FARRELL EM Book 1995 Lost for words

CHAPTER 3

The Body and Body Products as Transitional Objects and Phenomena

Eating disorders have never been simple. Symptoms are multi-determined and have multiple meanings. This has become increasingly clear over the last ten years. The earlier the difficulties start, the harder it is to find simple answers and solutions to any of the questions that may be asked. What can be said is that the complexity of eating disorders is ever more apparent, as is the pre-Oedipal nature of the disturbance. Anorexia and bulimia are no longer automatically seen as involving unresolved Oedipal issues. Problems can come from any stage of development (Schwartz, 1988). As the layers are peeled back so we delve deeper into primitive processes and the early mother–child relationship. 'The ultimate roots of bulimic behaviour reach into the earliest stages of life when the mental and the physiological aspects of experience are virtually inseparable' (Reiser, 1990, p. 246). I think it is useful to take things one step further back. It may seem hard to go back any further, but I think we need to return to the mother's body, the child in her womb and the conscious fantasies and unconscious phantasies she has had about her baby, both before and after she/he is born. This may provide additional ways of understanding the death wishes of these patients, their pathological narcissism and their failure to integrate body and mind.

One way to do this is to use Winnicott's (1953) concept of the transitional object to explain what the mother may be attempting to do for herself. It will then be possible to explore what this might mean for her child. I shall describe Winnicott's ideas of transitional objects in general terms before

looking at more recent ideas on intermediate objects which will provide a means of exploring mother's pathology in a particular way. I shall then look at the historical appreciation of the mother's presence in these disorders and how this can be understood. The effect that the mother's own frame of mind has on her baby, before, during and after his/her birth. The devastating impact on the child that may occur perhaps gives us a clue to understanding the difference between bulimics and anorexics and anorexic bulimics. A baby may be thought of as being a poor attempt by mother to create/use some kind of a transitional object. If this is the case then the effect on the baby of being used in this way needs to be explored. The components of the bulimic ritual can then be thought through and explored using this paradigm.

Winnicott's Transitional Objects

Winnicott's conceptualisation of the area of transitional space and transitional objects creates that much needed concept, one which can link and be a bridge between the inner and outer worlds, a place where the two interact uninterrupted with the help of the first 'not-me' possession, as perceived by the infant, the third area of experience. The area described by Winnicott as being 'between the thumb and the teddy bear, between oral erotism and true object relationship' (Winnicott, 1953, p. 89). Winnicott describes the special qualities with which the child embues its relationship with a transitional object:

(1) The infant assumes rights over the object, and we agree to this assumption. Nevertheless, some abrogation of omnipotence is a feature from the start.
(2) The object is affectionately cuddled as well as excitedly loved and mutilated.
(3) It must never change, unless changed by the infant.
(4) It must survive instinctual loving, and also hating, and, if it be a feature, pure aggression.

(5) Yet it must seem to the infant to give warmth, or to move, or to have texture, or to do something that seems to show it has vitality or reality of its own.
(6) It comes from without from our point of view, but not so from the point of view of the baby, neither does it come from within; it is not an hallucination.
(7) Its fate is to be gradually allowed to be decathected, so that in the course of years it becomes not so much forgotten as relegated to limbo. By this I mean that in health the transitional object does not 'go inside' nor does the feeling about it necessarily undergo repression. It is not forgotten and it is not mourned. It loses meaning, and this is because the transitional phenomena have become diffused, have become spread out over the whole intermediate territory between 'inner psychic reality' and 'the external world as perceived by two persons in common', that is to say, over the whole cultural field. (1953, p. 91)

Part of what I want to discover is if it is possible to understand the earliest mother–baby dyad in terms of a narcissistic mother's use of her baby to attempt to heal and find her own way to a third area of experiencing. This is an unusual approach to transitional objects. I am assuming that the mother's development has gone awry and that she herself has not progressed beyond the stage of confusion between inner and outer. She is, in effect, attempting to use her child's body improperly, as a transitional object for herself, not as a transitional object proper, but as an intermediate object as defined by Kestenberg (1970) and Kestenberg and Weinstein (1988).

They describe body products and food as being intermediate objects. They are three dimensional, able to change shape and fuse with the individual's body and separate from it. They are attached and linked to the baby's body in a way that transitional objects are not. From an observer's point of view intermediate objects are not those given to others by the child, but rather originate within the body itself. They are linked to particular organs, such as vomit being linked to the mouth and faeces to the anus, and are essential

bridges in the development of a secure body image. They are objects that are in themselves transitional to transitional objects. They are not fully transitional because of both their source and their function. For they are usually a bridge to mother herself. They change and decay and are destructible unlike true transitional objects. Intermediate objects may be thought of as being a special type of precursor to true transitional objects. They add an extra stage in the move from the body itself to the use of a blanket or teddy bear, a stage where, as yet, there is neither a secure internal mother, nor a secure internal body image. They change and decay quickly, unlike true transitional objects. They are usually a bridge to mother herself. The use of the child's body by the mother is what is at issue, and I shall start by looking at the perceived role of the mother in the literature on eating disorders.

Mother's Feelings about her Child

From the time of Gull (1873) onwards the problem of the eating disordered individual was seen, in part, as a problem of separation from mother. In one reported case Charcot disclaimed all responsibility for an anorexic's life when he discovered that his instructions to separate her from her mother had not been followed. His initial advice was then taken, and the mother left the daughter in the hospital where she did eventually recover (Charcot, 1889, pp. 210–11). The reasons why it was necessary to separate mother and daughter were not thought through, but the trend continued. Lorand tells of a patient who remembers her mother repeating to her many times: 'Mothers should never be born because they suffer so much' (Lorand, 1943, p. 302) and forty-one years later Lerner says of a patient: 'She related thinking about the many times her mother would tell her that she wishes she had not been born or that she was dead' (Lerner, 1983, p. 52).

As Schwartz says, 'It is this focus on the pathogenic role of the mother's unconscious psychic life that uniquely characterizes the psychoanalytic literature on the eating disorders' (Schwartz, 1988a, p. 33). It is what the early historical cases imply: despite the parent's conscious eagerness to help,

there was something in the mother's relationship with her child which could threaten her life. It is not always unconscious, as Lerner's example shows. The father has not been forgotten, but his rare appearances in the material from now on mirror a trend among eating disorder families where the father is often a shadowy and absent figure (Neubauer, 1960; Yarrow, 1964). In practice this often means that the baby has to bear extra emotional burdens of which she is quite unaware.

Otto Sperling suggests that a mother perceives her child to be, in a very concrete sense, an extension of herself. This idea is well illustrated by David Krueger who quotes a mother saying to a therapist in a family therapy session: 'When she left home it was like losing a part of me – like my arm or part of my body' (Krueger, 1990, p. 262). Bird (1957) describes the failure of differentiation between the ego of mother and child and suggests that the child's ego 'responds directly to the id of the mother, with her ego reacting in turn to the id of the child' (Schwartz, 1988a, p. 35). This thought can perhaps be understood as an extrapolation of Melitta Sperling's (1949) idea that the baby is unconsciously viewed by the mother as representing a hated sibling or parent or a hated or a wished-for part of the self (particularly a phantasised penis).

> Moreover, for the first time she could remember what she had really been acutely aware of throughout early childhood, namely, that both her mother and father had been greatly disappointed that the patient, their last child, had not been born a boy. (Masserman, 1941, p. 334)

A mother's relationship to her child may be determined well before his/her birth.

> In working through the termination phase of her analysis she recognised that her pregnancies had not been in order to bear a live child, but in order concretely to assert her bodily separateness from her mother; the foetus inside her was concretely the hated mother controlling the body, who she expelled in phantasy through the abortions. (Pines, 1993, p. 132)

This woman's babies may be thought of as being an intermediate object, connected to the body zone of the vagina where the aim was to create a bridge to mother to attack her, but also to confirm her sense of separateness from her, to confirm her own body boundaries and body image.

This theoretical area is fraught with difficulties and there is much to be thought about. McDougall suggests that if a baby is a mother's sole source of libidinal and narcissistic satisfaction it will 'predispose the adult-to-be to the creation of what I have termed pathological transitional objects or "transitory objects"' (McDougall, 1989, p. 82). It is feasible that the baby might be seen as a fetish object and indeed Kestenberg and Weinstein say of intermediate objects: 'They are frequent forerunners of fetishes, whereby the object that stands for the maternal phallus has developed in analogy to the shape of the fecal column' (1988, p. 91). A baby cannot be thought to be an intermediate or transitional object in that it has its own life and neither does it change in the way either intermediate or transitional objects do. I would suggest that for some mothers, those whose own internal body image is insecure, their baby is used by them as though it were an intermediate or a transitional object. They do not know the difference.

Dinora Pines' example, quoted above, of a mother repeatedly having abortions, echoes a bulimic episode where the knowledge of the other is destroyed. Contrary to the Kleinian approach to the requirements for developing a secure inner world, there is no psychological intercourse, no internal creative couple who have given birth to the child. In phantasy, she is the sole provider of her own life and life with the object. She is also its destroyer. This phantasy is often present during the bulimic ritual:

> There will be time to murder and create,
> And time for all the works and days of hands
> That lift and drop a question on your plate. (Eliot, 1917, p. 14)

Mother can be eaten up, destroyed and created in phantasy during the bulimic ritual. It is a phantasy of self-creation,

where no intercourse, no conception and no gestation is required.

> The vomiting symbol is a calling back by someone who is not able to tolerate separation and loss, which are experienced concretely, as though the act of swallowing the food 'disappears' the mother. (Shulman, 1991, p. 340)

By inference the vomiting brings her back. The lines between murder and creation are blurred, the lines between mother and child even more so.

> The foetus inside her own body now represents good and bad aspects of the self and of the object, and the mother may not give it a licence to live if she herself feels that she has never been granted one by her own mother. The pregnant mother's ambivalence towards her unborn child may reflect earlier intense ambivalent feelings towards her own mother, resulting in a difficulty in self-object differentiation and further difficulty in separation-individuation ... Separation is unconsciously equated with death of the self or the object. Difficulties in accepting the mother as a good mother may lead to a woman's difficulties in accepting the creative and life-giving aspects of herself. (Pines, 1993, p. 115)

The implication seems to be that the pathology of the mother may mean that she creates a world where her child has to remain attached to her, or in phantasy her very life is threatened.

> The effect of a pregnancy in such cases may depend on whether the fetus is experienced as a hostile, ego-alien invader (perhaps more often in restrictor cases), or as a comfortingly ever-present being more integral to the self and thus worthy of nurturance (perhaps more likely among bulimic patients). (Cross, 1993, p. 59)

The distinctions between the groups are not simple or clear cut, which is part of why work with these patients is so hard.

We are very far removed from a child's unconscious envy (above, pp. 24–7) and are closer to a state of mutual and perhaps terrifying confusion and entanglement of bodies and mind. How is the child likely to understand, take in and try to work with these experiences? All of these formulations support the idea of eating disorders being narcissistic in nature, but they go further in suggesting not only that the problem is one of separation of child from mother, but that it is the mother's pathology that is the issue. She is the heavyweight. The baby is but an extra in her mother's film.

> These patients have been attached to a domineering and controlling mother who attempts to attain passive submission and perfection for the child as her own fulfilment. Power and control exerted by the omnipotent mother is overwhelming, remarkably interfering with separation and individuation in all phases of the child's development. (Sours, 1974, p. 571)

Its possibly malevolent power is suggested by Rizzuto:

> The mother may impose from her own reality *something unrelated to the child, something that is not there.* She may attribute evil intent to the child's gestures or words or perceive them as excessive demands that must not be responded to. (Rizzuto, 1988, p. 374)

The state of the mother's inner world and her use of her baby may go some way to understanding why one individual develops bulimia, another both anorexia and bulimia and another bulimia by itself. It will only be a tentative thesis as the baby, its constitution and its experiences both with and without mother, together form the matrix of development. The pathology of a mother of an eating disordered individual can on occasion be strikingly similar to that of her child (Williams, 1994). It is implicit in the above example that the baby's function is to provide something for the mother, either as an object to attack, or use. How the baby is unconsciously perceived by the mother, whether she is allowed to exist in the mother's mind, and what kind of an existence she is allowed to have may influence the nature of the eating disorder the child develops. Anorexia and anorexic bulimia are both life threatening. Normal weight bulimia can be, but usually this is as a result of conscious suicidal impulses rather than the illness itself.

Anorexics' mothers are often described as being over-controlling and intrusive (Sperling, 1949; Bruch, 1973; Palazzoli, 1978, Wilson *et al.*, 1992); no separation by the baby is allowed. Many anorexics carry this feeling with them throughout their lives. They meet what they perceive to be their mother's needs and ambitions – usually intellectually and emotionally – and use their body as their own and their only arena of control and selfhood, which they can unconsciously and consciously use to attack and attempt to separate from mother. Normal weight bulimics have suffered intentional or unintentional neglect by their maternal caregiver, who is often a mixture of over-controlling and abandoning (Johnson and Conners, 1987; Johnson, 1991b). Their mothers are not, for whatever reasons, able to be constant in the care of their child. Anorexic bulimics' mothers have not been thought about in such general terms, but perhaps they manage to combine positions, showing extreme and violent ambivalence towards their children, being at one point over-controlling and overwhelming and at another abandoning and neglectful.

Baby as an Intermediate/Transitional Object

Rizzuto wrote: 'Food, feces, menstrual blood, the penis, and finally the fetus can all be experienced as the "other" within' (1988). I want to explore the idea of the mother trying to use her baby, both as an intermediate and transitional object. She wishes to use her baby both to confirm her own physical boundaries and as a bridge towards whole object relations. The use of the transitional object occurs in the area between the external and internal worlds. Winnicott makes it clear that the use of the object is what matters. It must be allowed to be loved, hated and attacked and it must also seem to have some vitality of its own, whether in texture, smell or movement. It is a stepping stone towards whole object relations and reality testing and its importance as a developmental move must be appreciated for its role to be understood.

All of this is meant to apply to babies and their bodies, not to adults – not to mothers and babies. Adults are meant to have progressed to art, literature and culture as their transitional phenomena (Winnicott, 1953). But a woman may have a baby in order to attempt to restore, create or get in touch with a good internal object, and to restore a missing element in her body image. This is when the trouble begins. Transitional objects can only be used effectively as tools towards whole object relationships if there is a good internalised mother to begin with. Winnicott puts it so: 'The transitional object may therefore stand for the "external" breast, but *indirectly*, through standing for an "internal" breast' (Winnicott, 1953, p. 94). Intermediate objects fill an in-between space before a stable internalised object and a stabilised internal body image is formed, and it is in this area that mothers can be thought of as trying to renegotiate with the help of their child.

The Child as an Essential Intermediate Object

A mother's peculiar relationship to the actual body of her baby is the focus of much psychoanalytic literature on eating disorders. That the mother is failing in a basic parenting task is very clear. Krueger explains this in terms of pathological narcissism:

> The preverbal experiences in the first year of life have failed to acknowledge and confirm a body self separate from the mother (Krueger and Schofield, 1987). It is as if the mother is incapable of accurate, consistent mirroring; of reflecting the child's aliveness, special distinctness, and body and psychic boundaries. In such cases the mother is unable to allow the child the opportunity for an autonomous, internally directed origin of experience and action. (1988, p. 58)

Cross makes the use of the body of the baby by the mother even more apparent:

> Among other factors, a parent's fetishistic focus on the infant's bodily functions and physical appearance – with

> little interest in the infant's emotional states – or a parent's massively unempathic responses to the infant's bodily needs and somatic signals can foster the kind of early psyche/soma split that results in an eating disorder or delicate self-mutilation (Bruch, 1973; Doctors, 1979; Geist, 1985). (1993, p. 56)

Marie Maguire, in an article on bulimia and perversion, tells of a patient who perhaps was also used in an eroticised way by her mother.

> There is a sense in which Mrs K sees her body as a pornographic object which she tries to control. From infancy, Mrs K seems to have experienced herself as a pretty, passive doll, to be displayed enticingly and played with by others. It has, she says, taken her a long time to realize that she can actively engage in, and feel herself a part of, her own sexual life. This sense of objectification is reflected in her concern with the physical functions of her body and its fluctuations of weight (1989, p. 120).

A patient of mine, a Ms P, suffered severely from bulimic anorexia. She was black, in her early twenties, and came to me after seeing many other professionals. She had attempted to take her own life on a number of occasions. She tried to destroy her body on a daily basis. She would drink a litre of wine per day, take sixty or so laxatives, eat little, or what she ate she would then vomit. She would walk into the room on legs which seemed to belong to a puppet. She looked and walked like 'Loopy Loo', a wooden puppet worked by strings. Her body came in, and she sometimes did. It was purely an appendage, a doll, in which she did not seem to have a presence. She had no use for it. She believed her body was indestructible, that death meant peace and contentment and still being alive. Her body could die. She would not. This psychotic belief rested on her knowledge that she was 'a thing'. She would often refer to her mother as having treated her like a doll or a toy. One day she brought in a photograph album for me to look at. In the pictures of her as a child, she was beautifully dressed and looked as though she had been placed, like a china ornament, on chairs, sofas or floors – to be taken out and dusted when the occasion merited it.

In our work together it became apparent that the only way she could behave towards herself was aggressively; this behaviour was both exciting and addictive. She was certain that she didn't want to change it. Over time, it became clear that she was unconsciously attacking an internal representation of her mother viciously and persistently, without ever being able to be aware of it. She wanted simultaneously to separate from her mother by murdering her own body. She had the delusion that she would then exist in her own right. At the same time her unconscious belief was that by killing herself she would also destroy her mother. This need to dispense with the self, and to use herself as she had experienced herself being used within her relationship with her mother, suggests how and why object relationships among these patients may appear warped and impervious to change. She behaved as though she were still her mother's intermediate object, if not her fetish, and by hurting herself she was thus hurting her mother and her mother's precious possession, herself. It was herself who was so inaccessible, as though she never had room to grow, except in response to mother's demands, demands that she internalised as her own.

The nature of the psychodynamics of the individual with bulimic or/and anorexic symptoms always necessitates a specific understanding, but this does not invalidate a general understanding of a symptom also being suggested. Not all anorexic bulimics perceive themselves as Ms P did, but I do think that the breadth of pathology needs to thought about in terms of the mother's unconscious and conscious use of her child, both physically and emotionally. I think what does distinguish these disorders from others is their narcissistic base, not only in the patient, but in the mother as well. Then detailed individual work needs to be done on the nature of her phantasies in relation to her damaged and narcissistic objects.

Effect on the Child

What is taken in by the child is the mother's own pathology. She is used by mother as an object, as a container (Lerner,

1983). But unlike a mother, a baby cannot process mother's feelings, whether good or bad, and unlike a transitional object cannot but be affected by them. The symptom of not eating, not digesting, can be seen as a clear message to mother that her child has either felt starved or that she needs to starve herself in order to free herself from mother. Mothers failure to contain and process her baby's emotions and her attempt to use her baby as a container for her own feelings means that the baby's emotions and experiences are not felt to have been recognised. This point is well described by David Krueger:

> These individuals' nuclear sense of self has not been cohesively formed, and remains disorganised and primitive. They have never integrated mind and body and are, therefore, unable to deny or defensively split them. The resulting maladaptive behaviors represent deficits rather than conflicts. The individual may not simply be denying a painful affect, she may have not developed an ability to recognise or distinguish different affects and bodily sensations. The narcissistic individual may not have a consolidated body image to either deny or achieve. (1988, p. 60)

This is not a good beginning.

> *Of the transitional object it can be said that it is a matter of agreement between us and the baby that we will never ask the question 'Did you conceive of this or was it presented to you from without?' The important point is that no decision on this point is expected. The question is not to be formulated.* (Winnicott, 1953, p. 95)

I think that many anorexics and bulimics are not asking this question from the inside out. The question is more fundamental for intermediate objects, because they come from inside rather than outside and their physical separateness from the body is therefore less in evidence. Anorexics are not able to question their belief that they are an object, and an essential one, for their mother. For to ask might threaten their mother's existence and their own. They do not know it can be asked, answered and survived. A patient of Charcot's was

reported to have said: 'I prefer dying of hunger to becoming big as mamma' (Janet, 1929, p. 157). Mary, a clinical example in Sugarman and Kurash's article, 'The Body as a Transitional Object in Bulimia', says: 'I would rather *kill* myself than be like her, and that's when I throw up, when I become my mother' (Sugarman and Kurash, 1982, p. 65). An anorexic or bulimic anorexic is unlikely to be able to make use of transitional objects because a stable internalised representation of mother is so obviously absent.

An individual with an eating disorder cannot know how to move from intermediate to transitional objects – partly because she has been misused in a confused way, as both an intermediate and transitional object herself. She attempts to achieve an internal experience of mother by using herself as she felt used. It is in these terms that Sugarman and Kurash place their understanding of the use of a patient's body as a transitional object. However, the individual does not have a good internal representation of mother which would allow her to use transitional objects effectively. She only has the experience of being used as an intermediate object, and like her mother is busy trying to negotiate this earlier stage of development.

If the nursing experience has not allowed a good internal breast to be created, then a child will not be able to begin to make use of a transitional object, but is still able to make use of intermediate objects, which are used in a more direct form as a communication to others. The prototype for both of these comes from the nursing situation in the experience of the baby being held and playing. As Kestenberg and Weinstein have written, 'Both playing and holding, are the basic methods of building and maintaining the body-image' (1988, p. 82). They added:

> Secure holding provides the milieu for undisturbed drive satisfaction and the freedom to play. The feeling of mutual support facilitates the child's formation of a stable body-image, both of himself and of his nursing mother. This fosters the feeling of owning, of possessing both his own body and that of his mother. (pp. 86–7)

The play originates with the infant's own body – using toes and fingers – and the role of the transitional object is to be played with and held to recreate the illusion of being held safely by mother and able to play. The role of the intermediate object is to confirm the internal body image of the area connected to the product (faeces and anus for example) and bridge the gap from self to other by presenting the product to mother. Few eating disordered patients make it as far as using transitional objects. They remain fixed in the position of an intermediate object where the illusion of being safely held is exactly what is lacking and where a secure body image has not yet been achieved.

The absence of play is often very noticeable among this group of patients and the rigid structure of family life has often been observed, particularly among anorexic families. These patterns were noticed by Hilde Bruch in her pioneering work with anorexics and expanded upon by Philip Wilson in *Psycho-Dynamic Technique in the Treatment of the Eating Disorders* (1992). If the mothers of these patients had successfully negotiated the use of intermediate and transitional objects they would not have had to use their children in this way. In other words, I wish to suggest an area where intermediate objects were used by mother as though they were transitional but were not used effectively as stepping stones to whole object relations, because of the absence of a secure internal mother. This means that the patient has been played with by her mother, as though she were a transitional object, and she had to mould herself to her mother's wishes and expectations – in effect – to be without thought or the ability for self-directed action.

The Binge

This view of the absence, evacuation of thought, among some bulimics, is a point made by Diana Shulman in her article 'A Multitiered View of Bulimia', where she says:

> There is a sense of the bulimic ridding herself of her mind. She attempts to escape her capacity to think as thinking leads to painful thoughts about loneliness, loss, and abandonment; she instead spends all her time evacuating her mind. The crowning achievement is a patient such as Ms Ames sitting in front of a blank television screen, which symbolises her mindlessness, or a patient, such as Ms Baker, who makes light of her weekend gorging and presents the details of her exploits almost as though they are concrete things subject to expulsion. (Shulman, 1991, p. 341)

What she does not address is how these psychotic islands, or perhaps autistic cysts (S. Klein, 1980) may be enabling. Shulman has suggested: 'Although the bulimic is able to return to the real world, she, too, is relying upon psychotic mechanisms during the periods of time when she is actively engaged in the binge–purge cycle' (1991, p. 342).

In my clinical experience her view is valid for some bulimics, some of the time, but a binge is not always a retreat into an autistic state, even for those for whom it may be so at times. A binge is multi-determined and may represent internal object relationships from any stage of development, and perhaps represents more than one at a time.

An adult with bulimic symptoms can be thought to be re-enacting her earliest and repeated experiences with mother during a binge (Krueger, 1988). A potentially and often momentarily nourishing experience becomes an unpleasant and destructive one. Mother is overwhelming and unsatisfactory and then has to be got rid of by vomiting. In the whole episode what is re-enacted is the experience of mother forcing herself and her wishes upon them, which are not nourishing and cannot be dealt with, except by vomiting them out, or not allowing them in at all, as is the case with anorexics. A fleeting experience of mother is found, but not consciously. The physical behaviour itself re-enacts being fed by mother. I now want to side-step the black hole of the bulimic episode itself, and look at its adjuncts: the vomit, the environment and the cleaning-up process.

Vomit as a Transitional Object

What are some of the possible meanings that food has once it has entered the mouth, food which is mixed with saliva

and partially digested, whether in the form of vomit, in the mouth or outside the body, and in the form of the presence of large amounts of semi-digested food in the body itself? It is not the same as the food going in before it has been chewed, but the ingredients are usually recognisable. I shall also look at the presence of faeces, in and outside the body, and the nature of the procedures surrounding the ritualised ending of a binge. To elucidate the possible meanings I shall describe four clinical vignettes, focusing only on the progress of a binge and vomiting ritual. For Winnicott 'an essential feature of transitional phenomena and objects is a quality in our attitude when we observe them' (1971, p. 113). This is worth bearing in mind when reading about the patients cited below. David Krueger has written in this regard that:

> These individuals, because of their concrete, non-symbolic mode of operation, are not able to move to an external non-bodily transitional object. They seem instead to struggle to *create* a transitional object which *is* external, concrete and specific. The effectiveness of the object is fleeting, however, and can remain no more fixed in emotional consciousness than the defective internal images of body, self or other. (1988, pp. 61-2)

Krueger is using 'transitional' where I would use the word 'intermediate' due to its transitory nature, its creation within the body and its role in helping to define and restore a more complete internal body image.

Patient F

Patient F was a normal weight bulimic who binged and vomited many times a day. She did not feel able to work. After bingeing she would make herself sick. Sometimes the action would be very violent and the vomit would splatter back into her face, around the loo and onto her clothes and shoes. She would then spend time carefully cleaning up herself and the bathroom. She took numerous laxatives on a daily basis, and after the bowel movement or movements, she would change her clothes if necessary, and wash her body with care.

Patient E

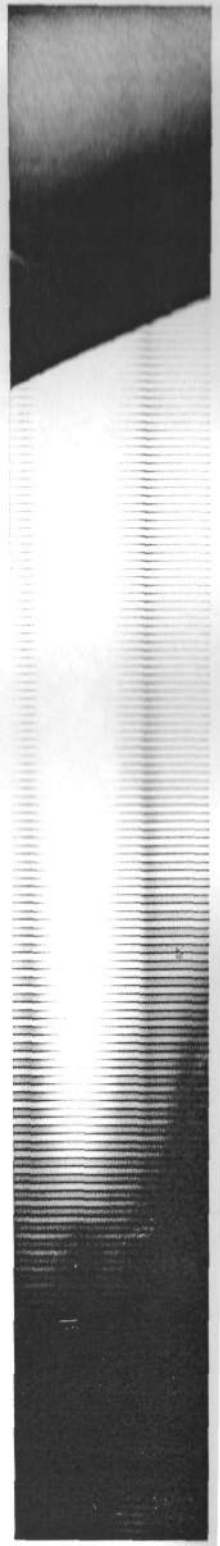
E worked in an office and did not enjoy her job or her surroundings. She was extremely creative and used her skills to earn extra pocket money away from the office. While at work she would sit at her desk and whenever she could, she would eat a procession of biscuits, sandwiches and chocolate bars. She made them last all day long. She would eat something, and for an hour or two hours afterwards she would ruminate, bringing the food back up into her mouth where it would be chewed and swallowed again. This happened without her conscious awareness, although she could prevent it happening when she wanted or needed to.

Patient C

C was a very fit, normal weight bulimic. She lived at home with her mother and sisters. Her mother locked up the food at certain times during the day to try and stop her from bingeing. This failed, and C would binge secretly in her room. She kept the packaging and wrappers of the food she ate. When she had finished bingeing she would not go to the bathroom to be sick, as she was too frightened of being caught. She would vomit into plastic bags in her bedroom, which she then placed either in her wardrobe, her chest of drawers or under her bed. She did dispose of the vomit filled bags, but not at the first opportunity, which meant there was always more than one bag of vomit in her room.

Patient M

M was a normal weight bulimic who ate compulsively on a fairly regular basis. She worked in a hotel and did shift work. Sometimes she would binge and vomit, normally in the evening, before going to bed. After bingeing and vomiting she would then eat again, until she felt full, at which point she would lie down and go to sleep. She would be aware of the food inside her and her body shape on the bed as she was going to sleep. She would often report dream-like images before slipping into sleep.



Patients E, C and M use vomit in a rare and particular way. A normal weight or anorexic bulimic may have many different phantasies about her vomit, at different stages in her illness and on different days. For the nature of the vomiting and the vomit depends on what is eaten, what is drunk, how long it is allowed to stay in the stomach, and whether it is brought up by a clenching of the stomach muscles, or by using the hand or another object to tickle the back of the throat. Vomit can be thought about generally as being an intermediate object, as with Patient F. What is rare is its attempted use as a transitional object. For these patients have failed, as their mothers before them failed, to differentiate between intermediate and transitional objects. I think they turn to their body products, their intermediate objects, and try to turn them into transitional objects proper, in an attempt to integrate their body image and connect up with some experience of a good – rather than a controlling and abandoning – internal object.

I believe the above vignettes give credence to this idea. For patient E, the experience of partially digested food, which was chewed and swallowed, and chewed and swallowed again, worked as a method of assuaging her anxiety. The vomit was available, she played with it in her mouth, and this provided a third area of experiencing which removed her from an awareness of the barrenness of her inner and outer worlds. She could stay at work as a result. It proved itself to be enabling. It was for her a transitional object.

For patient C both her vomit and the remnants of food in the form of its wrappings and packaging were there for her to use as transitional objects, but for a limited time only. They were moved around the room, felt, played with, thrown away. In a bag, vomit has all the sensory requirements of a transitional object, a smell, a texture, a mobility and a life of its own. However, it is not a transitional object as it came from within her body and decayed quickly. It had to be thrown away after a certain time, as it became mouldy.

For a baby, going to sleep with a blanket in one hand is not unusual. So, too, for patient M, who could sleep once her transitional object of food was inside her. This is different from the sleepiness of the compulsive eater, for it was related

to the vomit that had already been expelled, and hunger and destruction had been dealt with in fantasy. The good mother had been experienced and the bad mother had gone. Then came time for something to play with, to feel in a safe place with, which enabled her to sleep.

For patient F the clearing up process itself was soothing and provided an important in-between stage which enabled her to return to reality. The vomit may have helped to define and clarify her body boundaries, which in turn enabled her to take care of herself, however briefly. This use of the post-vomit time as a transitional arena is a common, though rarely talked about part of the bulimic ritual, for many normal weight and anorexic bulimics. Marilyn Lawrence does refer to it, although she understands it in a different way. She says: 'Some women spend hours cleaning up after themselves so that others will not discover the secret, messy part of them' (Lawrence, 1987, p. 199).

One of Winnicott's defining characteristics of the use of transitional objects is that there is no climax during play:

> It is to be noted that the phenomena that I am describing have no climax. This distinguishes them from phenomena that have instinctual backing, where the orgiastic element plays an essential part, and where satisfactions are closely linked with climax. (1971, p. 115)

I think this supports the thought of vomit being used as an intermediate object for bulimics, but not the act of vomiting itself. For there is a climax when at some stage the point is reached where the food has to be expelled. I do not think it is always orgiastic, although many would disagree, seeing the action of self-induced vomiting as being a symbolic representation of coitus, in one form or another (see Chapter Two). However, the very early nature of the disturbance suggests the act of expulsion of the food is a much earlier representation of a dynamic which occurred with mother and whose prototype may have been found in the feeding dyad.

Role of Stereotyped Rituals

Winnicott suggested that an addiction in adult life is an attempt to return to a time when the existence of transitional objects was not questioned. Yet he describes the third area as

> an area which is not challenged, because no claim is made on its behalf except that it shall exist as a resting place for the individual engaged in the perpetual human task of keeping inner and outer reality separate yet interrelated. (Winnicott, 1953, p. 90)

It is a place of illusion. It is this quality, more than any other that I think prevents the body from being understood as a transitional object during bingeing. For the whole point of the bulimic ritual is to work out what is 'me' from what is 'not-me' by the act of vomiting. This is the very opposite of the third area of experiencing where the question is never to be asked.

I do not, however, think there is ever only one way of understanding an individual's bingeing behaviour. What bingeing means is always dependent on the underlying phantasies. Diana Shulman (1991) argues that a binge recreates the experience of mother without having to think about her. It deletes reality, and the thinking process is forfeited for a period of time. If this is accepted for even a few patients, it represents a concrete attempt to have a good mother inside. I think this can then help to explain the behaviour which takes place after the food has been brought up. It is here that the vomit in a small number of cases is used as though it were a transitional, rather than an intermediate, object. In a greater number of cases the vomit is used as an intermediate object to clarify body boundaries, and the cleaning-up ritual is used as though it were a transitional object. It is used to return to a world of whole object relating and perhaps provides the one area where a semblance of Winnicott's third area of experiencing is appreciated, however painfully. It becomes a bridge back to reality. In work with patients, bingeing and vomiting are often used to enable them to undertake a task which they felt they could not do. For patient M bingeing and vomiting and then eating again allowed her to go to sleep; for patient E ruminating enabled her to stay and perform at work.

What I hope has become clear is the very varied and complicated nature of the internal worlds of these patients. This is demonstrated by their reliance on the bulimic ritual itself. A ritual that cannot be thought of as normal, or healthy, but

is secretive and destructive. It must not be forgotten that viewing the bulimic ritual as being a way to create and use transitional objects is only one way of understanding it: a way which adds a more benign understanding to a ritual usually thought of as only being destructive. It seems likely that the less well the individual the more likely she is to try and use vomit as a transitional object. I would suggest that the same may apply to individuals who abuse laxatives excessively and in phantasy thus speed up and increase the production of faeces, with which they become overly preoccupied, in some cases becoming attached to the often painful and time-consuming process of evacuation and clearing up. Layers of meaning, from sexual phantasies to primitive destructive phantasies in relation to mother's and father's bodies, are always present and need to be explored. The one generalisation that seems to be possible is the narcissistic nature of these disorders, both in the patient and in her mother. Once that is said the range and nature of the disturbance needs to be looked at individual by individual.

The narcissistic quality suggests that many eating disordered patients' early experiences with their mother have prepared them for unreliable and misunderstanding relationships, where they survive by picking up on the expectations and wishes of the other and by responding to them, as far as they are able. They keep themselves in hiding. They are terrified of being known or seen and some indeed hardly know they have a self and believe that knowing it threatens their very existence (Rizzuto, 1988). For their mother may have used them as an intermediate object – which suggests that life apart from her would lead to decay and death.

This has important implications for the therapeutic relationship. The therapist, for instance, is likely to be experienced as mother, with her own hefty agenda. She is often thought of as being there for herself, the patient being there to help her, rather than vice-versa. There is rarely an awareness of a good object, but a definite awareness of a persecuting, controlling, envious bad one. Negative feelings tend to prevail, particularly with the more self-destructive patients, and the thought of a safe space will be alien. The make-up and intensity of these feelings will obviously be very different from

individual to individual, but I think the idea of being aware of the importance of these patients' vicious perceptions of their internal relationship with their mother, and the expectations they bring to therapy, provides an essential space for the therapist. This is essential so that the therapist can think and show concern, and succeed in avoiding the powerful pull in the countertransference towards frustration, control and sadism in either tone of voice or content of interpretations.

By focusing on the mother's conscious or unconscious use of her baby as an intermediate object, I have tried to draw us up to the edges of Winnicott's third area of experiencing. I use 'up to' with care, as intermediate objects always remain precursors to transitional ones. Vomit, faeces and babies are all intermediate objects as they come from within, and cannot remain in an unchanged state. They either change or decay. Some bulimics and anorexic bulimics use vomit in such a way as to convince themselves that it possesses the characteristics of a transitional object proper, that it can be used as they like, for as long they like. It is this line of enquiry that I will pursue in connection with technique and the experience in both the transference and countertransference.

CHAPTER 4

Implications for Technique

The physical appearance of anorexic and anorexic bulimic patients is shocking. The outward appearance of normal weight bulimics is not shocking. This vital piece of information is usually ignored in the literature, where anorexics and bulimics are thrown together as though the experience of working with one is the same as working with the other, which, of course, it is not. Before looking in detail at some of the transference and countertransference issues presented by anorexics, anorexic bulimics and normal weight bulimics, I wish to look at why psychoanalytic work with these patients has often been opposed. Some have opposed it outright, and others have suggested that particular techniques are necessary to work with these patients. When I look more closely at working with eating disordered patients I hope some of the technical issues will emerge from the theoretical understandings already referred to, and perhaps point to ways of thinking about material and making interpretations that allow these resistant patients to begin to appreciate that they have a digestive tract in their internal world which can be used to good effect.

As mentioned in the Preface, working with eating disordered patients can be frightening. On the surface and in reality, this is truer for anorexics and anorexic bulimics. They frequently put their lives at risk, and yet are often consciously unaware of it. To see a skeletal figure walking and talking is deeply disturbing. Skull's heads, death, torture, concentration camps and starvation are some of the thoughts that instantly come to mind. Lasègue's frustration and feeling of impotence is apparent when he describes an anorexic's state of mind as being: