The anorexic-bulimic symptom during the therapy

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Abstract

This article seeks to investigate particular features of the anorexic symptom in women who begin therapy between the ages of 23 and 27 and who indicate the presence of it only after the start of therapy. Through the presentation of two cases, the article then analyzes the management of this symptom in the therapeutic relationship from a psychodynamic perspective.

Key-words: anorexic symptom , internal space , secrets , therapeutic relationship

The hidden symptom

The anorexic symptom, in its restricted version or in the bulimic behaviour with vomit, still hides its secrets, notwithstanding its large diffusion.
It is present in many of the pathological situations that arrive to the therapist. Not always though the anorexic symptom is the motivation for the therapy.
Often this symptom is accepted by the subject because it gives also the secondary advantage to allow to the patient to keep the weight and the physical asset which makes him feel consistent with the social rules about beauty and health.
Even if the symptom is not expression of a complete anorexic pathology, it is often inside a character organization that contains typical signs of the anorexic organization.
The patients are often active or iperactive girls with a very good scholastic career. They have a strong intellectual engagement, with sentimental relations characterized by a strong dependence from the partner and at the same time with a very strong need to control and dominate the partner. They are girls who live the sexual part of the relation without much interest and capacity of physical and emotional participation.
In this kind of patients, who are not completely and strongly anorexic, the symptom often becomes for the therapist of particular interest just because it is the signal that, in spite of an improvement of the style of life and the level of general satisfaction, the therapy must go beyond that, to reveal why it so strangely resistant.
I am talking about women who start therapy around the age of 23 -27 years. They ask therapy for different motivations and they give an importance to the anorexic symptom only after some time from the beginning. The alimentary pathological behaviour must be kept almost secret, it is kept in a secret place.
This character of the symptom and the way in which the patients manage it in the therapeutic relation looked to me interesting and I put attention on some peculiarities which I think are common to the patients I had in therapy.

A patient's history

Only one of them has been sent to me with the diagnosis of 'anorexia'. The other ones had the anorexic symptom with the obsessive idea of loosing weight but the main pathology were of phobic-obsessive and psychotic type.
N. starts her therapy when 25 and has the anorexic symptom of bulimic crisis and vomit with pathological thinness, all declared and accepted as her only problem.
She is 44 kg. but she feels her body heavy and fat. She is sent to me by a colleague for anorexia
The therapist sends her to me after two years of therapy because she had become bulimic with vomit and thinness. He sends her to me because he doesn't want to take care of anorexic patients.
A short time after the start of the therapy I will know that the symptomatology had appeared after some erotic stimulations that the therapist had done on the patient with the aim that his doing could be useful to teach her that the erotic excitation could coexist together in a relation with empathic and trustful feelings. I think he really believed right to behave in that way.
N. did not criticize or refused this behaviour but after a short time she began to have the anorexic symptom and so the therapist sent her to me.
Perhaps N. had some way received the information that her therapist refused anorexic patients.
I did not understand if this information was used by N. to build the symptom which made the therapist not any more available to her. She anyway chose this symptom, she did not deliberately choose to leave the therapist.
The therapist, as she told me, during the therapy used to invite her to be very strong and self-confident with men, as if he suggested her to have a very dominating and imperious attitude, like Turandot.
He did not take into the right consideration her real capacities to manage the emotional and the sentimental relations.
N. had started this first therapy for difficulties with her fiancée whom she left shortly after.
Here, as K. Schweizer (2007) suggests, there is a perverse element which enters the relation. A relation of care and trust introduces also elements of untenable excitation. This does not create a neurotic conflict but a bodily behaviour, bulimia with vomit, which invades N.'s life.
Perhaps during the stimulations made by the first therapist she lived the reproduction of psychosomatic traumatic moments of pain rooted in her infancy, as the ones indicated by Ferenczi (1932a).
Ferenczi (1932b) describes the sexual trauma for the child as a situation in which a strong state of fear is produced so to constrain the child to submit to the adult's will. The result of this type of event, because of the identification with the adult's aggressiveness and wit his guilt feeling which the child introjects, makes the child,

when and if he comes back to consciousness, confused and splitted «innocent and guilty at the same time, and his trust in the capacity of testifying of his perceptions is broken»[1] (p. 420).
During the first two years of therapy with me N., who had left her fiancée during the first therapy, started a very high number of sentimental relations with many boys. All of them started with great enthusiasm and great disponibility-submission to them. After a short period of 2-3 weeks she started to be very angry with the boy because she realized that her availability did not get the response she expected. "I had given a lot to you, now it is your turn to give me what I want". So after one or two horrible quarrels she left them or, often, was left, without any more thought about the man or keeping any kind of friendly or affective tie with him.

Hints about the therapy

My role with N. was to accompany her in living these real events of her life without criticizing or interpreting anything, I could only try to make clear to her her feelings and the requests she made to the boys.
From every one of these stories she learned something: that she was too attentive to the other's wishes; that she was always afraid to be used. (This still happened in her relation with the mother who kept her in balance between "in this way you are ok, in this one now you are not ok" which depended on the fact that N. made or not her mother proud with her success and beauty), that she was guided or stopped by the interiorized or real mother's judgement, that she wanted to have an ideal story like in a tale.
For N. it was very important not to have conflict or break with the mother because being in a good connection with her she could feel part of a social group that the mother represented. When some misunderstanding happened she felt guilty and lost. She got a strong feeling of safety and identity from her almost symbiotic belonging to her familiar group. She also needed to belong to the mates she frequented and from which she used to choose all her partners, and she adapted to that group even if it did not satisfy her needs.
Slowly, through the analytical work she modified her attitude and started a love story which was acceptable for her, with an affective and not dominating man.
At this time she had improved her relation with her father, who was separated since her first adolescence, and to think about making a couple with the man. When she felt sure of herself an to be loved she could speak clearly about the bulimic crisis and to decide that they had to be brought into the therapy. So we could start to talk about them and to observe them.

The symptom

This happened because having found been able through the work done together to find a man with whom she wanted to stay she had partly solved the affective

problem. After some months of sentimental tie, during which she had behaved as usual but with a better capacity to stand to frustration and a stronger wish not to loose this man, she could then start to recognize and affirm her needs in spite of the invading and judging mother fearing les the fear to loose the man. She could face her secret bulimic crisis and talk about the ways and the moments in which they appeared and performed.
N. typically did not openly ever took into consideration almost any of my interventions, both the strictly analytic ones or the supporting ones.
It was never possible to understand whether she heard them or she forgot them. Almost always she looked absent minded staying silent or thinking to the daily things to do, she never connected my interventions to anything or thought about them, she only justified herself for being still so sick.
I think that having left her those spaces of silence and hiding she could slowly start to elaborate my interventions. My impression was that she had to hide to me in whi9ch way she used them, she could not make me participate to her work, she behaved in the session as she did with the bulimic crisis and the vomit, but she could not dominate this behaviour.
Describing the crisis we could gradually understand that they happened when she was in a very difficult emotional situation of which she was not able to find the motivation. For ex.: she went to eat at her mother's house and even if she had prepared herself to her criticism or her strange requests, she did not feel touched by the mother's stimuli and she was tolerant while being with her, but then she took refuge in the crisis.
With her partner she often was more accommodating than she could stand, giving up her own engagements, adapting to his style of life, showing understanding and tolerance, but soon later she had a crisis with which she had the impression to take a personal space, eat all she wanted and then free herself from the disease produced by the bunching.
That was her private space in which she could get angry and refuse-vomit what she did not like of herself or of the other people.
With the crisis, for a short time, she broke her dependence. As she herself says, in so doing she created a space which no one else knew.
The paradox consists in the fact that she created a space and a time in which she experienced not to have an internal space, or better, that she could have it only for a very short time, the time to eat a lot and immediately the big space had to be free again. She does not have the right to have a private space.

Internal space

I believe that the relation with the internal space is very typical for the anorexic person and for the alimentary crisis. These people's space is too empty or too full, anyway they cannot dominate it.

Marion Milner (1987), who sees the roots of creativity in the "good state of union with our own body", (Di Benedetto, 1998) uses these words: «one must trust in what looks like nothing, absence, emptiness. But it is not so, there always is the sea of our breath and the sensation of our weight and the silence […].»
N. must build this feeling of trust and to do so she must be able to realise a very delicate balance between feeling of emptiness and of fullness, as M. Milner suggests. How to get to perceive 'the sea of our breath'?
This reminds us of the 'sufficiently good mother' who with her holding, both physical and psychic, and through *rêverie* builds with her child that situation of calm which is necessary for the baby in order to grow up and get consciousness of himself and of its needs.

Femininity

'Sufficiently good mother' means a mother who is capable enough to identify herself with her child and that for this reason does not communicate too much conflictuality, specially, in these cases, about her relation with her body, her feminine body, and with the male object of her desire.
She should be a mother who brings inside her, and who is able to have in her real life, a relation with the man sufficiently well structured and that does not have too many inhibitions and conflicts with corporeity.
She should allow the passage from an infantile and relational corporeity to a sexual and gradually adult body feeling.
N. later on in the analysis starts to accept a deep relation with her partner and has with me a stronger and trustier relation, at this point she dreams her body producing small and repulsive insects and animals. May be they are the representation of old experiences of infancy still present, about exciting emotions almost traumatic for her little infantile body. May be produced by the maternal conflictuality toward femininity and her relation with the sexual desire. During her childhood N. had to listen to her mother's, a passionate woman, about her private difficulties with the husband so creating in the little girl a feeling of fear and the anxiety of a continuous danger.
This mother attacks, even in her present life, the capacity of her daughter to have a satisfying sentimental relation always criticizing and giving negative judgement on her partners.
Or she dreams destruction, blood, dead people and fear.
N. could now start to tolerate these images and feelings, and even if she was not able to actively accept the meanings that we tried to find together, she could change and find new perspectives.
She put those meanings inside me because she needed that I accept and contain them, so that she could feel her body free and alive.

I realized with her the maternal *rêverie* sharing with her the meaning of what she told me, accepting and keeping in my mind her anxieties, without giving them elaborated back to her.

To be' and 'to do'

Perhaps this kind of patients puts the therapist in front of the problem of the relation between "to be" and "to make", as Winnicott (1971) discusses in *Play and Reality*.
The mother must give the child a relation in which the doing of the mother herself allows the baby to start being which for Winnicott, being is the distilled element of femininity.
The relation based instead on drive, always following Winnicott, belongs to the masculine element of the personality: «We see now that it is not the instinctual satisfaction which makes so that the child starts to be and to feel that life is real, and find life worth to be lived. In reality instinctual gratifications start as partial functions and become seductions unless they are not based on a well established capacity in every person of total experience and of experience in the area of transitional phenomena. It is the self that must precede the use of instinct by the self; the rider must ride the horse, not be drawn by the horse» (Winnicott 1971, p. 158).
The masculine element of the personality is related with excitation. If the baby is exciting for the mother, both it be in a positive as in a negative way, this brings the «masculine element […] to do something» (Winnicott 1971, p. 129).
The mother, through her caring behaviour introduces in the child an exciting stimulus which, when excessive, prevents him to live the condition of calmness and emptiness of which Milner talked and which is necessary to make the subject able to assume its creativity. This can happen during the taking care of the child's body, in talking later about sex, in explaining any event in an intellectual and rational way, in being g, if I can say, too much reasoning. The process of *rêverie* which should be formed by the subtle balance between being accepted (being) and communicate (doing), is substituted by the project of teach to the child how to learn and understand.
The capacity of the child to learn how to recognize its own emotions, both the ones produced by his body as the ones produced by external stimuli, in order to live them in a calm way, are so strongly damaged.
Kernberg (1995) resumed and completed this conception of the formation of the infantile emotional development saying that affects are the "building material" for the drives. Kernberg confirms that the emotions and then the feelings are deeply rooted in the body. These, following Damasio (2003), are the conscious result of the sum and the acknowledgement of the perceptions, of the emotions and the affects of the subject. He also believes that the libidinal and aggressive drives arise from the psychical and psychophysiological biologically determined organization, which is activated during the development (Kernberg, 1995).
The mother's role is complementary to that of the father, who forms the couple with her, in creating a situation with perverse character. This will gradually force the child

to deny, to isolate and remove or split the painful or intolerable emotional events of its life if the therapist let them live.

The bulimic crisis

N. gradually discovers that she is able not to have the bulimic crisis if she can face and live in the moment in which they happen, the rage due to different emotions or affective need, not necessarily negative ones, for ex. humiliation, but also pleasure for being loved. When she can recognize the strong emotions that she before ignored and that she lived later during the crisis.
When N. decides to have a baby I realize that this is a way to satisfy her wish to take care of herself through the child. Her satisfaction is at the top when she knows that the baby will be a female.
I think also very important for her to organize her life to be alone with the baby for two months after its birth, without familiar invasions, the mother, or friends and to stay then with the partner.
She prepares herself to finally build a space and a time for herself and for the baby so in which to learn how to 'be there' and to know herself.
It is important to understand that in these patients the change can happen only living the real experiences that can correct the past life events and that the therapy can only help them to get better realism in life, to feel that life is real (Winnicott, 1971).
At that point analysis ended. She had not any more bulimic crisis because she could gradually take her place in the relation with the partner and with the mother and could trust herself. Even her relation with her own body is more accepting and softer.
Now she must live by herself. Maybe she will come back to me when and if she will feel the need to do some more work.

Another history

Another patient has this kind of anorexic symptom and this confirms to me this way of living the crisis as secret moment, unchained by the incapacity to become conscious of the emotions or, better, of the presence of uncontrollable emotions which suddenly stemmed from a condition of almost complete emotional indifference and anaesthesia.
Another aspect concerns the relation with hurry, with doing .
A. is a young woman 25 years of age who had an anorexic episode in adolescence and that, after having started therapy for her sadness and apathy, maintains the use of marijuana which had begun when in high school with her friends, and starts an abuse of cocaine. She hides this to me very carefully, for a long time. I get to know about it after an hospitalization for a persecutory episode. She then decides to start to eliminate the abuse being followed by a psychiatrist specialist of detoxification and psychiatric therapy.

The abuse of cocaine was very recent and it depended on her relation with a boy who, following her description, looked to me as having toward her sadistic attitudes in which possession and domination were very strong. She accepted these attitudes with great effort but at a certain moment a particularly bad episode, in which she felt actually in danger, pushed her to leave him immediately bringing the episode and her fear in the therapy. She wanted to get her degree soon in order to make happy her parents and her personal aspirations, but she was not able to study. Beside this she had chosen a very complicated graduation thesis as if she were a great intellectual.
During the relation with the addicted boy she had again bulimic crisis with vomit and she hides them very attentively to her mother and to me for some months. After the hospitalization for an almost paranoiac and dissociative episode that happened during the summer holidays while she was in a group of friends using drugs she finally talks to me about her abuse. I find again in her the need to keep the experience secret and the impossibility to elaborate our work as it had happened with N.
In this case this aspect has a psychotic character but can gradually be faced.
A strong argument which appeared and was treated with the patient and also in some talks with the parents, was related to her need to be 'calm' in front of the expectations that she felt about her.
Specially the mother, an anxious and perfectionist woman, is anyway also tender and able to change her attitude. She had always made big requests to the daughter and she did not tolerate the time necessary for the therapy and for the daughter's needs. She was always stimulating her, encouraging her and communicating about everything, of the life, of her own sexual life and of the sexual life of her couple, since the daughter's infancy. A. during the 'psychotic' episode has the impression to remember a sexual stimulation made by her grand father, who was a very cold man whom she feared, who one day took her in his arms, making her feel very anxious.
Reality is not important for A.. She goes on trying to work on her graduation thesis, which is very difficult. It must satisfy her image of intelligent girl of which the parents are very proud. She must feel to be part of the group of intelligent people to which her parents and her mates belong. Without this belonging she feels denied of identity. Here again, as in the case of N., belonging to a group, even if only an idealized one, has a very important role for her feeling safe and for her need to be. For this reason she renounces to her need to free herself from the heaviness of this intellectual, severe and rational model, in which she feels constrained since her far childhood.
There are now two parallel relations, one with the mother, who protests and pushes her to do more and sooner and one with me who accepts her slow times.
When she finally can start to talk about her bulimic crisis, she also starts to fight them actively. She can have a more realistic attitude, changes the graduation thesis into an easier one that she likes more and that she will end in a short time. She now starts to face her lack of capacity to a recognize and take care of her own emotions.

The crisis appears at the beginning of the day when she almost always feels empty and confused, and she must decide what to do and how to organize the day. The crisis stops this condition but it is not enough to make her feel well.
During this period the mother starts to be more patient and becomes able to wait, to give her daughter the times she needs. Gradually A. can start to distinguish her own needs and times from the mother's ones and resist to her push.
Also in the therapeutic relation her good disposition toward the relation was present but had to be secret to her, the *transfert* was so deep that it was impossible to create relations with it. I was for her a support as if it were an orthopaedic structure sustaining her.

'Masculine' and 'Feminine'

The crisis is an event which must happen secretly so the relation with the therapist must be hidden, because there is a strong fear that he becomes invading.
The need to create a space for herself is in conflict with the fear that it be then invaded.
The delicate balance that Winnicott proposes between femininity, being, and masculinity, doing, seems to me the key to be used in order to modulate the acceptance and the interventions on the communications proposed to the anorexic patient.
'Doing' becomes a very useful way to better hide the lack of internal liveable space and her need for it. Efficiency, safety and domination becomes perfect masks and try to substitute the feeling of not 'being'. The research of femininity is abandoned or denied.
The anorexic patient comes back to feel herself as the linear, absolute self, similar to the little man which drawn when a child, because she must always and only perceive her ideal oneness, erasing her living and emotional body.
My hypothesis is that this unbalance between being and doing that can be present in different way in different kinds of mother-infant couples and in the mother- father-infant triads, is probably at the base of many pathologies. Moreover I believe that in the anorexic symptomatology the passionateness of the couple, specially of the mother, has a strong role. The mother transfers probably on the child the sexual emotions, (exciting or frustrating) which are anyway exciting for the baby because it is not able to manage them. As Ferenczi (1932b) writes about the sexual infantile trauma, the child becomes confused and splitted, he feels «innocent and guilty at the same time and his trust in the capacity of his own perceptions to give evidence is broken»[2] (p. 420).

One thing I believe now is about the impression that in our society, in both women and men, prevails the attitude to do than the attitude to be and this makes me think that anorexia can represent the symptom socially recognized of big and diffused uneasiness which are still ignored and neglected but which regard us all.

Notes

[1] Translator's translation.
[2] Translator's translation.

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