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BOOK CHAPTER

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Eating disorders and object relations

Psychoanalytic thinking about eating disorders took an important step forward when it began to be possible to think about symptoms as representing disturbances in relationships. This is very much in the tradition of Freud's earliest formulations concerning hysterical and obsessional neuroses where the symptoms were considered as displacements of affects or ideas onto other ideas or onto parts of the body (as in hysterical conversion).

One very common example of such a dynamic in both anorexia and bulimia is a situation in which the patient is terrified of her own greed. She may deal with this by strictly and obsessively limiting her food intake, so as to make sure she is not guilty of greediness. Or, as in the case of bulimia, she may from time to time indulge in greedy gorging, which will be followed by self-induced vomiting in an attempt to rectify the situation. Usually we will find a similar pattern in the individual's relationships. She may be a highly dependent person by nature, but someone who at the same time is terrified of her own dependent feelings. She may equate dependency with weakness or helplessness and

try her best to create a sense of her own emotional self-sufficiency, refusing all help and understanding from other people. She may, from time to time, allow herself to form highly dependant relationships, but will suddenly pull away, terrified that she will become a helpless baby if she allows herself to make emotional contact with another person. The anorexic or bulimic individual may remain consciously unaware of her relationship problems, focusing her attention instead on the way she enacts the relationship problem with her food. And, of course, being obsessed with one's own body and food intake does mean that ideas about troubling relationships do recede, further bolstering the illusion of self-sufficiency. I want now to look at one very specific aspect of the object relationships found in anorexia and bulimia and the murderous phantasies involved in the attempts by the patients to control their internal worlds. Anorexia and bulimia are both violent, sometimes murderous symptoms, directed towards the self. I believe that there is also a great deal of deadly intent towards the objects as well.

Anorexia and bulimia: the issue of control

It was Hilde Bruch who first stressed the need the anorexic has to control her body, feeling that this must be to compensate for a lack of control in her life (Bruch, 1974). However, in my view it is her mind that the anorexic is attempting to control. There are certain thoughts and ideas so repellent to her that she seeks to create a "special" state of mind in which they are simply impossible. These thoughts are connected with sexuality—the sexual self, but most importantly the sexuality of the parents. Other unthinkable thoughts include those to do with development, change, growth, and creativity.

In this chapter, I argue that for all her efforts to control her weight and food intake, it is really an internal situation, a situation in her mind, concerning herself and her family, that the anorexic is seeking to control—and by murderous means. Bulimia seems to me to represent a linked and yet distinct attempt to control the internal world.

In this chapter I present material concerning three patients: Miss A, a chronic and seriously low-weight bulimic patient; Mrs B, a chronic anorexic; and Ms C, an atypical anorexic of late onset. Miss A and Ms C were treated in analysis, whereas Mrs B was seen for an extended assessment and subsequently entered once-weekly psychotherapy. I also briefly mention material from other patients with eating disorders to provide additional evidence.

The discussion focuses on the different means that the patients employ to feel in control of their internal worlds, and their possible motives for doing so. I argue that eating disorders could be considered as mechanisms that patients use to buttress manic defences against depressive pain associated with the reality of the oedipal situation. I conclude by attempting to link the symptoms and phantasies of the three patients with the varying nature and seriousness of their psychopathology.

Whenever one meets a patient in the grip 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, unconsciously, some kind of decision has been made. All sense of relatedness to an object is lost. The patient can hardly speak to us, if at all. If she does, she can appear flat and superficial.

The internal state that corresponds to this outward appearance is difficult to describe.

An anorexic patient in analysis, Ms C, would talk of a “white-out”—a situation in her mind in which snow had suddenly and heavily fallen, obscuring all sense of differentiation and, at the same time, annihilating all life. She loved this state, feeling that she alone knew how to survive it. The clumsy analyst would, of course, fall down a crevasse, and there she would be, gloriously alone in her white desert. The same patient would at times tell me in a dreamy way that what she appreciated most about analysis was that the analyst had no qualities, like her idea about God. To have an analyst who was a real person, she felt, would be quite unbearable.

Another anorexic patient dreamt *that she was having intercourse with her boyfriend, when suddenly everything went white.* She

explained that she loved white and often in her dreams everything went white. Her flat was all painted white.

I think the “white-out” represents an objectless world, a state of mind where the couple no longer exists. It is very significant that the state is white. It is felt by the anorexic to be “pure”, “clean”, and hence good. The murderous destructiveness that has been employed in order to bring about this state of affairs is entirely denied.

I have been trying to describe the very pervasive sense in which the anorexic patient seems to kill off a lively part of herself, represented by the creative couple. It is this unavailability of a part of the patient that could use help to grow and to mature that makes analysis so difficult. In her phantasy she has annihilated all need and the part of herself that could need—the feeding mother who could meet the need and the creative couple who gave life to her. In its place she has instated a sense of oneness, subtle yet pervasive, with a featureless object, a barren landscape, a white room, an analyst without qualities—which she feels to be far superior to a mother or to an analyst with a mind who might be able to meet her need for understanding. It is a sense of being unseparated, of being at one with—but, most of all, in control of—an object that she herself has created and that seems to have no human qualities.

In bulimia, the symptoms are overeating followed usually by vomiting or sometimes taking large quantities of laxatives. Patients describe a rising of tension in their minds, a kind of unbearable excitement, which can only be relieved by the eating and vomiting. The patients describe a sensation of sublime contentment and relaxation, a kind of nirvana state, which follows the end of the whole cycle.

My patient Miss A has been bulimic for twenty years. Since starting her analysis she has become able to read, something she had not managed since her teens. Yet the only books that interest her are books about serial murder.

For Miss A, and I believe for other bulimic patients, the episodes of vomiting represent a killing of internal objects, but these are

objects that do not stay dead, as they seem to do in the case of the anorexic. Serial killing is needed.

Another patient puzzled at her own terrible guilt about each episode of vomiting. She said she felt as though she'd killed someone, and she couldn't understand why it felt like that.

Although the bulimic patient may ideally wish to control her internal objects in the way the anorexic does, her objects seem more resilient and, from time to time, she is aware of her need of them. In fact, she often feels intense need, as demonstrated by her binges. Yet almost at once, like the anorexic, she hates her own alive and dependent self and the objects on whom she could depend. The vomiting represents her hatred and repudiation of the objects that, only minutes before, she has so greedily and cruelly devoured.

As in anorexia, it is not just the objects themselves that are attacked and killed: it is objects—and specifically the parents—in relation to each other.

Miss A, when she began analysis, insisted that her parents led entirely separate lives, although they lived together. According to her, they had separate bedrooms at different ends of the house. So intensely did she hate the idea that they might have any relationship with each other that she could not bear to see couples lovingly involved with one another. She said it made her feel sick. She couldn't watch television for fear of seeing a couple, and should she accidentally catch sight of one, she would resort to uncontrollable vomiting.

Her life, up until she began her analysis in her mid-thirties, had been a constant protest against the reality of her parents' love for each other. She insisted they never were together, and even her own conception and birth had not convinced her differently.

I am suggesting that bulimia represents the serial killing of internal objects, specifically the parental couple, which keep coming back to life. Such patients often think of themselves as failed anorexics. They do not have the anorexic's iron will to resist food. In fact, I think these patients usually retain an intense interest in their

objects, much as they might want to deny that this is the case. Put another way, for whatever reason they cannot kill off their love and dependence as effectively as the anorexic appears to be able to do. Rather than the “clean” white-out, there ensues a series of terrorist attacks or serial murders, often going on for many years (in the case of Miss A, for two decades).

In terms of recovery, many anorexics progress on to bulimia. They rekindle their interest in an object—or, rather, they cannot resist doing so—but such an interest is feared and hated. Nonetheless, bulimia and the state of mind that it represents is a movement towards life, in spite of the conflicts involved. In bulimia, there is at least an acknowledgement of the existence of the hated parental couple.

It seems to me that the secrecy of the vomiting symptom is highly significant. (Dana & Lawrence, 1987). Anorexia could not possibly be kept a secret: its symptoms and effects are too noticeable. In addition, I think the anorexic needs a helpless object to watch her destructiveness. By contrast, in secret vomiting, the destructiveness is hidden and denied. The patient is often able to live a creative life as long as she holds onto her secret symptom. While in anorexia the problem is lived out, in bulimia it is encapsulated. It is as though the part of the self that hates life and is opposed to all contact is encapsulated in the vomiting symptom, thus leaving other parts of the self relatively more intact.

Control in the transference and countertransference

For all the differences in the kinds of symptoms they present and in the pathology underlying the symptoms, patients with eating disorders do have in common a peculiar way of controlling the analyst and the analytic situation. In very obvious terms, they frequently create such a crisis with regard to their physical health that the analyst cannot do his or her job properly or may feel obliged to intervene in extra-analytic ways, such as speaking to physicians. But even in analyses in which the patient's weight and physical health is stable, and there seems to be at least some sort of working alliance, I still believe the pressure on the analyst

to comply with a particular view of a relationship is a marked characteristic. It is normally a pressure to be entirely ineffective, either by way of being an extension of the patient herself or in some other way being rendered lifeless and helpless. Of course all patients put pressure on the analyst to become the transference object, but in these cases I think pressure is often very subtle and very powerful. A further characteristic is the anxiety the analyst feels about resisting this pressure and the often catastrophic reaction of the patient when some of this is pointed out.

I would like to continue with some clinical material relating to the assessment and beginning of treatment of Mrs B, a woman in her 30s who had been anorexic since her early teens.

In spite of her illness, she had managed to marry a man much older than herself and have a child. In the year prior to her assessment, she had been admitted to hospital with a diagnosis of "restrictive anorexia". Her reason for seeking treatment at this point was, she said, not so much for her eating disorder as for her obsessive anxieties about her son. She was seen for four assessment sessions and subsequently taken into once-weekly psychotherapy.

The assessment was dominated by the patient's need to control the process and, in particular, to feel part of a couple. Her concern from the outset seemed to be about what kind of pairing was to take place and between whom. It is significant that the assessment took place in an institutional setting, where patients often anticipate and expect a pairing between the assessor and the institution or perhaps the referring doctor. Two days before her first appointment, the patient phoned to ask if she could bring her 2-year-old child. She was encouraged to make alternative arrangements, which she did, but she arrived 30 minutes late. The assessing therapist had been left to experience the feelings of being alone, not knowing whether to expect a single patient or couple, and wondering what the others were doing during the first half of the session.

In the second assessment session, the patient tried hard to form a couple with the assessing therapist (a woman). Her attitude was confiding, with an appearance of intimacy. She said she

thought she might be gay and complained at length about her unsatisfactory relationship with her husband, with whom she had had no sexual relationship since the birth of the child. She spoke in glowing terms of her close and caring relationship with her mother. When questioned about father, she replied that he was largely absent during her growing up.

It emerged that the patient's husband, who had become grossly obese since the marriage, was felt to be impotent and rather disgusting—like her father, she said—and she constantly discussed with her mother and sister whether she should leave him. This situation had been going on for years.

In the third session, Mrs B's fears of being excluded were taken up, specifically in relation to the ending of the assessment and an anticipated wait for treatment with a different therapist. The patient was able to acknowledge that feeling left out was a constant problem; she could not bear to see her husband playing with their son. Although she had previously painted a picture of a close and supportive relationship with her own mother, she now confided that she always felt that her mother preferred her brother.

In the final assessment session, the patient arrived with her 2-year old and proceeded to demonstrate to the assessor what it was like to be excluded from a mother-child couple, while she, the patient, was able to shield herself from her own feelings about the separation from the therapist at the end of the assessment.

Within weeks of starting treatment, the patient had settled into a comfortable routine of telling the therapist (a man) how hopeless the husband was and, very indulgently, how hopeless the therapist was for not telling her what to do about it. The therapist reported that he felt as though he were trapped in a loveless marriage.

Mrs B had never been able to give up her exclusive attachment to her mother. She had been unable to tolerate the shift from being the baby at the breast to being part of a family in which there are two parents, each with their relationships to their

children and each other. Her mental life was organized around defending herself against the pain of the jealousy and envy this would involve. In her mind, she managed to maintain the illusion that she and her mother constituted the real and central couple, with father seen as an undesirable intruder. This, in my view, is very typical of patients who go on to develop anorexia.

Although this patient managed briefly to experience herself as part of a couple, the overwhelming impression was of her great hatred of couples, both her parents and her own married state. Mothers and children, especially daughters, seemed in her mind to be the important dyad. Her hostility towards her husband was graphically demonstrated by her constant cooking and providing fattening foods for him. In the transference, Mrs B sought to control the therapist in order to reassure herself that her internal world was, after all, under her control.

Mrs B is typical of many anorexic patients who seek therapy not in order to change and grow, but in order to re-establish control over their internal worlds. This particular patient sought help not because she wanted to change the way things were in her internal world, but because something new had started to happen with the birth of her child. She found herself facing new anxieties, which did not respond to the manic mechanisms she normally employed to control her internal objects. There were new pains, such as the pain of seeing her husband enjoying his son, and knowing they had a relationship of which she was not a part. It is interesting that the child was 2 years old when she sought help. While he was a baby, and particularly during the nursing period, he could be used to bolster her omnipotence and reinforce her illusion that mother and baby constitute the important couple. But when the baby began to show an interest in his father, this must have been a frightening challenge to her. One might almost wonder whether moves towards the depressive position in the child might not have allowed some depressive concerns to emerge in the mother.

In the course of the assessment, one could observe how she defended herself against these anxieties and the worsening of her eating disorder, necessitating a hospital admission, gives some

indication of the strength of her unconscious determination to maintain control. Her relentless cooking of fattening foods for the husband in the face of all medical advice seems another worrying indicator of the underlying deadly aspect of her illness. Although the problems quickly emerge in the transference, it seems unlikely that once-weekly treatment will be sufficient to allow them really to be addressed.

Patients like Mrs B often manage to negotiate very long-term, sometimes life-long, but ineffective treatment. In this way, they use the "treatment" to enable them to maintain a sense of control of their internal worlds, of which control of the therapist or setting becomes an important element. Non-analytic settings often consciously offer "support" to such patients. Such long-term and open-ended arrangements also go some way to satisfy the massive and unconscious dependency needs of such patients, while such needs can continue to be denied.

Here is another example, this time of a patient in psychoanalysis, whose attempts to control her internal parents are vividly illustrated in the context of the analysis. I shall give more detail of this patient and her treatment, to try to convey the quality of the control of the internal objects and the analyst.

Ms C came for analysis in her late thirties. Her psychiatric diagnosis was atypical anorexia nervosa. She had been brought up by a single mother, probably quite a disturbed woman. She knew little of her father, save that he had been a prisoner of war in the hands of the Japanese. She never met him. Ms C strove ceaselessly to keep her internal parents apart but to maintain in phantasy a special relationship with each. Her relationship with her father was via her anorexia, her self-denial, her prison diet, the way she pushed her abuse of her body to its limit, identifying with the way she knew he must have suffered. Mother, on the other hand, was felt to be mad and dangerous; the only way to relate to her was to placate her and appease her and make her feel important. In the patient's mind, she was very good at doing this. She could get mother to do things without mother realizing it. Her trick was always self-abasement; mother, she felt, needed someone to look down on.

The analysis took on the appearance of a serious attempt at treatment. The patient was thoughtful and intelligent and brought many painful and poignant memories from her past, together with dreams, which we seemed to be able to work on together. However, I began gradually to notice something else. It seemed to be contained in the way the patient came into the session. She would knock on my door, but only one knock and so quietly that I was always afraid I would cough or drop a book and fail to hear her. Of course, I always had to be in my consulting room by the front door waiting for her. Had I been in another part of the house, I would certainly not have heard her. Once in the consulting room, she would stand almost to attention while I made my way to my chair; only then would she roll up her coat, pushing it almost under the couch, and, very gingerly, take up her place.

I began to realize that all this was having a rather odd effect on me. Far from the neutral and receptive frame of mind I would have preferred, I found myself feeling like a rather benign headmistress with a small girl, anxious and deferential coming to see me. I also felt as though there was an unspoken assumption that I wanted things be arranged thus between us. I also realized that in spite of seeming so undemanding and compliant herself, she was persistently controlling not only my actions but also my state of mind. When I began to comment on some of this, which I did, I thought, in a very careful and quite friendly way, my patient was shocked and horrified. How could she have been so stupid as to behave like this? In a way that gave me such offence? The last thing she ever wanted to do was to assume anything about our relationship, and now she was guilty of having done the wrong thing, although she had been trying so hard not to. My patient was actually quite mad and for several days quite unreachable. In her mind I was the mad one, insisting that she behave in exactly the right way as she came into the consulting room.

What I have been trying to show with this material is the insistent yet subtle way in which the patient maintains a particular view of her relationship with me, which I am pushed to support and

confirm. She pretends deference, which I am supposed to demand. I am to be made to feel superior. In fact, of course, the patient silently feels superior, as she always did with her mother. Perhaps the most important point is that as long as she and I are held in the grip of this constellation, real analytic work is impossible. There can be no real exchange of views or honest attempts to understand things together, in spite of appearances to the contrary.

Shortly after the episode described above, the patient reported the following dream.

She was dressing her mother, getting her ready to go out. The patient's brother, B, was there. He let mother wander off. The patient got angry with him and shouted, "You must think like she thinks."

She said she thought that was what she wanted to say to me: that her mother is mad and her analyst might be mad too. She said it needn't have been a dream. It could be reality. She had always to think about how her mother thinks. That's how she could get her to do things. No one else could. Everyone admired it.

Her association to her brother in the dream was of someone who seemed to have a different kind of concern for mother, not merely wanting to control her. I interpreted that there was a part of her that didn't think I was mad, that wanted to use me and the analysis in a helpful way, rather than controlling things all the time. But another part of her was frightened and wanted to shout down her attempts to relate to me differently. What catastrophe might occur if my thoughts were allowed to wander off? This interpretation produced a more thoughtful response, but also brought more of a sense of reality to the session and a little more space for thought. The patient was able to think about her brother and wonder how he managed to have such a different view of her mother from herself. She conceded that probably I wasn't mad. Had I been, she thought, I'd have been "found out" by now, which I thought indicated a little more trust in external reality.

I would like finally to introduce a piece of material from later on in the analysis, when some progress had been made and at a time

when analytic breaks were a great source of concern and difficulty for the patient. In the previous session I had given the patient the dates of the coming Christmas break. She had responded by sitting up on the couch, shocked.

She began the session telling me that the holiday dates were the same as her term dates. She said the date of our last session was the date her parents had got married—or sometime around then. She was silent. Then she said she was just playing around with dates. Adding them, subtracting them . . . numbers . . . days . . . all odd associations. She said it's a funny kind of very quick thinking. I wondered what kind of thinking it really was. She said, "Isn't it thinking? What is it then? I've always done it. I've been reading Freud—the Botanical Monograph—he does it. What's wrong with that? Wasn't he thinking?"

I said I thought she was mixing up dreaming and reality in her mind, hoping that the coming break might turn out to be a dream. She said she was dreaming last night, half dreaming, half awake. The same thing was happening. She couldn't stop it. It was a sort of dream *in mother's hospital, where she worked. Symmetrical—medical and surgical. Different wards and words. All symmetrical.* Then she said she dreamt about a van. She thinks she often dreams about vans—death vans to gas the Jew; the van she went back to school in with a bucket in the back to be sick in. She said it doesn't go anywhere. This isn't thinking. But Freud does it about his dream. Why does it work with dreams?

My immediate concerns in this session were with the patient's persecutory anxieties about the coming break and with the worryingly manic tone of the material. She had often likened breaks in the analysis to the ends of holidays from boarding school and being sent away from the last session like being sent back. The death van in this context I took to be the analyst of the break, the poisonous container of the sad, sick little girl. However, I think the material is also interesting in terms of the total situation.

At first any difficulty about the coming break is denied (her term dates, not anything imposed by me). But at once she is put

in touch with thoughts of her parents as a couple, perhaps as a result of my assertion of an intention to take a break away from her, perhaps feeling forced to remember that I, too, am married and spend Christmas with my family. I think at this point she feels she has lost control of me in her mind and of the internal parents. She attempts to deal with the reality of my and her parents' freedom almost by a flight of ideas. She takes the meaning out of the dates, confuses dreaming and reality, tries to assert some sort of symmetry, equality, which might help her sort things out between herself and her parents, herself and me. But finally the inescapable image of the death van appears, which I think does represent for the patient the mother containing the father's penis—an image of murder and destruction rather than creativity and life.

When, in the earlier material, I pointed out to her how she was, in the transference, controlling me and preventing me from functioning to help her, she was, I think genuinely shocked at her own destructiveness. It had been her intention to preserve our relationship by not allowing any bad feelings to develop on either part. Similarly, her insistence on an analyst without qualities was more her attempt to create an analyst whom she could love unambivalently, rather than to annihilate the human features of the analyst, although that was certainly the effect she had. This is not to say that her attempts to control the analyst did not contain hostile and aggressive elements; however, to stress only those aspects of the situation would be to render too simple a much richer and more complex motivation.

What Ms C had been told of the very unfortunate circumstances surrounding her conception and birth readily lent itself to the creation in her mind of a catastrophic intercourse, though this had become greatly elaborated by her own mind. In the patient's conscious and unconscious phantasy, the relationship of the parents represented a coming together of fearful, mad, and damaged elements. While I do not think the creation of such a situation was primarily defensive against the pain of the actual Oedipus situation, it did also function to protect the patient from feelings of jealousy and envy towards her parents. These had to be faced and worked through during the course of the analysis.

Discussion

I have suggested that the dominant aim in both anorexia and bulimia is the control of the internal parents, and particularly the parents' relations to each other. By taking strict control of what is taken in, these patients support the phantasy that they can be in control of the creation and maintenance of the internal constellation of their objects and the interrelationships of them in the mind.

The internal objects, both mother and father, are subjected to violent attacks, starved, and made to suffer until they submit—and, typically, renounce their relationship to each other. Alternatively, they can be stuffed until they are hideously huge and helpless.

In my view, eating disorders function in a very concrete way to reinforce phantasies of control of the internal world. The internal world—the inner versions of the parents which exist in the mind—are built up by what is taken in from the external world, coloured by the subject's own attitude and feelings towards it. By controlling absolutely what is taken in and, in the case of bulimia, by what happens to it subsequently, eating-disorder patients feel as though this internal world is rigidly under their control.

This line of thinking derives directly from the work of Melanie Klein (1935). She links feeding difficulties in young children with the fear of dangerous internal objects. Her thinking on the control—and often murderous control—of internal objects occurs within her work on the manic defence, of which she considered control of internalized parents to be an integral part. Anorexia and bulimia, although syndromes complicated by a focus on the body, do, I believe, serve to buttress a manic defence. In particular, this is a defence organized around a repudiation of depressive feelings and anxieties, particularly those concerned with the working-through of the Oedipus situation.

Klein interestingly points to a particular feature of the manic state which finds full expression in anorexia. She takes the hyperactivity associated with mania as evidence of the ceaseless activity of the ego to master and control all its objects. In anorexia, the life of the patient frequently seems to revolve around activity that, to the external observer, seems pointless. This often includes intense

physical activity, but also the massive and unnecessary scholastic overachievement found in many young anorexics.

In bulimia, the hyperactivity is directly linked to the taking in and expelling of food, the gorging and vomiting. I think that in a very direct and concrete way, the bulimic patient feels as though she is doing all this specifically to control what she feels is going on inside her.

The wished-for internal situation seems to be similar in anorexia and bulimia.

Typically, patients seek to rid their minds of the possibility of a couple, and especially a sexual couple. Characteristically, it is this aspect of the parents and their relationship which is eradicated. At the same time, there is felt to be a merging, a fusion, with a maternal object, a version of the mother but stripped of all her qualities and individuality.

Many clinicians are familiar with the projection of this desired internal situation onto the external mother and family. Anorexic patients very often talk in an idealized way of their relationships with their mothers, implying that only mother understands them and that the relationship is close and without conflict. All too often when one meets mother, one finds someone who feels enslaved and terrified by her daughter's constant demands and threats. Often she is aware that she is neglecting her other children and her relationship with her husband, but she feels powerless to do otherwise.

In one sense, the difficulty experienced by these patients is not unusual. Indeed, as a number of contemporary writers—in particular, Britton (1989)—have pointed out, the acceptance of the parents as a sexual couple is one of the most difficult aspects of the Oedipus complex to negotiate, and failure to do so lies at the root of many forms of psychopathology.

What is very unusual about patients in whom an eating disorder becomes a part of their pattern of resistance to this reality is the relentlessness and violence with which they seek to impose their own illusions.

In a later paper Britton (1998) refers to a group of patients who spend their lives trying to protect their oedipal illusions and whose aim it is never to have to face the pain of the depressive position. All three of the patients I have described in this chapter

could be said to fall within this group. In addition, all three had discovered a mechanism that seemed to them to link their internal and external worlds—absolute control of intake of food, or of introjective processes—which enabled them to believe that their internal worlds could evade reality.

What I have yet to discuss is the motives such patients may have, or why they need to control their objects to the point of endangering their own lives. One of the things that makes eating disorders such complex problems to treat is that the motives behind the symptoms are not always the same. The three patients I have referred to seem to me to have different, though related, difficulties which they are trying to solve.

Comparisons between the three patients can only be tentative; while Miss A and Ms C were both treated in long analyses, the material relating to Mrs B is taken from a four-session assessment and the early stages of once-weekly treatment. However, there are important differences between the patients, which may lead on to thoughts about which are most amenable to treatment. It is these differences that I shall now try to articulate.

Miss A would often feel that she would rather kill both her parents than allow them to be together without her. Interestingly, though, such states of mind were transient. The patient had a capacity to forgive, and hence to repair, her internal world. This, I think, is reflected in her choice of symptom, bulimia, rather than anorexia. Although she could hate her objects and her analyst with a murderous ferocity, it did not have the “white-out” quality described in relation to the other two patients. Her mood and her approach to me would fluctuate from session to session, and good work and useful interpretations would often go some way towards mitigating her fury and getting her back into a more thoughtful state of mind.

Miss A's long illness had caused a great deal of damage to her, physically. She suffered from serious osteoporosis and in her mid-thirties was told she had the bone density of an 80-year-old. Remarkably, as she began to recover, and for the first time since she was 13 became a normal weight, so her bone density improved, and it seemed that perhaps at least some of the damage was repairable. This seems to reflect her psychic situation, which in spite of her deadly intent, retains a capacity for love and reparation.

Of course, in a way Miss A knew very well that her parents had a sexual relationship that excluded her, which is why she had to eat and vomit so compulsively to try to keep them apart in her mind.

An important difference between Mrs B and Miss A is Miss A's great interest in her father. Mrs B insisted that father simply wasn't there; no one was interested in him. Miss A, on the other hand, demanded an exclusive relationship with both of them, mother and father. She was not prepared to give mother up, but she wanted what mother had as well. In the transference she was extremely rivalrous with the analyst, whom she wanted to see as the unthreatening older woman, no longer interested in a sexual life of her own but safely ensnared in her preoccupation with the analysis of the patient!

In this sense Miss A had made a little more progress in her development than Mrs B. Although she hated the reality of her situation, unlike Mrs B, she did know that it existed.

Ms C, the patient whose treatment I have described at some length, is described psychiatrically as atypical. I think she is also atypical in terms of her underlying psychopathology. Ms C unconsciously believed that the coming together of her parents in her mind would result in a catastrophe, for both of them as well as for her. She felt them to be damaged, disturbed, and on the point of madness. Only by keeping them apart could she keep them alive, and even then, both were in a state that required her constant attention. Consciously, she did believe that their coming together to create her had been a terrible, shattering disaster for them both. Ms C was actually capable of a great deal of love and concern for her parents, internal and external, and her motive in seeking to keep them apart was by no means always to keep them for herself, though, of course, this also played a part. In this sense her illness is different from that of both Miss A and Mrs B.

The patients I have described seek to control their internal objects with the use of a great deal of murderous violence. The violence of the anorexic or bulimic patient towards her own body is well known and quite evident. This, I think, is a reflection of the violence that is felt to be done to the internal parents and their relationship. Some anorexic patients more than others are prepared to starve themselves to the point of death. I think it is likely that the

degree of murderousness towards the self and the body reflects the extent of the murderous intent towards the internal parents and their relationship.

All three of the patients mentioned had physical and psychological symptoms sufficiently severe to warrant psychiatric intervention. Miss A (the twenty-year bulimic) and Mrs B (the typical anorexic with the husband) had both had lengthy admissions to specialist psychiatric units, Miss A for the duration of a year just prior to starting her analysis. Ms C (the atypical anorexic patient), on the other hand, although her physical health did become seriously compromised during the course of her illness, never really seemed to me or to her psychiatrist to be at risk of death. Her internal struggle seemed more motivated to keeping her parents apart, which she believed to be an absolute necessity, than towards hurting them. In some respects, she lacked the cruelty of the two other patients.

All three patients demonstrate a need to control their objects, which has in each case a deadly aspect. While this produces problems in the treatment of all three, I would conclude that Mrs B—in some respects, a very typical patient in my experience of the anorexia nervosa group—would be the most difficult to treat.

Miss A and Ms C both have features that somewhat ameliorate the difficulties. Ms C, because her motives were not primarily envious, was able to value and struggle in her own way to protect the analysis. Miss A, although at times unleashing the full destructive power of her hatred towards the analysis, had a capacity for reparation and forgiveness which allowed the analysis to continue. Mrs B, at the time of writing, shows no such capacities, and this may well be why she has chosen the option of a less intensive treatment.