dereliction of duty’ had contributed to her daughter’s relapse.

Amy returned to therapy three months later. She told me that in hospital she had initially found it hard to settle, but then started to feel nurtured by the consistent care and predictable routine. She made friends with two eating disordered patients and these friendships, established within the facilitating hospital milieu, gave her an experience different from the superficial friendships with her school mates. With these hospital friends she felt she had something to contribute, she had become someone whose opinion could be valued and this affirming experience seemed to allow for a tentative movement towards separation and individuation. This was observable in the way she began to tentatively seek out friendships at school and to express the wish to live a normal life like her peers.

These were new, hopeful developments however after returning home Amy became distressed again by her parents' continual fighting. The old restrictive eating patterns resumed and most of the weight gained in hospital was lost. Nonetheless she retained something of an improved capacity for object relations which was evident in therapy. It was as if something of the experience had been able to penetrate her defensive encapsulation and, after her return in the second year of therapy, she was never quite as 'cut off' as before. This positive shift was almost certainly augmented by my decision to take Amy's case to supervision. However, before this important turning point is described, Amy's original 'cut off' state in the first year needs some elaboration.

FIRST PHASE OF THERAPY

This period saw me struggling with transference-counter transference dynamic where I was almost chronically unable to think. Amy would give me an ostensibly participative, albeit sanitised, rendition of the week's events, recounted in soft, even tones. Emotion was rarely allowed in. During our sessions it felt for me like we were both stuck in clay, as though we were trapped, immobile and helpless, in our chairs in the room for the duration of the session. I sometimes thought to myself that our sessions viewed from the outside by an observer would look like therapy, but from the inside it felt like all life and possibility had been sucked out of the room and I often experienced a profound sense of hopelessness at ever helping this patient. During our sessions it often felt like I had been given a sedative, causing me to become sleepy, my mind felt shut down and I battled to enliven myself and to harness my ability to analyse what was happening. The therapy seemed to be controlled by powerful, anaesthetising, unconscious processes that I felt unable to resist or understand. Yet on the surface this tiny, quietly spoken, beautiful wax doll of an adolescent seemed anxious to please and was quite passive.

Her bland material was peppered with accounts of her mother's intrusiveness, which she revealed it seemed despite herself, admitting that these disclosures made her feel guilty and disloyal. These disclosures felt to me like the only *real* material in the sessions, yet rather than being able to interpret my countertransference feeling that she might be seeking some sort of fusion with me, I enacted it, feeling inexorably drawn into a dyad with her against her mother.

I felt very protective of her, wishing to take her to my breast, to cocoon her. It was not until I took Amy to supervision, that my supervisor's 'third position' afforded the triadic space to see what was happening between us (Aron, 2006). The enmeshed dyad of the therapeutic situation seemed to mirror the mother-daughter fusion noted by Bruch (1973) where separateness had to be denied. We were like two overlapping surfaces with no space in-between, a state termed 'adhesive identification' by Bick (1968) and Meltzer (1975).

Another significant aspect of the countertransference during the initial phase revealed itself before our sessions. About half an hour before sessions I would feel an intense, even panicky hunger. After grappling with this strange experience I came to understand that this was probably the result of some kind of projective identification from Amy. Once again Bruch's (1973) work was enlightening in this regard; she noted that eating disordered patients experienced hunger sensations in a distorted way and appeared to confuse hunger with other signals of internal distress due to some deficit in the mother's attunement to her infant, including her baby's shifting physical and emotional states. Without a mother to 'translate' such states for her, the infant cannot distinguish between psychic and somatic sensation. This confusion leads to feelings of anxiety because she is unable to understand or discern various feelings and sensations. Bearing this in mind, I wondered whether Amy's needy feelings, which she experienced as a sort of hunger, were being put into me in the sessions. Prior to recognizing and understanding this I experienced it in an immediate and unmodified way.

In addition to my needing to eat before the session, as if preparing for a fast, I would also 'arm' myself with interpretations I thought I needed to make, which ostensibly should have been possible because in almost all of the sessions her material was quite similar. However, as soon as I was in the room with her I struggled to connect with the ideas I'd had just minutes before. It took a great deal of my mental strength to try to recapture my ideas and turn them into a communication worth making. In turn, any interpretation that I was able to make during this phase of the therapy was met with superficial agreement but never taken up, rendering the interpretation and my presence useless. Her verbal responses were appropriate at the level of content, yet I had the feeling that my utterances 'bounced off' her, never seeming to penetrate into the deeper layers of her psyche. Our fusion paralysed the therapy; neither of us could take in nourishment and grow and the ebb and flow of object relating was

arrested. It felt like the two of us were participating in a static 'thing' called therapy where we each had predetermined and unproductive roles to play.

Although my words were barred real access, it seemed that she drew some sort of relief from our sessions. After a time I came to understand that Amy was 'sticking adhesively' (Bick, 1968) to the 'surface' of the therapy which for her was as much made up of the contents of the room as by me and my interpretations. Eventually her experience in hospital, coupled with my supervision input, brought about a turning point in the therapy. Before discussing this second phase, the parental feedback sessions need be considered.

As is customary in work with adolescent anorexics, there were occasional parental feedback sessions, always conducted with Amy present and with prior agreement about content. The purpose was to set up a process whereby Amy could begin to communicate her difficult feelings to her parents. These sessions were discontinued after the first year due to their undermining effect on the therapy. Father remained silent unless I or mother as unsolicited co-therapist asked him a direct question. His answers were vague and un-insightful however his concern was evident in his non-verbal responses, his anxious expressions and his shifting uncomfortably in his chair during difficult moments. In the first such meeting, a few months into the therapy, mother described her daughter as intelligent, cold and undemonstrative. She despaired at Amy's social withdrawal and reserved personality. According to mother Amy's intelligence had been evident from the start but was always a rather shy and reticent child- "Just like her father." I learned that the subtext of this description alluded to the dyadic binaries of mother-son and father-daughter; it was the family narrative and all seemed to accept it. The two pairs were distinct even in physical appearance: blonde, blue eyed Amy closely resembled father while brother apparently looked like their Mediterranean mother.

Indeed by all accounts mother had found it easier to parent her son while she and Amy seemed to have always struggled to connect comfortably. It seemed that brother had, for whatever reasons, managed to get the best of mother and Amy the worst. Father had always been emotionally distant from both children.

Mother described her daughter as “hard” and “steely” and that “nothing gets to her”, remarks that I found to be dramatically at odds with my own countertransference of Amy. At times during the therapy I had been struck by her exquisite, excruciating vulnerability. In a session where she had seemed particularly fragile, my reverie drifted to a friend of mine who had been terribly burned in a fire. His burnt skin rendered him completely unable to endure the outside world; in order to survive his whole world had been reduced to his small artificially regulated hospital room. Amy felt to me like something of a burn victim too - so vulnerable and psychically skinless that even the slightest impingement would be intolerable. In sessions I would often sit with feelings vacillating between disquiet and despair, unable to imagine how she (like my burned friend) could ever bear the rough-and-tumble of life should she emerge from the rigid haven, the autistoid psychic retreat of her anorexia. Anorexia, like my friend’s hospital room, provided her with a reliable structuring container: her rigid routine was all consuming, it meant that socialisation was kept to an absolute minimum while only an ever narrowing range of ‘safe’ foods were permitted, eaten at specific times. Her illness seemed to offer her a way, possibly the only way, to survive.

Amy’s ‘frozen’ presentation in the first phase of therapy, corroborated by mother’s description of her, led me to wonder whether she might be in some sort of psychic retreat, specifically an autistoid psychic retreat as described by Tustin (1978) and S. Klein (1980). My feelings were strengthened by her realisation that ...“It’s like I have this shell around me and I want to be by myself and do things for myself but I know it’s not good for me and I should let other people in to help me”. In the context of that particular session in the second phase, I felt she was expressing her readiness to let me in a bit more which I interpreted. This led to the consideration of twice weekly therapy which had been a possibility for some time but she’d had to reach a point where she felt able to take this up.

THEORETICAL CONTRIBUTIONS

The role of countertransference in the diagnosis of autistic/oid states

Considering the complexities involved in the apprehension of autistic/oid states, most authors agree that close monitoring of the counter transference is the only way that these states can be identified (Golden & Hill, 1994; Gomberoff et al., 1990). Although the manner in which the autistoid defences are manifested is different in each patient, the clinician registers a very particular countertransference reaction to these most primitive modes of resistance. This characteristic countertransference experience is thought to be the result of the specific function of these resistances... [they] “*function as autistic barriers in maintaining non-relatedness and therefore warding off a common dread, the re-experience of annihilation linked to recognised separateness from the primal mother*” (Cohen & Jay, 1996, p. 912). When describing the nature and quality of these countertransference experiences authors mention a ‘cut off’ or ‘frozen’ presentation, patients who are unwilling or unable to engage in psychotherapy, despite attending their sessions (S. Klein, 1980; Tustin, 1986). They talk but do not adequately communicate, and get their therapists to collude with their powerful non-verbal defences so that a status quo of *deadness* in the therapy prevails. Typically the therapist feels frozen out, disconnected from the patient and experiences profound numbness, hopelessness and despair (Cohen & Jay, 1996; Gomberoff et al., 1990; S. Klein, 1980). Interpretations have little emotional impact and, though therapy continues, psychological movement is arrested. This description of a typically autistoid transference-countertransference seems reminiscent of the therapeutic experience with many anorexic patients; indeed, it would appear that these two psychoanalytic bodies of theory describe similar transference dynamics (Bruch, 1978; Farrell, 1995).

Autistic encapsulation

A psychoanalytic understanding¹² of how such an encapsulation might arise goes as follows; after the dramatic caesura of birth, described by Freud (1926), the infant’s world ceases to be defined by the amniotic sac and she requires, without *knowing* that she does, the mother to set up as gentle a transition to post-uterine life as possible. Due to an undeveloped ego capacity,

¹² Judith Mitrani (1996) has identified the work of these authors as having been crucial for the subsequent development of the autistoid literature.

all that the infant encounters in her earliest days is not experienced as outside herself, but as the boundary of herself. The absence of the secure boundary after birth leads to the infant's other primary need, and that is for 'holding' which is crucial for the development of primary integration described as the "*indwelling of the psyche in the soma*" (Winnicott 1960, p. 589). This post natal infant idyll is well captured in Bick's (1968) image of: "*the nipple in the mouth together with the holding and talking and familiar smelling mother...*" (p. 484). In due course the infant internalise a feeling of an 'amniotic sac inside', a secure boundary or 'psychic skin' that separates self and other, inside and outside (Bick, 1968; Meltzer, 1975; Winnicott, 1960).

Initially, according to Bick (1968), "*the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively by the skin functioning as a boundary*" (p. 484). In order for this boundary function to be internalised, the infant must be able to introject a containing external object. This relies both on the object's being adequate and the infant's capacity for introjection, which is absent in some disorders such as organic autism (Meltzer, 1975). Identification with the containing function of the object modifies the primary unintegrated state and allows the fantasy of internal and external spaces (Winnicott, 1960). It is the concept of internal space that is the necessary precursor to normal adaptive splitting, projection and projective identification (Bick, 1968; Mitrani, 1996).

Unfortunately, this optimal situation is not the lot of all infants. Various authors have considered the reasons for developmental disruption to the mother-infant pair. Inevitably, there is a premature confrontation with that which is undeniably outside the self (Cohen & Jay, 1996; De Cesarei, 2005; Tustin, 1978). Being separate is not conceivable for the infant at this early stage; she experiences her mother's eyes, hands, breasts, as indistinguishable from her own body (Winnicott, 1960). Any failure by the mother will be experienced as the loss of part of the infant's own body which impinging massively upon the infant's inchoate self as an overwhelming trauma (Tustin, 1981; Winnicott, 1960). Tustin (1981) called this event a 'premature psychological birth' and proposed that such a trauma would lead to "*unbearable terrors*" (Tustin, 1986, p.127) of falling or spilling out, associated with feelings of unintegration (Bick, 1968; Meltzer, 1975; Mitrani, 1996). It is against this apocalyptic

landscape that an autistic barrier or enclave may develop as a defensive shield against that which threatens to destroy the infant's psyche (S. Klein, 1980; Tustin, 1978).

Developmentally, the infant's normal unintegrated state would not have been anxiety provoking (Bick, 1968; Tustin, 1978; Winnicott, 1945), however in the case of a 'premature psychological birth', extreme anxiety is aroused without mediation and this becomes associated with the unintegrated state, transforming it into overwhelming helplessness. Thus, normal unintegration becomes malignantly imbued with overwhelming primitive terror and this is the content, the autistic nucleus, within the autistic enclave.

The role of secondary skin formations in the development of autistic/oid defences

The infant, desperate to survive psychic annihilation, begins a frenzied search for a containing substitute fragment-object, selected on the basis of its sensory stimulation, which provides an artificial experience of self-cohesion. This could be a light, the mother's voice, her smell or a sensual object to cohere her fragile state, if only briefly. This is known as a 'secondary skin' formation (Bick, 1968), a pathological yet essential substitute. According to Symington (1985), 'substitutes' or 'defences' available at this developmental stage comprise of autistoid shapes, objects and delusions which operate to enclose the unmentalized experience of devastating loss and unbearable longing for the object (Mitrani, 1996; Tustin, 1986). Winnicott (1962) conceived of these self generated cohesive 'substitutes' or 'defences' as being the product of a precocious mental development, whereby the infant's defensively escalated omnipotent fantasies allow her to use her inchoate mental processes to "*take over and organise the caring for the psyche-soma*" (Winnicott, 1962, p. 61), normally this function is fulfilled by the mother. Winnicott's idea of precocious mental development will be taken up in detail further on, first it is necessary to clarify the nature of pathological 'substitutes' or 'defences' in order to convey their 'autistic' quality.

As is the norm in this auto-sensual stage, hard and soft objects prevail. According to Tustin (1980), soft objects are any pleasant sensational experiences that are comforting and calming for the infant, whereas hard objects are the reverse, they represent hard edges and the feeling

of a firm external boundary. In both autism proper and autistic states, the traumatised infant turns away from mother and retreats to sensorially imbued autistic shapes and objects and self generated sensations for comfort rather than to the mother and normal transitional objects (Ogden, 1989; Tustin, 1980; Winnicott, 1962). Bick (1968) proposed that this “*temporarily holds the parts of the personality together*” (p. 484). These self generated sensations give the infant some comfort from terrors that Tustin (1986) described as: “*preverbal, pre-imaginal and preconceptual*” (p. 23). These autistic manoeuvres serve as a protective shell against the horrifying awareness of separateness, ‘the terror of two-ness’ which is synonymous with a terrifying sense of dissolving into nothing, spilling, falling forever (Bick, 1968; Tustin, 1986). I believe that Amy’s body functions as a sort of hard object to bind her anxieties (this will be explored in detail further on).

In neurotic or narcissistic psychogenic autistic states the withdrawal is not total and a compromised sort of development continues (S. Klein, 1980; Tustin, 1978). Ogden’s (1989) dialectical theory of psychological development elucidates how this might occur. He proposed three dialectical developmental modes or positions adding what he considered an earlier developmental position – the ‘autistic contiguous position’ to Klein’s (1946) paranoid-schizoid and depressive positions. It is through this, most primitive, autistic-contiguous position that the sensory ‘floor’ of experience is generated. “*Each mode creates, preserves, and negates the other*” (Ogden, 1989, p. 4) and each mode has its own distinctive anxieties, typical defences and particular mode of object relations. Mental illness is considered to be the result of a collapse in the direction of one of these positions: he regarded autistoid pathology as the result of infantile trauma during the earliest ‘autistic contiguous’, ‘presymbolic’¹³ mode, envisaging the characteristic defences of this period becoming “*hypertrophied*” and “*rigidified*” (Ogden, 1989, p. 31). This implies that in cases such as Amy’s, where there is early trauma, autistic-contiguous defences predominate especially during periods of autistoid psychic retreat. However there is always a dynamic interplay between the three modes; in the therapy one witness’s oscillation between the characteristic anxieties, defences and object relations typical to each mode. I have kept Ogden’s (1989) theory in mind when formulating

¹³ Ogden (1989) distinguishes between “presymbolic” and “asymbolic” realms. “Presymbolic” denotes a normal stage when sensory-based units of experience are organised in preparation for symbolisation proper. “Asymbolic” connotes an abnormal stasis characteristic of pathological autism where sensory experience does not ever become anything more than it is.

the following ideas set out below and with the benefit of her mother's account; I have constructed a tentative account of Amy's infancy.

As a little girl Amy would play with her dolls by taking the role of nurse and bandaging them up and putting them in bed. Mother wondered whether this was connected to Amy's witnessing father injuring mother. This tragic portrait of little Amy bandaging her dolls suggests an attempt to manage her mother's pain and her own experience of it, rather than being able to develop freely. Anorexics typically experience great difficulty introjecting and identifying with their mothers, this is central to the illness (Lussana, 1992; Williams, 1997a).

In Amy's case, in light of the preceding discussion, I am inclined to believe that there was an introjection of a sub-optimal containing function, as described by Bion (1962: 1970). Such a defective container introjected as a result of the developmental disruption to the mother-infant pair would mitigate against any consistent sense of a space inside and imply significant difficulty with introjection and identification. Accordingly it appears that her relationship with her mother has fusion at its core. I suggest that little Amy's bandaging her dolls can be understood as a concrete enactment, a defensive projection of part of her fused maternal introject, a wounded mother-self, outwards onto the dolls. She then omnipotently bandaged the dolls and thus did not have to be in touch with her vulnerable damaged mother-self. She became the nurse helping the wounded mother-dolls.

It seems that Amy's bandaging of the dolls is a reflection of an autistoid secondary skin formation, the bandages representing a cohesive binding substitute to prevent the 'spilling out' of her wounded mother-self which I suspect would have been experienced as the threat of annihilation. This splitting off and disavowal of the wounded mother-self, which seems to have included the disowning of her female body, together with her experience of her mother's early failure to contain her and possibly maternal intrusions into her has made it impossible for her to identify with her mother in a wholesome, uncomplicated manner (Lawrence, 2002). This complicates the anticipation of womanhood and motherhood. How could she live

comfortably inside a womanly body? Femaleness has been tainted with victimhood¹⁴, intrusions and intrusiveness and the terrifying unintegrated state.

Her profound anxiety about what it would mean to become a woman was evident in her terror of menstruation, an event that has not yet occurred. This anxiety became apparent after she had gained some weight in hospital and was told that this would in due course lead to the establishment of her menstrual cycle. She told me that she started checking her panties obsessively during the day for the ‘dreaded stain,’ which was how she perceived it, rather than a hopeful portent of fertility. I wondered whether for her, menstruation might be anticipated as some sort of raw, uncontained ‘spilling-out’, so to be the cause of such acute anxiety. Unsurprisingly, Amy sees herself in the future as probably not marrying, definitely not having children, and becoming a doctor or a vet.

The foregoing discussion would seem to imply that Amy’s troubled mother could not offer her adequate containment. Such environmental failure seems in Amy’s case to have led to a precocious mental development, a ‘secondary skin formation’ (Bick, 1968) along the lines of Winnicott’s (1949) “*pathological mind-psyche*” (p. 247) alluded to previously. This pathological structure arises when the environment has failed to facilitate the integration of the “*psyche in the soma*” (Winnicott, 1960, p. 589). The ‘pathological mind-psyche’ is a rigid intellectual defence, precocious mental development used as a way to attain and then maintain psychological control. During the course of therapy Amy’s assurance and pride in her superior intellect and her ability to rigidly control her eating are the only parts of her identity that she seemed sure of. These two cognitive qualities function as secondary skin formations by binding her chaotic feelings like a truss keeping the rest of a somewhat vague and formless self from slipping out or dissipating. Hence, in line with Ogden’s (1989) three dialectical modes of psychic functioning, I propose that Amy’s anorexia, especially in the initial acute phase, allowed her to retreat to a prior, rigidified, autistic-contiguous defence: the enclave of autistic functioning (Tustin, 1979) .

¹⁴ In therapy, she recalled that as a child she had witnessed her parents’ marital conflict and particularly her mother’s distress. She had been told by her mother that her father had struck her and she recalled feeling that her father was the perpetrator and her mother, the victim.

SECOND PHASE OF THERAPY

In the second phase of therapy Amy appears to have emerged from her autistic encapsulation somewhat because she is more able to engage and seems to be relating increasingly via projection. Amy has also started to consider the function of her anorexia. In a session she asked “Who would I be without anorexia?” “It gives me my identity.” “I’ve had it for so long, I don’t know who I am without it.” It seems she has realised that anorexia holds her together, giving her some elementary sense of her self. This is the nature of the secondary skin formation. I replied that it was almost like making a deal with the devil. Experiencing the hunger and deprivation of anorexia was worth it because it offered her an identity and a sense of security. She answered “Yes it does make me feel secure.” “It’s like a blanket around me but I know I can’t be anorexic forever because it will stop me from living the life that I want.” This latter statement appears to convey a dawning of the awareness that she must choose between her secondary skin autistic defence, the anorexia, or a life worth living.

Wish for fusion, fear of intrusion

Despite this progress, Amy’s adhesive identification is still evident in her constant thoughts about mother which take up much of the space in therapy. This fused relationship seems to fit with Sours’ (1974) hypothesis of a narcissistic mother who treats her anorexic child as a satellite. It follows that the insufficiently individuated satellite-child may well grow up feeling that she is lacking and impoverished with no choice but to stick limpet-like to mother, who both regard as possessing all that is valuable.

In an apparent paradox, Amy often speaks of her intense dislike of mother’s intrusive behaviour. Although I do not doubt her account, she seems particularly sensitive to her mother’s behaviour, readily interpreting it as intrusive. Birksted-Breen (1989) and Lawrence (2002) propose that at the heart of the anorexic object relationship there is the paradoxical desire for fusion and the terror of intrusion. This dynamic is an integral feature in non-organic autistic/oid defences too (De Cesarei, 2005; Gomberoff et al., 1990). Williams (1997b) suggests that anorexics who manifest ‘no entry defensive systems’ do so because they have

experienced psychic intrusion in infancy while Lawrence (2002) considers the notion of a genetic intrusive object in females. In anorexia the influence of this object might be magnified due to actual environmental impingement or the mother's failure to contain her daughter's intrinsic anxiety about impingement.

The following excerpt illustrates Amy's anxiety about mother's intrusiveness. In the vignette she described events that occurred during mealtimes on a recent family holiday that she had taken a friend along to:

A: At dinner my mom was irritating me because she eats even after she's full, even though she wants to lose a bit of weight and get healthier. She said 'Come on lets have dessert'. None of us wanted any but she insisted that we have some with her because she didn't want to eat alone so then finally my dad and gran said they would have some. She often says to me "enjoy food Amy, relax." But obviously I don't. She's joined a gym now but she's still the same, she doesn't really look any different.

Therapist: So you're worried that maybe there's also a greedy, insistent part of you that's like your mom, you're anxious that you won't be able to control yourself with food and you'll get bigger and become like her. You have said that your anorexia makes you feel different from your friends but maybe it feels like if you didn't have it, you might eat uncontrollably and become fat, so you can't see how you could ever relax and be normal about food.

A: Yes, I do feel abnormal. Like when we ate breakfast I ordered a sandwich with no butter and when it arrived it had butter. I didn't want to say anything in front of my friend because she'd think I'm strange so I wasn't sure what to do. Then my mom saw what was going on and she said "tell the waiter that you ordered it without butter. " But I didn't want to because I get really embarrassed to do those sorts of things but she insisted so I went and he changed it but I was uncomfortable. It's really spooky sometimes how she can read my mind. Like I've had this anorexia for three years and so now she knows exactly what my thoughts are but she says it in front of everyone and it makes me feel really embarrassed that she can know what I'm thinking and then says it out loud.

Therapist: *That must feel like she can get inside your mind and expose your thoughts. It's like the two of you become one person at times.*

A: *Yes, definitely. Like yesterday she made me eat an egg for lunch because she's decided that I have to eat an egg a week and I really didn't want the egg but she insisted and I felt bad about it for like the whole afternoon. Like she forced it into me.*

Therapist: *So there's something that feels very intrusive sometimes about her being able to look inside you and expose your secret thoughts but then she can also put things inside you that you don't want.*

A: *We have a very weird, intense relationship...*[said in a soft, bewildered voice].

Besides feeling intruded upon, the excerpt illustrates Amy's fear of being exposed in front of her friend as *different*. In the second phase of therapy she was able to admit her envy of the other girls at school, believing them to have some privileged knowledge of how to *be* in the world, that she did not. She said she observed them in order to establish how to behave so she could fit in. This 'adhesive' device more or less 'worked' for her during the period of simpler peer relationships in latency. However the more sophisticated object relationships of early adulthood could not be managed this way and her 'social ineptitude' – she feels boring and empty – is an almost unbearable narcissistic wound. On the rare occasions that these feelings were faced my countertransference was a sense of helpless desperation, in other words, I was feeling what she was feeling. This was very different from the fused countertransference in the first year of therapy.

Amy's wish to be normal like her friends was an ambivalently held one, split into idealised and denigrated aspects because it felt like something unattainable, a standard against which she must fall short. Hence her defence against her devastating sense of inadequacy and painful envy was that she would twist the coveted state of 'normality' around in her mind so that it came to mean ordinary and pedestrian, in contrast to her special-ness, afforded by her intelligence at first, and then later by the anorexia. In the transference she managed this sometimes by identifying with me as if we were colleagues, judging someone inferior. She often took this role in relation to brother who seems to function as her benchmark of

normality. According to Amy the siblings had been close until puberty but had become estranged since she'd become anorexic. Amy admitted she had cut herself off from him and he had in turn distanced himself from her. At times she would denigrate her less academically inclined sibling as if we, the superiors, were looking down on him and laughing at his inadequacy. At these times I experienced her as hard and brittle and had a glimpse of her mother's depiction of her as "steely". I realised she had inside her both the 'fragile burn victim' and the 'hard steely creature' and that these formed part of a pathological organisation regarded by Steiner (1982; 1987; 1990) as intrinsic to psychic retreats (Steiner, 1993).

The 'hard steely' self seems to be comprised of her highly developed cognitive functions and the 'bony outer casing' and rigid inner control. Both of these aspects can be understood to have grown out of her pathological mind-psyche and function as a secondary skin, autistoid defence preventing the spilling out of the 'odd', 'needy' adhesive 'burn victim' self. However this defensive structure also functions as a narcissistic defence allowing Amy to bury her feelings of inadequacy and her envy of people regarded as socially able. Her significant academic success has allowed her to feel superior to mother, brother and most of her peers. However her fused, confused relationship with her mother and the significant conflicts aroused are also projected onto her peers, this was illustrated in the following dream presented shortly after her father left home:

A dream

A: I had this dream the other night. I dreamt that I was with this girl Yvonne that I had been with in hospital. We were standing in line with a lot of other girls. Yvonne was normal weight and I was thinner than her. I think she was jealous of me. Then, I don't know how we knew (she blushes as she does when she senses that her dream symbols might be revealing). I think there was a newspaper article and it was headlines that someone was poisoning the other girls and it had made them lose a lot of weight. Yvonne had poisoned them. I was cross because now they would be thinner than me and Yvonne just did it because she couldn't lose any weight herself.

Therapist: Well I'm wondering what your associations are to the dream.

A: I don't know, I think Yvonne was cross because she couldn't lose weight and I think that reminds me of my mom, before my dad left she would always phone my aunt and say she can't lose weight even though she's trying to cut down what she eats and she's going to gym. Since my dad left, though, she's lost about 5kgs because she says she's lost her appetite. But I was cross, why did she have to give those girls poison so that they would be as thin as me?

My understanding of this dream which evolved in supervision was as follows: The 'headline news' seems to refer to the recent news of her parents' divorce. Her mother appears as both Yvonne and the other girls. Her envious mother/Yvonne has fed poison (toxic intrusion) to the other girls to diminish Amy's specialness, afforded by her thinness. However Amy's mother is also the other girls. Mother has taken the 'poison' of her divorce and has effortlessly lost weight, which angers Amy; poison that allows you to lose weight equals cheating, it is weight loss without the required suffering and dedication that anorexia demands. Also her mother is not sticking to her part of the shared body, she has left their fusion and has found her own impinging, competing body. In Kleinian terms, Amy's mother has fed herself the poisonous breast that Amy was faced with as a baby, that she now refuses to feed from as enacted by her anorexia. This is the unconscious accusation that Amy's starvation seems to make towards her mother: "Your poisonous milk is inedible and I could not grow and now everyone can see it, and you can't do anything about it." In the dream her mother's poisoning of herself allows her to wriggle out of the anorexic double bind. She has split off from Amy and has revealed, as Amy has always feared, that she is her daughter's hostile competitor.

The shared body

In her anorexia both the autistoid defences and the narcissistic aspects of her intrapsychic structure are apparent; Amy's body has become her object but because she has never separated from mother her body becomes the battle ground where her separation ambivalence is played out (Birksted-Breen, 1989). Amy's ambivalent fusion with her mother is clear, even in late adolescence, seen in her extreme dependence and intense hatred of her desperately needed mother. Hence Amy experiences her anorexia in a paradoxically competitive and fused dyadic relationship with mother. If she eats enough to gain weight, she feels her mother

has won and she has lost because at one level she suspects her mother secretly wishes to fatten her up, to intrude into her concretely with food to make her grotesque. In phantasy this corresponds with her internalisation of an envious, intrusive and competitive mother, a poisoning toxic breast, as noted by Birksted-Breen (1989). On the other hand if Amy manages to stay the same weight or to lose more, she has triumphed over her mother, by keeping her food out, demonstrating her control over this 'shared body', the somato-psychic fusion, adhesive identification that defends against terror of separation experienced as a terrible impingement. This is also present in the transference when I struggle to have my own body, my own mind. She has resonated with the 'shared' body interpretation in relation to her mother, which seems to have allowed some small measure of progress in that she is not completely starving her mother-self anymore and has stabilised at her low weight, rather than becoming thinner.

DISCUSSION

Anorexia can be seen to offer considerable utility as a defence because it serves to reinforce both the narcissistic structure, by allowing her to feel unique and special, and the autistic enclave against the threatened collapse provoked by puberty. The autistic enclave, like an apparently dormant volcano, is reactivated by overwhelming demands on the ego at this time, threatening an eruption from the cystic encapsulation. The autistoid psychic retreat of anorexics like Amy marks a turning away from the overwhelming demands of the external world. The starvation and bodily obsession are a return to auto-eroticism (Freud, 1914) which bolsters the sensate defences and adhesive identification around the autistic nucleus. In this way Amy takes her ego, represented by her body (which she experiences as shared with her mother), as her object and becomes the whole world for herself. Her all consuming obsession with her body can be thought about as a regression to the first bodily ego noted by Freud (1923).

It is proposed that Amy's anorexia, and perhaps similar cases, be considered a particular type of prolonged autistoid psychic retreat, one that incorporates the intentional starvation of the body and the manifold associated symptoms. The pre-anorexic infant who survives psychologically via an autistic encapsulation would appear to develop normally for a time.

However, the damage becomes evident when she is called upon to leave the safe camouflage of latency and square up to the adolescent challenges of the genital stage (Freud, 1905). Amy's failure to manage the transition exposes her pre-oedipal functioning and adhesive identification, her incapacity provokes extreme anxiety. The unbearable exposure of her intrapsychic deficit, which she calls her 'weirdness', her 'oddness', triggers the autistoid psychic retreat I have proposed as likely in anorexia resulting in the continuation of physical and intellectual development but the arrest of psychic and emotional growth.

The physical changes of puberty concretely and somatically mirror her internal chaos. Her body seems to be 'morphing' into something alien and uncontrollable, while simultaneously she is overwhelmed by strange new feelings. The anorexic feels increasingly out of control of her life, but she lacks a healthy internal object that she can draw on for succour. More and more of her energy is directed toward getting rid of her 'fat', metaphor for her scary, intangible terrors. This confusing new world of boys and sexual feelings, breasts and menstrual blood, feels threateningly disruptive, exceeding her psychic capacity. However, she can achieve certainty in one thing: control of her body. In streamlining, taming and conquering her body she creates a simultaneously brilliant and deadly defence mechanism that works against threats both from inside and out. Anorexia allows the 'steely' narcissistic part to omnipotently starve her body, thereby controlling and containing the split off denigrated 'burn victim', mother-self. She turns inwards, away from the overwhelming world as she once did from the overwhelming breast. She becomes invested in the absolute control of her body; she starves it, she measures it and she becomes increasingly sado-masochistically caught up in the physical sensations of starvation. She can suppress her gnawing hunger, she can take pleasure in her light headedness, and these are 'badges of honour'¹⁵. Her modified body becomes a 'bony shield' against her internal chaos. It is maintained under the critical eye of the scale and its less reliable counterpart, the mirror – less reliable because she sees herself in a distorted way. They show her that she is angular and defined, albeit never sufficiently for her liking. She can never cease her vigilance because she fears her body will explode into anarchy if she ever drops her iron guard. Hence, both the 'hard' 'steely' part of her and her bony anorexic body can be understood to operate as autistic objects, providing

¹⁵ Other authors have regarded thinness itself to be a "badge of honour" for the anorexic (Arnold, 2004; Pipher, 1994) but I use the phrase to draw attention to the pride and satisfaction attained by the anorexic from the physical sensations of self starvation.

edgedness and boundary and thus prevent the spilling out of the fragile 'burn victim' self. Anorexia can thus be understood as a desperate bid to prevent psychic dissolution. At the level of object relations, her body serves as a warning to others to *keep out*, as noted by Williams (1997b). Her body speaks simultaneously for the 'burn victim' part and the 'steely' part, seeming to say 'Do not put your expectations of normality on me for I am both too fragile to bear them but also superhumanly strong so you cannot pity me'.

CHAPTER SIX

INTRODUCTION

The following paper – *Two Types of Encapsulation in Anorexia* – is under review for publication in *Psychoanalytic Psychotherapy*.

The two research questions are actively responded to in the paper namely: *How do pathological defensive organisations manifest within intrapsychic structure and through the symptoms and interpersonal relationships (especially the psychotherapeutic relationship) of anorexics? And – How do autistoid phenomena (including autistoid encapsulation) seem evident- based upon clinical material from anorexic patients?*

The paper addresses the first research question with a deliberation of the pathological defensive organisations of ‘Jessica’ and ‘Amy’. In its engagement with this question the paper includes a consideration of the patient’s histories and the course of therapy.

The paper also attempts to answer the second research question by comparing two types of encapsulation in anorexia, namely autistoid encapsulation and secondary-adjunctive encapsulation (my term) in anorexia. The two types of encapsulation (autistoid and secondary-adjunctive) are discussed in detail in relation to the three patients to enable a distinction to be made between ‘Amy’s’ autistoid encapsulation with ‘Maya’ and ‘Jessica’s’ secondary-adjunctive encapsulation. It was argued that these two distinct types have important clinical implications and affect the course and duration of the disorder. To illustrate autistoid encapsulation, case material from ‘Amy’s’ psychotherapy is utilised. Case material from my patients ‘Maya’ and ‘Jessica’ were used to explore the idea of secondary adjunctive encapsulation – the result of sexual abuse in latency and/or adolescence.

TWO TYPES OF PSYCHIC ENCAPSULATION IN ANOREXIA

ABSTRACT

Using case material from three anorexic patients, this paper suggests that two different sorts of psychic encapsulation are commonly encountered in work with anorexics and that each type seems to imply a somewhat different therapeutic course. The distinction is made between anorexic patients who appear to display evidence of autistic/oid encapsulation (Tustin, 1978; 1981; 1986; S. Klein, 1980) as opposed to those who seem to manifest non-autistoid/late traumatic encapsulation – termed secondary-adjunctive encapsulation in this paper. Defensive encapsulations are associated with pathological organizations of the personality and both within and beyond these structures they exert an organizing power over central mental processes. Psychic encapsulation and pathological organisations are defensive structural developments – the result of psychic trauma (Hopper, 1991; Nissen, 2008). Patient material is presented to illustrate the different presentations of the two types of anorexic patient argued for in this paper. The question of technique in relation to the two types of anorexic patient mentioned is discussed in the latter part of the paper.

INTRODUCTION

Using case material from three patients, this paper suggests that encapsulated phenomena are commonly encountered in work with anorexic patients. Specifically, a distinction will be made between two different types of psychic encapsulation (Adams, 2006; Hopper, 1991; S. Klein, 1980; Mitrani, 1992; D. Rosenfeld, 1986; Tustin, 1978; 1981;1986) found within two different sorts of anorexic patient. I must immediately add the caveat that I do not wish to suggest that there are only two types of anorexic patient. The purpose of this paper is to deeply interrogate the two types that are the focus of this discussion. I will now start with material from the case that initiated the development of the ideas that follow.

During my internship at an in-patient eating disorders unit, I was confronted by the inherent difficulties in treating eating disorders and especially anorexia. Most of the cases seemed to fit with contemporary psychoanalytic understandings, namely that the anorexic girl lacks a

healthy maternal representation (Farrell & Magagna, 2003; Lane, 2002); resists having a womanly body like mother (Birksted-Breen, 1989; Brough, 2004) and wishes for fusion with the object yet is terrified of being intruded upon (Bruch, 1973, 1978; Lawrence, 2002; 2008; Williams, 1997). The anorexic requires total control of her body (Likierman, 1997; Williams, Williams, Desmarais, & Ravenscroft, 2004). and denies instinctual needs, concretely representing her strong drive to control her internal world (Lawrence, 2008; Sours, 1974). The fathers of anorexics are typically described as being emotionally distant, weak or seductive (Bruch, 1973; 1978; Risen, 1982; Williams et al., 2004).

From the start of my work in the unit, it became apparent that for most anorexics, a relationship of two separate yet connected individuals was difficult, if not intolerable (Birksted-Breen, 1989; Petrelli, 2004). Indeed, it is well documented that anorexics are typically experienced as being emotionally cut-off and very challenging in therapy (Williams et al., 2004). Establishing a therapeutic relationship is particularly difficult for them, it is at times fiercely resisted while in other moments merger is sought (Birksted-Breen, 1989; Lawrence, 2008). I have subsequently found Frances Tustin (1978; 1981; 1986) and Sydney Klein's (1980) descriptions of autistoid encapsulated defences to often be particularly useful for understanding these typical, cut-off anorexic patients. However it was at the unit that I also encountered my first 'atypical' sort of anorexic patient, the sort that I am suggesting as a specific sub-type here. Over the years I have encountered this sort of patient again – rarely but repeatedly. I have found that this atypical sort of anorexic patient has a different therapeutic *feel* right from the start and therefore stands out.

My first experience of such a patient was with 'Maya', an anorexic woman in her late thirties. Regarded as a 'revolving door' patient, she had been admitted to the unit more-or-less annually for over a decade. Despite her being labeled intransigent – usually a source of frustration and despair – the permanent treatment team were very fond of her. She was regarded as a sweet but hopeless case.

My countertransference to Maya was different from the other anorexic patients I had encountered at the unit. She was more 'alive' and able to work in her therapy from early on,

despite being as underweight as the others. We formed a good working alliance in contrast to the rigid resistance or enmeshed fusion I was becoming accustomed to. Unusual too was the fact that she was a wife and mother who was able, during periods of better functioning, to have three children and to help her husband in his business. Their marriage also seemed to have relatively functional periods.

A few months into her hospitalization Maya's material led me to suspect sexual abuse in her past. When I gently raised it she became tearful and confided that she had been sexually molested by two different family members, an uncle during her latency and a much older male cousin in her early teens. She had never disclosed the abuse to anyone, not even to her mother with whom she had a close relationship. She said this was because both of her abusers heralded from mothers family but especially because her own impoverished family had taken these men in as paying boarders. Maya had believed that if she disclosed the abuse to her parents they would have sent the men away and desperate poverty would have ensued. Consequently, she had consciously tried to repress all memories of it.

In therapy the revelation of her painful secret gave way to palpable relief. For the remainder of her time in the unit we worked through the sexual abuse and she blossomed. She was later able to disclose her abuse to her husband who was supportive. By the time she was discharged she had reached an acceptable weight and reported that she was feeling better than she ever had, like a heavy burden had been lifted off her. Maya never returned to the unit. She has contacted me a few times over the years and as far as I know has not yet relapsed.

Maya was clearly an unusual anorexic patient and in those early days I was just glad to have a patient who responded so well to psychotherapy. However, over the years I have encountered this sort of anorexic patient again, albeit infrequently – to date I have worked with four such patients. These patients have led me to seek a distinct formulation regarding these sorts of anorexic patients based on their common characteristics, which I will now describe.

‘Atypical’ anorexics

Most strikingly, I have found that the overt anorexic symptoms of these atypical patients seem to improve quickly, within six months to a year in therapy which is remarkably quick for anorexia. Current research suggests five to seven years as an average recovery period and even this is only when effective treatment has been sought (Strober, Freeman & Morrell, 1997). Only 33% make a so-called full recovery (Hertzog et al., 1999) while a large proportion remain ‘forever chronic’. Lamentably there is at least a 5% mortality rate for the disorder (Arcelus, Mitchell, Wales & Nielson, 2011).

The anorexic symptoms of these atypical patients seem to have a strong link to an un-metabolized, non-penetrative, sexual molestation in latency or adolescence. Additionally, these patients seem to have had ‘good enough’ mothers in childhood and as an apparent consequence are able to work well in therapy. Notwithstanding, there seems to have been a lack of sustained parental support in the aftermath of the sexual abuse. Significantly, at their sickest, these atypical anorexics are just as emaciated and at risk of dying as their more intractable counterparts.

The distinctions I have made regarding both sorts of anorexic patient described, require exploration and explanation because they appear to have profound clinical significance. It seems important from the outset to make a terminological distinction between these two types of anorexic patient. I will therefore use the term ‘autistoid’ when I refer to more typical, frozen anorexic patients like ‘Amy’ while ‘later encapsulated’ will imply atypical, non-autistoid patients like Maya and ‘Jessica’. The notion of psychic encapsulation will now be rehearsed.

PSYCHIC ENCAPSULATION

The term encapsulation-used to describe defensive structural manifestations-has appeared in the literature with increasing frequency (Adams, 2006; Hopper, 1991; 2003; D. Rosenfeld, 1988; 1992; Mitrani, 1992). Although various writers laid the basic foundations for its current usage, (Bion, 1957; 1962; Meltzer, Bremner, Hoxter, Weddell & Wittenberg, 1975; Meltzer,

1963; Nissen, 2008; H. Rosenfeld, 1965, 1971a), Frances Tustin (1978; 1981; 1986) and Sydney Klein (1980) crystallized the concept. It is used metaphorically to describe adult patients, some merely neurotic, who carry a split off 'encystment' or 'enclave' within psychic structure. All types of encapsulation are thought to be the consequence of overwhelming trauma (Bergstein, 2009; Cohen & Jay, 1996; Hopper, 1991; 2003; S. Klein, 1980; Mitrani, 1992; 1996; Alvarez & Reid, 1999; Tustin, 1978; 1981; 1986). They are defensive structures that developed to ward off annihilatory anxiety; the psychic borders of an unmetabolized petrified state (Cohen & Jay, 1996; Hopper, 1991; 2003; Mitrani, 1992; 1996). According to the psychoanalytic literature, traumatic encapsulations are found across a broad diagnostic spectrum from the neurotic, narcissistic, borderline and even in psychotic patients (Nissen, 2008).

Contemporary authors have since developed this work, elaborating on it (De Cesarei, 2005; Mitrani, 1992; 1996; Spero, 1998; Tarantelli, 2003). This has meant that the term is not used in a uniform way anymore, yet the different permutations have received little direct attention, with the notable exception of Nissen (2008). Variations have included so-called 'positive' encapsulation (Hopper, 1991; D. Rosenfeld, 1992).

This paper is concerned with what I will term 'negative encapsulation' implying the encapsulation of sensations and proto-elements associated with an unmetabolised trauma. These 'negative' encapsulations are understood as defensive structures, the product of a process of barricading off overwhelming unmetabolized terrifying experience. However, negative variations of encapsulation are written about variably in the literature.

As mentioned previously, it is important that a distinction be made, not necessarily about the personality structure of the patient that harbors the encapsulation- as this is not in itself delimiting – but about the type of encapsulation. This distinction is directly linked to the developmental stage when the trauma occurred. Notwithstanding, this paper is not an attempt to classify every type of encapsulation but rather seeks to make only two distinctions; Firstly, between two different types within the broad area of 'negative' encapsulation, and secondly, regarding the way that this applies to two different types of anorexic patient.

AUTISTOID VERSUS OTHER FORMS OF ENCAPSULATION

Autistoid encapsulation

Autistoid encapsulation will be considered first. In the literature the term is used to refer to psychogenic autistic-like defences, distinct from autism proper, thought to develop in early infancy as a result of a disruption to the earliest mother-infant dyad (Cohen & Jay, 1996; Innes-Smith, 1987; S. Klein, 1980; Korbivcher, 2005; Mitrani, 1992; 1996; Nissen, 2008; Alvarez & Reid, 1999; Tustin, 1978; 1981; 1986). Prevalent in the early histories of these patients are mothers who were depressed, psychotic or severely physically ill, which had a profoundly negative impact on maternal capacity. Cases in which the infant herself was severely physically ill or underwent medical traumas at this time can have the same effect – the infant is likely to have experienced periods of uncontained pain and intrusion causing overwhelming annihilatory anxiety (Dubinsky, 2004).

Maternal failure which occurs at this early stage will be experienced as if it were the loss of part of the infant's own body because she can perceive no difference between self and other, psyche and soma (Tustin, 1978; 1981; 1986). The infant's primary need for 'holding' is crucial for the development of primary integration, described by Winnicott as the "*indwelling of the psyche in the soma*" (1960, p. 589). If holding fails it is experienced as a massively impinging trauma, an intrusion of the intolerable 'not-me' causing a "premature psychological birth" (Tustin, 1981). By definition then, autistoid encapsulation refers to "*pathological intrapsychic derivatives of breakdowns in the earliest mother-infant interactions*" (Cohen and Jay, 1996, p. 913). These autistoid encapsulations have been referred to in a number of ways such as an 'autistic enclave', 'a pocket of autistic functioning' or 'autistic barriers/defences' (Bergstein, 2009; Cohen and Jay, 1996; De Cesarei, 2005; Innes-Smith, 1987; S. Klein, 1980; Tustin, 1978; 1981; 1986).

The work of Bick (1968) and Meltzer (1975; Meltzer et al., 1975) regarding on the concept of 'psychic skin' is relevant here. It refers to the need of all infants to introject a binding force which sets up a boundary within the self. If this has not been achieved due to some sort of detrimental occurrence a 'second/ary' skin must be artificially manifested by the desperate infant (Bick, 1968; Meltzer, 1975). Patients with autistoid encapsulations-as infants-used

sensation based ‘distractions’ as a binding force in the face of traumatic intrusion (Alvarez & Reid, 1999). The inchoate self must be held together against being overwhelmed by annihilatory anxiety (Cohen & Jay, 1996; Tustin, 1981; 1986) or Winnicott’s (1962) *unthinkable anxiety*. However the nature of these pathological ‘distractions’ or ‘substitutes’ must be considered in order to understand their ‘autistic’ quality.

According to Tustin (1980; 1984), early infancy is an auto-sensual stage where hard and soft objects are encountered. Soft objects are any agreeable sensational experiences that are soothing and reassuring for the infant, whereas hard objects are the opposite; they represent hard edges, conveying a sense of a firm external boundary (Tustin, 1984). In both autism proper and autistic states, the traumatised infant retreats to sensorially imbued autistic shapes and objects and self-generated sensations for succour. Sensate distraction provides a focal point around which the remnants of the immature ego coagulate; it marks a violent turning away from the mother and a move towards auto-sensuousness (Tustin, 1986). This can be achieved for example if the infant focuses intently on the sensation provided by a light, the mother’s voice, or intense muscular contraction. This allows the infant to survive psychically although in an enduringly compromised state.

Drawing on the work of Bick (1968), Meltzer (1975) and Tustin (1980; 1981; 1986), Thomas Ogden (1989) introduced a developmental hypothesis which entailed the addition of a third, most primitive position-autistic-contiguous – preceding Klein’s (1946) Paranoid-Schizoid and Depressive positions. Disturbances in this most primitive period disrupts the development of a sense of going-on-being-of a bounded sensory floor. He envisages the three developmental positions to be in continuous dialectical tension with each other throughout life. A rupture in any one of these interacting plains of experience will lead to a breakdown in functioning characterized by the anxieties of that particular position which will also impact upon the other two. Significant disruption occurring during the earliest infancy will have particularly serious consequences for intrapsychic structure and mental functioning. Ogden’s notion of a bounded sensory floor relates in many ways to Tustin’s idea of a rhythm of safety and Bick (1968) and Meltzer’s (1975) notion of ‘second/ary skin’ functions. Various authors have described how

their adult autistoid patients engineer such second skin substitutes to cohere themselves (Mitrani, 1992; 1996; Nissen, 2008). Amy¹⁶ was one such patient.

Amy

She had been anorexic for two years before she entered therapy. In the first year her sessions comprised of a rote account of her week devoid of emotion¹⁷. Amy's relationship with her mother was enmeshed and intrusive, from early on I was left with no doubts about mother's intrusiveness (Lane, 2002; Likierman, 1997) as I experienced it first-hand. Mother persistently attempted to contact me throughout the first year, despite my polite but firm refusals to discuss Amy. In this initial phase of therapy, Amy would occasionally complain about mother's behaviour but would seem to quickly feel very guilty and then stop. On rare occasions she told me that her father was emotionally distant but then she would come close to tears and quickly change the subject, becoming 'matter of fact' about his detachment, explaining that this was just how he was.

Indeed for the first year of therapy, Amy mostly avoided being in touch with any real feelings. The transference-counter transference was marked by a frozen stasis rather than the dynamic oscillations of object relating (Williams et al., 2004). Regarding my counter-transference, I struggled to think during sessions experiencing a pervasive sense of paralysis (Cohen & Jay, 1996). During our sessions I would be taken over by a numbness, even anesthesia, where I couldn't gain access to my intuitive mind but rather felt like I was just barely conscious (Cartwright, 2006). At other times my reverie went to an image of fossils preserved in amber, enduring yet lifeless. Nothing I said seemed to reach her and she showed very little emotion, remaining polite and ostensibly cooperative as if I were a teacher at school¹⁸.

Eventually after much internal grappling and supervision, I came to understand that what was happening in therapy was my encounter with an enclave of autistic functioning (Spero, 1998),

¹⁶ A fuller case history of 'Amy' was presented in my 2011 paper - Autistoid Psychic Retreat in Anorexia, *British Journal of Psychotherapy*, 27.

¹⁷ Tustin (1986) presented two such anorexic patients - 'Margret' and 'Jean'.

¹⁸ Marilyn Lawrence (2008) speaks of feeling like a "benign headmistress" with her patient 'Ms C' (p. 51).

an autistoid encapsulation in Amy. Once I was able to think about the therapeutic situation in this way, something different started to happen in the therapy. I became more able to access my thoughts in our sessions and to reflect on what was happening between us rather than to enact it. In turn Amy began to shift slowly over time as she became able to tolerate some sort of relationship with me. Eventually the autistoid shell seemed to have cracked and she started to risk a tentative sort of connection to me. I learned that father had been physically abusive towards mother while Amy was growing up. Amy found her parents fighting to be very distressing. Equally disturbing for her was mother's making Amy her confidante, especially regarding issues pertaining to the marriage. Finally Amy's internal distress was surfacing and could begin to be processed in the therapy.

The discussion of Amy will be taken up again further on. Now, the concept of *later* encapsulation will be considered.

Secondary-Adjunctive encapsulation

In the literature, the term encapsulation has also been used to describe the traumatic aftermath of the so-called "brute event" of Baranger, Baranger & Mom, (1988, p.123). Hopper (1991) explains it thus, that:

"[T]he fear of annihilation and encapsulation as a defense against it is prevalent amongst those who have suffered various kinds of massive social and collective trauma" (p. 617).

He gives examples of accidents, natural disasters, conditions of war and Holocaust.

So it seems that a distinction can be made immediately, relating to the developmental stage when the trauma occurred. Most of the survivors of those traumatic events, who go on to manifest encapsulated defences, were not infants at the time of the trauma. In regards to making a distinction about encapsulated defences then, two important points arise: firstly with this sort of trauma, a good enough mother-infant bond is not necessarily precluded. Secondly, the ego has had more, sometimes far more, time to develop prior to the trauma. This is very

different from the scenario in autistoid encapsulations. An individual who experiences trauma later on in development may have been relatively psychologically healthy with good ego functioning before a trauma is experienced. I have therefore called this other sort of encapsulation *secondary-adjunctive* encapsulation because it is secondary i.e. it occurs after a level of ego maturation has occurred as compared with the inchoate nature of the ego in autistoid encapsulated states. Therefore at the time of secondary-adjunctive encapsulation the ego is capable of *secondary* process operations. It is *adjunctive* in that it is as if it becomes affixed to existing psychic structure- like a tumour on healthier flesh. Of course delineating an exact temporal cut-off point separating the two types is difficult and beyond the scope of this paper.

However the idea of the two different types of encapsulation is clinically/technically important because it directly affects the nature and duration of the therapeutic work. Therefore this theoretical distinction is important at the level of clinical practice. In the case of secondary-adjunctive encapsulated anorexic patients, the work in therapy progresses far more easily and rapidly seemingly as a result of their prior, underlying psychological robustness. These sorts of patient have a very different countertransferential feel as compared to the autistoid encapsulated patients.

However in distinguishing secondary-adjunctive encapsulation by using the proviso that it is not directly related to the mother-infant dyad, I am not disagreeing with the fundamental idea that all trauma is experienced in relation to the object. This point is absolutely essential in all trauma work. Baranger et al. (1988) explain:

“...the anxiety provoking object because of its absence, its internal or external presence, its hyper-presence, always appears subjectively as the possibility of ascribing the trauma to someone who failed to do what should have been done or did what shouldn't have been done” (p. 122).

Interestingly Lawrence (2008) has noted an association between so-called ‘brute event’ trauma and anorexia, although not sexual trauma specifically.

‘Jessica’

I will now introduce the case of ‘Jessica’, a secondary-adjunctive patient somewhat like Maya, who developed anorexia at puberty seemingly also due to the psychologically uncontained experience of sexual molestation trauma. Her anorexic crisis at puberty seemed to be due to a re-awakening of the annihilatory anxiety experienced at the time of this trauma which became encapsulated. Her anorexia seemed to be a symptom that re-enacted the, as yet, unsymbolized abuse.

At her sickest point, Jessica was as gravely ill as Amy had been however from the beginning of therapy she was far more *alive* and accessible. She was self-reflective and able to think about what her anorexia did for her. She was also able to hear my interpretations and to use them productively, in other words the therapy progressed. One important difference was that Jessica seemed to have a healthy relationship with her mother. This seemed apparent not only from the transference-countertransference but also in my few interactions with Kate, I was struck by how unlike my other anorexic patients’ mothers she was.

Jessica shared her experience of feeling awkward around her peers, never feeling as pretty or as clever as the other girls. She started to re-gain weight after the first few months of once weekly therapy and stabilized at a low but healthy weight¹⁹ before the first year was up. After about six months of therapy she began to discuss her fear of men. She could not understand this fear and I too was rather puzzled. After one of our sessions she broached this subject with her mother. Kate then disclosed to her that when she was six, Jessica had told her that the uncle of one of her school friends had touched her on her “private parts.” Mother understood from Jessica’s account that the sexual abuse had involved the rubbing of Jessica’s external genitals rather than penetration.

Mother had reported this to the police and the man was prosecuted, however he was not jailed due to lack of conclusive evidence. Kate believed that the molestation had probably occurred

¹⁹ The GP monitored her weight – at first on a weekly and later on a monthly basis – in the first year of therapy.

on the one or two occasions when Jessica had played at her friend's house. Jessica's father was also very active in the wake of the disclosure. However a few months after the sexual abuse came to light, father died suddenly in a car accident, leaving the family emotionally bereft. Kate admitted to having become depressed and withdrawn for a period of about a year after her husband's death and the sexual abuse. Over the months and years after the dual traumas, Jessica gained a lot of weight and became withdrawn at school. At thirteen she was overweight and felt highly ashamed of her body. When she reached puberty at fourteen she began to diet, this soon became excessive and anorexia was diagnosed by her GP who then referred her to me about a year after the onset of her anorexia.

Jessica struggled to remember the period of the dual traumas and had no memory of the sexual molestation, however it seemed to emerge in her recurrent nightmares of a menacing male figure watching her as she slept, which she'd had for as long as she could remember. She would wake from these dreams in a state of panic and run to her mother's room where she'd remain for the rest of the night.

Father's death was undoubtedly significant in Jessica's case and could justifiably lead to scepticism regarding the argument that uncontained sexual abuse trauma was a primary factor in her anorexia. Of course each patient is unique but equally, similarities between cases can be identified. Thus in Jessica's case, processing father's death and the unconscious oedipal link she'd made between the abuse and father's death was a very important part of the work. Indeed with all anorexic patients there are oedipal difficulties that need to be worked through (Shipton, 2004; Williams et al., 2004) however this is beyond the scope of this paper.

I have found that in all of the secondary-adjunctive cases I have worked with, there has been non-penetrative sexual abuse which is not psychologically contained by the parents for various reasons. At this point, I can only speculate that penetrative sexual abuse- whether oral, anal or vaginal- might possibly have had a different sort of meaning for such individuals. Additionally, it seems important that the molestation was not perpetrated by the father or the brothers of these patients.

Nonetheless, in the cases of secondary-adjunctive encapsulation under discussion here, it seems that as a result of the unmediated sexual molestation trauma, there was a defensive splitting of the psyche and the soma. This seems to have been an attempt to keep the mind pure and separate from the transgressed, despoiled body. Thus one of the most important distinctions between the two types of encapsulation seems to be that later encapsulated anorexic patients were mentally capable of making the psyche/soma distinction prior to the trauma, unlike autistoid patients. This thesis offers a way to understand why patients like Maya and Jessica generally make quicker, more robust and sustained recoveries after the sexual trauma has been processed psychologically, as opposed to autistoid patients like Amy, where progress is very slow.

Of course certain individuals surely suffer both infantile as well as later traumas and as a result seem to manifest multiple encapsulated parts of the self. I have treated patients like this and various authors too describe such cases (Adams, 2006; Parker, 1993; Shipton, 2004) however this is not the focus of this paper.

The discussion now turns to greater or overarching defensive structures.

PATHOLOGICAL ORGANISATIONS AND PSYCHIC RETREATS

Whether an encapsulation is autistoid or later traumatic, it forms part of a broader defensive organization which John Steiner (1982; 1987; 1993) called a pathological organisation. In a prior paper I suggested that pathological organisations underlie many, if not all, eating disorder syndromes. I suggest here that with both anorexic types, the encapsulation is held tumour-like within the body of the pathological organization and both within and beyond it, exerts an organising power over central mental processes.

Pathological splitting

Steiner agreed with Melanie Klein's (1952), hypothesis that under the weight of overwhelming anxiety, the individual's first line of defence is normal splitting processes which implies the splitting of the object with its resulting splitting of the ego or self. If splitting fails to bring about equilibrium the individual may then align herself with the good object and good parts of the ego to ward off the bad object and bad parts of the self. Eventually if all manner of normal splitting processes fail, a last ditch, archaic form of splitting and projective identification must be employed, which sees the violent expulsion of the self and the object fragmented into bits comprised of good and bad, self and object.

Pathological reconstitution

I suggest that in the case of encapsulations, the unsymbolised (Segal, 1957) somatic memory of the trauma becomes encapsulated at this point. As for what remains of the psyche, a reconstitution of the personality is attempted via the inception of a pathological organisation, unique in nature to each individual, which develops to 'collect the bits together' including the encapsulation. It is a compromised assembly of jumbled up good and bad bits of the self-projected into objects. This new structure, comprised of contaminated 'building blocks,' testifies to a desperate effort to repair the former good/bad split within, but instead a composite, 'Frankensteinian' structure emerges-the pathological organisation.

There are two important ideas implicit in Steiner's pathological organisations. The first pertains to the inner workings of the pathological organization and the second to the psychic retreat aspect.

Seduction and sado-masochism

I will deal with the inner workings aspect first. According to Steiner (1982; 1993) the pathological organisation takes over functioning after psychic breakdown, such breakdown occurs with both autistoid and later encapsulations. In the inner workings of these organisations, a highly destructive part of the self is engaged in a sadomasochistic relationship

with a vulnerable libidinal part. The destructive part, which operates something like a mafia boss or gang, as described by H.A. Rosenfeld (1971a), dominates the personality ostensibly protecting the vulnerable, libidinal part from pain and danger. The vulnerable, libidinal part is seduced into compliance by the offer of an escape from current distress under the auspices of the supposedly 'protective' mafia boss/gang part. This escape was called a *psychic retreat* by Steiner (1993). However, as part of the 'bargain' that is struck between parts of the self, the libidinal part is devalued, despised or even destroyed, while the dominating component is idealized. When this sado-masochistic dynamic takes hold, development in any wholesome sense is halted.

Elsewhere, I likened the operation of the pathological organisation to a *default psychic skeleton* which takes over functioning after psychological resources are overwhelmed (Kadish, 2012). For some individuals this default mode takes over in the short term, in others it operates as a continuous manner of functioning. I suggest that with later encapsulated anorexics, the pathological organization is more recent and therefore more readily accessed in therapy. When the pathological organisations of these patients can be worked through and the anorexic symptoms relinquished, a prior, healthier intrapsychic structure underlies. However with autistoid anorexics like Amy, there is no prior healthier intrapsychic structure, but rather an inchoate, damaged ego underlying. This is why work with those anorexic patients is so slow and why it is so difficult for them to let go of their anorexia. Autistoid anorexics are all too aware that they have few other coping mechanisms and little measure of psychic robustness (Brough, 2004).

In both sorts of anorexic patient, the sadomasochistic tone and method of operation of the pathological organisation can be seen to manifest in the symptoms and in the self-experience of such patients. It seems that both sorts of anorexic patient also use their anorexic symptoms and preoccupations as a psychic retreat²⁰ where time appears to stand still and reality can seemingly be evaded. The sadomasochistic pathological organisations and psychic retreats of Amy and Jessica will now be discussed.

²⁰ Shipton (2004) discusses an eating disordered patient who consumed chocolates and soft drinks to accompany her grandiose fantasies in her psychic retreats.

Jessica spoke about two different parts of herself in a sadomasochistic internal relationship from early on in her therapy. She shared her memory of an event that occurred prior to her anorexia but after the sexual abuse. One day she'd hurt her beloved dog by accident - so she bashed her head against a wall as a punishment, so that she would feel the pain that her dog had felt. Pertaining to the anorexia she described a part of her that seemed to take pleasure in her own pain when she stopped herself from eating food that she strongly desired. She was able to consciously associate these two experiences with something inside her that she said "likes seeing me suffer." She added "it's so abnormal." "Are other people this abnormal?"

In this light, Freud's (1914) observation regarding unrepresented mental states seems especially pertinent, namely, that what cannot be remembered is repeated over and over in action. In this light it is suggested that autistoid patients' anorexic symptoms can be understood to have originated from a turning away from mother towards autistic protections, shapes and objects (Barrows, 1999; Kadish, 2011). It seems that their anorexic symptoms display a turning inwards once again to auto-sensuousness, to the somatic sensations of starvation, obsessive ruminations and their fascination with boney, hard, bodily edges. On the other hand the symptoms and behaviours of secondary-adjunctive anorexic patients might be understood to be more like the repetitions and re-enactments documented in the broader trauma literature (Baranger et al., 1988; Nissen, 2008).

The anorexic's crisis is experienced particularly intensely during times when separation and individuation is demanded such as at puberty or during a later period which requires too much of her i.e. separation, sexual maturation and depressive functioning (Shipton, 2004; Williams et al., 2004). These demands are psychologically overwhelming and anorexia has sometimes been discussed as a defence against the perceived threat of insanity. This fear can be heard in Jessica's anxious question – *are other people this abnormal?* Also in autistoid states, under the tremendous pressures of puberty, the encapsulation is experienced as threatening to erupt or crack, spewing out pure madness – the un-symbolized, annihilating proto-mental states (Tustin, 1986). In both autistoid and later encapsulations the content of the encapsulation is

unsymbolized terror which none the less exerts pressure to be represented in a symbolic register and consciously transcribed and historicised.

In a particular session in the latter, more productive phase of therapy, Amy admitted that there was a part of her that was aware that starving herself was very unhealthy for her. But there was also another, destructive part that demanded that she severely restrict her intake. Frustrated she asked: “Who would I be without anorexia?” “It gives me my identity.” “I’ve had it for so long, I don’t know who I am without it.” It seemed that she had become aware that anorexia functioned to cohere her providing a “*kind of protective outer shell*” (Lawrence, 1995, p. 22). It provided her with a rudimentary sense of self, albeit at huge cost to herself. Her anorexia functioned as a pre-oedipal, secondary skin (Kadish, 2011; Shipton, 2004) that gave her a sense of psychic boundedness but it was also a manifestation her sadomasochistic pathological organisation. I said it was almost like making a deal with the devil. Experiencing the hunger and deprivation of anorexia was worth it because it offered her an identity and a sense of security. She replied: “Yes, it does make me feel secure.” Seeming intuitively to understand the association between the encapsulation and the psychic retreat of her anorexia she said “It’s like a blanket around me, but I know I can’t be anorexic forever because it will stop me from living the life that I want.” This statement seemed to suggest the beginning of an awareness that she must choose between her autistoid psychic retreat, the anorexia, or daring to live more fully and authentically.

In secondary-adjunctive encapsulations the powerful sexual drive energy experienced at puberty threatens to evoke seemingly intolerable memories of the sexual abuse. I saw this when Jessica, after achieving a normal weight, began to face the issue of her sexuality. She told me what her school friends ‘got up to’ with their boyfriends. She castigated their behavior – they were ‘sluts’ or ‘skanks’. After a few sessions with this theme, she admitted in a quiet, shameful way that she was very scared that she would become a ‘skank’ if she allowed any physical contact with a boy. She admitted that becoming sexually aroused terrified and disgusted her as it meant she could ‘go wild’ and surpass any of her friends’ exploits. This opened up the way for us to explore the issues around her sexuality and to try to help her make sense of her jumble of fantasies and fears. I was very moved when, about a

year later, she had her first romantic relationship and despite her anxieties, was able to relate in an intimate and authentic way.

Discussion

The formulation presented in this paper is not in any way intended to reduce the depth, breadth and richness of psychoanalytic understandings of anorexia. Rather, it is offered as a particular lens through which the disorder can be viewed. To this end, it is hoped that the paper will be clinically useful. The foregoing arguments will now be summarized.

Autistoid and later encapsulations are different, happening as they do in different phases of development. The individual who suffers later trauma has developed symbolic function, has a more sophisticated, robust ego and is therefore potentially able to symbolize the traumatic experience and to renounce the anorexic symptoms. On the other hand the autistoid anorexic suffers trauma when mental structure is primitive and symbolic function has not yet been established. In essence then the autistoid anorexic has had a compromised psychic structure from very early on whereas the anorexic patient with secondary-adjunctive encapsulated manifestations is developmentally sound before the trauma. In both cases the unsymbolized contents of the encapsulation must be in some way mentalized (Allen, Fonagy & Bateman, 2008), that is, symbolized and mentally processed. In this way primary process is transformed into secondary process. This transforms proto-elements into psychic processes and positions them historically for the individual (Levine, 2009).

CHAPTER SEVEN

INTRODUCTION

The following paper – *The Role of Culture in Eating Disorders* – has been accepted for publication in the British Journal of Psychotherapy. It is presented here with the journal's permission. It was also awarded second prize in the American Association for Psychoanalysis in Clinical Social Work's special honour award for student/candidate papers. The paper will be presented at their 2013 conference in Durham, North Carolina.

This paper diverges slightly from the approach used in the other three papers in that a consideration of the literature on the role of contemporary culture on eating disorders is included as an essential part of the argument.

The paper answers the first research question namely: *How do pathological defensive organisations manifest within intrapsychic structure and through the symptoms and interpersonal relationships (especially the psychotherapeutic relationship) of anorexics?*

This question is addressed via a detailed discussion of how contemporary cultural trends relating to the appearance of the female body become part of the pathological organisations of eating disordered women. Case material from an anorexic patient, 'Holly', and a binge eating disordered patient, 'Brenda', were used as data. Two new terms were introduced – 'the normalized body order' (internalisation of cultural norms regarding the idealisation of an unhealthy slender body) and 'the abject body object' (a specific, negative internal object). These two phenomena were seen to operate within the pathological organisations of these eating-disordered women. The role of contemporary culture was thought about in two ways. Firstly, the eating disorder symptom was seen as a culturally facilitated expression of extreme distress. Secondly, the question of whether contemporary cultural trends might in themselves constitute a traumatogenic element, was also considered.

THE ROLE OF CULTURE IN EATING DISORDERS

ABSTRACT

A comprehensive understanding of eating disorders should include engagement with the role of contemporary cultural trends. Feminists and critical social theorists have made significant contributions in this regard. Using two clinical cases, this paper contemplates the relationship between culture and psyche in eating disorder, proposing a psychoanalytic conceptualisation underpinned by John Steiner's (1982; 1987; 1993; 2011) theory of pathological organisations and psychic retreats. Two conceptual terms will be introduced namely 'the normalized body order' and 'the abject body object' to develop the argument. One of the clinical cases will be used to explore a particular kind of therapeutic impasse that can occur when therapist and patient are both female. In this particular case, the normalized body order emerged temporarily obstructing therapeutic progress; the impasse was understood to be an example of the so-called anti-analytic third (Straker, 2006).

INTRODUCTION

Feminist and critical social theorists consider the influence of culture to be a vital element in the aetiology of disordered eating. On the other hand contemporary psychoanalytic authors, seem for the most part, to foreground individual psychology (Malson, 1998) although this is not true of all authors (Chernin, 1985). These theoretical trajectories have contributed significantly by deepening understandings of the intricate, multifarious entities comprising the field of eating disorders. This paper proposes an argument for a particular sort of answer to the question of *how* contemporary cultural trends come to play a role in eating disorders.

This argument will be underpinned by John Steiner's (1982; 1987; 1993; 2011) concept of pathological organisations and psychic retreats which will be used to engage with the question of how contemporary culture might manifest in eating disorders. Two conceptual terms will be introduced namely the *normalized body order* and the *abject body object* to help illustrate the arguments. Such arguments do not represent an attempt to be all-encompassing but rather a particular approach is offered. Two cases will be presented, one of which will be used to

explore a particular kind of therapeutic impasse that may occur when therapist and patient are both female. In this case, the normalized body order emerged temporarily impeding therapeutic progress; the impasse was understood to be an instance of the so-called anti-analytic third (Straker, 2006).

Feminist beginnings

This discussion of feminist and critical social theory's contributions to the eating disorder literature is an adumbration intended to touch upon aspects relevant for the paper. It is not intended to be a comprehensive account as this is beyond the scope of the paper. Only arguments and research considered to be directly pertinent have been included and it is against this backdrop that the central arguments will be made.

Susie Orbach's (1978) seminal work 'Fat is a feminist issue' initiated the feminist/socio-cultural debate by critically examining the way that a woman's fat body and compulsive eating could be understood as reactions to contemporary social norms that idealise slenderness. Other feminist writers extended the argument to anorexia, seeing it too as a reaction (over-compliant or rebellious) to the current socio-cultural milieu via the adoption of a particular type of embodied self (Showalter, 1985 in Gordon, 1990; Lawrence, 2008; Malson & Burns, 2009). Subsequently, bulimia has been depicted as an ambivalent reaction to the inherent bipolarity of contemporary culture, namely, the juxtaposition of an ethos promoting greedy consumerism versus an impellent demanding dietary restraint (Malson, 1998).

In the main, the feminist approach offers a sharp, multilayered analysis of the social milieu that women, especially, internalise. Authors Malson and Burns (2009) argue that "... 'eating disorders' are not so much viewed as pathological responses to patriarchal culture, rather eating dis/orders are theorised [here] as (multiply) constituted within and by the always gendered and discursive contexts in which we live: individual disorder is re-theorised as part and parcel of the (culturally normative) order of things" (p. 2).

Bordo (1993) considers cultural transmission to be multilayered and pervasive, suggesting that: *“These [elements] point to culture-working not only through ideology and images but through the organisation and the family, the construction of personality, the training of perception- as not simply contributory but productive (italicised) of eating disorders”* (p.50). She continues further on: *“virtually every proposed hallmark of “underlying psychopathology” in eating disorders has been deconstructed to reveal a more widespread cultural disorder* (p. 55).

Indeed cultural transmission works through so many avenues of psychological influence that it is hard to dismiss out of hand the imputation that contemporary culture itself might be considered pathogenic. Some feminist authors have made the argument that eating disorder can be understood as gender-political advocacy – that the driving force behind anorexic and bulimic manifestations in women is an impellent to symbolise their socio-political oppression (Gordon, 1990). A problem with this argument however is that although the *“contemporary female dilemma”* is certainly a very important contributory factor, most anorexics and bulimics do not consciously consider themselves martyrs for the feminist cause (p. 195). The tensions between the ‘individual versus cultural impellent’ remain to be explored.

Psychological trauma

It seems then that an incorporative approach is in order, one that can hold in mind the unique psychology of the eating disordered individual in an ongoing psychic engagement with her cultural milieu (Butler, Flasher, & Strupp, 1993). The psychological health of the individual is understood in this paper to be directly affected by the quality of the mother-infant (preoedipal, dyadic) relationship and the nature of the internal oedipal (triadic) configuration – as well as the individual’s exposure to traumatic experiences at any stage of development. Psychological trauma is understood here to include: disruption to the mother-infant relationship, psychologically unmediated losses and any other personal or collective traumatic exposure. Early mother-infant disruptions and sexual abuse trauma are often documented in the histories of eating disordered patients (Farrell & Magagna, 2003; Hertzog et al., 1993; Sands, 2003; Shipton, 2004).

Psychoanalysis tells us that early trauma has a direct influence on the development of the ego while developmentally later trauma causes a rupture to the protective shield of the ego (Freud, 1920; De Cesare, 2005). In all cases trauma – by definition – leaves the individual psychologically vulnerable. Elsewhere²¹ I have discussed the association between traumatically induced psychic encapsulation and eating disorder.

As mentioned previously the link between trauma and eating disorder has been established; an additional factor for consideration is whether the psychological impact of trauma might increase the individual's susceptibility to internalising (or incorporating) malignant socio-cultural trends normalizing unhealthy practises and unrealistic or unattainable standards for the female body²². Subsequently social impellent might then be used as a way of communicating personal distress. These social imperatives can be seen writ large in eating disorder symptoms of the eating disordered individual. The argument can then be made that contemporary cultural trends facilitate the *manner* in which psychological distress is expressed in eating disorders, i.e. the form of the symptoms. However the idea that cultural exposure can in itself be considered traumatogenic, and if it is, how it is, is a more complicated one.

Before the finer points of this multifaceted debate can be engaged with, certain conceptual clarifications and important historical background will be discussed.

Introducing the term: normalized body order

This paper supports the assertion (Orbach, 1978; Chernin 1981; 1983; Bordo, 1993; Malson & Burns, 2009) that the thin body has become a revered symbol or emblem and the fat body a devalued one in contemporary society. It seems that a body falling on either end of the fat/thin continuum has common projections, meanings and biases ascribed to it through contemporary western discourses and these narratives effectively construct *reality* (Striegel-Moore, 1997;

²¹ (Kadish, 2011; 2012b)

²² Increasingly the male body seems to have fallen under a similar sort of socio-cultural scrutiny but this does not yet appear to be as powerful and pervasive as that which pertains to the female body. The question of whether men would express distress in similar ways to the women currently under discussion is beyond the scope of this paper.

Polivy & Herman, 2002). It seems that bodily size accrues to the individual either kudos and respect or disapproval, even aversion. It would not be a gross exaggeration to say that these designations could be compared to a modern-day caste system and that entrée is conferred depending on one's fatness or thinness. It is suggested that the actual size and shape of the body is commonly registered and evaluated based upon whether it conforms, or not, with contemporary ideals of thinness.

The term *the normalized body order* will be employed in this paper to denote the conceptual structuring of bodily size and shape into a taxonomy of social desirability, whereby thinness (but not to the extreme of anorexia) confers entree to the highest 'caste', and obesity relegation to the lowest. These are the poles between which bodies of greater or lesser adiposity fall. It is vital that the difference between the terms *normal* and *normalized* is made clear. The term normalized body order has been used to make the point that the thinness ideal has been imposed on women's bodies so that what is *commonly* aspired to is a body shape, weight and bodily practices that are unhealthy (Bordo, 1993; Fallon, Katzman & Wooley, 1996; Hesse-Biber, Leavy, Quinn, & Zoino, 2006; Zerbe, 2008). It seems that the normalized body order is prevalent, even predominant in contemporary western society especially among young women. Various authors propose that eating disorders be regarded as existing on a continuum with dieting and so-called 'normal eating' (Malson, 1998; Butler et al. 1990); the italics imply that this term is fraught in this current socio-cultural climate.

Using case material this paper will explore the manner in which the cultural imperative espousing the normalized body order manifests intrapsychically, using Steiner's (1982; 1987; 1993; 2011) abovementioned theory of pathological organisations and psychic retreats. The idea that a pathological organisation operates defensively within the (eating disordered) individual may offer a coherent explanatory model explicating the way in which the individual's socio-cultural milieu becomes internalised and personalised.

The tyranny of slenderness

Reducing one's food intake to become thinner is not a contemporary trend but one that became fashionable in the late Victorian era. Prior to this however the Aristocratic Greeks had attempted to regulate food intake in an effort at self mastery and a balanced life. Food restriction was also documented in Christianity in the Middle Ages where fasting was viewed as a way to purify the spirit (Bordo, 1993). Both of these earlier forms of food restriction were intended as vehicles for the improvement of the "self": a public self for the Greeks and an inner self for Christians. However these rituals of fasting or asceticism were the preserve of the elite aristocrat or priest who attempted to reach the pinnacle of the human spirit (Bordo, 1993). Conversely by the late nineteenth century body management through food restriction had become an endeavour of the body rather than the spirit. The "tyranny of slenderness", a term coined by Chernin (1981; 1983), had come to power.

At this point a conceptual distinction is necessary - Chernin's term – the tyranny of slenderness – communicates the general pressure to be *thin* rather than *fat* while the normalized body order reflects that in the 21st century the requirement that women's bodies conform to the lower end of the healthy weight spectrum, in a quest for what might be an unnatural thinness for some, though not quite clinical anorexia (Throsby in Malson & Burns, 2009). Hence a somewhat unattainable, tyrannical bodily ideal is currently held out as a desirable, achievable goal.

There is little doubt that social significations relating to body weight and shape have tremendous import over the way in which the female body is discursively constructed (Malson, 1998). This argument can be substantiated by a body of research from feminist writers and critical social theorists. For example Wetherell's (1996) discourse-analytic study of young women demonstrated that through cultural narratives *fat* and *thin* bodies are assigned specific meanings imputing personal and moral values. Research results conveyed that subjects believed that an individual with a fat body would have poor self esteem and bodily shame. Thinness, in and of itself, was believed to be connected with happiness and positive self-worth and considered to be a common aspiration.

In other research, Stice, Schupak-Neuberg, Shaw & Stein (1994) found that female subjects exposed to media endorsing the thinness ideal and extreme dieting practices – directly correlated with the development of eating disordered symptoms – although not full blown disorder. They concluded that mediational links also exist between gender role endorsement, ideal body stereotype and body dissatisfaction in subjects.

In Goodman's (2002) research on Latina and White women, subjects reported a feeling of power after successfully attaining their thinness goals. There was also evidence to suggest that subjects associated economic success with thinness. She concluded that "bodily self-control was their primary means to exert control in the social world" (p.722).

Other relevant research performed by Hesse-Biber et al. (2006) investigated the way that contemporary mass marketing and mass media might affect the development of eating disorders via the use of four social psychological theories. These aspects taken together formed a "nexus of influence" on women (p. 208).

Contemplating the interaction between individual vulnerability and cultural ill psychoanalytically

Of course the effect of culture on the psyche is not a foreign one for psychoanalysis; on the contrary, Freud's superego illustrates the critical importance of socio-cultural dictates on psychological development (Laplanche & Pontalis, 1973). The fundamental discoveries of psychoanalysis developed out of Freud's studies on hysteria – which was understood as a psychical illness with a particular etiology – it was "*a malady through representation*" (Laplanche & Pontalis, 1973, p. 195). Hysteria was considered to be an individual response involving a combination of specific events together with multifaceted personal psychology and cultural prohibition. Culture, in and of itself, was not however conceived of as *causing* psychological disorder.

Although Freud did not address anorexia per se as a specific syndrome, its association with hysteria is evident retrospectively in his early case studies. Although the symptom compound now called anorexia had been ‘discovered’ in the 1870’s (Gull, 1874), it was regarded as highly obscure and was little known to the public until the second half of the twentieth century (Gordon, 1990). It now seems quite clear to contemporary readers that Freud’s famous hysterical patients ‘Anna O’ (Breuer & Freud, 1895) and ‘Dora’ (Freud 1905) both exhibited symptoms of the current clinical conceptualisation of anorexia nervosa (Fallon et al., 1994).

Hysteria as a diagnosis has fallen out of use for the most part in contemporary psychoanalytic eating disorder literature while in feminist eating disorder literature the term has almost never been used, but for different reasons. Young-Bruehl (1993) observes that “...*the eating disorders have been disconnected nosologically from hysteria*” (p. 320). In the case of psychoanalytic writers it seems to have fallen out of use due to a belief that different times bring different symptomatic manifestations. She suggests that in the case of feminist authors however it is due to a broad tendency to exclude any engagement with Freud’s libido theory. Notable exception Juliet Mitchell (2000) argues against the relegation or repudiation of hysteria in contemporary literature proposing that: “*Hysteria [also] migrates. Supremely mimetic, what was once called hysteria manifests itself in forms more attuned to its new social surroundings*” (p. ix).

For the purposes of this paper’s argument, hysteria remains a valuable concept, if controversial diagnosis, because it conveys the idea that psychic distress in an individual can be manifested through culturally meaningful symptoms. However this argument does not allow for the possibility that culture itself might cause significant psychological trauma. Becker’s (1995) research on body concept in Fiji provides fertile ground for this debate. Becker’s first project, conducted in the 1990’s, evidenced that Fijian women of all ages were heavier than their western counterparts. The women’s attitudes to their generous bodies were appreciative, even celebratory. Culturally, fat symbolised strength, sound nourishment, vigour, and the highly valued personal qualities of kindness and generosity. Conversely, thinness was imbued with meanings of ill health, incapacity and/or having been poorly

treated. There was no record of eating disorder and a wide range of body shapes were acceptable, although fatness was preferred over thinness.

When Becker returned in 1998, she witnessed a drastic shift in attitude. A large proportion of the women, especially the young women, had become unhappy with their ample bodies and many had begun to diet. Feminists explain the dramatic change in mindset as a response to the introduction of western influences, especially via television, to Fiji. American programmes depicting slender women as objects of male desire such as “Melrose Place” were now being screened.

Becker’s research is an informal experiment testifying to the effects of the dissemination of western cultural values on women of a formerly non-westernised culture that had held disparate ideas historically²³. It the relative ease of transmission of the normalized body order demonstrating that the thinness ideal can mould opinions and behaviours especially those of young women. However it does not indicate the direction/s of the causal relationship linking individual, socio-culture and eating disorder.

In the Fijian case, it is likely that the televisual depictions of western female beauty ideals induced some sort of collective shame in these women. Acculturation often works in this unfortunate way (Zerbe, 2008). Pubertal Fijian girls especially may have experienced the exposure to westernised bodily norms as a devastating attack on their personal beliefs regarding beauty linked to cultural norms. This could arguably be considered traumatic when encountered at a critical time in development when identity is negotiated. In a pubescent girl’s mind, this might not only involve cultural shaming but also the loss of her mother as a credible, worthy object of identification.

However the question of how female distress was expressed *before* western cultural influence arrived must be considered too. Therefore the idea that exposure to western cultural norms

²³ Indeed similar attitudinal shifts have been documented in contemporary Black South African women (Szabo and Allwood, 2006).

might be traumatic, especially in the case of young women, should be considered together with a consideration of prior individual psychological health. While western beauty ideals may well have induced some deep level of collective and personal shame in young Fijian women – additionally – a new narrative is introduced, providing another channel through which pre-existing personal dissatisfaction and distress can be communicated.

The vulnerability of pubertal Fijian girls particularly is not surprising. Certainly at puberty – the forerunner to adult sexuality – narcissistic disturbance related to the body-ego come to the fore and anorexia often begins then. I have discussed this in detail in an earlier paper (Kadish, 2011) however a thorough discussion is beyond the scope of this paper.

I will now present two clinical cases to explore the questions raised so far. Holly was an anorexic patient who attended psychotherapy twice weekly and Brenda, a patient with a sub-clinical eating disorder in once weekly psychotherapy.

CLINICAL CASES

Holly

Holly, a single anorexic woman in her thirties, had suffered from the disorder since her early teens. Although she was no longer emaciated, she was certainly underweight, still exercising rigorous dietary control. She was petite and childlike in speech and manner and it felt like I had a twelve year old in the room. This initial impression was jarred when she mentioned that her tertiary qualification was in actuary; she had graduated *cum laude*; although tellingly, she had not taken up employment after her internship. She was still financially dependent on her wealthy parents despite her considerable earning potential. She had no friends, keeping the company of her two married sisters despite fierce sibling rivalries. She had a certain degree of insight and was mindful that her anorexia had become a comfortable, albeit defensive, modus operandi. She was aware that her anorexic obsessions and rituals took far too much of her time and energy and that this foreclosed on her chances to have a romantic relationship. She restricted herself, eating only certain low calorie foods and didn't like to eat anywhere but

home. She was also a dedicated runner and would not miss a day of training despite illness or injury.

Holly had come to therapy in a crisis about her age and the stage in life that she felt she should be at. Her distress seemed to be strongly influenced by her cultural beliefs pertaining to how a woman should *be*, in all possible aspects. Of traditional background, she was fixed on the idea that she wanted to be married as soon as possible and was very fearful of what people might say if she remained single. She felt she was in a terrible bind- if she did not marry and have children-a terrifying idea for her-she would be regarded as a failure by her family and broader community. Her running and restrictive eating seemed to operate as both compliance and resistance to her socio-cultural environment in interesting ways. Slenderness was endorsed in her family and she was certainly thin, no-one could deny that, however hers was the very extreme sort of thinness that seemingly functioned to preclude the possibility of marriage and babies. She thought the married women in her family and community regarded slimness as ‘a means to an end’- the end being to attract a husband. After this had been achieved you could *let yourself go*. The idea of growing large after marriage was appalling to her and her thinness was in part a way of triumphing over her mother and sisters.

Brenda

Brenda, a significantly overweight woman in her late thirties, dressed and carried herself with a sort of lumbering heaviness that made her seem much older. She had sub-clinical eating problems; she binged at times and at others over-ate mindlessly as a response to distress. She was in a relationship with an abusive long-term partner whom, after the second year of therapy, she felt able to leave. Part of his denigration of her had involved verbal insults such as “fat bitch” or “fat cow”. He would often taunt her saying “who would want to have sex with someone who looks like you?” He had been unapologetically unfaithful throughout their relationship. Her somewhat masochistic acceptance of his sadistic behaviour was rationalised by her belief that his behaviour was a valid response to her fat body. She had even considered drastic, life threatening surgical interventions she had read about in magazines to lose weight. In sessions she would pull at her stomach flesh and say: “I need to get this cut-off”

Brenda had been overweight for most of her life and had never felt attractive. According to her, mother was a beauty as was Brenda's slim fraternal twin sister. Father was an emotionally distant man who had very little time for his daughters. He had suffered both abuse and neglect in childhood. Brenda excelled at school and university where she studied law. It became apparent that the legal firm she worked for held her in high esteem for her hard work and ethical behaviour.

From the beginning of therapy an important aspect of the work had been about her negative image of her body, how she loathed it. This aversion was certainly affected by her exposure to socio-cultural trends and she often mentioned the perfect bodies of media celebrities; she would often speak about slim women in general in an idealizing way and as if they were a superior, homogenous group. This became a source of renewed pain now that she was entering the world of dating again. She would have to compete with thinner women for men and she did not fancy her chances. Brenda felt she should lose weight in order to be more attractive. However this was extremely difficult for her because she used food and sometimes alcohol as self-regulating mechanisms, when her difficult feelings became overwhelming. After these eating and drinking binges she would feel useless and worthless and would be filled with self-loathing. However, therapy revealed deeply buried beliefs that thin women were more likely to be promiscuous, an idea that scared her and against which her fat body provided security. She was very anxious that if she lost weight she might become a 'loose woman.' For Brenda this term and its specific, personal meaning had its roots in her religious upbringing.

PATHOLOGICAL ORGANISATIONS AND PSYCHIC RETREATS

In the course of these patients therapies it became evident that to different degrees each displayed a sadomasochistic pathological organisation as theorised by John Steiner (1982; 1987; 1993; 2011). For readers who are unfamiliar a brief overview is in order. Steiner proposed that at any time- whether early in development or as an adult- the individual might temporarily need to 'rely' on a rigid configuration of defences to take over psychological functioning if they were to experience overwhelming, psychically destabilising, anxiety against which normal defensive measures failed. In most cases the pathological defensive

organisation-formed due to psychological crisis-recedes after the distress subsides. However in certain individuals these highly organised defensive structures endure and dominate. In these cases the pathological organisation operates much like a 'mafia' or 'gang' (Rosenfeld, 1971a, Steiner, 1982) demanding total compliance to a *sadomasochistic regime*. Such compliance allows the individual feelings of omnipotence granting escape via transformed mental states – psychic retreats – that allow the individual respite from overwhelming anxiety (Steiner, 1982; 1987; 1993; 2011). In fact sadomasochistic components-these unconscious destructive parts of the self- were believed by Klein (1958) not to be part of the superego but split off and separate from both ego and superego.

If the pathological organisation comes to dominate the personality, healthy growth is stalled. This is because psychological development necessitates the flexible use of projective identification for object relationship. Since pathological organisations are comprised of multiple, fractured, disavowed parts of the self in complex formation, no one component can be detached identified as being part of the self, mourned and then accepted. In cases where these organisations are deeply rooted, the flexibility of projective identifications is hindered and development is halted (Steiner, 1993).

In eating disorders

Many authors have addressed the violent subjugation of the body in eating disorders (Birksted-Breen, 1989; Chasseguet-Smirgel, 1995; Sands, 2003; Shipton, 2004). I have suggested elsewhere that sadomasochistic pathological organisations are a prevalent feature in eating disorders (Kadish, 2012a) and this was an important aspect of my work with Brenda and Holly. In this paper I wish to take the argument further, to propose that a personalized representation of contemporary culture exists as a component of the pathological organisations found in eating disordered patients. In order to illustrate this hypothesis the origins of these pathological organisations in eating disorders specifically, need first be considered.

As mentioned previously, Steiner postulates that pathological organisations develop as a result of psychological trauma occurring during any phase of life. In much of the eating disorder literature the role of psychological vulnerability due to early disruption to the mother-infant dyad is given prominence (Shipton, 2004; Williams, 1997). Such disturbance is described as an unimaginable trauma for the infant because it confronts the inchoate ego with a premature, terrifying experience of the ‘not me’ before a sense of subject and object has developed (Winnicott, 1960). The infant is unable to make sense of the overwhelming intrusion; her only way to survive psychically is via a split in the ego which in time leads to a split into idealized and disavowed parts of the self.

In some cases of eating disorder an overwhelming psychic trauma occurs developmentally later and in the absence of early mother-infant disruption. An example that one sees with some regularity is an eating disorder seemingly precipitated by sexual abuse, as previously mentioned (Farrell & Magagna, 2003; Hertzog et al., 1993); unfortunately, a thorough exploration is beyond the scope of this paper. Importantly – whether psychological trauma occurs very early or later – in all cases the pre-eating disordered individual’s distress is not adequately contained so the trauma cannot be metabolized or mentalized (Allen et al., 2008). Rather, the terrifying undigested experience is psychically ‘walled off’ or ‘encapsulated’ (Hopper, 2003; S. Klein, 1980; Tustin, 1978; 1981; 1986) to allow some sort of survival.

Williams (1997) coined the term no-entry defences to refer to the eating disordered patient’s attempt to seal him/herself off from psychic intrusion – originally experienced at the hands of the primary object/s. Indeed no-entry defences may well refer to similar defensive phenomena as those seen with psychic encapsulation within pathological organisations. In this paper I take up Steiner’s argument that a pathological organisation emerges – somewhat like a *default psychic skeleton* – to take over psychological functioning after psychic trauma (Kadish, 2012a).

As mentioned previously, Steiner and Rosenfeld describe cases where dynamic interactions within the pathological organization function like a ‘gang’ or ‘mafia’ populated by bullies and victims, domination and submission. In eating disorders we see these sadomasochistic

elements come to life, for example, in the supreme triumph of an anorexic patient like Holly who believes she has overcome all personal frailty by being able to starve herself, despite pangs of hunger. Such a patient subjugates her body as an attempt to dominate and thereby prevail over needy self experience (Birksted-Breen, 1989; Chasseguet-Smirgel, 1995; Sands, 2003) while simultaneously triumphing over her mother and socio-cultural expectation. Conversely we observe the profound shame and self-loathing of patients like Brenda who binge eat, associating this with heinous personal weakness while paradoxically perceiving her excess weight as offering protection from the even ‘more heinous’ weakness of her sexual desires.

Culture as symbolic function

I suggest that with patients who suffer early developmental disruption, the inception of the pathological organization predates real exposure to the normalized body order. When such an individual later comes to be exposed to socio-cultural impellent, previously unnamed – traumatically induced – distressing internal states (masochistic and sadistic aspects) resonate with the good/bad binary of the normalized body order. In this way, through the internalization of socio-cultural imperative, sadomasochism becomes organized along socio-cultural lines, offers a mode of *elucidating* previously incomprehensible internal states.

In the case of eating disorders precipitated by later traumas, the individual would have been exposed to the normalized body order prior to the crisis. Once the pathological organization defensively takes over functioning, already internalized socio-cultural impellent becomes intertwined with the sadomasochistic operations of the organization. The individual enacts the internal sadomasochism on her body via behaviours such as strict dieting, purging over-exercising etcetera. In this way she tries to control confusing and distressing internal experience. In either case the normalized body order comes to be incorporated into the sadomasochistic internal dynamics of a pathological organisation and used defensively but also to provide symbolic functionality, which I will now discuss.

Contemporary 'rules' pertaining to fat and thin perform a symbolising function; the amalgamation of individual psychic structure and cultural imperative operate to confer a comprehensible narrative, a set of meanings and regulations to explicate internal sadomasochism. It seems that a sadomasochistic pathological organization is made sense of through socio-cultural *translation* i.e. their disorderly eating can be understood as a way of reaching toward a sense of narrative coherence and belonging. In this way split off parts of self, object, body and mind become restructured and contained by the pathological organisation which is understood through the language of socio-cultural impellent. Therefore in eating disorders the individual's experience of her internal world is given meaning, sanity even, when translated into the language of the normalized body order via projection and introjection. In order to explain how this operates within a sadomasochistic pathological organisation the concept of abjection should be considered.

The abject body object

Julia Kristeva (1980), in her book 'Powers of Horror', introduced the notion of abjection especially in relation to the development of self. For Kristeva, abjection implies the expulsion of that which feels other to the self as a way to delineate the borders of self and other, to define subjectivity. "*The abject is what one spits out, rejects, almost violently excludes from oneself; sour milk, excrement even a mothers engulfing embrace*" (McAfee, 2004, p. 46). Abjection as a mental process is different from Freudian repression (Freud, 1915) because that which is expelled is not relegated to the unconscious but remains on the borders of consciousness, always threatening to undo the self that has been constructed - "*To each ego its object, to each superego its abject*"... "*On the edge of non-existence and hallucination, of a reality that, if I acknowledge it, annihilates me. There, abject and abjection are my safeguards. The primers of my culture*" (Kristeva, 1980, p. 2). I have used Kristeva's notion of abjection to convey the tone of a particular sort of malignant projection onto the body, which I have called the abject body object. This 'waste bin' masochistic object is a concretization of all that is deemed bad and disgusting in the self which is split off into the body/self and kept separate from the mind/self. In this way the normalized body order allows the individual to preserve part of herself from the sadistic attacks of the organisation. If she can concentrate all her efforts to controlling her hated wayward body/self it allows the mind/ self to survive

It is my contention that the abject body object can be most easily demonstrated in the particularly harsh and self destructive pathological organisations of clinically eating disordered women. However a full-blown eating disorder is not the only outcome of an abject body object; it is present in sub-clinical cases as well as illustrated by Brenda's case. It is suggested that the normalized body order offers a psychologically vulnerable individual a two dimensional 'road map' of how to be in the world. Of course in every case this manifests differently because of the unique psychology of each individual.

Holly

An anorexic patient like Holly needs to remain very thin in an attempt to stabilise her internal world. In her mind so long as she remains very thin she can, for the most part, avoid having to face the split off, terrifying, disavowed parts of herself. Clinicians who work with eating disordered patients can attest to the description of a bad day as a 'fat day'. 'Feeling fat' seems to mean feeling out of control, scared and/or without internal boundaries. The alexithymia so often associated with eating disorders is patent when 'feeling fat' is the language chosen to convey a difficult emotional state.

In Holly's case her pathological organisation was manifest in the manner that she engaged with me from the outset. Steiner explains that one can observe the patient who has withdrawn from contact into a psychic retreat by particular sorts of transference-countertransference configurations. Such a patient may present with a detached superiority, alternatively she might engage 'as if' she were a patient in treatment, without any real therapeutic contact or she might participate in a dishonest even devious manner. The clinician in turn will feel frustrated, excluded and/or pressured to act out in a shallow, dishonest, colluding or perverse manner (Steiner, 1982; 1993; 2011). Steiner suggests that what happens with this sort of patient is that she hides her vulnerable self behind the protective walls of a rigid, highly organised pathological organisation of the personality. This allows psychic retreat from intolerable anxieties.

I came to understand that in Holly's mind she had come to therapy so that we could work on the issue of her being single and 'rectify' this situation without any of her dynamics needing change. This was because she could not begin to conceive of an existence without anorexia. I came to see that her anorexia was the crystallization of a very rigid, sadomasochistic pathological organisation. The clinical material that follows will illustrate this.

In a session some months into therapy, she said "I don't want to want anything that I don't already have." She explained that she did not like to feel need, it felt like deprivation. "*That is why I never think of things like that.*" "*My anorexia helps me a lot with that, I can decide what I will and won't eat and then I don't feel need.*" I asked what would happen if she wanted the things she had decided not to have. She said she had been anorexic for more than half her life, since she was twelve, she didn't even think of wanting, that was just how she was. In a session a few weeks later she stated "*My worst nightmare would be feeling needy and getting fat.*" "*I don't ever want anything that I can't have because I don't let myself want things I can't have.*" To illustrate this she described going out for coffee with her sister who was on a diet and was "*really dying for a piece of cake*". Her sister remarked on Holly's willpower, that she did not even seem to want the cake. In a smug tone she explained to me that she didn't ever feel that way - dying for something. "*I decide whether I can have something or not and then I have it or not.*" I said that not allowing herself to want things might be related to a desperate wanting, felt throughout her life in relation to her mother. She agreed saying that her anorexia was the only reason that her mother cared about her at all. She remembered as a little girl she had spent endless hours over the years, waiting for her mother while mother took her talented eldest daughter to ballet and violin lessons at the "*best teachers*" far from home.

The few times that Holly allowed herself to reconnect with those feelings her terrible longing was palpable. She would leave the session depleted and somewhat disorientated. Her ability to connect with these very difficult feelings made me cautiously hopeful. However she could not bear being connected with these feelings for long and would inevitably come to the next few sessions, aloof and superior, safely behind the wall of her pathological organisation.

Her omnipotent defence hinged on her ability to remain skinny, an impossibly valuable achievement in the context of her extreme loathing of fat. She had once remarked with a cold, self-satisfied smile that she would “*rather die now than live as a fat person*”, as if this was some sort of a moral victory that I would understand and admire. This was linked in her mind to our shared socio-cultural context. With hindsight it seems that her horror and disgust at fatness – the un-bearableness of her needy self/object body object – portended the therapy’s failure.

After a year in treatment I thought she seemed to make some progress; allowing her iron guard to slip a little, she ate a bit more, exercised a bit less and gained two kilograms. This was devastating for her however; she came into therapy furious and hating me. She said that it was my fault that she was now fat and still didn’t have a husband, which was the only reason she had come to therapy. I tried to interpret her terrified, chaotic feelings saying that this unbearable vulnerability was what ultimately underlay her anorexia, but that we would work through these feelings together. I offered her an additional session to contain her however she was implacable, not wanting to hear anything I said. She left the therapy a few weeks later saying “*you earn money from this so you would never admit that things were going wrong because you want the money!*” The sadism of her defensive organisation was unmistakable in her denigrating tone; she had retreated and would not re-emerge. I had no doubt that she would quickly lose the two kilograms, erasing our work and her knowledge of the agony that would always lie in wait beyond the protection of her defensive organisation. For Holly anorexia *binds* and condenses her chaotic feelings which can then be split down the lines of the idealized, sadistic mind/self and denigrated masochistic body/self. Thus as long as she remains thin she can ‘manage’ her unbearable feelings and disavow them, cloaked in the defensive omnipotence of the organisation.

With a patient like Holly, the driving force behind her anorexia seemed to be a need to protect her weakened ego, damaged in the earliest months of life. Her mother had lost her own mother a month after Holly’s birth and sunk into depression, it seemed that the mother/infant bond never really recovered. Holly would always secretly long for the mother who would never come.

Her pathological organisation seemingly came into existence from almost the beginning of her life as a result of the early mother-infant disruption which was then compounded by the experience of feeling like the least important sister. Because the disruption to the mother/infant dyad was so early the damage to her inchoate ego was pervasive. This could be seen in her profound sense of abjection in relation to her bodily self which can be directly associated with Freud's stipulation that the first ego is a bodily ego (1923). For Holly, the normalized body order offered symbolic function – a way to translate and then control her internal world via the control of her body. The language of *fat* and *thin* allowed her to name her chaotic feelings. 'Fat' was synonymous with terrified, unbound, needy feelings, these were projected into her body/self crystallized in an abject body object. 'Thin' meant contained, superior and without need, these feelings were associated with her idealised mind/self. Through the structures of her sado-masochistic pathological organisation the mind/self was then able to sadistically control the body/self. This offered her a way to disavow unbearable, needy feelings – so long as she remained in total control of her body i.e. abstemiously skinny. Unfortunately it seemed that the pervasiveness of her pathological defensive structure meant that she would probably be unable to leave its sanctuary of until she reached a point of greater motivation to relinquish it.

The discussion now turns to the way in which the normalized body order and the abject body object might manifest in the therapeutic situation especially where therapist and patient are both female. Such a therapeutic couple have usually lived within a similar cultural milieu where the normalized body order is particularly significant for women. The manner in which the normalized body order constructs or writes the body, and especially the female body, makes this shared history a trauma history. I suggest that the actual bodies of therapist and patient come into the room and *speak*, as it were. Sometimes the therapeutic couple's embodiment of the normalized body order; especially in the case of a patient with an abject body object; leads to a particular sort of therapeutic impasse due to the appearance of the so-called anti-analytic third (Straker, 2006). This was the case with my Brenda.

Ogden (1994a) proposed that ‘the analytic third’ is the unconscious, intersubjective construction of analyst and analysand. It is a dynamic combination of the unconscious processes of both but where conscious emphasis is put on the history and unconscious of the analysand. Straker’s (2006) anti-analytic third refers to cases when the analytic third breaks down, especially due to a shared trauma history.

Brenda

In the first two and a half years of therapy our work was difficult but productive and I was fond of Brenda. However in the last six months of the third year the therapy became stuck as a result of what I believe to be a case of an anti-analytic third. We had been exploring her feelings about being a woman, her sensuality and her body. This work was very difficult for her as she felt she did not have a way of getting in touch with her sensuality as a result of the negativity she projected onto her body. Brenda wished to meet someone new to have a ‘proper’ relationship with. She spent many sessions considering the kind of man she wanted and didn’t want. The problem of how one met men “at her age” troubled her. We spent many sessions addressing her fear that no man would look beyond her external appearance and be interested in having a relationship with her. An important aspect of the work from the beginning of therapy had been about her negative image of her body, how she despised it. This issue became even more prevalent for her now that she was entering the world of dating again. Brenda felt she should lose weight in order to be more attractive however this was extremely difficult for her for many reasons.

Our sessions started to become stuck and repetitive. She said she knew she should love her body as it was but she couldn’t. Neither could she change it as she felt unable to prevent her eating binges. Thinness – imbued with multiple cultural meanings – was idealized by her and it functioned like a cruel mirage promising to be everything she needed but remained ever out of reach. For several sessions we were caught up in what felt like a stalemate. Then in a particular session she exploded in an angry, accusing tone saying that it was easy for me, that I didn’t have to walk around looking like she did. She said she was tired of trying to accept her body the way it was and to make peace with it. “*When I meet a man for the first time this fat body is all that he sees and he’ll be completely turned off*”. She wondered what help I

could offer as a slim therapist and thought that she should rather have stomach stapling or liposuction as we were going nowhere.

Her words had a dramatic effect on me. I felt diminished, even foolish, my words felt empty and useless. How could I, how dare I, pretend that I knew what it was like? Actually I did have some experience of what it felt like, having been overweight in latency, however I felt I couldn't disclose this to her. I also could not deny that a man might not initially find her body appealing. This ran counter to my own strong feelings of indignation about the normalized body order and my fondness of her. My internal dialogue was confusing, were my own beliefs about women's bodies actually irrelevant, even narcissistic, in the face of her distress? Shouldn't I be encouraging her to diet in order to comply with contemporary cultural imperatives? Like the liberal white therapist with a black patient or the heterosexual therapist with a homosexual patient, at that therapeutic moment our social histories intersected causing dissonance. My guilt and her indignation led to paralysis while she felt I could never understand her experience. With hindsight, this seems to have been an eruption of the anti-analytic third.

Straker (2006) applies this term when the shared trauma histories of patients and clinicians lead to therapeutic deadlock. As previously mentioned, her examples relate to race and homosexuality. However I believe that such an anti-analytic aspect related to the normalized body order might also cause such a sticking point in therapy in much the same way. We know that there is intergenerational transmission of trauma relating to the stigmatisation of race and homosexuality (Straker, 2006). It follows then that bodily stigmatization is likely to be transmitted in a similar way. Theory confirms that clinically eating disordered women who become mothers often transmit their own bodily issues to their children (Pike & Rodin, 1991). In light of all that has been discussed in this paper, it almost seems to go without saying that the normalized body order is conveyed across generations and through families *in the absence of* clinically eating disordered members. Thus micro interpersonal and familial relations can be seen to interconnect with macro social relations in the genesis of eating problems.

When the anti-analytic third seemed to stall Brenda's treatment, my embodiment of the thinner end of the normalized body order together with her abject body object apparently led both of us to feel that I could not be of help to her. I believe that I was on the receiving end of a powerful projective identification from her but was unable to view this with therapeutic distance. Eventually I was able to regain my own mind and to make some sense of what was happening between us and interpret it in the transference. Brenda's abject body object and overweight body paradoxically offered defensive utility. It meant that she perceived herself as hating herself *because* she was fat. She would tell herself that she did not hate herself, she hated her fat, her unacceptable body/self but not her mind/self. The thin-fat binary therefore serves both as a *pseudo container*, a place to put feelings about the self, and a means of representing what she feels; hence it was utilized for symbolization as well as defence. The fact that the sense of abjection was felt in relation to her body and not her mind is a dichotomous concretization, a primitive defence against the pain of feeling like an ugly/unwanted person. She could tolerate having a fat/bad body because at least this allowed her to keep her mind separate and good. In due course Brenda was able to think about her defensive use of food and her body. Essentially, Brenda was psychologically healthier than Holly and we were able to get beyond the therapeutic impasse and the treatment survived.

This paper has presented a variety of ideas from diverse sources. Ultimately the common driving force seemingly underlying all of the different concepts discussed is that they can be understood as a flight from libido and sexuality.

CONCLUSION

Therefore it seems that psychological trauma precedes the development of eating disorders which then develop in the following ways. Trauma may lead to the inception of a pathological (defensive) organization at any time in development i.e. either before the child is fully cognizant of the socio-cultural impellent or afterwards. Socio-cultural impellent can operate to *translate* distressing internal states so that they become powerfully linked to a cultural phenomenon. The normalized body order confers symbolic function by providing a common language which transforms previously unknowable internal states for the eating disordered individual. She can use the pathological organisation clothed in the language of the

normalized body order to split her internal world down idealised (mind/self) and denigrated (abject body object) lines. The mind/self then sadistically and serially attacks the masochistic body/self and a particular, often enduring, defensive status quo comes to dominate psychological functioning.

CHAPTER EIGHT

DISCUSSION AND CONCLUSION

DISCUSSION

In this thesis three theoretical trajectories were synthesized in an original way. These were: contemporary psychoanalytic understandings of anorexia (and the eating disorders); contemporary Kleinian literature on pathological organisations and psychic retreats; and the literature on autistic-like (autistoid) defences in non-autistic adults. This was done in an attempt to advance the overarching hypothesis that particular modes of defensive organisation operate in anorexia. Furthermore, that autistoid and secondary-adjunctive encapsulation seem to be manifest in the material of the anorexic (and other eating disordered) patients presented. In the course of the research process additional arguments and hypotheses, which also offer original contributions, were made. It is hoped that the findings, summarised below, will make a useful contribution to psychoanalytic theory and assist clinicians in their work with such patients.

The intention of the research project was to explore the idea that pathological defensive organisations might manifest within intrapsychic structure and through the symptoms and interpersonal relationships of the anorexic patients presented; and additionally how this might manifest in the transference-countertransference with such patients. Secondly, whether autistoid phenomena, including autistoid encapsulation, seemed evident - based upon the clinical material.

Here follows an integration of the four papers in order to bring all the ideas and arguments together in one coherent narrative.

Pathological organizations and psychic retreats in anorexia

The central theoretical thrust of this thesis is as follows: that pathological organisations and psychic retreats (Steiner, 1993) offer important insights into the theoretical understanding and treatment implications of eating disorders, and especially in anorexia. This was the central tenet for my paper entitled *Pathological organisations and psychic retreats in eating disorders*. As mentioned previously the term pathological organisation denotes a tightly knit, rigid assemblage of defences that develop within personality as a result of psychically overwhelming events which have led to a breakdown in psychological functioning (Steiner, 1982; 1987; 1993; 2011). Their purpose is to protect individuals against experiencing devastating persecutory and depressive anxieties through the avoidance of emotional contact. In essence the organisation is looked to as the only way to fend off threats emanating from internal and external reality (Spillius et al., 2011). I have suggested that a pathological organisation can be envisaged as functioning like a *default psychic skeleton* superimposed, as Steiner (1993) described it, over the individual's usual personality structure during times of profound anxiety. It develops as the result of the failure of the individual's usual psychological defence mechanisms and may be short-lived or long-standing. Pathological organisations work in tandem with psychic retreats; these provide a psychic 'escape mechanism', offering temporary relief from overwhelming anxiety.

This paper explored the manner in which participants 'Cassie', 'Jenna' and 'Sarah' used their bodies and bodily products (food, vomit, faeces and bodily sensation) as 'intermediate objects' in their psychic retreats. An intermediate object is different from Winnicott's (1953) notion of a transitional object in that the former originates from the body, whereas the latter does not (Kestenberg, 1968; Kestenberg & Weinstein, 1988). Intermediate objects are able to change shape and merge or separate from the individual's body; they transform and decay quickly, unlike true transitional objects. Intermediate objects may thus be considered a special type of forerunner to transitional objects - an additional stage in the progression from the use of the body and its products to the use of, for instance, a piece of blanket or a rag doll (Kestenberg, 1968; Kestenberg & Weinstein, 1988). This contributes to the unique nature and quality of each eating disordered individual's pathological organisation and psychic retreat. Although these organisations are personalised in each case, I argued that similarities are

apparent in the nature and tone of the pathological organisations of eating disordered patients, which appear to manifest sado-masochistically – most likely as a consequence of psychological trauma (Birksted-Breen, 1989; Chasseguet-Smirgel, 1995; Sands, 2003; Shipton, 2004).

It has been argued in all four papers that psychological trauma is instrumental to the genesis of pathological organisations and psychic encapsulations (whether autistoid or secondary adjunctive). For this reason psychological trauma is of primary significance for the current research and is understood here to include such factors as: disruption to the mother-infant relationship, psychologically unmediated losses and other types of personal or collective traumatic exposure. Indeed, early mother-infant disruptions and sexual abuse trauma are often documented in the histories of eating disordered patients (Farrell & Magagna, 2003; Hertzog et al., 1993; Lane, 2002; Sands, 2003; Shipton, 2004). I will now attempt to provide a developmental illustration of how this unfortunate scenario might occur. This is an attempt at a developmental reconstruction, looking backwards in time i.e. from the infant to the patient.

(Primary) Autistoid encapsulation

Trauma in earliest infancy is understood to be the cause of autistoid encapsulation (Tustin, 1986) and anorexia can be understood in some cases to be directly related to an autistoid encapsulation within the psyche as discussed in my paper – *Autistoid psychic retreat in anorexia*. An autistoid psychic retreat can be understood as a defensive withdrawal by a predisposed individual, during any stage of life and for any period of time, to a primitive, enclosed part of the self that has been damaged as a result of early infantile trauma (Mitrani, 1992; Nissen, 2008; Tustin, 1981). Such trauma to the infant's inchoate ego during the phase when mind and body were one is often re-awakened at puberty – a defensive response to a current psychological crisis.

In accordance with autistoid theory it is claimed that the infant, desperate to survive psychic annihilation, begins a frenzied search for a containing substitute fragment-object, selected on the basis of its sensory stimulation and ability to provide an artificial experience of self-

cohesion. This could be a light, the mother's voice, her smell or a sensual object to cohere her fragile state, if only briefly. An absorption in mother's smell or voice could be completely object related in healthy infants, however this is very different to the 'secondary skin' formations of traumatised infants (Bick²⁴, 1968; Meltzer, 1975), a pathological yet essential substitute. 'Substitutes' or 'defences' available at this developmental stage comprise of autistoid shapes, objects and delusions which operate to bind the unmentalized experience of devastating loss and unbearable longing for the object (Mitrani, 1996; Tustin, 1986). The defences mustered by the desperate infant lead to the fossilization of autistoid nuclei within the evolving structure of the nascent mind. These nuclei are encapsulated in their 'frozen animation' by sensationally based, preverbal manifestations. In some cases self-generated cohesive 'substitutes' or 'defences' can be seen in precocious mental development, whereby the infant's defensively escalated omnipotent fantasies allow her to use her inchoate mental processes to "take over and organize the caring for the psyche-soma" (Winnicott, 1962, p. 61) – a function normally fulfilled by the mother.

In both autism proper and in autistic states, the traumatized infant turns away from the mother and retreats to sensationally imbued autistic shapes and objects and self-generated sensations for comfort rather than to the mother and normal transitional objects (Ogden, 1989a; 1989b; Tustin, 1980; Winnicott, 1962). Bick (1968) proposed that this "temporarily holds the parts of the personality together" (p. 484). These self-generated sensations give the infant some comfort from terrors that Tustin (1986) described as "preverbal, pre-imaginal and preconceptual" (p. 23). These autistic manoeuvres serve as a protective shell against the horrifying awareness of separateness, the terror of *two-ness*, which is synonymous with a terrifying sense of dissolving into nothing, spilling, falling forever (Bick, 1968; Tustin, 1986). In the case of 'Amy' (and possibly other anorexic patients with similar sorts of defences) it seems that her bony, emaciated body operates as a sort of hard object to bind her anxieties.

The (pre-anorexic) infant who survives psychologically via an autistic encapsulation would appear to develop normally for a time. However, liveliness and *real* growth are sacrificed. This vulnerability becomes evident when the pre-anorexic is called upon to leave the safety of

²⁴ It should be noted that although Bick's concepts are very relevant to autism, she did not write about autism herself.

latency and square up to adolescent challenges. It is not possible for her to have more adult sorts of relationships (including being prepared for sexuality) when she is still functioning pre-oedipally. This 'deficit' is revealed in anorexia when chronological growth continues but psychological progression is stalled (Zerbe, 2008).

Thus when one works with autistoid anorexic patients like 'Amy', 'Jenna' and 'Holly' there are significant therapeutic challenges, especially regarding the transference-countertransference, as discussed in the literature and encountered in my own work. The therapist often experiences a powerful countertransference where she feels unable to think, like she is stuck or trapped – immobile and helpless. These patients often also induce a feeling of sleepiness in the therapist who must struggle to stay awake and mentally alive (Cartwright, 2006). The patient appears to engage in therapy but there is limited or no emotional engagement. This countertransference seems to be the result of the autistoid defences. These patients insulate their emotional selves behind an emotional 'shell' or 'wall' (Mitrani, 2001). In sessions the therapist often experiences feelings vacillating between disquiet and despair, unable to imagine how such patients could ever bear the rigours of life – should they ever feel able to leave the rigid haven of the autistoid psychic retreat to anorexia.

Thus this thesis argued that anorexia offers considerable utility as a defence because it serves to reinforce the autistic enclave (which has been reactivated by overwhelming demands on the ego) against the threatened collapse provoked by puberty. The autistoid psychic retreat of anorexics like 'Amy', 'Jenna' and 'Holly' mark a turning away from the overwhelming demands of the external world. The starvation and bodily obsession can be understood as a return to auto-eroticism (Freud, 1914) which bolsters the sensate defences and adhesive identification around the autistic nucleus. The all-consuming obsession with the body can be thought about as a regression to the first bodily ego noted by Freud (1923). It is proposed that in the cases of 'Amy', 'Jenna', 'Holly' and perhaps similar cases, anorexia could be considered as a particular type of prolonged autistoid psychic retreat, one that incorporates the intentional starvation of the body and the manifold associated symptoms.

Primary/Autistoid and Secondary-adjunctive encapsulation

This thesis has suggested however, that this autistic dynamic is not found with all anorexic patients. In the literature (De Cesare, 2004; Grotstein, 1983; Hopper, 1991; Innes-Smith, 1987; Klein, 1980; Lawrence, 2001; Nissen, 2008; D. Rosenfeld, 1984; Tustin, 1972; 1981; 1986; 1990) no distinction has thus far been made between autistic encapsulation as opposed to later occurring forms of encapsulation. This was attempted in my paper: *Two Types of Encapsulation in Anorexia*.

According to the literature, autistic encapsulation occurs only in relation to the mother/primary object during the earliest period of infancy (Nissen, 2008; Tustin, 1986). Therefore it cannot be correct to speak as if the psychic encapsulations of, for example survivors of terrible trauma such as *Shoah*, war, torture, sexual abuse, etcetera are of the same order. Survivors of these horrors are no doubt terribly traumatised (Hopper, 1991). In terms of psychic structure however, I have argued that there are differences. Autistic encapsulation, happening when it does, implies drastic early damage and therefore a curtailment in regards to the development of the psyche, particularly the ego. In order that a distinction be made, it is helpful to think of autistic encapsulation as being *primary* in that it occurs in the earliest days in the mother-infant dyad when the ego is inchoate.

This means that the psychic effects of autistic or *primary* encapsulation are pervasive. Secondary-adjunctive encapsulation, in contrast, has been suggested here to be a later and more discrete form of encapsulation. Overwhelming trauma that occurs after mental structure has developed, while of course being devastating, must be of a somewhat different order to trauma that occurs very early on in development. An individual who experiences trauma later on in development may have been relatively psychologically healthy with good ego functioning before a trauma is experienced (Volkan, Ast & Greer, 2002). I have therefore called this other sort of encapsulation, *secondary-adjunctive* encapsulation because when it occurs the ego is capable of *secondary* process operations. It is *adjunctive* because it is as if it becomes affixed to existing psychic structure, like a tumour on healthier flesh. 'Maya' and 'Jessica's' cases were offered as illustrations of this type of encapsulation. Of course

delineating an exact temporal cut-off point separating autistoid from secondary-adjunctive encapsulation is difficult. Trauma that occurs between the ages of one and three takes place in a grey area, or interim period regarding the exact type of encapsulation that will occur. The possibility of a hybrid type is likely, with mixed aspects of both types. The possibility of the two different types of encapsulation also offers a second clinically/technically important contribution because it directly affects the nature and duration of the therapeutic work. Therefore, this theoretical distinction is important at the level of clinical practice. In the case of secondary-adjunctive encapsulated anorexic patients, the work in therapy progresses far more easily and rapidly seemingly as a result of their prior, underlying psychological robustness. These sorts of patient have a very different countertransferential feel as compared to autistoid encapsulated patients.

I have argued that this particular sub-type of anorexic patient, less frequently encountered, typically presents with (as discussed in the cases of 'Maya' and 'Jessica') the following scenario: A secondary-adjunctive encapsulation which is the result of sexual molestation trauma in latency or adolescence. In the cases presented, the abuse was neither incestuous nor penetrative. These patients, at the height of their illness are as emaciated and as life-threateningly thin as their counterparts. However, they seem to make much quicker and more robust recoveries if the trauma is identified and worked through. Similar to autistoid anorexics, the pathological organizations of these patients are sadomasochistic in nature; however it seems that an explanation for the quicker and more sustained recoveries of this particular sort of anorexic patient may lie in a prior level of psychological health and that therefore some sort of recovery in line with prior healthy functioning is possible. The patients I have presented seem to have had 'good enough' mothers, even 'good enough parents', who nevertheless (for various reasons) failed them in the aftermath of the sexual abuse trauma. Clearly the degree of recovery from secondary-adjunctive encapsulation is largely dependent on the nature of the trauma. Unfortunately in the severest cases of later trauma – such as survivors of torture or Holocaust – the individual's psychological functioning is irreparably impaired despite having been formerly relatively psychologically healthy (Hopper, 1991; Volkan et al., 2002).

The link between trauma and eating disorder has been established (Lane, 2002); an additional factor for consideration in this thesis was whether the psychological impact of trauma might increase the individual's susceptibility to internalising (or incorporating) malignant socio-cultural trends normalizing unhealthy practises and unrealistic or unattainable standards for the female body²⁵. This was an important area to explore as many authors have debated the link between contemporary cultural trends and eating disorders. Paper four – *The Role of Culture in Eating Disorders* – aimed to contribute to that debate via a psychoanalytic consideration of the effect of contemporary socio-cultural trends regarding thinness and the female body in relation to pathological organisations and psychic retreats.

This final paper drew upon literature that had not featured in the other three papers, namely, a brief discussion of the feminist and feminist psychoanalytic literature to add a context for the question of whether current socio-cultural trends might affect the development of eating disorders. The final chapter engages with the question of how such socio-cultural trends, as transmitted, for example by the family, media and peers find their way into the pathological organisations of eating disorder sufferers. It was suggested that these socio-cultural trends provide a symbolic and symbolising function for individuals, insofar as they offer a framework for the individual to organise and communicate her chaotic or inexpressible internal world: distressing internal states become powerfully linked to a cultural phenomenon.

The term *normalized body order* was conceptualised to make the point that in contemporary culture, the thinness ideal has been imposed on women's bodies so that what is *commonly* aspired to is a body shape, weight and bodily practices that are unhealthy. There seems currently to be a socio-cultural trend that structures bodily size and shape into a taxonomy of social desirability (Chernin, 1981; 1983). It was suggested that the *normalized body order* could confer symbolic function from within a pathological organisation to *translate* confusing affective states in patients who struggle with an unstable sense of self.

²⁵ Increasingly the male body seems to have fallen under a similar sort of socio-cultural scrutiny but this does not yet appear to be as powerful and pervasive as that which pertains to the female body. The question of whether men would express distress in similar ways to the women described in the paper is beyond the scope of this study.

A second concept introduced was *the abject body object*, which implies a particular sort of malignant projection onto the body. This 'waste bin' object is a concretization of all that is deemed bad and disgusting in the self which is split off into the body/self and kept separate from the mind/self. It is my contention that the abject body object can be seen in the particularly harsh and self-destructive pathological organisations of eating disordered women. However, a full-blown eating disorder is not the only outcome of an abject body object; it is present in sub-clinical cases as well. The normalized body order and the abject body object operate in tandem in that the former allows the individual to preserve part of herself from the sadistic attacks of the organisation. If she can concentrate all her efforts to controlling her hated wayward body/self via her use of the abject body object, it allows the mind/ self to survive.

The fourth paper, like the previous three, investigates the association between psychic trauma and eating disorders. In this paper the question of whether socio-cultural trends might evoke a therapeutic impasse, seemingly syntonic with Straker's (2006) concept of the anti-analytic third, is considered. This adaptation of the concept is a contribution to the literature regarding thirdness, analytic impasse as well as eating disorders. Straker (2006) applies this term when the shared trauma histories of patients and clinicians lead to therapeutic deadlock. As previously mentioned, her examples relate to race and homosexuality. However it is feasible that such an anti-analytic aspect, related to the normalized body order, might result in a similar impasse in therapy. We know that there is a trans/intergenerational transmission of trauma relating to the stigmatisation of race and homosexuality (Maiello, 2001; Straker, 2006). Bodily stigmatization might also be open to such transmission. Theory confirms that clinically eating disordered women who become mothers often transmit their own bodily issues to their children (Pike & Rodin, 1991). But it is important to consider whether the normalized body order could also be conveyed across generations and through families without clinically eating disordered members. Thus micro interpersonal and familial relations can be seen to interconnect with macro social relations in the genesis of eating disorders.

Limitations of the research project

The most important limitations of this thesis pertain to the acquisition of participants. Firstly, the ethical requirement that patients are asked for permission regarding the use their material meant that there were restrictions placed upon my choice of patients to be participants. This was a very important consideration which necessitated that great care be taken when deciding whom to approach. In my vigilance I avoided asking many potential participants which implied some sort of limitation regarding the potential richness, although not the scope, of the research.

The second limitation regarding participant selection pertained to the sex of participants. This research focused on female anorexics and/or eating disorder sufferers, while male sufferers were not discussed at all. This all female focus did not seem to be a severe limitation because of the predominance of female eating disorder sufferers in this patient population (Fairburn & Brownell, 2002). On a practical level the relative rarity of males with eating disorders meant that I had treated very few such patients and none recently. Therefore I had insufficiently detailed process notes about those rare cases and so the data was insufficient as compared with the female patients. Certainly not enough is known about the defensive organisations of males with eating disorders. It may in fact emerge that males with eating disorders manifest particular structural dynamics – different from female sufferers.

A critique can also be made regarding the research project's primary focus on the pre-oedipal dynamics of the participants. Although tightly focusing on a circumscribed area is advantageous for research, it means that one must always choose to emphasize certain aspects in favour of others. In the case of the current research, my focus leaves the question of the contribution of oedipal dynamics for the pathological organizations and psychic retreats of anorexics unanswered. This is certainly an area for further research.

Finally, because the research design of the current project was qualitative, based on a small sample and utilised a phenomenological-hermeneutic approach – the findings reported cannot be generalised. Indeed this was not the intention of this research project which aimed to

investigate anorexia (and other eating disorders) from a particular theoretical angle. The research findings are offered as an invitation for readers to consider in light of their own eating disordered patients. The research design employed here was entirely appropriate for the particular conceptualisations considered.

Other areas for further research

This research considered a theoretical integration of the concepts of pathological organisations and psychic retreats and autistoid and secondary adjunctive encapsulation with application to eating disorders, particularly anorexia. Given that these theoretical links have not often been made in the existing literature, further research into the operative nature of this synthesis and application to eating disorders is warranted.

The subject of technique was beyond the scope of the research. However, pathological organizations and psychic retreats, as well as encapsulations, all imply particular technical challenges for psychotherapy. Particular attentiveness and patience is needed when working with patients who display pathological organisations and even more so when they also show evidence of traumatic encapsulation. These defensive structures need to be carefully worked with and worked through. The purpose of the present research project was to highlight these particular sorts of defensive structures in eating disorders to help clinicians to identify them. And although technique was beyond the scope of the thesis, some aspects of technique have been briefly explored in two of the chapters. In Chapter Five I discussed my work with ‘Amy’ in some detail and described the way in which she was able to make some progress once I became aware of her autistoid dynamics. In Chapter Six I described how during the course of my work with ‘Maya’, a patient who showed signs of secondary-adjunctive encapsulation, the processing of her sexual abuse trauma seemed to facilitate a rapid improvement of her anorexic symptoms. Further research regarding technique is required.

Another issue that arose, but which could not be explored in the current project, regarded the possibility of the co-existence in the same individual of the two different types of encapsulation. It would be fruitful to explore the inherent challenges that present in working

with eating disordered individuals with autistoid as well as secondary-adjunctive encapsulation

CONCLUSION

This thesis brought together particular concepts from psychoanalytic theory with the purpose of exploring intimate intrapsychic operations in anorexia from a specific vantage point. I will therefore conclude with an excerpt from my paper - *Autistoid Psychic Retreat in Anorexia*; this passage, inspired by my work with these patients, was intended to convey a phenomenological description of the adolescent anorexic's frantic attempt to manage the demands of the external world, her body and her internal world.

The anorexic feels increasingly out of control of her life because she lacks a healthy internal object that she can draw on for succour. More and more of her energy is directed towards getting rid of her 'fat', metaphor for her scary, intangible terrors. This confusing new world of boys and sexual feelings, breasts and menstrual blood, feels threateningly disruptive, exceeding her psychic capacity. However, she can achieve certainty in one thing: control of her body. In streamlining, taming and conquering her body she creates a simultaneously brilliant and deadly defence mechanism that works against threats both from inside and out. Anorexia allows the 'steely' narcissistic part to omnipotently starve her body, thereby controlling and containing the split-off denigrated 'burn victim', mother-self. She turns inwards, away from the overwhelming world as she once did from the overwhelming breast. She becomes invested in the absolute control of her body; she starves it, she measures it and she becomes increasingly sado-masochistically caught up in the physical sensations of starvation. She can suppress her gnawing hunger, she can take pleasure in her light-headedness; these are 'badges of honour.' Her modified body becomes a 'bony shield' against her internal chaos. It is maintained under the critical eye of the scale and its less reliable counterpart, the mirror – less reliable because she sees herself in a distorted way. They show her that she is angular and defined, albeit never sufficiently for her liking. She can never cease her vigilance because she fears her body will explode into anarchy if she ever drops her iron guard. Hence, both the 'hard', 'steely' part of her and her bony anorexic body

can be understood to operate as autistic objects, providing edginess and boundary and thus prevent the spilling out of the fragile 'burn victim' self. Anorexia can thus be understood as a desperate bid to prevent psychic dissolution. At the level of object relations, her body serves as a warning to others to keep out, as noted by Williams (1997b). Her body speaks simultaneously for the 'burn victim' part and the 'steely' part, seeming to say: "Do not put your expectations of normality on me for I am both too fragile to bear them but also superhumanly strong so you cannot pity me" (Kadish, 2011, pp. 33-34).

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APPENDIX A – PATIENT INFORMATION AND CONSENT FORM

My name is Yael Kadish, I am a clinical psychologist. I am currently in the process of undertaking research towards my PhD degree. To fulfill the requirements of the degree, I am expected to complete an extensive thesis. Sections of my research are likely to be published in accredited academic publications. My completed thesis would be available in the library of the University of the Witwatersrand. Please note that in all cases the identities and privacy of research subjects will be protected by using pseudonyms and removing any identifying details from the material.

The PhD study is in the area of eating disorders. The research is being undertaken so that any useful knowledge that arises out of it will be used in the understanding and treatment of eating disorders. In the course of my work with you, I might encounter aspects of our work that would be relevant for my research. I am therefore routinely asking all patients (and their parents, in the case of minors) who have eating disorders for their consent to participate in the research. My asking for consent does not mean that you are a suitable participant for the research; this can only be decided after some time in psychotherapy.

Taking part in the study would involve neither interviews nor questionnaires. Participating in the research would not mean any intrusion or deviation from the normal course of psychotherapy.

Professional standards dictate that psychologists keep notes after all psychotherapy sessions. If I believe that material arising from our work would be relevant to the research, with your consent, I would incorporate appropriate material from session notes. This material will be suitably disguised before it is written up so that your privacy is protected, as mentioned before.

There will be no direct benefit gained from participating in the research. However it is hoped that this research would go some way to shedding light on this subject.

You are free to withdraw from the study at any time without any negative consequence to yourself

I have read the above and agree to participate in the research.

Patient's Name: _____

Patient's signature: _____

Date: _____

APPENDIX B – PARENTAL INFORMATION AND CONSENT FORM

My name is Yael Kadish, I am a clinical psychologist. I am currently in the process of undertaking research towards my PHD degree. To fulfil the requirements of the degree, I am expected to complete an extensive thesis. Sections of my research are likely to be published in accredited academic publications. My completed thesis would be available in the library of the University of the Witwatersrand. Please note that at all times the identities and privacy of research subjects will be protected by using pseudonyms and removing any identifying data from the material.

The PHD study is in the area of eating disorders. The research is being undertaken so that any useful knowledge that arises out of it will be used in the understanding and treatment of eating disorders. In the course of my work with your child, I might encounter aspects of the work that would be relevant for my research. I am therefore routinely asking all patients (and their parents, in the case of minors) who have eating disorders for their consent to participate in the research. My asking for consent does not mean that your child is a suitable participant for the research, this can only be decided after some time in psychotherapy.

Taking part in the study would involve neither interviews nor questionnaires. Participating in the research would not mean any intrusion or deviation from the normal course of therapy.

Professional standards dictate that psychologists keep notes after all psychotherapy sessions. If I believe that material arising from my work with your child would be relevant to the research, with your consent and your child's, I would incorporate appropriate material from my session notes. This material will be suitably disguised before it is written up so that patients' privacy is protected, as mentioned before.

There will be no direct benefit gained from participating in the research. However it is hoped that this research would go some way to shedding light on this subject.

Your child is free to withdraw from the study at any time without any negative consequence to herself.

I have read the above and agree that my child may participate in the research.

Patient's Name: _____

Parent/guardian's Name: _____

Parent/guardian's signature: _____

Date: _____

APPENDIX C – ETHICS CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

R14/49 Mrs Yael A Kadish

CLEARANCE CERTIFICATE

M090223

PROJECT

On The Prevalence of Autistic Enclaves with the
Psychodynamics of Anorexics and
Bulimarexics.....A Qualitative Study

INVESTIGATORS

Mrs Yael A Kadish.

DEPARTMENT

Psychology Department

DATE CONSIDERED

09.02.27

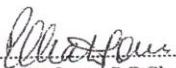
DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 09.03.02

CHAIRPERSON


(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof G Ivey

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

.....

APPENDIX D – TARA CLEARANCE CERTIFICATE**DEPARTMENT OF HEALTH**

TARA The H. Moross Centre

Private Bag X7
RANDBURG 2125**SOUTH AFRICA**Mr. Mogale MC
(011) 535-3101
Fax (011) 535-3026

TO: Ms. Yael Kadish
FROM: MR. MOGALE MC
AD. OT
DATE: 02/04/2009

Dear Ms. Kadish,

RE: APPROVAL GRANTED TO CONDUCT RESEARCH

The above matter refers.

It is with great pleasure for me to inform you that Tara Hospital research committee has approved your application to conduct a research in our hospital. The title of your research is: **On the Prevalence of Autistic Enclaves Within the Psychodynamics of Anorexics and Bulimarexics... A Qualitative Study.**

Please contact me should you have any queries.

Thank you,

Compiled by:


.....
Mr. Mogale MC
Research Committee Secretary

APPENDIX E – INTERVIEW MATERIAL

SARAH'S INTERVIEW

For me, the story of my binge usually starts with eating a normal meal or ... ja eating something that I feel is acceptable which is usually sort of low fat, low calorie. And ... once I've eaten then like the thoughts will start and it's usually because I still feel hungry and would like to eat something more, but because of the restrictions that have been imposed on how much I should be eating, it would be unacceptable to eat more. So then the kind of struggle begins and the anxiety begins because ... I would like to ... my body is saying to me "I want more" and my mind is saying "you've had enough. You're not allowed" ... And that's when the sort of panic begins to rise ... begins to build and I would try to, first of all have something that will fill me ... that's still acceptable like fruit, or for example an apple or a glass of water or a cup of tea or something like that or I would try to distract myself and talk to myself because over the years of struggling with bulimia, I know ... quite a lot about how to fight it and you know and I mean I would use a sort of logic and say "you've only eaten this much, it would be fine to have something more, you know" and give myself permission to have ... it but just keep talking against you know these sort of 'voices' in your head that are ... um kind of pushing you to either get rid of what you've already eaten or to eat more and more and then get rid of it. And um I would put that off by distracting myself with some form of busy-ness um but at times I can, I can push it back and not actually give in to it, at other times for some reason it just keeps building this anxiety or panic or um I ... haven't actually found a word that describes exactly what it is that ... sort of grows inside um and at some point I would have something else to eat , and usually by the time I'm actually eating it and I've convinced myself that it's okay just to have this ... that it would be okay ... alright ... it would be okay just to have one more piece of bread, or it would be okay just to have that, um and at some point during the eating I ... um know that I'm not going to be able to stop and that I might as well just now eat everything I feel like eating because I'm gonna get rid of it um and a binge, a binge for me is usually not ... huge in comparison to binges I've read about um ... but it would be a couple of slices of bread with syrup or um some or some ice cream or you know the traditionally taboo things that all the diets tell us are forbidden and then as quickly as possibly I'd go and get rid of it fast. Um ... and then guilt starts ... "you're revolting, how could you have done that?" for me during a lot ... um probably for the first sort

of four years that I was in the struggle with bulimia, the feelings of guilt were very um religious in nature or were linked to my faith in that I'd disappointed G-d or I'd let down G-d in actually eating um and throwing up ... in wasting my food ... in hurting my body, you know all those kind of things. So there'd be guilt in relation to what I'd done and shame in relation to G-d because of ... because of what I'd done. So I think always before the binge there's kind of the promise of "you can eat whatever you want and you can get rid of it". There's this sort of freedom, "you can do it and you'll feel better afterwards because you will have the things you want and you won't feel hungry anymore, you know all that kind of thing. And that promise was never fulfilled because always afterwards there was the guilt and the shame so you never actually felt good afterwards ... um the only moment of feeling good I think was when you actually brought things up ... the relief that ... I got rid of! Um but that was so short lived I mean the guilt and the shame ...

[Researcher asks if she has anything else to add — Sarah brings out her personal journal and reads from it]

Can I, can I actually read something. The ... just the context for this was that I was overseas studying and my husband was in South Africa, I'd gone on my own and um I'd been at a bible study with friends and as I was walking home it started to snow, and I'd got to my flat and I sort of walked inside ... just after having experienced the snow ... um ... okay:

I should have guessed that the peace would not last, as I'd got to my block of flats and began to walk up the stairs, familiar feelings tugged at my feet. I tried hard to hang on to the joy, but it melted as quickly as the snowflakes clinging to my face. An overwhelming loneliness washed over me as I opened the door and walked into my flat. The silence was broken and the voices started again ... "This is something you should only experience with Jonathan, how can you be so selfish as to enjoy this on your own, you shouldn't even be here, you're just self centred, egotistical ..." etcetera. I tried not to listen this was such a magical, unique experience, I didn't want to let go of the peace and the beauty. As I took off my wet coat and gloves I realised that I was shivering. I longed for the taste of something warm and sweet in my mouth – hot milk and sugar. I hugged a smile to myself as I thought of my dad pouring out tall glasses of hot milk and ceremoniously stirring two spoons of sugar in each. The memory warmed me as the milk had warmed our bodies ... I put some milk in a saucepan on the stove and went over to the curtains. From my first floor flat I could see the usually busy walkway behind. It was almost deserted now, a layer of shiny snow concealing the grey of the

concrete ... I retrieved my milk just before it bubbled over the rim of the saucepan. I poured it into a mug. I looked at the sugar tin, but decided that having the milk was dangerous enough. I switched off the lights and walked back to the window. I held the milk up to my lips enjoying the sensation of the rising steam on my face. A sense of longing washed over me and was followed by the feeling of shame. The voices seized the opportunity ... "you greedy pig how can you have a glass of milk when you've had a full supper and a slice of cake." Earlier that evening at the bible study we'd been offered cake with our coffee, I think someone was celebrating a birthday. I had tried desperately to think of an excuse not to have any but I knew that I was already being carefully watched by the study leaders who were rather concerned about my diminishing appetite. After an intense inner struggle, I'd accepted a small piece and eaten half of it. My fears were justified as the voices began to attack me with this latest evidence of my gluttony, my sloth. "No wonder you're so fat, you're just a glutton, how can you...can't you even say no to one piece of cake, and you could have left some of your supper as well. If you'd have taken the plates to the kitchen no one would have noticed. You'll just have to exercise more tomorrow or you can get rid of it now." Oh no, not tonight. I tried to stop the thoughts? It was just a small piece of cake and I ate less than everyone else at supper. I'll get up early and do exercise. I'll go for a long walk in the snow tomorrow. Please, I don't want to be sick, I promised Jonathan I wouldn't. And what if I can't? The last few times I tried it was so hard and my throat ended up bleeding and sore for days, it's not worth it. I feel so tired and drained afterwards and I've got a full day's lectures tomorrow. I have to be able to concentrate ... G-d please help. G-d please help. But the familiar contraction of anxiety in the pit of my stomach just tightened. I looked out at the falling snow again and again and cried, was there no escape? I could phone someone and talk it through but who? The sense of shame and disgust at what I was contemplating prevented me from reaching out. As the panic feelings rose I knew that I'd have to do it. If it wasn't now it would be later. There would be no rest from the voices until they were appeased, until I carried out due penance for my lack of control. I suddenly remembered a box of chocolates that I'd been given for a Christmas gift. Although it was March they were still in the cupboard sealed in the cellophane for my protection. I had known that opening the box would be fatal. I'd hidden them away and tried to forget their existence but now they taunted and taunted from their hiding place. The struggle continued to rage inside me for a long time while I stared into the silently falling snow. Slowly and mechanically I walked over to the cupboard and took out the chocolates. I chose one that I liked and then closed the box and put them away. Just one, just a little treat because it's snowing. I dipped it into the milk and savoured its soft rich sweetness in my

mouth. It was a long time since I'd allowed myself chocolate, it tasted so good, but the voices were having none of that."Chocolate! That is what fat people gorge themselves on. You have no self control ... how could you open a whole box? Now what are you gonna do with the rest? I suppose you intend to ration yourself to one a day - that's a joke. You've got no self-control you could never do that. You may as well just eat them all now and be done with it, if you do it quickly. If you eat quickly and vomit them all up they won't affect your weight". The rest of the chocolates disappeared fast. I continued to watch the gently falling snow but it no longer looked white and pure, the whole world had been contaminated by my evil greed. I stuffed and stuffed and stuffed to try and fill the gaping need that was never satisfied. Then I went and vomited until my heaving only yielded blood, I could no longer even swallow saliva through my swollen throat.

I hadn't actually ... read that for a long time, I knew it was there but ... it's just um ... very real again. Those were the kinds of thoughts and feelings that are always there just about ... um ja how disgusting I am, how terrible, you know, how greedy, fat pig these are words that are ... sort of ... often around during those times.

[Researcher asks about anxiety, if it was in any way a factor in binge]

I don't know it's almost ... the anxiety gradually builds ... it's a bit different now to what it was then because then ... it was so overwhelming that whatever I ate there was guilt around it and so the anxiety around food and weight was just a permanent fixture and it just depended on how intense it was at that particular time. And it would just begin to build and I would know that within sort of a day or so I would have a binge and then get rid of it and then at one stage it was every day so the anxiety would start in the morning and um sometimes I kind of got it over and done with early in the day because I very seldom binged and vomited more than once in a day, so sometimes I would just get it over and done with and other times when I was feeling stronger I would fight it um ... you know during the day and eventually give in sort of late at night so I think the anxiety was always there and it just intensified. Um and sometimes it was almost a relief just to start the binge because I knew that while I was eating ... I don't know, the anxiety was not as intense because I knew that I was doing it and I was going to get rid of it you know as soon as I could ...

And then afterwards the anxiety would revolve around ... "what am I doing to my body?" You know "Am I ever going to be free from this." You know all those kind of things so, as it was building the anxiety was always around you know "what have I eaten? How fat am I?"

and that sort of thing and afterwards there would be the reality anxiety around you know "this isn't actually okay" and "What am I doing, how can I get free from this?" I don't know its um, I think something else that bulimia uses very effectively is the whole thing of guilt and shame, because um somehow you're convinced that this is the most terrible thing that anybody could ever do um to actually eat food and vomit and its absolutely disgusting and nobody is ever gonna understand and as long as you're sort of trapped in that you can never actually get free so ... And there's anxiety what other people will think about your behaviour and there's also this whole feeling of being a fraud because people look at you and you're thin or you've got a normal figure or whatever, and they don't know what your actual relationship with food is and you feel like, or I felt like I was just basically a greedy pig and the only way ... the only way that I was able to present another picture to the world was by getting rid of the food. So I was actually a fraud and there was anxiety about people seeing through and discovering the truth um ... and ... looking back on it it's a strategy that bulimia uses very effectively to kind of keep you where it wants you because as soon as you break that, as soon as you actually start talking to people and for example in telling my husband once he knew about it and he didn't reject me and he ... didn't understand but he tried to understand. And it was, it was almost that whole thing of "this is so terrible; this is so awful; this is the worst thing anybody could ever do" that was broken. And I must say that in all the years ... and certainly since I was actively kind of fighting it and beginning to come through I've been quite open with people about the fact that I was bulimic, well that I still struggle with it and nobody has ever rejected me, nobody has ever said "oh that's so disgusting" They may have behind my back I don't know but um people have just been very accepting and understanding and that, that was one thing I could never have believed possible when I was sort of in the active stage of bulimia. So ... (breaks off to talk to her baby). Um ja so there's that, just that anxiety that I think a lot of people who struggle with bulimia have to deal with is you know, what people will think. I mean I don't know what your experience is but I think without fail everybody that I've spoken to who has struggled with bulimia it's just this incredible sense of shame and guilt ... (speaks to baby).

[Researcher - do you believe that there is full recovery? Or do you believe that "once a bulimic or anorexic, always one?"]

Ja, that I believed that once I'd overcome it I would just never have to think about food or weight ever again, I'd be completely free from it. And what I've realised is that our society won't allow me to take that kind of passive stance because I'm bombarded every day from

TV, magazines, newspapers ... radio even, about what kind of woman I should be and what kind of woman society expects me to be and the only way I can maintain my freedom is to take an active stance against the voices of anorexia and bulimia in society as they speak to me every day. So it's, I've got to become an activist against it, in order to stay free.

APPENDIX F

Published version of paper: Kadish, Y.A. (2012a). Pathological Organizations and Psychic Retreats in Eating Disorders. *The Psychoanalytic Review*, 99:227-252.

APPENDIX G

Published version of paper: Kadish, Y.A. (2011). Autistoid Psychic Retreat in Anorexia. *British Journal of Psychotherapy*, 27:19-36.