This paper argues that anorexia may be understood to be a particular kind of autistoid psychic retreat: a defensive withdrawal to a primitive enclosed part of the self that has been damaged by early infantile trauma, the result of a disruption to the mother–infant pair. This damage can be envisaged as an enclosed ‘cyst’ or ‘tumour,’ defensively ‘sectioned off’ from the rest of the individual’s psychic life. When a patient takes refuge in an autistoid psychic retreat she is typically experienced as emotionally ‘cut off’ by others, including her psychotherapist, thereby making it difficult to establish and maintain a ‘living’ therapeutic alliance. The resulting countertransference, a crucial diagnostic tool for establishing the existence of an autistoid retreat, simultaneously challenges the therapist with a range of unsettling feelings that require processing in order to access the anorexic’s inner world. The case of a female adolescent anorexic in psychodynamic psychotherapy will be presented. There were two distinct phases in this therapy, the second phase suggesting emergence from the autistoid retreat. This material will be used to illustrate autistoid dynamics and their implications for treating such patients.

Key words: adolescence, anorexia, autistoid, countertransference, eating disorders, projective identification, psychic retreat, psychotherapy

Introduction

Drawing on case material from the psychotherapy of a female adolescent anorexic patient this paper suggests anorexia as a particular kind of autistoid psychic retreat (Nissen, 2008; Steiner, 1993) and seeks to examine the relationship between ‘autistic/oid states’ and anorexia in an attempt to advance understandings of autistic/oid phenomena (Tustin, 1978). Although a few authors have suggested such an overlap, presenting patients who display both an eating disorder and an ‘autistic barrier’ or ‘enclave’, none have explored how common this pathological configuration is or what the precise relationship between anorexia and autistoid psychic retreats might be (Barrows, 1999; Farber, 2008; Mitrani, 2007; Tustin, 1986). This paper is not concerned with the prevalence of autistoid retreats in anorexia but rather with the manifestation and function of these dynamics in anorexic disturbance.

An autistoid psychic retreat can be understood as a defensive withdrawal by a predisposed individual, during any stage of life and for any period of time, to a primitive, enclosed part of the self that has been damaged as a result of early infantile trauma (Mitrani, 1992; Nissen, 2008; Tustin, 1981). This damaged part of the self can be envisaged as an enclosed ‘cyst’ or ‘tumour,’ defensively ‘sectioned off’ from the rest of intrapsychic structure (Klein, S., 1980). In the psychoanalytic literature this sort of structural manifestation is referred to as an ‘enclave of autism’ (Tustin, 1984), ‘autistic barriers’ (Golden & Hill, 1994) or ‘pockets of autistic functioning’ (Innes-Smith, 1987). These terms are used interchangeably to describe defence mechanisms, very much like those
documented with ‘autism proper,’ within the personality structures of some neurotic or narcissistic adult and adolescent patients (Tustin, 1978; Klein, S., 1980). The terms ‘autistic’ and ‘autistoid’ are used synonymously (Nissen, 2008) in the case of adult and adolescent autistic/oid states (Tustin, 1978). Despite the variation in clinical picture, almost all authors agree on a common origin: autistoid pathology is the result of some traumatic impingement on the mother–infant dyad, occurring in the earliest, presymbolic stage of life (De Cesarei, 2005; Innes-Smith, 1987; Mitrani, 1992; Tustin, 1981), prior to Melanie Klein’s (1946) paranoid–schizoid position.

The paper begins with the case of an adolescent anorexic patient including the first phase of her therapy. This is followed by a theoretical discussion of the countertransference, origins and role of secondary skin formations in autistic/oid states. There follows a detailed consideration of the second phase of therapy including an analysis of the clinical material. The paper concludes with a discussion elaborating upon the author’s argument in relation to the relevant literature.

**Case Material**

‘Amy’ has been in once weekly psychotherapy for just under two years but has recently started to come twice a week. There have been two quite distinct phases in the therapy; the first phase, spanning roughly the first year, was marked by a dyadic fusion in the transference–counter transference whereby I was drawn into an involuntary collusion with her autistoid retreat. The second phase has seen a shift towards a more triadic dynamic characterised by increasing room for each of us to think (Aron, 2006). This shift can be mostly ascribed to two important occurrences: the patient’s positive experience of hospitalization and the impact of supervisory input. Both of these have opened up a more productive therapeutic space. More will be said about this in due course.

Amy, the only daughter and second child of her unhappily married middle-class parents, was born about 18 months after her brother. Her parents were experiencing significant conflict in their marriage at this time and father was frequently away on business trips leaving mother alone with their two young children. When father was home, the couple fought frequently and on occasion father had struck mother. Although the physical fighting stopped when Amy was about five years old the marriage seems always to have been marred by hostility. Recently the couple have begun divorce proceedings and Amy’s father has left the parental home.

Before proceeding with the case material it is necessary to address the fact that this paper focuses more on the role of Amy’s mother than on her father or the role of domestic violence due to the pre-oedipal nature of Amy’s disturbance. This does not imply that I regard mother as the sole cause of Amy’s anorexia; certainly many factors were significant. Unfortunately, it is impossible to fully interrogate all the contributing aspects in one paper.

Amy began to develop anorexia towards the end of her first year of high school. She had, as usual, excelled academically but a quarrel and subsequent betrayal by her best friend caused her to become withdrawn. Although not
overweight, she gradually reduced her food intake whilst exercising compulsively. She had the idea that she was “chubby” and that if she lost weight things would be better. She did this to the extreme and was briefly hospitalized a year later at a very low weight. She stayed for only a week because her tearful pleas convinced her parents to take her home against medical advice. Amy’s parents agreed to take her home on condition that she promised to cooperate and get well. Mother kept her out of school for three months and the pair seemed to resume a quasi mother–infant nursing relationship in that Amy was mostly on bed rest with mother at her side, making sure she ate each carefully measured morsel. From the accounts of both, this regressive ‘honeymoon period’ was mutually satisfying. Amy felt secure that she had her mother hovering over her attentively and her mother was gratified by her seeming ability to restore her daughter to health. However, after gaining some weight, mother’s careful ministrations eased off and Amy returned to school. Quite soon after, the anorexia waxed again.

A few months into the relapse, mother had to acknowledge that help was needed and Amy was brought to me for therapy. Amy’s mother was able to tolerate my having a special relationship with her daughter as long as she was able to have access to me as well. This access took the form of periodic phone calls and text messages, usually to ‘tell on’ Amy, that she “wasn’t trying hard enough” or she “was being difficult and hostile”. I think she imagined I would admonish Amy in our next session. These communications were met with my polite but consistent refusal to talk about Amy which decreased but did not prevent mother’s attempts to make contact with me. Notably, Amy’s mother was steadfast in her commitment to her daughter’s therapy and would be quite put out by my infrequent breaks. While I was away during the first such break of three weeks, towards the end of the first year of therapy, Amy’s weight dropped to a predetermined level which all had agreed would necessitate re-hospitalization. On my return I was informed that she had been hospitalized in the eating disorder unit of a psychiatric hospital. Mother’s curt, accusing tone seemed to convey that my ‘dereliction of duty’ had contributed to her daughter’s relapse.

Amy returned to therapy three months later. She told me that in hospital she had initially found it hard to settle but had then started to feel nurtured by the consistent care and predictable routine. She made friends with two eating disordered patients and these friendships, established within the facilitating hospital milieu, gave her an experience different from the superficial friendships with her schoolmates. With these hospital friends she felt she had something to contribute; she had become someone whose opinion could be valued and this affirming experience seemed to allow for a tentative movement towards separation and individuation. This was observable in that she began to cautiously seek out friendships at school and to express the wish to live a normal life like her peers.

These were new, hopeful developments; however, after returning home, Amy became distressed again by her parents’ continual fighting. The old restrictive eating patterns resumed and most of the weight gained in hospital was lost.
Nonetheless she retained something of an improved capacity for object relations which was evident in therapy. It was as if something of the experience had been able to penetrate her defensive encapsulation and, after her return in the second year of therapy, she was never quite as ‘cut off’ as before. This positive shift was almost certainly augmented by my decision to take Amy’s case to supervision. However, before this important turning point is described, Amy’s original ‘cut off’ state in the first year needs some elaboration.

First Phase of Therapy

This period saw me struggling with a transference–countertransference dynamics where I was almost chronically unable to think. Amy would give me an ostensibly participative, albeit sanitized rendition of the week’s events, recounted in soft, even tones. Emotion was rarely allowed in. During our sessions it felt for me like we were both stuck in clay, as though we were trapped, immobile and helpless, in our chairs in the room for the duration of the session. I sometimes thought to myself that our sessions viewed from the outside by an observer would look like therapy but from the inside it felt like all life and possibility had been sucked out of the room and I often experienced a profound sense of hopelessness at ever helping this patient. During our sessions it often felt as though I had been given a sedative, causing me to become sleepy, my mind felt shut down and I battled to enliven myself and to harness my ability to analyse what was happening. The therapy seemed to be controlled by powerful, anaesthetizing, unconscious processes that I felt unable to resist or understand. Yet, on the surface, this tiny, quietly spoken, beautiful wax-doll of an adolescent seemed anxious to please and was quite passive.

Her bland material was peppered with accounts of her mother’s intrusive-ness, which she revealed despite herself it seemed, admitting that these disclosures made her feel guilty and disloyal. These disclosures felt to me like the only real material in the sessions yet rather than being able to interpret my countertransference feeling that she might be seeking some sort of fusion with me, I enacted it, feeling inexorably drawn into a dyad with her against her mother. I felt very protective of her, wishing to take her to my breast, to cocoon her. It was not until I took Amy to supervision that my supervisor’s ‘third position’ afforded the triadic space to see what was happening between us (Aron, 2006). The enmeshed dyad of the therapeutic situation seemed to mirror the mother–daughter fusion noted by Bruch (1974) where separateness had to be denied. We were like two overlapping surfaces with no space in-between, a state termed ‘adhesive identification’ by Bick (1968) and Meltzer (1975).

Another significant aspect of the countertransference during the initial phase revealed itself before our sessions. About half an hour before sessions I would feel an intense, even panicky hunger. After grappling with this strange experience I came to understand that this was probably the result of some kind of projective identification from Amy. Once again Bruch’s (1974) work was enlightening in this regard; she noted that eating disordered patients experienced hunger sensations in a distorted way and appeared to confuse hunger
with other signals of internal distress due to some deficit in the mother’s attunement to her infant, including her baby’s shifting physical and emotional states. Without a mother to ‘translate’ such states for her, the infant cannot distinguish between psychic and somatic sensation. This confusion leads to feelings of anxiety because she is unable to understand or discern various feelings and sensations. Bearing this in mind, I wondered whether Amy’s needy feelings, which she experienced as a sort of hunger, were being put into me in the sessions. Prior to recognizing and understanding this I experienced it in an immediate and unmodified way.

In addition to my needing to eat before the session, as if preparing for a fast, I would also ‘arm’ myself with interpretations I thought I needed to make, which ostensibly should have been possible because in almost all of the sessions her material was quite similar. However, as soon as I was in the room with her I struggled to connect with the ideas I had had just minutes before. It took a great deal of my mental strength to try to recapture my ideas and turn them into a communication worth making. In turn, any interpretation that I was able to make during this phase of the therapy was met with superficial agreement but never taken up, rendering the interpretation and my presence useless. Her verbal responses were appropriate at the level of content yet I had the feeling that my utterances ‘bounced off’ her, never seeming to penetrate into the deeper layers of her psyche. Our fusion paralysed the therapy; neither of us could take in nourishment and grow and the ebb and flow of object relating was arrested. It felt as though the two of us were participating in a static ‘thing’ called therapy where we each had predetermined and unproductive roles to play.

Although my words were barred real access, it seemed that she drew some sort of relief from our sessions. After a time I came to understand that Amy was ‘sticking adhesively’ (Bick, 1968) to the ‘surface’ of the therapy which for her was as much made up of the contents of the room as by me and my interpretations. Eventually her experience in hospital, coupled with my supervision input, brought about a turning point in the therapy. Before discussing this second phase, the parental feedback sessions need be considered.

As is customary in work with adolescent anorexics, there were occasional parental feedback sessions, always conducted with Amy present and with prior agreement about content. The purpose was to set up a process whereby Amy could begin to communicate her difficult feelings to her parents. These sessions were discontinued after the first year due to their undermining effect on the therapy. Father remained silent unless I or mother as unsolicited co-therapist asked him a direct question. His answers were vague and un-insightful. However, his concern was evident in his nonverbal responses, his anxious expressions and his shifting uncomfortably in his chair during difficult moments. In the first such meeting, a few months into the therapy, mother described her daughter as intelligent, cold and undemonstrative. She despaired at Amy’s social withdrawal and reserved personality. According to mother, Amy’s intelligence had been evident from the start but she was always a rather shy and reticent child – “Just like her father.” I learned that the subtext of this
description alluded to the dyadic binaries of mother–son and father–daughter; it was the family narrative and all seemed to accept it. The two pairs were distinct even in physical appearance: blonde, blue-eyed Amy closely resembled father while brother apparently looked like their Mediterranean mother.

Indeed by all accounts mother had found it easier to parent her son while she and Amy seemed to have always struggled to connect. It seemed that brother had, for whatever reasons, managed to get the best of mother and Amy the worst. Father had always been emotionally distant from both children.

Mother described her daughter as “hard” and “steely” and that “nothing gets to her,” remarks that I found to be dramatically at odds with my own countertransference of Amy. At times during the therapy I had been struck by her exquisite, excruciating vulnerability. In a session where she had seemed particularly fragile, my reverie drifted to a friend of mine who had been terribly burned in a fire. His burnt skin rendered him completely unable to endure the outside world; in order to survive his whole world had been reduced to his small artificially regulated hospital room. Amy felt to me like something of a burn victim too – so vulnerable and psychically skinless that even the slightest impingement would be intolerable. In sessions I would often sit with feelings vacillating between disquiet and despair, unable to imagine how she (like my burned friend) could ever bear the rough-and-tumble of life should she emerge from the rigid haven, the autistoid psychic retreat of her anorexia. Anorexia, like my friend’s hospital room, provided her with a reliable structuring container: her rigid routine was all consuming, it meant that socializing was kept to an absolute minimum while only an ever-narrowing range of ‘safe’ foods was permitted, eaten at specific times. Her illness seemed to offer her a way, possibly the only way, to survive.

Amy’s ‘frozen’ presentation in the first phase of therapy, corroborated by mother’s description of her, led me to wonder whether she might be in some sort of psychic retreat, specifically an autistoid psychic retreat as described by Tustin (1978) and S. Klein (1980). My feelings were strengthened by her realization that: “It’s like I have this shell around me and I want to be by myself and do things for myself but I know it’s not good for me and I should let other people in to help me.” In the context of that particular session in the second phase, I felt she was expressing her readiness to let me in a bit more which I interpreted. This led to the consideration of twice-weekly therapy which had been a possibility for some time but she had had to reach a point where she felt able to take this up.

**Theoretical Contributions**

**The Role of Countertransference in the Diagnosis of Autistic/oid States**

Considering the complexities involved in the apprehension of autistic/oid states, most authors agree that close monitoring of the countertransference is the only way that these states can be identified (Golden & Hill, 1994; Gomberoff *et al.*, 1990). Although autistoid defences manifest differently with each patient, the clinician registers a very particular countertransference reaction to these.
most primitive modes of resistance. This characteristic countertransference experience is thought to be the result of the specific function of these resistances: [They] “function as autistic barriers in maintaining non-relatedness and therefore warding off a common dread, the re-experience of annihilation linked to recognized separateness from the primal mother” (Cohen & Jay, 1996, p. 912).

When describing the nature and quality of these countertransference experiences authors mention a ‘cut off’ or ‘frozen’ presentation, patients who are unwilling or unable to engage in psychotherapy, despite attending their sessions (Klein, S., 1980; Tustin, 1986). They talk but do not adequately communicate, and get their therapists to collude with their powerful nonverbal defences so that a status quo of deadness in the therapy prevails. Typically the therapist feels frozen out, disconnected from the patient and experiences profound numbness, hopelessness and despair (Cohen & Jay, 1996; Gomberoff et al., 1990; Klein, S., 1980). Interpretations have little emotional impact and, although therapy continues, psychological movement is arrested. This description of a typically autistoid transference–countertransference seems reminiscent of the therapeutic experience with many anorexic patients; indeed, it would appear that these two psychoanalytic bodies of theory describe similar transference dynamics (Bruch, 1978; Farrell, 1995).

Autistic Encapsulation

A psychoanalytic understanding of how such an encapsulation might arise goes as follows; after the dramatic caesura of birth, described by Freud (1926), the infant’s world ceases to be defined by the amniotic sac and she requires, without knowing that she does, the mother to set up as gentle a transition to post-uterine life as possible. Due to an undeveloped ego capacity, all that the infant encounters in her earliest days is not experienced as outside herself, but as the boundary of herself. The absence of the secure boundary after birth leads to the infant’s other primary need, and that is for ‘holding’ which is crucial for the development of primary integration described as the “indwelling of the psyche in the soma” (Winnicott, 1960a, p. 589). This postnatal infant idyll is well captured in Bick’s (1968) image of: “the nipple in the mouth together with the holding and talking and familiar smelling mother . . .” (p. 484). In due course the infant internalizes a feeling of an ‘amniotic sac inside’, a secure boundary or psychic skin that separates self and other, inside and outside (Bick, 1968; Meltzer, 1975; Winnicott, 1960a).

Initially, according to Bick (1968), ‘the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively by the skin functioning as a boundary’ (p. 484). In order for this boundary function to be internalized, the infant must be able to introject a containing external object. This relies both on the object’s being adequate and the infant’s capacity for introjection, which is absent in some disorders such as autism proper (Meltzer et al., 1975). Identification with the containing function of the object modifies the primary unintegrated state and allows the fantasy of internal and external spaces (Winnicott, 1960a). It is the concept of internal space that is the necessary precursor to
normal adaptive splitting, projection and projective identification (Bick, 1968; Mitrani, 1996).

Unfortunately, this optimal situation is not the lot of all infants. Various authors have considered the reasons for developmental disruption to the mother–infant pair. Inevitably, there is a premature confrontation with that which is undeniably outside the self (Cohen & Jay, 1996; De Cesarei, 2005; Tustin, 1978). Being separate is not conceivable for the infant at this early stage; she experiences her mother’s eyes, hands, breasts, as indistinguishable from her own body (Winnicott, 1960a). Any failure by the mother will be experienced as the loss of part of the infant’s own body which impinges massively upon the infant’s inchoate self as an overwhelming trauma (Tustin, 1981; Winnicott, 1960a). Tustin (1981) called this event a “premature psychological birth” and proposed that such a trauma would lead to “unbearable terrors” (Tustin, 1986, p. 127) of falling or spilling out, associated with feelings of unintegration (Bick, 1968; Meltzer et al., 1975; Mitrani 1996). It is against this apocalyptic landscape that an autistic barrier or enclave may develop as a defensive shield against that which threatens to destroy the infant’s psyche (Klein, S., 1980; Tustin, 1978).

Developmentally, the infant’s normal unintegrated state would not have been anxiety provoking (Bick, 1968; Tustin, 1978; Winnicott, 1945); however, in the case of a premature psychological birth, extreme anxiety is aroused without mediation and this becomes associated with the unintegrated state, transforming it into overwhelming helplessness. Thus, normal unintegration becomes malignantly imbued with overwhelming primitive terror and this is the content, the autistic nucleus, within the autistic enclave.

The Role of Secondary Skin Formations in the Development of Autistic/oid Defences

The infant, desperate to survive psychic annihilation, begins a frenzied search for a containing substitute fragment–object, selected on the basis of its sensory stimulation, which provides an artificial experience of self-cohesion. This could be a light, the mother’s voice, her smell or a sensual object to cohere her fragile state, if only briefly. This is known as a ‘secondary skin’ formation (Bick, 1968), a pathological yet essential substitute. According to Symington (1985), ‘substitutes’ or ‘defences’ available at this developmental stage comprise of autistoid shapes, objects and delusions which operate to enclose the unmentalized experience of devastating loss and unbearable longing for the object (Mitrani, 1996; Tustin, 1986). Winnicott (1962) conceived of these self-generated cohesive ‘substitutes’ or ‘defences’ as being the product of a precocious mental development, whereby the infant’s defensively escalated omnipotent fantasies allow her to use her inchoate mentational processes to “take over and organize the caring for the psyche-soma” (Winnicott, 1962, p. 61); normally this function is fulfilled by the mother. Winnicott’s idea of precocious mental development will be taken up in detail further on; first it is necessary to clarify the nature of pathological ‘substitutes’ or ‘defences’ in order to convey their ‘autistic’ quality.
As is the norm in this auto-sensual stage, hard and soft objects prevail. According to Tustin (1980), soft objects are any pleasant sensational experiences that are comforting and calming for the infant, whereas hard objects are the reverse; they represent hard edges and the feeling of a firm external boundary. In both autism proper and autistic states, the traumatised infant turns away from mother and retreats to sensationally imbued autistic shapes and objects and self-generated sensations for comfort rather than to the mother and normal transitional objects (Ogden, 1989a, 1989b; Tustin, 1980; Winnicott, 1962). Bick (1968) proposed that this “temporarily holds the parts of the personality together” (p. 484). These self-generated sensations give the infant some comfort from terrors that Tustin (1986) described as “preverbal, pre-imaginal and preconceptual” (p. 23). These autistic manoeuvres serve as a protective shell against the horrifying awareness of separateness, ‘the terror of two-ness’ which is synonymous with a terrifying sense of dissolving into nothing, spilling, falling forever (Bick, 1968; Tustin, 1986). I believe that Amy’s body functions as a sort of hard object to bind her anxieties (this will be explored in detail further on).

In neurotic or narcissistic psychogenic autistic states the withdrawal is not total and a compromised sort of development continues (Klein, S., 1980; Tustin, 1978). Ogden’s (1989a) dialectical theory of psychological development elucidates how this might occur. He proposed three dialectical developmental modes or positions adding what he considered an earlier developmental position – the ‘autistic contiguous position’ to Klein’s (1946) paranoid–schizoid and depressive positions. It is through this, most primitive, autistic–contiguous position that the sensory ‘floor’ of experience is generated. “Each mode creates, preserves, and negates the other” (Ogden, 1989a, p. 4) and each mode has its own distinctive anxieties, typical defences and particular mode of object relations. Mental illness is considered to be the result of a collapse in the direction of one of these positions: he regarded autistoid pathology as the result of infantile trauma during the earliest ‘autistic contiguous’, ‘presymbolic’ mode, envisaging the characteristic defences of this period becoming “hypertrophied” and “rigidified” (Ogden, 1989a, p. 31). This implies that in cases such as Amy’s, where there has been early trauma, autistic–contiguous defences predominate especially during periods of autistoid psychic retreat. However, there is always a dynamic interplay between the three modes; in the therapy one witnesses oscillation between the characteristic anxieties, defences and object relations typical to each mode. I have kept Ogden’s (1989a) theory in mind when formulating the following ideas set out below and, with the benefit of her mother’s account, I have constructed a tentative account of Amy’s infancy.

As a little girl Amy would play with her dolls by taking the role of nurse and bandaging them up and putting them in bed. Mother wondered whether this was connected to Amy’s witnessing father injuring mother. This tragic portrait of little Amy bandaging her dolls suggests an attempt to manage her mother’s pain and her own experience of it, rather than being able to develop freely. Anorexics typically experience great difficulty in introjecting and identifying with their mothers; this is central to the illness (Lussana, 1992; Williams, 1997a).
In Amy’s case, in light of the preceding discussion, I am inclined to believe that there was an introjection of a sub-optimal containing function, as described by Bion (1962a, 1962b, 1970). Such a defective container introjected as a result of the developmental disruption to the mother–infant pair would mitigate against any consistent sense of a space inside and imply significant difficulty with introjection and identification. Accordingly it appears that her relationship with her mother has fusion at its core. I suggest that little Amy’s bandaging her dolls can be understood as a concrete enactment, a defensive projection of part of her fused maternal introject, a wounded mother–self, outwards onto the dolls. She then omnipotently bandaged the dolls and thus did not have to be in touch with her vulnerable damaged mother–self. She became the nurse helping the wounded mother–dolls.

It seems that Amy’s bandaging of the dolls is a reflection of an autistoid secondary skin formation, the bandages representing a cohesive binding substitute to prevent the ‘spilling out’ of her wounded mother–self which I suspect would have been experienced as the threat of annihilation. This splitting off and disavowal of the wounded mother–self, which seem to have included the disowning of her female body, together with her experience of her mother’s early failure to contain her and possibly maternal intrusions into her, have made it impossible for her to identify with her mother in a wholesome, uncomplicated manner (Lawrence, 2002). This complicates the anticipation of womanhood and motherhood. How could she live comfortably inside a womanly body? Femaleness has been tainted with victimhood, intrusions and intrusiveness and the terrifying unintegrated state.

Her profound anxiety about what it would mean to become a woman was evident in her terror of menstruation, an event that has not yet occurred. This anxiety became apparent after she had gained some weight in hospital and was told that this would in due course lead to the establishment of her menstrual cycle. She told me that she started checking her panties obsessively during the day for the ‘dreaded stain,’ which was how she perceived it, rather than a hopeful portent of fertility. I wondered whether, for her, as the cause of such acute anxiety, menstruation might be anticipated as some sort of raw, uncontained ‘spilling-out’. Unsurprisingly, Amy sees herself in the future as probably not marrying, definitely not having children, and becoming a doctor or a vet.

The foregoing discussion would seem to imply that Amy’s troubled mother could not offer her adequate containment. Such environmental failure seems in Amy’s case to have led to a precocious mental development, a ‘secondary skin formation’ (Bick, 1968) along the lines of Winnicott’s (1949) “pathological mind–psyche” (p. 247) alluded to previously. This pathological structure arises when the environment has failed to facilitate the integration of the “psyche in the soma” (Winnicott, 1960a, p. 589). The pathological mind–psyche is a rigid intellectual defence, precocious mental development used as a way to attain and then maintain psychological control. During the course of therapy Amy’s assurance and pride in her superior intellect and her ability to rigidly control her eating are the only parts of her identity that she seemed sure of. These two cognitive qualities function as secondary skin formations by binding her chaotic
feelings like a truss keeping the rest of a somewhat vague and formless self from slipping out or dissipating. Hence, in line with Ogden’s (1989a) three dialectical modes of psychic functioning, I propose that Amy’s anorexia, especially in the initial acute phase can be understood as a retreat to a prior, rigidified, autistic–contiguous defensive structure.

Second Phase of Therapy
In the second phase of therapy Amy appears to have emerged from her autistic encapsulation somewhat because she is more able to engage and seems to be relating increasingly via projection. Amy has also started to consider the function of her anorexia. In a session she asked: “Who would I be without anorexia?” “It gives me my identity.” “I’ve had it for so long, I don’t know who I am without it.” It seems she has realized that anorexia holds her together, giving her some elementary sense of her self. This is the nature of the secondary skin formation. I replied that it was almost like making a deal with the devil. Experiencing the hunger and deprivation of anorexia was worth it because it offered her an identity and a sense of security. She answered: “Yes, it does make me feel secure.” “It’s like a blanket around me but I know I can’t be anorexic forever because it will stop me from living the life that I want.” This latter statement appears to convey a dawning of the awareness that she must choose between her secondary skin autistic defence, the anorexia, or a life worth living.

Wish for Fusion, Fear of Intrusion
Despite this progress Amy’s adhesive identification is still evident in her constant thoughts about mother which take up much of the space in therapy. This fused relationship seems to fit with Sours’s (1974) hypothesis of a narcissistic mother who treats her anorexic child as a satellite. It follows that the insufficiently individuated satellite–child may well grow up feeling that she is lacking and impoverished with no choice but to stick limpet-like to mother, who both regard as possessing all that is valuable.

In an apparent paradox, Amy often speaks of her intense dislike of mother’s intrusive behaviour. Although I do not doubt her account, she seems particularly sensitive to her mother’s behaviour, readily interpreting it as intrusive. Birksted-Breen (1989) and Lawrence (2002) propose that at the heart of the anorexic object relationship there is the paradoxical desire for fusion and the terror of intrusion. This dynamic is an integral feature in non-organic autistic/oid defences too (De Cesarei, 2005; Gomberoff et al., 1990). Williams (1997b) suggests that anorexics who manifest ‘no entry defensive systems’ do so because they have experienced psychic intrusion in infancy while Lawrence (2002) considers the notion of a genetic intrusive object in females. In anorexia the influence of this object might be magnified due to actual environmental impingement or the mother’s failure to contain her daughter’s intrinsic anxiety about impingement.

The following excerpt illustrates Amy’s anxiety about mother’s intrusiveness. In the vignette she described events that occurred during mealtimes on a recent family holiday that she had taken a friend along to:
Amy: At dinner my mom was irritating me because she eats even after she’s full, even though she wants to lose a bit of weight and get healthier. She said: “Come on, let’s have dessert.” None of us wanted any but she insisted that we have some with her because she didn’t want to eat alone so then finally my dad and gran said they would have some. She often says to me: “Enjoy food, Amy, relax.” But obviously I don’t. She’s joined a gym now but she’s still the same, she doesn’t really look any different.

Therapist: So you’re worried that maybe there’s also a greedy, insistent part of you that’s like your mom, you’re anxious that you won’t be able to control yourself with food and you’ll get bigger and become like her. You have said that your anorexia makes you feel different from your friends but maybe it feels like, if you didn’t have it, you might eat uncontrollably and become fat, so you can’t see how you could ever relax and be normal about food.

A: Yes, I do feel abnormal. Like when we ate breakfast I ordered a sandwich with no butter and when it arrived it had butter. I didn’t want to say anything in front of my friend because she’d think I’m strange so I wasn’t sure what to do. Then my mom saw what was going on and she said: “Tell the waiter that you ordered it without butter.” But I didn’t want to because I get really embarrassed to do those sorts of things but she insisted so I went and he changed it but I was uncomfortable. It’s really spooky sometimes how she can read my mind. Like I’ve had this anorexia for three years and so now she knows exactly what my thoughts are but she says it in front of everyone and it makes me feel really embarrassed that she can know what I’m thinking and then says it out loud.

T: That must feel like she can get inside your mind and expose your thoughts. It’s like the two of you become one person at times.

A: Yes, definitely. Like yesterday she made me eat an egg for lunch because she’s decided that I have to eat an egg a week and I really didn’t want the egg but she insisted and I felt bad about it for like the whole afternoon. Like she forced it into me.

T: So there’s something that feels very intrusive sometimes about her being able to look inside you and expose your secret thoughts but then she can also put things inside you that you don’t want.

A: We have a very weird, intense relationship . . . [Said in a soft, bewildered voice.]

Besides feeling intruded upon, the excerpt illustrates Amy’s fear of being exposed in front of her friend as different. In the second phase of therapy she was able to admit her envy of the other girls at school, believing them to have some privileged knowledge of how to be in the world that she did not. She said she observed them in order to establish how to behave so she could fit in. This ‘adhesive’ device more or less worked for her during the period of simpler peer relationships in latency. However, the more sophisticated object relationships of early adulthood could not be managed this way and her ‘social ineptitude’ – she feels boring and empty – is an almost unbearable narcissistic wound. On the rare occasions that these feelings were faced my countertransference was a sense of helpless desperation, in other words, I was feeling what she was feeling. This was very different from the fused countertransference in the first year of therapy.
Amy’s wish to be normal like her friends was an ambivalently held one, split into idealized and denigrated aspects because it felt like something unattainable, a standard against which she must fall short. Hence her defence against her devastating sense of inadequacy and painful envy was that she would twist the coveted state of ‘normality’ around in her mind so that it came to mean ordinary and pedestrian, in contrast to her special-ness, afforded by her intelligence at first, and then later by the anorexia. In the transference she managed this sometimes by identifying with me as if we were colleagues, judging someone inferior. She often took this role in relation to brother who seems to function as her benchmark of normality. According to Amy the siblings had been close until puberty but had become estranged since she had become anorexic. Amy admitted she had cut herself off from him and he had in turn distanced himself from her. At times she would denigrate her less academically inclined sibling as if we, the superiors, were looking down on him and laughing at his inadequacy. At these times I experienced her as hard and brittle and had a glimpse of her mother’s depiction of her as “steely”. I realized she had inside her both the ‘fragile burn victim’ and the ‘hard steely creature’ and that these formed part of a pathological organization regarded by Steiner (1982, 1987, 1990) as intrinsic to psychic retreats (Steiner, 1993).

The ‘hard steely’ self seems to be comprised of her highly developed cognitive functions and the ‘bony outer casing’ and rigid inner control. These aspects can be understood to have grown out of her pathological mind–psyche and function as a secondary skin, autistoid defence preventing the spilling out of the ‘odd’, ‘needy’ adhesive ‘burn victim’ self. However, this defensive structure also functions as a narcissistic defence allowing Amy to bury her feelings of inadequacy and her envy of people regarded as socially able. Her significant academic success has allowed her to feel superior to mother, brother and most of her peers. However, her fused, confused relationship with her mother and the significant conflicts aroused are also projected onto her peers. This was illustrated in the following dream presented shortly after her father left home:

Amy: I had this dream the other night. I dreamt that I was with this girl Yvonne that I had been with in hospital. We were standing in line with a lot of other girls. Yvonne was normal weight and I was thinner than her. I think she was jealous of me. Then I don’t know how we knew [She blushes as she does when she senses that her dream symbols might be revealing.] I think there was a newspaper article and it was headlines that someone was poisoning the other girls and it had made them lose a lot of weight. Yvonne had poisoned them. I was cross because now they would be thinner than me and Yvonne just did it because she couldn’t lose any weight herself.

Therapist: Well, I’m wondering what your associations are to the dream.

A: I don’t know, I think Yvonne was cross because she couldn’t lose weight and I think that reminds me of my mom, before my dad left she would always phone my aunt and say she can’t lose weight even though she’s trying to cut down what she eats and she’s going to gym. Since my dad left, though, she’s lost about 5 kilos because she says she’s lost her appetite. But I was cross, why did she have to give those girls poison so that they would be as thin as me?
My understanding of this dream which evolved in supervision was as follows. The ‘headline news’ seems to refer to the recent news of her parents’ divorce. Her mother appears as both Yvonne and the other girls. Her envious mother/Yvonne has fed poison (toxic intrusion) to the others girls to diminish Amy’s specialness, afforded by her thinness. However, Amy’s mother is also the other girls. Mother has taken the ‘poison’ of her divorce and has effortlessly lost weight, which angers Amy; poison that allows you to lose weight equals cheating, it is weight loss without the required suffering and dedication that anorexia demands. Also her mother is not sticking to her part of the shared body; she has left their fusion and has found her own impinging, competing body. In Kleinian terms, Amy’s mother has fed herself the poisonous breast that Amy was faced with as a baby, that she now refuses to feed from as enacted by her anorexia. This is the unconscious accusation that Amy’s starvation seems to make towards her mother: “Your poisonous milk is inedible and I could not grow and now everyone can see it and you can’t do anything about it.” In the dream her mother’s poisoning of herself allows her to wriggle out of the anorexic double-bind. She has split off from Amy and has revealed, as Amy has always feared, that she is her daughter’s hostile competitor.

The Shared Body

In her anorexia both the autistoid defences and the narcissistic aspects of her intrapsychic structure are apparent; Amy’s body has become her object but, because she has never separated from mother, her body becomes the battleground where her separation ambivalence is played out (Birksted-Breen, 1989). Amy’s ambivalent fusion with her mother is clear, even in late adolescence, seen in her extreme dependence and intense hatred of her desperately needed mother. Hence Amy experiences her anorexia in a paradoxically competitive and fused dyadic relationship with mother. If she eats enough to gain weight, she feels her mother has won and she has lost because, on one hand, she suspects her mother secretly wishes to fatten her up, to intrude into her concretely with food to make her grotesque. In phantasy this corresponds with her internalization of an envious, intrusive and competitive mother, a poisoning toxic breast, as noted by Birksted-Breen (1989). On the other hand, if Amy manages to stay the same weight or to lose more, she has triumphed over her mother, by keeping her food out, demonstrating her control over this ‘shared body’, the somato-psychic fusion, adhesive identification that defends against terror of separation experienced as a terrible impingement. This is also present in the transference when I struggle to have my own body, my own mind. She has resonated with the ‘shared’ body interpretation in relation to her mother, which seems to have allowed some small measure of progress in that she is not completely starving her mother–self any more and has stabilized at a low weight, rather than becoming thinner.

Discussion

Anorexia can be seen to offer considerable utility as a defence because it serves to reinforce both the narcissistic structure, by allowing her to feel unique and
special, and the autistic enclave against the threatened collapse provoked by puberty. The autistic enclave, like an apparently dormant volcano, is reactivated by overwhelming demands on the ego at this time, threatening an eruption from the cystic encapsulation. The autistoid psychic retreat of anorexics like Amy marks a turning away from the overwhelming demands of the external world. The starvation and bodily obsession are a return to auto-erotism (Freud, 1914) which bolsters the sensate defences and adhesive identification around the autistic nucleus. In this way Amy takes her ego, represented by her body (which she experiences as shared with her mother), as her object and becomes the whole world for herself. Her all-consuming obsession with her body can be thought about as a regression to the first bodily ego noted by Freud (1923).

It is proposed that Amy’s anorexia, and perhaps similar cases, be considered a particular type of prolonged autistoid psychic retreat, one that incorporates the intentional starvation of the body and the manifold associated symptoms. The pre-anorexic infant who survives psychologically via an autistic encapsulation would appear to develop normally for a time. However, the damage becomes evident when she is called upon to leave the safe camouflage of latency and square up to the adolescent challenges of the genital stage (Freud, 1905). Amy’s failure to manage the transition exposes her pre-oedipal functioning and adhesive identification; her incapacity provokes extreme anxiety. The unbearable exposure of her intrapsychic deficit, which she calls her ‘weirdness’, her ‘oddness’, triggers the autistoid psychic retreat I have proposed as likely in anorexia resulting in the continuation of physical and intellectual development but the arrest of psychic and emotional growth.

The physical changes of puberty concretely and somatically mirror her internal chaos. Her body seems to be ‘morphing’ into something alien and uncontrollable, while simultaneously she is overwhelmed by strange new feelings. The anorexic feels increasingly out of control of her life because she lacks a healthy internal object that she can draw on for succour. More and more of her energy is directed towards getting rid of her ‘fat’, metaphor for her scary, intangible terrors. This confusing new world of boys and sexual feelings, breasts and menstrual blood, feels threateningly disruptive, exceeding her psychic capacity. However, she can achieve certainty in one thing: control of her body. In streamlining, taming and conquering her body she creates a simultaneously brilliant and deadly defence mechanism that works against threats both from inside and out. Anorexia allows the ‘steely’ narcissistic part to omnipotently starve her body, thereby controlling and containing the split-off denigrated ‘burn victim’, mother–self. She turns inwards, away from the overwhelming world as she once did from the overwhelming breast. She becomes invested in the absolute control of her body; she starves it, she measures it and she becomes increasingly sado-masochistically caught up in the physical sensations of starvation. She can suppress her gnawing hunger, she can take pleasure in her light-headedness; these are ‘badges of honour’. Her modified body becomes a ‘bony shield’ against her internal chaos. It is maintained under the critical eye of the scale and its less reliable counterpart, the mirror – less reliable because she sees herself in a distorted way. They show her that she is angular and defined, albeit never
sufficiently for her liking. She can never cease her vigilance because she fears her body will explode into anarchy if she ever drops her iron guard. Hence, both the ‘hard’, ‘steely’ part of her and her bony anorexic body can be understood to operate as autistic objects, providing edginess and boundary and thus prevent the spilling out of the fragile ‘burn victim’ self (Joffe, 2009, personal communication). Anorexia can thus be understood as a desperate bid to prevent psychic dissolution. At the level of object relations, her body serves as a warning to others to keep out, as noted by Williams (1997b). Her body speaks simultaneously for the ‘burn victim’ part and the ‘steely’ part, seeming to say: “Do not put your expectations of normality on me for I am both too fragile to bear them but also superhumanly strong so you cannot pity me.”

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**Notes**

1. Unfortunately the issue of domestic violence cannot be explored due to spatial constraints. However, it is my belief that Amy’s early exposure to her father’s physical abuse of her mother as well as the ongoing tension between her parents contributed significantly to the development of Amy’s anorexia.

2. Judith Mitrani (1996) has identified the work of these authors as having been crucial for the subsequent development of the autistoid literature.

3. Ogden (1989a, 1989b) distinguishes between ‘presymbolic’ and ‘asymbolic’ realms. ‘Presymbolic’ denotes a normal stage when sensory-based units of experience are organized in preparation for symbolization proper. ‘Asymbolic’ connotes an abnormal stasis characteristic of pathological autism where sensory experience does not ever become anything more than it is.

4. In therapy, she recalled that as a child she had witnessed her parents’ marital conflict and particularly her mother’s distress. She had been told by her mother that her father had struck her and she recalled feeling that her father was the perpetrator and her mother, the victim.

5. Other authors have regarded thinness itself to be a ‘badge of honour’ for the anorexic (Arnold, 2004; Pipher, 1994) but I use the phrase to draw attention to the pride and satisfaction attained by the anorexic from the physical sensations of self-starvation.

**References**


