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This is the author's manuscript

Original Citation:

Availability:

This version is available <http://hdl.handle.net/2318/147348> since 2017-05-25T22:28:54Z

Published version:

DOI:10.1080/02668734.2013.872172

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This is the author's final version of the contribution published as:

A. Granieri; A. Schimmenti. Mind–body splitting and eating disorders: a psychoanalytic perspective. *PSYCHOANALYTIC PSYCHOTHERAPY*. 28 (1) pp: 52-70.

When citing, please refer to the published version.

Link to this full text:

<http://hdl.handle.net/2318/147348>

Mind–body splitting and eating disorders: a psychoanalytic perspective

Antonella Granieri¹ and Adriano Schimmenti

One of the possible consequences of affect dysregulation, resulting from developmental experiences with caregivers who have not been able to attune with the child's emotional needs, is the development of a dysfunctional relationship with food and the subsequent development of eating disorders (ED). ED patients internalize a primary sadistic object with which they can only identify in an adhesive way. The resulting ego ideal is hypertrophic and its inaccessibility generates deep feelings of shame and worthlessness. For these patients, the disordered eating behaviours often represent a way of recovering their subjectiveness and provide opportunities for a relational impact. At the same time, the body becomes a sort of 'safe haven' in which ED patients can imagine protecting themselves from the sadistic object's intrusive attacks. Psychoanalytic work with ED patients requires an analyst who is genuinely available to deeply listen and who knows how to reach these patients and their psychic experience 'beyond words'. The analyst should offer the emotional support necessary to face the self-destructive impulses of a frightened and helpless self.

Keywords: eating disorders; body; splitting; affect dysregulation; developmental trauma

Introduction

Over the years, theoretical and empirical research have helped detect a number of risk factors in the development of eating disorders (ED). These include, among other factors, neurobiological vulnerabilities that implicate an alteration of the functional modulation of serotonin neurotransmitters (5-HT), combined with a diminished activation in the insula cortex, which is assigned to the elaboration of somatosensory information in the shape of interoceptive awareness (Castellini et al., 2012; Groleau et al., 2012; Kaye, 2008); pathogenic family configurations during childhood characterized by entanglement, emotional neglect, and problems

related to the separation-individuation process (Bruch, 1962, 1973/1979, 1978; Minuchin, Rosman, & Baker, 1978; Pace, Cacioppo, & Schimmenti, 2012; Selvini Palazzoli, 1963–1995; Trombini et al., 2003); childhood experiences of abuse (Brewerton, 2007; Vanderlinden & Vandereycken, 1997); and an interpersonal and professional context that exacerbates the value of being thin (Lindner, Tantleff-Dunn, & Jentsch, 2012; Sinton & Birch, 2005).

These data undoubtedly enrich psychoanalytic knowledge, as well as the clinical practices used with patients suffering from ED, thus making the integration of the evolving theoretical reflections on these disorders within the different psychoanalytic models particularly fruitful as well as necessary.

More importantly, from a psychoanalytic perspective, ED are often related to a deficit in self-regulation and in the interactive regulation of emotional states (Jenkins & O'Connor, 2012). ED patients indeed internalize a primary sadistic object with which they identify in an adhesive way. Thus, a hypertrophic and inaccessible ego ideal is created which inevitably generates profound feelings of shame and worthlessness (Chasseguet-Smirgel, 2003/2005; Kestemberg, Decobert, & Kesymborg, 1972). This can lead to primitive unconscious destructiveness directed at the internal persecutory object that may fuel feelings of impotence, guilt and disembodiment, which can consequently play a pivotal role in the onset of these disorders (Klein & Riviere, 1953; Reilly, 2004). Hilde Bruch's contribution (Bruch, 1962, 1973/1979, 1978, 1988) has undoubtedly been one of the most important in this direction. In Bruch's view, the mother, unable to perceive her baby as a separate other, projects her feelings and needs onto the baby. This could lead to the child disowning the boundaries of the ego from the very beginning of his psychic life, consequently being deficient in constructing his or her body image and unable to recognize and differentiate between enteroceptive perceptions such as hunger, repletion, cold, excitement or fatigue. The lack of appropriate and consistent responses to his or her needs would deprive the child of the basic awareness on which to build his or her own sense of identity. Thus, if the typical developmental process normally implies the ability to read data from reality and create mental representations in relation to the specific context in which the experience takes place (Hampton, Passanisi, & Jönsson, 2011), when significant failures of care occur during childhood, the individual's psychic functioning will develop according to the negative expectations generated by parental neglect and abuse. This may lead to a paralysing sense of inefficacy, loneliness and pervasive anxiety in adolescence and adulthood.

In such circumstances, the ED onset could be a genuine attempt to take care of one's self, a search for a sense of subjectivity and interpersonal efficacy through the control of eating behaviours. In this way, the patient successfully gains a degree of autonomy, although played out only in the realm of eating. In fact, as Lunn and Poulsen (2012) point out, ED can be understood as specific strategies of affect regulation, linked to an inability to contain, metabolize and mentalize affects. On the one hand, the anorexic patient tries to manage her affects through a rigid control over contact with the external world and 'no-entry

defences' (Williams, 1997). On the other hand, the bulimic patient accepts greater contact with the outer world (Willner, 2004), even though this could lead to the emergence of unbearable affects that can only be managed by their being alleviated or destroyed through bingeing and vomiting. In the first case, affects are denied and evacuated, whereas in the second they are cyclically owned and disowned (Lunn & Poulsen, 2012).

Affect dysregulation as an outcome of a developmental process

The initial dimensions of a newborn's self are mainly bodily and physiological (Stern, 1985). If the emotional experience is pre-symbolic and driven by innate motivational systems, the formation of more complex psychological states actually requires the child's emotional responses to be empathically interpreted by caregivers.

Therefore, special attention should be paid to the relational processes that have structured the mental representations of the experience in ED patients and the intrapsychic and interpersonal strategies these patients use for affect regulation, as their psychosomatic integration and personal identity will be based on these variables.

There seems to be a legacy of relationships with emotionally neglectful caregivers who were unable to foster self-awareness and the natural assumption of affects as an activity of the ego. This faculty enables individuals to grasp and assess environmental and bodily conditions – as well as psychic objects – as integrated configurations (Rayner, 1991/1996). In other words, the earlier the trauma, the harder it is for individuals to find accurate memories capable of bearing witness to what really happened within their early child–caregiver relationships. Moreover, the earlier the trauma occurs, the rawer and more archaic the defence mechanisms are, and the deeper the negative impact is on development (Schimmenti, 2012; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Vanderlinden, Vandereycken, Vandyck, & Vertommen, 1993). These early experiences may not be symbolically signified through words, but they are not lost. They are kept in areas of the mind separated from those where memories are codified, stored and reused.

Parenthetically, neuroscientific research has demonstrated that we can count on two different memory systems with different functions. The first, called explicit or declarative memory, can be retrieved consciously and verbalized; through explicit memory, the individual's history and personal experiences can be reconstructed. This memory system involves the medial temporal lobe, the frontal-basal areas, the hippocampus and the amygdala. The amygdala, in particular, plays a pivotal role in the emotional aspects of memory and can modulate its codification and storage at the hippocampus level. Implicit memory, instead, seems to involve the amygdala, the basal ganglia, the cerebellum, and the posterior temporal–occipital and parietal areas of the right hemisphere. As structures and circuits involved in explicit memory mature later than those

in implicit memory, the memories of early childhood are codified in the areas responsible for implicit memory, and make up an early unrepressed unconscious nucleus of the self (Mancia, 2006).

When the dyadic regulation fails in infancy, the child is likely to develop some behavioural disorders that may also concern his feeding habits. The earlier the trauma, the stronger the chance for the child to develop a dysfunctional eating behaviour, as feeding is the primary organizer of a child's mental life and the primary means of communication and relation (Bion, 1962).

The dysfunctional patterns of interactions between the child and his or her caregivers tend to exert serious consequences on the child's mental and behavioural functioning, and his or her ability to regulate affective states (Schimmenti, 2012; Tronick & Beeghly, 2011). The psychic wounds caused by the caregivers' abuse and neglect may indeed give rise to a kind of psychic laceration that could make these children less capable of adequately facing and coping with the unavoidable sense of anxiety and helplessness brought about by the painful events to which they might subsequently be exposed. In support of these assertions, many neurobiological studies confirm that early experiences of abuse and neglect produce major changes in the network of cortical and subcortical neural interactions, which remain 'stuck' in the traumatic stimuli (Ford, 2005). This often occurs precisely as a result of inappropriate caregiving and parental misattunement with the child (Granieri, 2011a).

In terms of technical theory, the clinical work on personifications (Gaburri, 1992) that takes place during therapy sessions is unavoidable with these patients. The analytical work on early experiences does not emerge as interpretive work based on verbal associations. The mere presence of a verbal level is not enough for obtaining useful insights and for giving voice to the emotional configurations that are pre-verbally rooted. Sometimes, interpretation alone may be harmful, not because it is wrong in itself but because it is far from and alien to the patient's emotional reality.

Meeting patients 'beyond words' (Seganti, Albasi, & Granieri, 2003), through a type of communication that takes their experiences of body and self-states as they resonate in their intersubjective exchanges into account, allows the patients to enhance their mental states, starting with the body and the bodily affective resonances. We need to go beyond what the patients say in order to embrace how they are saying it (Bion, 1962; Borgogno, 2008, 2011), helping them to create new symbols and integrating both the newer and the older representations into a 'polysemic bundle' (Harrison & Tronick, 2011).

Mind–body splitting in ED psychoanalytic treatment

As already mentioned, one of the possible outcomes of affect dysregulation is the development of a dysfunctional relationship with the food.

Patients who develop ED often do not have a proper sense of relational competence. The presence of neglectful or abusive parents implies an alteration

in psychic and somatic development, compromising the boundaries in the self. Such primary interactions interrupt the subject in a psychic state permeated by primary defences. These defences often lead the psychic life to an impasse in which the internalized objects are experienced as confusing and harmful.

These profound turbulences regarding self-perception and relationships with the world find a sense of continuity in the way in which ED patients represent their bodies, which retain traces of the implicit memory of something that happened during infancy and early childhood.

Mind–body splitting marks a deficit in the ability to integrate the symbolic processes and to mentalize the bodily experiences: this is expressed through unbearable anxiety, perceived as a source of threat to the integrity of the self. Specific to ED, splitting on a psychic–somatic level makes the body a safe place for withdrawing into a psychic retreat in which patients could try to protect themselves from intrusive attacks by dysfunctional objects (Schimmenti & Caretti, 2010; Steiner, 1993). The advantage of withdrawing into psychic retreats is that the psychological suffering is directed at the interpersonal relationships: the patients put their overwhelming states of mind and unbearable bodily states in a deeper and safer place within the self. While it is necessary for borderline patients to repeat certain ideational and relational patterns so that they can feel their own existence, the psycho-somatic split in the ED patients emerges as a somewhat exasperated method of finding a way of maintaining relations with an object without being invaded by it.

Sometimes, ED patients attempt to neutralize some of the aspects that allow them to ratify the relationship with an external object, making the body insensitive to the demands of an external world perceived as dreadful. At the same time, the body maintains its role of container, in which the access to the other (as the access to food) may or may not be permitted. The omnipotent experiences that make up the internal world of ED patients create a sort of ‘substitute covering of affects’ that operates by denying the importance of interpersonal relationships in order to avoid an even more intense mental suffering related to traumatic memories and dreadful mental states that might threaten a precarious narcissistic balance (Bleichmar, 2004). In some ways, the body is two-dimensional, with a ‘second skin’ (Bick, 1968) that creates a sort of ‘defensive armour-plating around the personality, a carapace [...] an impervious barrier’ (Willner, 2002, p. 129) that attempts to protect the self from disintegrating by means of ‘pseudo-independence’ (Bick, 1968). Bromberg (2001) postulates indeed that ED patients appear to be thoroughly dominated by overwhelming physiological and affective states, as they have had no opportunity to turn to emotionally close and accessible caregiving figures during their development.

Therefore, ED symptoms can be seen as an attempt to find shelter from both the inner and the outer world (Williams, 1997). Sure enough, the feelings of despair these patients experience are not easily reachable, because they are encapsulated in their body and their disordered eating, even though body and eating behaviours are disembodied and desymbolized (Birksted-Breen, 1989;

Lavender & Freedman, 2002). In ED, the body has been deprived of the dimensions of pleasure and desire, constantly forced by compelling needs and demands into impulsive and compulsive eating behaviours or, on the contrary, into obsessive and hyper-controlling dietary restrictions. For these patients, the body is an antireflective object, the repository of overwhelming states of mind and unbearable bodily states.

It can be said, therefore, that symbolization of bodily experience (Seganti et al., 2003) is a factor which should be taken into account in the treatment of ED patients. In order to achieve an authentic elaboration of the emotional experience that would also lead to a better psychosomatic integration, it is essential to work with patience and endless sensitivity on the integration of feelings of shame in the self (Franzoni et al., 2013; Kilborne, 2002; Lewis, 1971; Schimmenti, 2012; Wurmser, 1981). As it happens with many patients suffering from somatic complaints and medical conditions (Leanza, Passanisi, & Leanza, 2013), particular focus must be given to experiences of bodily shame, which is the shame felt in relation to one's exterior appearance and to one's own body image (Lightstone, 2004), as well as to existential shame, which can be defined as shame about the fact that we exist (Wille, 2013).

Therapeutic work with ED patients is exacting and calls for extreme patience and sensitivity. The clinician has to take care of an infantile ego stuck in its very first steps towards integration. Through clinical work, patients can fill the gap between who they truly are and who they came to personify in order to please their internal objects. Step by step, they can start to feel integrated and contained in their own skin. The analyst must hold the body in high regard and help these patients give it meaning, through careful and attuned listening to its specific language.

The case of Mark will help describe many of the above-mentioned dimensions in the psychoanalytic work with ED patients.

The case of Mark

Patient description and case formulation

Mark is a 28-year-old, black-eyed and tall young man who walks with a stoop.² He was sent by a physician for analysis. He has been in a four-sessions a week analysis for two years and his analysis is still in progress. The sessions take place on the couch in the analyst's consulting room. The verbatim transcriptions presented in this paper are drawn from the analyst's process notes.

As Mark reports in the first five consultations, he suffers from severe depressive states and lasting feelings of hopelessness. His personal history reveals the presence of depressive symptoms with frequent cyclical episodes of non-self-induced vomiting.

Mark is an only child; his parents divorced when he was in his teens and he currently lives alone. He has regular contact with his mother and occasional contact with his father. His mother has a prominent job in the field of healthcare and she is an intellectually talented woman. His father, a man who was violent at

times and was subject to sudden mood swings, had demanded special obedience and respect for himself and his family of origin. Also, his father continually devalued his mother, often negatively comparing her physique and looks to other women, and doubted her qualities as a mother. His mother was very attentive to Mark's scholastic performance and devoted much of her free time to following his progress, but her husband deciphered this behaviour as a desire to be the best and thus admired.

During the first year of analysis, both Mark's family and the context in which he lived were described as becoming progressively negative. Everybody eventually disappointed him: his mother, his grandparents, aunts and uncles, his teachers and so on. Their inaccessibility and unpredictability prevented him from developing trust and from considering them as a secure base. Hence his attachment to caregivers was severely hampered.

The picture of Mark's childhood that gradually emerged included a father unable of being physically close to his wife and son, yet very concerned by raising a family that matched his internalized patterns and values, starting from his humble cultural origins. Mark's mother was unable to express her own identity, values and aspirations while engaging with the masculine gender: a mother silenced by her husband's stiffness and by his tendency to respond with violence whenever refuted in any way. Mark was mainly interested in any kind of external stimulus that would make him feel alive and equal to his peers, rather than being in contact with his psychological and physical conditions.

At first, Mark seemed very low-key when describing his severe mental pain and his intense need for help. A phrase he repeated continuously was: 'Please help me, I can't bear it any longer, you're my last hope.' However, a demanding and critical attitude towards the clinical setting emerged later on.

Showing poor contact with his infantile aspects, Mark usually tends to describe himself in a grandiose way within the various situations in which he is the key player. For example, when taking part in friendly swimming competitions, in his fantasies he pictures himself as a champion. When attending a gym, he imagines himself as a bodybuilder who would 'take a break' from training only to go to his analytical sessions.

On the countertransference level, the analyst feels a sort of tyrannical projection of neediness and omnipotence (Reilly, 2004).

In my life I always get by alone. In these long days when my knee was so painful I was always in my bed in the evenings, with the pain getting worse and worse. My mother was always in her flat on the floor below. I think my mother and my grandmother made a mistake when they went to book the scan for me and indicated the wrong leg ... I know this way of behaving very well: I myself unplug the switch and plug into, or better still, move around in situations without thinking.

His relationships become packed with aggressiveness, excitement and anxiety, which cannot be shared and properly regulated. In a sort of crescendo, the anger felt overwhelms his psychic life and bursts out in repetitive behaviours in which syncopated vomiting becomes a sort of punctuation in the recounting of his

suffering, also during his sessions. Everything is performed during a constant toing and froing to the bathroom, in which Mark seems almost ashamed of exposing the analyst to the sight of him vomiting, although in doing so he forces her to be a part of these procedures, to the extent of occupying the time of her next patient. The analyst is obliged to 'remain there' and countertransferally begins to experience profound anger and feelings of 'not being able to take any more' of such a situation.

During the sessions, the analyst often felt burdened (like Mark's mother) and becomes the container of Mark's unbearable psychic pain.

Course of treatment

The atmosphere and clinical material produced in the first months of analysis were a foreshadowing of the themes that would be repeated again and again. The verbal exchanges in the sessions presaged what would happen between the analytic dyad in an increasingly psychological violence. These were often highly coloured verbal examples of the type of violence heard in the chants screamed by certain extremist football fans in the stadiums.

Therefore, the climate was completely different from that of the first meetings: whereas Mark seemed talkative and able to move toward mental representations of relationships in the first sessions, he later exhibited a repetitive ritual which included his quick way of entering the room and a shorter use of the time available, often inserting long silences between his words. This behaviour can perhaps be linked to his need of being controlling and in control. Sometimes, he would pose direct questions, asking for help with several 'urgent' issues; at other times, he would rail against figures that had changed over time (e.g. his mother, his father and his teachers). It all seemed like a sort of plea produced in a state of trance rather than a choice of topics to be communicated to the analyst.

The relationship with his body was a key indicator of the quality of the contact the patient had with himself. Suffering from a congenital foot ailment, he was obliged to use crutches several times during his life. For a long time, Mark had denied his physical condition. Only later, during late adolescence, Mark decided to undergo serious physical rehabilitation.

In his first year of analysis, Mark sheltered himself in a cocoon. Acting out, both at physical level (such as his recurrent arrival on crutches to the session, or vomiting for days to make his sickness more credible) and at verbal level (the way he talked to the analyst during the sessions), became a method by which Mark attempted to force the analyst into a relationship different from the psychoanalytic one. Those behaviours were still painful for the patient but certainly more familiar to him. Indeed, experiencing unfamiliar relationship models in the consulting room has been a cause of pain and violent anger for Mark due to his feelings of inadequacy.

His breathing appeared regular but very shallow; his belly sometimes seemed immobile. The image of pre-term newborns, who sleep long hours during the day

in a very deep sleep and in a rather fixed posture, often came into the analyst's mind. Mark's posture would change in the sessions that followed a vomiting episode that had taken place earlier at home: in these moments he became almost obsessed with seeking a position on the couch that 'would not fold his stomach'. If this happened, the pain would induce him to vomit again.

As the analytic work progressed, a thaw in this routine script occurred and he would return to those behaviours only when experiencing extremely disturbing feelings.

The way in which the patient recounted his early dreams was also significant: this happened most often just before the sessions were about to end, leaving both the analyst and Mark without any free association; also, Mark had a sort of magical thinking that the analyst, as if she was looking into a crystal ball, could unravel in real time those wildly impulsive images, thoughts and feelings that were always expressed in such dark tones like an archaic nightmare. It soon became clear that Mark was neither capable of thinking about his dreams, nor of internalizing their meaning. When describing his dreams, Mark's recurring sighs, long silences and tears seemed to announce an imminent emotional breakdown:

I am with you in the corridors of my high school. It's strange that no one is surprised by your presence. I show you the school; you don't say anything, but I feel that you have agreed to visit the school with me. We go towards the exit. After you leave, I find a picture of you in my hands and this makes me feel good. At this point my Italian teacher, Mrs. R., comes up to me, and I'm happy that you are no longer here, so that I don't have to introduce her to you. While Mrs R. is approaching, your picture, or better 'your image', appears like a tattoo on my right leg (the one with the weak knee).

Thus, it was easier for him to dream about adequate relationship in terms of adhesive process, as in the example of the picture of the analyst on his leg.

In the next session, Mark arrives on crutches. He says he injured the same knee by going to the gym; he also nearly fell on the stairs in the entrance hall coming to the session. He says: 'I feel as though I'm in a coma,' followed by an intense silence. Then he speaks at length about a phone conversation he had had the afternoon before with his teacher Mrs R. She appears uninterested in the football matches that Mark is enthusiastically describing to her in the hope that she will offer to go with him; however, she unexpectedly invites him to go skiing with her. Mark declares:

What a disappointment! My knee is so bad. I'd already told her about it shortly before. How upsetting, talking for talking's sake . . . I never say anything just for the sake of saying it . . . And skiing was something said by Mrs R. just for the sake of saying it.

It is like his disappointment about the conversation with Mrs R. has suddenly evoked some early experience: the feeling of not being seen or heard by the people he loves, and the feeling of not being accepted for who he is, for what he says and for what happens to him.

In the following session, there was another dream:

We were walking, you and I, along a beach at dawn; the sea on the left was very calm and the colours were beautiful. It was impossible to hear what we were saying but it was obvious that we were communicating. I had an arm around your shoulder and you were supporting me with your other arm. We each had the other in mind, otherwise we would have stumbled. If I knew how to paint without having a photo in front of me I would paint a picture.

It was very difficult for him to freely associate, and he wanted some words by the analyst: 'I like it when you talk to me; slowly I feel better, I don't really know what happens, but I feel something happens.'

Mark established with the analyst an adhesive and 'hasty' transference (Washington, 2009). On the one hand, Mark could not really meet the other's mind, he could only imprint the analyst's image into his own flesh like a tattoo; on the other hand, in his fantasies, there were little borders between the self and other people, and over time the experience of borders between him and other individuals, especially the analyst, became so indigestible that he had to vomit.

This was a sort of deadly combination. The analyst thought, a bit fearfully, that she was asked to become his legs. In fact, on the countertransference level, the analyst felt that Mark had progressively tried to devour her. The analyst's actual contours have faded, and in Mark's mind he was a privileged patient who could ask for anything.

For example, Mark finds it very difficult to accept that the analyst does not grant him sessions at his request during the weekend, or that the consulting room is closed for two months in the summer, which allows sufficient time for patients to plan their own holidays.

He fully knows the rules of the clinical framework but if his anxiety overflows for any reason, then the analyst becomes a figure 'within reach' inside him who surely would not refuse to 'have a chat'. In his mind, the analyst has to satisfy all his needs, even beyond the limits of the sessions, for fear of inciting angry reactions. When the analyst brings up the Christmas holiday, Mark explodes: 'Bloody hell! Excuse me! You know that I think you have every right to relax . . . but bloody hell! Look, I'm talking to you and smiling, maybe even laughing out loud . . . But bloody hell, I really can't swallow this one!' The session is about to end, so the analyst does not mention the violent stance in the room, but she comments: 'The idea that we must separate during the holiday period makes you terribly angry.'

In the following session, the patient says:

I've thought about Friday's session and said to myself: 'Go fuck yourself! I come here four times a week, I try to tell you everything I feel and what I don't say I leave out, not because I want to but because I don't know how to say it . . . And you, at the end of the session, shut the door and who knows if you even remember who I am. It's not my fault if I get close to people and like to spend a bit of time with them. This happens to me, but not to others! Your holidays . . . I was really shocked . . . I can't bear the thought of needing you and you are not here. If I get close to someone I want to do things together with that person, spend time together.'

This script is repeated every time before a separation occurs: whenever an interruption is communicated, Mark replies first by imploring, then by presenting a volley of unbearable problematic situations that profoundly modify his mood while the analyst is absent. During the holidays, Mark is physically ill many times, demonstrating a particular somatic fragility: vertigo, high temperatures, pain in his knees that totally immobilizes him, and intolerable back pain. His mind is full of the darkest fantasies, is prey to the most profound inability to think. His anger is not recognized and expressed through his body. Finding no way out, his anger makes the body burst. The list of ailments is incredibly detailed: all his organs and systems in turn seem to be inflamed, and the tone of his voice is most sinister.

Together with the patient, the analyst tries to work through the idea that if the analytic dyad becomes able to 'unstick' Mark's false layers, it perhaps may find the 'original' Mark, the one about whom the patient talks and who is very alive, a sort of bizarre and distant internal object. In order to succeed in this difficult work, it is necessary to give time to the psychoanalytic work, without being tempted by quicker solutions. The analyst thinks that Mark was often perceived by his relatives as a xerox conforming to the stereotype of the 'good child', a child who cannot take into account his original attitudes, desires and relational dispositions.

The lack of providing an environment led to an infantile ego with reduced strength: despite his age, Mark still needs for someone to really look after him and with due continuity. For a long time, this happened with the analyst too, until Mark eventually succeeded in developing a deeper awareness of his states of mind.

In fact, Mark has a limited number of real friends; his romantic encounters are brief and unhappy and most of the time leave him disappointed, unsatisfied, tormented by a fantasy of being abandoned and destined to be left alone for the rest of his life. At the same time, the individuals who relate with Mark feel like they are prisoner of his relational plot. When the patient is not embodying his character driven by 'refreshing' grandiose fantasies, the dreadful and dangerous condition of a child at the mercy of adults may come out: he feels lost and doomed to play the role of victim with no chance of redemption, transferring to the analyst the task of containing his anxiety (Borgogno, 2004, 2011).

The analytical frame has often been polluted by persecutory anxiety (Willner, 2002): as details emerged in the sessions that showed an even more archaic, primitive way of functioning, the analyst feared the patient might breakdown and self-harm.

This is illustrated by a recurrent dream in which Mark is running to find the way out of his family members' homes:

I'm in a room with other people and if I continue to remain there I will be in danger. This time I manage to say no: I escape and realize that we are in my paternal grandmother's house; I look out of the window to see if and where I can throw myself so that I don't fall into a dangerous place. I can feel people catching up with me though, and in any case I jump. I fall into emptiness, but haven't hurt myself.

Close by I see my jeans and t-shirt. People are looking out of the window and I make faces at them and say 'Best wishes, best wishes, my crappy friends.' I don't know what to do to escape these dreams. At times I've even thought of you, in the sense that inside me I was wondering who I could call on to help me.

On these occasions, the analyst also experienced the same sense of defeat and danger that Mark so often felt in himself. The analyst chose to communicate with minimal 'communicative acts', especially when the patient was most gripped by persecutory anxiety. This helped 'punctuate' the relational space during the sessions and, little by little, within Mark: few words that would help him sort out whether he had come to the session in a certain mood or if that mood had been triggered in the consulting room by something that the analytic couple had or had not said. It was a work on the quality of feelings, on the importance of recognizing when, where and with whom such feelings had been experienced (sometimes by the patient on his own, in the absence of another individual, but still in the wake of his traumatic relational memories).

For example, the patient recounts that when he was little, while he was in his father's arms playing and jumping up and down, he had had a bit of an erection. His father had turned to his wife and had commented: 'And they say that children aren't sexual.' His father's comment had made Mark feel deeply 'exposed', and in the session the analyst was superimposed onto the figure of the father who had exposed Mark each time she highlighted anything intimate or private. On the countertransference level, the analyst's rêverie was that she had to play a difficult game of pick-up-sticks, engrossed in a constant and attentive search for the right stick to move, the right words to say, and the right time to say them, with the constant fear that moving the sticks in the wrong points or at the wrong times would result in the collapse of Mark's self.

The core of the analytic work was a psychoanalytic listening to the unsayable things and the ability to find the necessary time to talk about them together. Silences must be calibrated but sympathetic and interrupted only when needed by short, neutral sentences aimed at fostering the continuity of the work together.

A mental space of this kind has been internalized by the patient slowly but progressively, to the extent that the analytic dyad could draw on it in the darkest times of the analysis. This allowed the analyst to feel a bit more comfortable about her role and about the patient's psychic survival.

Mark can now think about his own growth within himself: an intense growth process understood as a path that includes a starting point and a consequent journey, which, of course, requires effort, determination and even passion, but which offers the opportunity for new experiences (Borgogno, 2008). Mark's attitude towards his job in the field of public relations has also changed in this direction; his absences from work due to illness have decreased as he has become more able to disclose the emotional dimension of some of his discomforts and can subsequently live with them.

To get sufficiently stabilized to these new relational patterns took a lot of hard work. There are still sessions in which Mark expresses his need for an intensive,

almost adhesive attention. These were the times when he discussed material in a drawling voice, in a kind of whisper, due to a total lack of energy caused by excessive vomiting, that compelled the analyst to physically lean forward to hear him and that risked both of them falling asleep or closing their eyes. Eventually, it was possible to naturally recognize that, at times, it had been extremely meaningful for Mark to be able to rest in the consulting room, free from any feelings of guilt for the time wasted, distancing himself from his need to devastate himself and his surroundings.

In the relationship between the analyst and the patient, these transformations were accompanied by constant negotiation, which was not always explicit, in order to distinguish between what belonged to the analyst and what belonged to the patient. In this way, the patient came to the understanding that his needs and desires cannot be spread like wildfire in the surrounding space. Also, his feelings of deep rage towards others slowly turned into a more tolerable sense of discomfort.

The reason why he needed to act out in order to quickly achieve his goals now becomes clearer: blind and numb to the pain caused by relational failures during childhood, he had just wanted to leave his history of failures behind him. The tyrannical rule 'I think it's like this, so it's like this' had always prevailed among the adults around him: this had created an abusive and neglectful atmosphere that was difficult for Mark, the youngest and most fragile person in the family. It is all about restarting, when needed, from 'Mark the child' and acknowledging his need for friendly, supportive people who see all his peculiarities and attitudes, yet let him experience things and grow up.

The analyst is present in the patient's thoughts with more stable features now, although always assailable if the stressful conditions intensify and his need to possess becomes more pressing. Unlike in the past, however, it is now possible to discuss it together without the patient being overwhelmed by nameless dread (Bion, 1967) which, as he used to say, was manageable only by vomiting and experiencing the resulting sense of freedom.

Although Mark's determination to learn to think for himself is very strong, the glue that binds him to his past and to his childhood is equally intense; a difficult and painful journey led to this awareness. Some inner spaces remained hidden for a long time, full of unbearable and unspeakable content. Mark's attraction of escalating violence and extreme relational situations has slowly faded and he now feels the need to move away from memories and images of the past in which he had been the protagonist of nothing but destructive experiences.

Mark is now able to think about what makes him feel good and he tries to achieve feelings of well-being by choosing the places to stay, the food to eat and the people he is willing to spend his time with. He still does not have many friends, but those he deems as such are people he can trust. He lacks a stable relationship with a woman but he often says smiling: 'I won't lose my hope, though!'

Some aspects concerning Mark's relationships with other people are slowly changing. For example, he can now cherish personal desires about the potential qualities of his ideal woman. Perhaps by giving himself more time, he might be

able to find her. This could well happen if Mark can see not only his valuable qualities but also his flaws, which he has learned to keep in mind a little better. In Mark's fantasy, there is something particularly meaningful in the encounter between two people, but his personal history and his developing ability to represent it have not yet turned such encounters into sharable experiences. This lack of a meaningful meeting of minds (Aron, 1996) likely have been at the core of his request for analysis; over time, this lack has adopted the shapes of depression, anorexia, and whatever else could sound frightening and worrying in the imagination of Mark and his family.

One of his last dreams describes the patient's experience so far:

I was in the mountains at the end of the day, when the ski-lifts stop. I was at the end of a road in a car and I realized that I would probably have to turn back because I had taken the wrong road... I don't remember well... By my side was a friend from elementary school who turned into a friend from high school and then my friend G. I began to back up the road looking in the rear-view mirror, in which I saw a certain number of cars arriving. The disturbing thing was that if I turned around to look at them with my eyes, I saw many more. In the mirror even the road seemed wider; with my eyes, it seemed very narrow. In some way we got to the top. There were many roads but G. and I knew which was the right one. We had to wait some time though because we had to pay an entrance fee and then wait for the fixed times of the timetable.

Mark's excitement in telling the analyst this dream was palpable. Driving backwards down a dangerous and busy road led the analyst to think that there might be again a risk of collapsing; but Mark succeeded in associating the rear-view mirror – which provides a different image from the one obtained when looking directly at the object – with the function of filtering his family's desires and wishes for him from his own desires and wishes.

Today, Mark understands very well that using his eyes without any filter tires and frightens him. However, a road that requires 'waiting some time' and for which it is necessary 'to pay an entrance fee and then wait for the fixed times of the timetable' indicates a more stable sense of trust. In a free association during a session following the dream, Mark says:

I like to think that the road in the dream of the rear-view mirror (the one with the entrance fee and fixed times) may be a road that will make me more toned and fit regarding the opportunity to use my perceptions with greater serenity.

Today, the analyst feels that although Mark can begin to think about trust and self-confidence, he is far from having a concrete understanding about how much work is needed before he can experience it. There is still much work to do with Mark. However, the analyst is heartened by his relative freedom from anger and his new confidence about carrying out plans on both a professional and an affective level. He is a young man who is extremely frightened by the feminine world, but not to the extent of thinking of himself as a homosexual in order to avoid women. He is starting to mourn for his father: feelings of sadness for the way things have transpired between them are beginning to emerge.

Discussion

Over time, the analyst gained a deeper understanding of Mark's extreme need to be recognized, accepted, and helped in his personal and relational growth. It was very difficult for Mark to accept that the psychoanalytic journey would basically deal with words and, indeed, he repeatedly demanded that it should be about action as well. All this exposed the analyst to feelings of intense countertransference. Mark relentlessly asked for proximity in order for him to understand those split feelings that he had not been able to think about. The analyst first had to think those feelings for him, without dwelling on their content. Instead, by means of small and constant interventions, she steered the patient towards becoming responsible for anything that was not represented in his stories.

The clinical material was sometimes repetitive and stereotyped, at other times it was marked by a destructive anger directed towards himself and other people. Starting from feelings related to bodily sensations, the patient and the analyst became with time able to share experiences regarding the profound lack of harmony between Mark's body and mind.

The analyst clearly perceived Mark's tendency to act, or make others act, rather than to think, especially at times when he felt unable to keep in his mind/stomach the thoughts/food that could be thought/digested (Borgogno & Vallino, 2011). For a long time, Mark was not able to do anything about his reactions and emotions except let them occur. Only now the possibility of thinking about them appears more stable.

To conclude, the clinical work was based on experiencing the need for a real emotional availability and attunement, experienced day after day. With patients like Mark, the countertransference should be constantly monitored, otherwise the negative feelings would likely lead the analyst to experience a lack of closeness to these patients at the exact times their trauma is enacted in the consulting room.

Clinical implications

Closer examinations of the desire for a repairing object in ED patients may lead to a deeper understanding of their feelings of loneliness, guilt and shame. This may help ED patients with exploring and more cohesively integrating their mental and somatic states. At the same time, an inquiry into the developmental roots of these unsayable feelings within a clinical relationship, where communication can convey, beyond words, a sense of confidence and interpersonal validation, allows these patients to assign a meaning to their own life and history (Granieri, 2011b; Schimmenti, 2012). In doing so, the patients can relocate their symptoms to a more comprehensive frame in which they can look at themselves as individuals with unexpressed needs and with emotional deprivation. Often this emotional deprivation during childhood gave rise to their symptoms. This is the reason why psychoanalytic work on early experiences, so fundamental for the psychic development of these patients, does not turn out to be a work of interpretation

through verbal associations: memory is kept in the body (Ferenczi, 1932/1988) and it is precisely through the body that memory will manage to find its way out.

Today, cognitive–behavioural therapy and drug treatment are the most common approach for ED in the public sector (Halimi, 2005). However, ED and related disorders are associated with a deficit of affect regulation (Taylor, Bagby, & Parker, 1997/1999), thus patients suffering from ED may largely benefit from intensive interventions (such as psychoanalytic treatment). In any case, even in the public sector, these patients may benefit from a careful analysis of their mental functioning and their affect regulation abilities, regardless of the severity of their symptoms (PDM Task Force, 2006). Also, the growth of a psychoanalytic culture in the public sector would be beneficial, because it can promote effective treatments which are not merely aimed at symptom reduction but increase the patients' emotional awareness and their ability to regulate affects; psychoanalytic knowledge may also inform any clinical assessment concerning the quality of the patients' internal experience (e.g. level of security, self-esteem and internal standards) and their ability to develop a therapeutic alliance.

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