LOVING THEM TO DEATH:
THE ANOREXIC AND HER OBJECTS

MARILYN LAWRENCE, LONDON

The author suggests that eating disorders function to reinforce phantasies of control of the internal parents, a feature of Klein’s view of the manic defence. Using this hypothesis, she attempts to differentiate between anorexia and bulimia. It is argued that in anorexia objects are felt to be permanently in thrall, suspended or frozen, whereas in bulimia they are attacked in a frenzied and intermittent way. Using case material from three seriously ill patients, the author draws attention to some important differences between them. Two of the patients were treated in psychoanalysis, while the third was seen for an extended consultation and once-weekly treatment thereafter. It is suggested that the nature and degree of the murderous attack on the internal couple may determine the severity of the illness as well as the patient’s capacity to benefit from treatment. The conclusions drawn are discussed in relation to some contemporary views on eating disorders as well as writings on the difficulties of working through the Oedipus complex more generally. The author suggests that eating disorders may represent a special case of oedipal illusions.

‘My family? I love them all. Especially my Mum. I love her to death’.

This was the response of a 30-year-old anorexic woman with a long history of illness, when asked about her family. She had come for the latest in a long line of attempts at psychotherapy and had begun the consultation with a series of descriptions of her various symptoms and an account of all the psychiatrists and physicians she had seen.

She seemed to be telling me that as far as her family were concerned, they were in her mind a ‘given’—so much so that she hadn’t even bothered to mention them. She loved them and that was that. But then she added this other, more sinister comment; that she loved her mother to death.

In this paper I shall 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, by more or less murderous means. Bulimia seems to me to represent a linked and yet distinct attempt to control the internal world.

I shall 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, while Mrs B was seen for an extended assessment and subsequently entered once-weekly psychotherapy. I will briefly mention material from other patients with eating disorders to provide additional evidence.

The discussion will focus on the different means the patients employ to feel in control of their internal worlds, and their possible motives for doing so. I shall 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 will then discuss these conclusions in the light of some contemporary literature on eating disorders. I will conclude by attempting to link the symptoms
and phantasies of the three patients with the varying nature and seriousness of their psychopathology.

**Anorexia and Bulimia**

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 psychologically 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 painted white throughout.

I think the ‘white out’ represents a phantasy of an objectless world; a state of mind in which the parents as a couple in particular no longer exist. It is very significant that the state is white; it is felt by the anorexic to be ‘pure’, ‘clean’ and hence good. In fact, something vital and alive inside herself has been killed off, but the anorexic patient herself sees no blood upon the snow.

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 a sexual couple. It is this unavailability of a part of the patient that needs help to grow and to mature, which 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 parents 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. This, I think, is the mother loved to death.

My patient, Miss A, has been bulimic for twenty years. Since starting her analysis she has become able to read, something she has 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 phantasy of killing internal objects, but objects that do not stay dead, as they seem to do in the case of the anorexic. Serial killing is needed.

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

Although the bulimic patient may ideally wish to exert control in the way the anorexic does, her objects seem more resilient and she is aware of her intense need for them, 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 fleetingly depends. The vomiting represents her hatred and repudiation of the objects that, only
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minutes before, she has so greedily and cruelly devoured.

When she began analysis, Miss A 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 otherwise.

Miss A could not bear the thought of being excluded. During an early holiday break, she began two sexual relationships, one with a man, the other with a woman. This seemed a remarkably clear statement to me, that whatever I did, she was never again going to be in the position of the little girl, left out while the parents were together. She had all possibilities covered.

The reaction of Miss A to analytic breaks also reflected her terror of being left alone and abandoned. I was later to discover her almost phobic anxiety about the safety of an object, first myself, and later a partner on whom she came to depend. As she began to recover, she would frequently say that she didn’t know how people could bear to be together when there was the possibility that one of them might die.

In the case of Miss A, I came to understand that in part at least, her murderousness was a means not merely of controlling her objects, but of controlling death itself. To kill her objects was preferable at least to living with the possibility that they might die.

The aspect of bulimia that I want to stress here is the underlying phantasy of the serial killing of internal objects that keep coming back to life. Such patients often think of themselves as failed anorexics. They don’t 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 are a movement towards life, in spite of the conflicts involved.

It seems to me that the secrecy of the vomiting symptom is highly significant (Dana & Lawrence, 1987). Anorexia couldn’t possibly be kept a secret; its symptoms and effects are too noticeable. But 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 on to her secret symptom. Whereas 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 intact.

While pointing out the murderousness of the attack upon the internal world and its objects, I should stress that the need for control is paramount for such patients. The ultimate means of control in the unconscious phantasy of the patient is murder, but control is the aim. One of the important issues in assessing the suitability of such patients for treatment is assessing the degree of murderousness. I hope to show in the later clinical material that while anorexia and bulimia always have a deadly aspect, this varies in intensity and also in motive.
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 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 by 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 helpless 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 now like to present some clinical material relating to the assessment and beginning of treatment of Mrs B, a woman in her thirties 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 the 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 thirty 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 while she was 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 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 were two parents, each with their relationships to their children and each other. Her mental life was organised around defending herself against the pain of the jealousy and envy that this would involve. In her mind, she managed to maintain the illusion that she and her mother constituted the real and central couple, with the 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, the child could be used to bolster her omnipotence and reinforce her illusion that mother and baby constitute the important couple. But when he 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 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. Another example of loving someone to death perhaps. Although the problems quickly emerged in the transference, it seemed unlikely that once-weekly treatment would be sufficient to allow them to be addressed.

Patients like Mrs B often manage to negotiate very long-term, sometimes lifelong, but ineffective treatment, usually in NHS, but sometimes also in private settings. 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 towards satisfying the massive and unconscious dependency needs of these 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 have already mentioned her in relation to her tendency to 'white out' her objects from her mind, which I take to be an important feature in anorexia. I shall now 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 in which 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 her mother to do things without her realising it. Her trick was always self-abasement; mother, she felt, needed someone to look down on.

As I have mentioned earlier in this paper, the patient had from the start a tendency to idealise her sense of loneliness, to make me in her mind into a kind of inhuman force, rather than a person she might miss and think of sadly at weekends. However, she seemed able to think about my comments to this effect and I felt increasingly that I had a patient whom I was at least sometimes being allowed to understand.

The following material is taken from the second year of the analysis when I felt it was taking 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 upon 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 once 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. If I had 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 rolling up her coat, pushing it almost under the couch and then, very gingerly, taking up her place.

I began to realise 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 to be arranged thus between us. I also realised 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. *I was dressing my mother, getting her ready to go out. My brother B. was there. He let mother wander off. I 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 might not have been a dream. It could be reality. She had always to think about how her mother was thinking. That was 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 would have been 'found out' by now, which I thought indicated a little more trust in external reality.

Finally, I would like 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 some time 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 her mother's hospital, where she worked. *Symmetrical—medical and surgical. Different words and words. All symmetrical*. Then she said she dreamt about a van. She thought she often dreamt about vans—death vans to gas the Jews. The van she went back to school in with a bucket in the back to be sick in. She said it didn't go anywhere. This wasn't thinking. But Freud did it about his dream. Why did 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; these are because of 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 parent. 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; but 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**

After briefly summarising the main points that I should like to draw out of the preceding material, I will discuss my conclusions as developing from the work of Klein on the manic defence. While there is a huge psychiatric literature on eating disorders, far fewer psychoanalysts have written about them. Accounts that focus on the object relations of the patient and their manifestation in the transference are few and far between. I will briefly mention two important and quite recent papers, one on anorexia (Birksted-Breen, 1989) and the other on bulimia (Burgher, 1997), which link directly to my thinking in this area. Finally, I will situate my conclusions in some of the contemporary post-Kleinian literature on the Oedipus complex.

I have suggested that the dominant aim in both anorexia and bulimia is the control of the internal parent, 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 their interrelationships 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.

One of the first writers on eating disorders to stress the importance of control in the minds of these patients was the pioneering American psychiatrist, Hilde Bruch (1973). She also noted the unseparated quality of the mother-daughter relationship. Not working within a psychoanalytic framework, Bruch’s hypothesis, couched in terms of learning theory, is that
children who go on to develop eating disorders fail to learn autonomy. They cannot easily differentiate between their own and their mothers' needs and desires to the extent that they do not even know when they are hungry. The symptom is seen by Bruch as an attempt to take control of the body and what goes into it, as a kind of last-ditch attempt at autonomy.

My line of thinking in this paper derives from the work of Klein (1935). Although like Bruch, I think that control is the paramount goal in anorexia and bulimia, I am more concerned with attempts to control the internal world. Klein links feeding difficulties in young children with the fear of dangerous internal objects. Her thinking occurs within her work on the manic defence, of which she considered control, and often murderous control of internalised 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 organised around a repudiation of depressive feelings and anxieties, particularly those concerned with the working through of the Oedipus situation. The omnipotently controlling state of mind found in eating disorder patients may defend some patients against unbearable anxieties about the loss and particularly the death of their objects.

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 over-achievement found in many young anorexics.

Henri Rey (1994) contrasts anorexia and manic depressive illness. I think one of the important points he makes is that anorexia is a kind of unsymbolised manic defence, a concrete, even magical way of declaring a total lack of need, a sense of self-sufficiency. This lack of symbolisation is taken up by Birksted-Breen (1989), who describes the first four years of analysis with an anorexic patient. The patient presents with many typical features, immediately recognisable, including an overwhelming sense of negativity and hopelessness. This is a complex and many-layered account in which the wish for and fear of fusion with the mother is emphasised as an important aspect. The analysis begins in an almost lifeless way and it is only gradually that the phantasy of being merged with the analyst unfolds. As the analysis progresses, the patient's terror of the death of her objects comes to the fore and it begins to be possible to see the patient's need to be in control of the process in this light.

The author points to the lack of space for symbolisation, the lack of a third position, a father who disrupts the phantasy of fusion. To have a sense of two separate objects who could together be concerned about her would fill her with a sense of humiliation and fury. Interestingly, in this paper, the analyst discovers rather late in the day that the patient has been seeing another clinician, a doctor at the psychiatric hospital, ostensibly for 'psychotherapy', an arrangement that has been kept secret from the analyst. The author concludes that anorexia 'is an attempt to annihilate the very nature of human existence—inequality, progression through the life cycle, death'. She points to a further highly important feature of the transference, the seeming impossibility of both patient and analyst to be adult sexual women. I am sure this will prove to be a crucial difficulty to be worked through in the analysis of such patients.

Marian Burgner, in writing about analytic work with a highly disturbed bulimic adolescent, describes a situation in which the symptom is used in phantasy to control the parents and their relationship to each other. In this case, each of the parents separately is felt to have an exciting and sexualised relationship to the patient, while the parents' relationship to each other is felt to be dependent on the patient herself who believes herself to be the glue that holds them together.
Burgner describes a complex and interesting oedipal situation. Working with an adolescent, she finds the actual parents to be, in a psychic sense at least, incestuously over-involved with the patient in an exciting and violent way. This is the kind of 'first-hand' impression of the external parents one almost never has access to with adult patients such as I have described. Thus, although Burgner is acutely aware of the murderousness of the patient's intent towards both parents and analysis, she understands it within the context of a set of profoundly damaged family relationships. This may well be the experience of many patients who are seen suffering from an eating disorder later in life.

The patient described in Burgner's paper does seem to be driven to wreck her analysis, raising the question of the assessment of such patients and the extent to which such hatred and negativity can in fact be contained within an analysis.

In one sense, the psychic difficulty experienced by these patients is not unusual. Indeed, as a number of contemporary writers—in particular Britton (1988)—have pointed out, the acceptance of the parents as a sexual couple, apart from the subject and with their own exclusive relationship, 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 part of a pattern of resistance to this reality is the relentlessness and violence with which they seek to impose their own illusions.

In a later paper (1998), Britton 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 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.

Comparisons between the three patients

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 that they are trying to solve.

Comparisons between the three patients can only be tentative; while Miss A and Mrs 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 that 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 her a great deal of physical damage. 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 some of the damage at least was reparable. This seems to reflect her
psychic situation, which in spite of its deadly aspect retained 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. As mentioned earlier in relation to Miss A, her murderous phantasies also in some senses defended her against the reality of the loss, the death of her objects. Her sense of being able to kill them and then bring them back to life allowed her to remain omnipotently unconcerned about the real safety of those she loved, which she could not control.

An important difference between Mrs B and Miss A is Miss A's great interest in her father. Mrs B insisted that her 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 wasn't prepared to give her mother up, but she wanted what her 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. As was suggested earlier in relation to Birksted-Breen's patient, this difficulty in tolerating the idea of two adult women may well evolve as a marked feature in the analysis of such patients.

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 (bulimic for 20 years) 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 that 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.

TRANSLATIONS OF SUMMARY

L’auteur montre que les troubles de l’appétit fonctionnent pour renforcer les phantasmes de contrôle des parents internes, point de vue caractéristique de Klein en ce qui concerne les défenses maniaques. À partir de cette hypothèse, l’auteur s’efforce d’établir une différence entre l’anorexie et la bulimie. Elle montre que dans l’anorexie les objets sont ressentis comme étant constamment asservis, suspendus et gelés, alors que dans la bulimie ils sont attaqués de façon frénétique et intermittente. À l’aide du matériel clinique de trois patients sérieusement malades l’auteur indique certaines différences importantes entre eux. Deux des patients furent traités en psychoanalyse, et le troisième fut vu pour une consultation diurne puis entré en traitement d’une séance par semaine. L’auteur suggère qu’il est possible que la nature et le degré des attaques meurtrières sur le couple interne détermine la sévérité de la maladie ainsi que la capacité du patient à bénéficier du traitement. Elle traite des conclusions qui en résultent par rapport à certains points de vue contemporains sur les troubles de l’appétit ainsi que, plus généralement, certaines études sur les difficultés de la perurbation du complexe d’Oedipe. L’auteur suggère qu’il est possible que les troubles de l’appétit représentent un cas spécial d’illusions oedipiennes.


La autora sugiere que los conflictos alimenticios tienen que ver con el refuerzo de las fantasias inconscientes de controlar a los padres internos, lo que es un aspecto de la defensa maniaca, según Klein. A partir de esta hipótesis, se trata de establecer la diferencia entre anorexia y bulimia. Se sostiene que, en la anorexia, los Objetos se vivencian como permanentemente esclavizados; mientras que, en la bulimia, éstos son atacados de un modo frenético e intermitente. Por medio de material clínico de tres pacientes gravemente enfermos, la autora destaca algunas diferencias importantes entre ellos. Dos de los pacientes fueron tratados con psicoanálisis, mientras que el tercero fue visto primero en una consulta muy larga y, después, en un tratamiento de una vez por semana. La autora sugiere que son la naturaleza y el grado del ataque asesino a la pareja interna los que pueden darnos una idea tanto de la gravedad de la enfermedad como de la capacidad del paciente para beneficiarse de un tratamiento. Las conclusiones a las que se llega se ponen en relación con algunos puntos de vista actuales sobre problemas alimenticios y también con publicaciones sobre las dificultades de elaborar el complejo de Edipo, de un modo más general. La autora sugiere que los problemas alimenticios podrían representar un caso especial de fantasias edíeicas engañosas.

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Marilyn Lawrence
61 Godolphin Road
London W12 8JN
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