ANOREXIA, MASOCHISM, SELF-MUTILATION, AND AUTOEROTISM: THE SPIDER MOTHER

Robert C. Lane

This paper will present a psychoanalytic view of eating disorders and their treatment, particularly anorexia, and its relationship to other self-harm problems, such as masochism and self-mutilation. According to this view, anorexia originates in the childhood relationship with the mother, which leads to difficulties through the psychosexual stages in separating from the mother and developing an autonomous self. The individual becomes self-punishing and self-controlling, expressing her feelings and inner conflicts through her body, either in symbolic meaning, or as a way to discharge tensions, comfort herself, displace mental pain onto the body, purify herself of bodily impulses, or as a way to passive-aggressively seek revenge on parental figures.

THE SOMA

The body and its parts lend themselves to representation and expression, imagery, symbolization, the use of metaphor, and symptom formation. Shilder (1935) believed that “Conflicts choose for their expression organs which have to do with the functions involved in the conflict” (p. 187). How one chooses an organ or part of the body to later hypercathect for use of symptom formation seems to be dependent upon one’s constitution, life’s experiences, the parents, trauma, illness, identification, and the like.

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It is through the body ego that the child experiences and responds to its world and the life space that surrounds it. The ego uses the body, the mouth specifically, orality and eating activity in general, as both the object of the instincts in a drive-regulating manner (Hoffer, 1952) and as a device for the discharge of the vicissitudes of the instincts. One's own body can become the object of a drive or instinctual wish in an attempt to achieve mastery, or, for defensive purposes, the direction of a drive may be reversed, from an external object to an internal one.

Sacksteder (1989) points out that there are people who experience “estrangement and alienation” between their psyche and soma. They may view the soma as hostile or persecutory, the source of embarrassment, shame, and humiliation. The soma may be seen as trying to annihilate the psyche, the psyche trying to ruthlessly control the soma, each persecuting the other, at war with each other, such that a sadomasochistic relationship between them develops. Sacksteder (1989) states that this condition is often exemplified in anorexia nervosa, where the self and the body are seen as distant entities rather than a psychosomatic unity. He says, “rather than being identified with their body, liking it, enjoying it, caring for it, nurturing and developing it, they hate it, and cruelly, unrelentingly attack it” (p. 38). They even starve it to death. Yet, in her withdrawal, the anorectic spends a great deal of time alone with her body. Sacksteder, like Winnicott (1965), believes that the lack of relatedness of the psyche and soma begins with failure in infant care. The mother introduces the baby to soma and psyche, and conveys an attitude to her baby by how she handles her.

When an infant lacks a healthy maternal representation for internalization and soothing purposes, the infant does not have the capacity to differentiate or regulate overwhelming affects or intense bodily discomforts. In addition, lack of consistent care and proper handling regarding all aspects of the baby's body becomes another contributing factor in shaping body dysmorphia. The inability of the mother to provide adequate homeostatic regulation can greatly affect the developing psyche. When the child’s internalization of the maternal caring functioning is experienced as punitive and prohibiting, there is difficulty in ac-
cepting and tolerating one’s affects: “The psychic elaboration of affects is derailed, leaving the soma to bear the burden of psychic expression” (Krystal, 1988). Faulty maternal attunement in the early oral phase can affect the child’s ability to symbolize or put feelings into words. Thus, these patients present with a multitude of bodily symptoms that communicate and speak to their disturbed psychopathology.

We have patients who do not seem to acknowledge our words; what we say seems to fail to penetrate them. In these cases, it is wise to tune in with sensitive attunement and empathic awareness to what was missing in their early years. There is a powerful need to be comforted by their therapist’s words, as they once wished to be comforted by their mother’s body, and to feel emotionally and securely held within the therapeutic space. McDougall (1989) points out the difficulty in treating such patients within the realm of “symbolic space of words and meanings” when there are somatic complaints of various degrees and manifestations. Many of these patients lack the right words for their emotions (alexithymia) and will use their bodies to express the “ejected affects.” In therapy, we must address what was left unspoken, perhaps by introducing precise words that appear to correspond to the patient’s feeling state. Symbolic words can serve to bridge bodily sensations and psychic pain.

ORALITY AND EATING

Oral problems begin with the onset of life, are a primary conflict area from the earliest days of life (eating problems), and are transformed through other areas of conflict, for example, anal, phallic, or genital problems and their derivatives. The need for control, bisexuality, ambivalence, and magical and omnipotent thinking are examples of anality and its derivatives. The phallic phase and its derivatives (exhibitionism and voyeurism), and genital problems and their derivatives all may require greater mastery than oral problems, which are older, more familiar, safer, and provide a much more comfortable base (Ritvo, 1984, 1985).

Ritvo (1984) points out that adolescence is a “fertile period” for the study of body image, body functions, and body intactness in relation to the representation of body conflict (p. 451). He
comments, "Eating can be used for the expression of conflicts over loving and being loved, loving and hating, attacking and being attacked, punishing and being punished" (p. 452). The body and its parts, their shape and size, eating and food intake and output or incorporation and elimination in general, can all be used metaphorically and symbolically to express and represent unconscious fantasy and psychic conflict and defense.

Ritvo (1984) examined seven cases of eating disturbance in adolescence, one male, the rest female. The male's restriction of his eating was described by Dr. Ritvo as, "monastic ascetic, and solitary" (p. 455), more monk-like than typical restrictive anorexic. The women described by Ritvo have a number of traits in common, including a dependent attachment to an ambivalent mother, conflict over bisexuality, broken relationships, rage, and depression. These patients took their own bodies, which are more available to the ego, as the object of the drive in place of some external object. The eating function can become an important factor in the control and regulation of the drives, especially when guilt and shame over pregenital, preoedipal, and oedipal hostile and sexual fantasies are intensified. In their need to attack their bodies, some of these girls would starve or stuff themselves until they obtained the hated or desired female figure. Dieting or not eating represents denying one's appetites and is a magical way of stopping or undoing bodily changes. They try to extinguish or get rid of their sexual hunger by substituting hunger and food for sexual appetite. I view anorexia as a form of both masochism and self-mutilation. Therefore, the background of the anorectic should show similarities to those of patients suffering from masochistic and self-mutilatory conflicts.

THE PHALIC MOTHER

Lane and Chazan (1989) described three symbols—the spider, the witch, and the shark—that represent the phallic mother and her bisexuality. All three of the symbols are oral sadistic: The spider entraps and eats its victims; the witch uses her magic to cast spells over her victims and eats them; the shark emerges from the depths to tear its victim apart. With such a mother, the child feels brutalized, teased, bullied, and beaten. He splits, that
is, he idealizes the mother while taking in all of her undesirable traits. He sees himself as the prime mover of all the world’s evil and fantasizes magically to prevent his annihilation (Bloch, 1978, 1985a, 1985b; Novick & Novick, 1972).

In our paper (Lanc & Chazan, 1989), we symbolized the “killer” mother as a spider mother who is terrifying and many-legged, and who traps, catches, poisons, paralyzes, and kills. Such mothers overwhelm, smother, crush, encircle, engulf, squeeze to death, annihilate, and devour their victims. One must flee from a mother with these characteristics. But, to where can the untrusting child flee? The patients who run from the spider or killer mother often flee to their own bodies, and so the spider (or any other member of the many-legged, clawed, or tentacled family—such as the crab or octopus) also becomes symbolic of autoerotism. These patients who feel crushed, unable to move, paralyzed, have to establish themselves in some manner and do this by being different. This need to be different even manifests itself in their autoerotic practices. They may use other than typical autoerotic practices (masturbation), such as self-mutilation, strange exercises, anorexia, or beating themselves. The killer mother causes gender difficulties, and all kinds of disturbed ideas concerning the girl’s body image and body intactness, as well as inducing sadomasochistic fantasies in the daughter and a sadistic notion of sexuality. These mothers may lack acceptance of female sexuality and organs, belittle men of whom they are envious, and induce excessive dependency and the false self in their offspring, who must avoid eliciting maternal disfavor at all costs.

Their children have strong dependency needs, feel they do not own their own body parts, and display an intense fear of merging, which is seen in negative therapeutic reactions, attacking the analyst, breaking down any sameness, accentuating differences, and needing to be in total control (Lane & Goeltz, 1997). Underneath these defenses are feelings of vulnerability, fears of bodily harm and injury; hypersensitivity, hypervigilance, helplessness, and excessive concern with survival and death. They remain close to the mother, sharing her pain and suffering as an adaptation to their pathological relationship.

The similarities between the mothers described by Asch
(1971, 1988), Bloch (1978, 1985a, 1985b), Lane and Chazan, (1989), Lane and Goeltz (1998), Lerner (1991), Lerner and Lerner (1996), and Novick and Novick (1972, 1987, 1988) are striking. These mothers are described as neither able to repair mismatches with their babies, nor handle their offspring's normal hostility or explorative drive.

I wish to distinguish between Andre Green's "dead mother" (Kohon, 1999) and the "killer of spider" mother I am describing. Green's "dead mother" syndrome follows some trauma to the mother (e.g., an object loss of severe narcissistic injury) in which she becomes depressed; shows little interest in the infant; exhibits feelings of emptiness, loneliness, and despair; and gradually decathects the child. The child in turn decathects the maternal object, while also identifying with her. Whereas Green does say that decathexsis "is an act of murder," this murder is the result of a lack of contact, or relationship (Kohon, 1999, p. 5). In contrast, anorectic patients are murdered by hypercathexis. These mothers are literally all over the child, highly intrusive, excessively controlling, enmeshed with their offspring, so that boundaries are blurred: they are angry ladies who suck the blood out of their daughters, or squeeze them to death.

MASOCHISM

In the paper, "Identity Confusion, Bisexuality and Flight from the Mother" (Lane & Goeltz, 1998), we summarized the masochistic boy's situation as follows:

- The presence of an oral sadistic, annihilating killer mother, and a father who is absent or pathologically weak when present.
- The mother's externalization of anything unwanted onto and into the child, including infantile and negative affective states, helplessness, feelings of failure, and lack of impulse control. The child splits, idealizing her on the one hand, and accepting the mother's discards on the other. Everything that causes her pain and suffering is taken as his own, denying both her murderous rage to him and his murderous rage to her at each level of psychosexual development, turning his anger against him-
self. Safety resides in staying tied to mother and her pathological symptoms.
• The more rage he feels, the greater he sees himself as evil and wicked, resulting in greater masochism, pain and suffering, and greater grandiose, narcissistic, magical, and omnipotent fantasies to control the environment and escape annihilation.
• The absence of mother–child boundary differentiation leads the child to believe that the mother owns both his soma and psyche, that he and mother are one, and any self-destructive masochistic behavior is an unconscious attack on mother as well as himself. These children deny hostility directed at the mother at each stage of psychosexual development, and adapt by way of a “false self.”
• The threatening nature of the mother and pathological helplessness of the father produces an identity confusion and a struggle with bisexuality in the child due to confusing interaction in the roles.
• The child’s avoidance of pleasure and success and the necessity for suffering and pain are in the service of maintaining the pathological mother–child relationship, while retaining the state “of being special.” They experience events magically, and feel they are the prime movers or cause of all events. Their need to control their environment is overwhelming.

If “successful” they are no longer special. By feeling helpless and dependent they can maintain their special relationship with mother, who reinforces these feelings, and they can continue to feel magical and omnipotent in the service of controlling their feelings. Their masochism continues to fuel their omnipotence. Success, which is associated with destructiveness and hostile triumph over others, represents the annihilation and destruction of their love objects and is forbidden to them.

The Novicks (1987) “essence of masochism” is the fixed beating fantasy these masochistic boys seem to exhibit. Masochistic impulses are organized around fixed beating fantasies serving multiple ego functions, which resist modification in treatment. There is a reunion with their principal object through pain and suffering, which is a defense against the loss of the object.
The beating fantasy has a complex structure. The drive is determined from all levels of psychosexual development and is composed of both preoedipal and oedipal components, but principally preoedipal. The child accepts the blame for everything bad in his life. Although the problem is with the mother, the father is usually the one who beats the child in the fantasy. There is a quest for pain, humiliation, and suffering in the transference. Countertransference feelings can be the first clue to the oncoming sadomasochistic relationship. There may be greater sarcasm, impatience, and inappropriateness on the therapist's part. This may lead to heavy-handedness in response to patient provocation (Lerner, 1991). There are patient threats to quit therapy and battles over who is in control. The beating fantasy is the thread that links the various psychosexual fixation points which must be dealt with in the transference.

There is a delusion of omnipotence which may take the form of a wish to be the other sex, superboy, spiderman, and the like—a sense of personal power in the service of controlling the environment. These patients do not accept reality and cling to delusions of omnipotence. All of Lerner's (1991) masochistic patients, similar to the Novicks' (1972) masochistic boys, had delusions of omnipotence. This ego defect significantly interferes with reality testing, as there are both fragile defenses and a deficient superego.

The mother's lack of empathic mirroring and the formation of a healthy holding environment creates the need for an all-giving, all-knowing therapeutic mother. Maternal impingement (the spider mother) leads to pervasive passivity of the ego, highly receptive and compliant behavior, the development of a false self, and an active pursuit of pain and failure (Lerner, 1991; Novick & Novick, 1987). The intrusive, impinging object has failed to hold or mirror the patient, unable to answer the infant's cry for help. The false self is a self-protective response to premature separation anxiety. Maternal impingement can lead to an identification with mother's pathology, a reaction concerned with feeling hopeless, incompetent, and ineffective. Patients are turned away from their natural preprogrammed capacity to relate (Lerner, 1991). Patients through their own sense of power, magic, and control feel they are the responsible party.
The hostile feelings to the mother are denied, the patient not wishing to give up the feeling of being mother’s chosen one. There is a lifelong difficulty in sleeping and being alone, fear of losing control, and separation and annihilation anxiety. Pain and magic are mutually dependent on each other, while the experience of pleasure, especially sexual pleasure, represents their greatest threat.

ANALITY AND CONTROL

In writing a paper on the role of the anal and rapprochement phases in anorectic girls (Corn & Lane, 1997), the profile of the anorectic masochistic girl has become significantly clearer. In still another paper (Lane & Goeltz, 1998), we pointed out, “If the [girl’s] attachment to the mother is too strong and boundary differentiation too weak, the girl cannot renounce the pre-oedipal object and turn to the father” (Greenson, 1968, p. 305). An overly enmeshed relationship or a highly sexualized relationship with the mother can be detrimental to the gender identification and heterosexuality of the girl in general. In the Corn and Lane paper (1997), we attempted to point out the large number of anal character traits manifested by anorectic girls and their desperate struggle to emancipate themselves from a controlling mother.

Anal training is a “powerful experience around which intrapsychic processes and interpersonal relationships coalesce”; it is “the time when the child must learn to comply with external pressure” and “struggle between the instinctual impulse and compliance with the demands of an autonomy-robbing environment” (Corn & Lane, 1997, p. 282). This training highlights the conflict between “narcissism and object relatedness,” the symbiotic oneness of the oral stage and the autonomous strivings of the anal stage. The rapprochement crisis occurs during this phase. An overcontrolling mother, however, does not want her little girl to move away from her, stressing the need to stay close to her. This is accomplished by emphasizing orderliness in the form of conformity, compliance, obedience, punctuality, and perfectionism. She may overstress “being good,” and that “cleanliness is next to godliness.” The mother induces guilt and shame,
and threatens the child with separation and loss of love. In the child, these feelings of unworthiness and shame are avoided by the emergence of the "false self." Maternal control is not to be challenged. The negative "no" is perceived as an insult to mother, as well as disobedience, denigration of mother's authority, and the destruction of her perfectionism.

Indeed, the mothers of classic restricting anorectics have been described as domineering, overprotective, intrusive, and discouraging of separation/individuation, either overtly or subtly (Bruch, 1980; Crisp, 1980; Johnson, 1991; Podhoritz, 1997; Steiner-Adair, 1991). The mother is said to encourage enmeshment and often responds to her child according to her own needs rather than the child's, treating the child as a narcissistic extension. This enmeshment prevents the development of a cohesive sense of self, or self-regulation, encourages dependency, and frustrates autonomous independent action. Thus, despite intrusive overconcern, there is neglect and inhibition of important aspects of the child's functioning. There is relatively little pressure to disrupt this mother–daughter symbiotic attachment until the arrival of puberty with its new demands to individuate and accept greater female responsibility.

Sacksteder (1989) describes the restrictive anorectic mother as infantilizing, angry, given to holding grudges, unpredictable in criticism and praise, displaying oscillating affect, pleased by complete submission, guilt-producing, questioning the perception of others, and narcissistically self-absorbed (p. 42).

In summary, these mothers do not encourage independent action in their daughters, discourage autonomous thinking, and prevent age-appropriate spontaneity and normal assertiveness, thereby frustrating the emancipation or individuation of the child.

Mayman (1963) broke down anal configurations into retentiveness, expulsiveness, and sublimations or reaction formations. Under retentiveness, he included willful stubbornness; withholding; defiance such as refusing such as refusing to eat, take a bath, or go to bed; passive–aggressive noncompliance or an inability to produce what is asked for or expected. Under expulsiveness, he included hurting oneself or others by destroying them or treating them like dirt (vilification of others, spitting, demean-
ing, throwing things, pushing others away or distancing them), or being the object of vilification (being treated like dirt). In defense against all these aggressive feelings, reaction formations develop, such as "being good," doing what one is supposed to, avoiding conflicts with coercive parents, excessive attention to cleanliness, and a preoccupation with one's own or another's possessions, with emphasis on quantity, orderliness, and ownership. Mayman (1968) saw these negative anal features as characteristic of anorectic patients who are stubborn and willful. However, they also are fearful of the mother's rejection, and therefore need to be good, clean, and obedient, which leads to the formation of the "false self."

All three of Freud's anal character traits—orderliness, parsimony, and obstinacy—(Freud, 1908) are represented in the behavior of the female restrictive anorectic. Parsimony is seen in the restriction of affect, the emotional tightness, the closing of the mouth, mind, and body openings. The need to keep in and withhold is also reflected in the hoarding of family secrets. Obstination is seen in the anorectic's persistence, stubbornness, general refusal to listen and eat, and sadistic delight in making others have to clean up.

In the child's relationship with the parent, normal reactions and erotic wishes are either punished for, or not given an opportunity for expression, resulting in disturbances in the pleasure economy between mother and daughter, with a mutual lack of pleasure. These pleasures include the child's self-assertive "no" and enjoyment in both retaining and eliminating (the gratification of practicing the use of muscles to hold on to or let go of). Other gratification includes the normal protest against the primary caretaker, oppositional behavior in general, and the development of a sense of mastery. In the relationship with an overcontrolling mother, the child is forced to swallow feelings, such as anger at being controlled, resulting in the squelching of autonomous strivings and the frustration of normal self-assertiveness. This frustration leads to the coexistence of opposites such as being both kind and cruel, taking both sides, and the heightened ambivalence and bisexuality of the anal stage. The mastery of normal anally driven behavior, such as the search for power and magical and omnipotent thinking, is compromised.
Although we have concentrated on the anal phase, the control struggles, and the object-relatedness crisis associated with it (Mahler, 1968), difficulty first occurs at the oral phase (Ritvo, 1984, 1985), resulting in a fixation on food and eating. It is in the early oral phase, in which closeness and bonding to the mother occurs, that feeding becomes a pleasurable activity for both parties. All subsequent phases are markedly influenced by what happens in the early oral phase. The mothers of anorectic girls have difficulty handling each successive psychosexual stage in their daughters, with fixations and character traits remaining from each. Lack of attunement in the first oral phase can lead to angry feelings and the wish for revenge in the oral sadistic and later phases. The anal phase with its numerous battles for control offers many opportunities for acting out. Each psychosexual stage brings new problems with it.

THE FATHER

The father appears to be much less involved in the problem of anorexia. However, fathers of anorectic daughters are often absent, unavailable, or when present emotionally preoccupied. In a paper titled “The Role of the Father in Anorexia” (Fitzgerald & Lane, 2000), we attempted to outline where and how the father does fit it. The father appears to be important in the girl’s dealing with her dependency, perfectionism and expectation of high achievement. His presence is particularly necessary with the onset of puberty when his daughter needs his affirmation. When she moves from childhood to womanhood, it is imperative that he does not pull away from her as she matures and develops sexually, and that he is supportive as she goes through the socialization process in our patriarchal society. She needs his support at every level of development, particularly at puberty. Most important would be a loving and mutually respectful relationship with the mother.

In addition to unsatisfactory family eating experiences, the anorectic girls report that their fathers were absent, and their parents did not get along; he did not intervene as the mother stifled the girl’s attempts at independence and her explorative drive. In general, his role is described as “weak” or “absent” as
the facilitator of the girl’s independent strivings. The role of fathers has been found to include emphasizing success and achievement, and having high expectations, as well as teaching and explaining. With adolescence, there are new challenges and demands and the father is needed as a facilitator to help solve unresolved conflicts. His role is critical to the daughter’s acceptance of her feminine role. Any rejection of her new body at puberty can have disastrous results. Fearful that his wishes to love his daughter might be seen as incestuous, he may remove himself from her, causing her to feel rejected and to reject her body. The girl may feel that father stopped loving her, or that she has to be thinner to be loved, causing her to diet or control her food intake. In our culture, girls learn that being thin brings popularity, influence, and power.

Selvini-Palazzoli (1974) argued that the changes occurring and expected at puberty are “overwhelming” and “engulfing” to the maturing girl (p. 90). Crisp (1980) also emphasized that the anorectic girl was ill prepared for the psychological and biological demands of puberty, and that the anorexic symptom returns the girl to a prepubertal state. The elimination of secondary sex characteristics as a result of the symptom helps the girl to avoid dealing with both sexuality and separation, as the symptoms encourage further enmeshment and attachment to and by the mother. The symptoms are adaptive as they protect the girl from the demands of maturity for which she is ill prepared. The manipulation of her body weight permits the girl to control her body and the timing of puberty.

EATING DISORDERS AND SELF-MUTILATION

The diagnoses most associated with anorexia are depression, masochism, and obsessional personality (Rothenberg, 1986, 1988, 1990). These diagnoses share in common emotional constriction, a feeling of being closed off, tight rigid defenses, concern with control, restricted movement, rich fantasy associated with hostility, the inability to assert oneself, with much repressed anger and rage, fear of reprisals, wish to mess up or destroy, anxiety about feeling dirty, and no clear sense of self.

Lerner’s article (1991) beautifully describes the symptoms
of his masochistic patients with subclinical eating disorders (eating disorders that do not quite meet rigorous criteria for anorexia/bulimia). These patients are very similar in their childhood histories to the anorexic patients I have described in this paper. Lerner says, “In all of my cases [referring to his masochistic patients] the natural narcissistic need for empathic mirroring by a caring agent has gone seriously awry and cannot be integrated into the developing personality” (p. 116). The lack of “good enough” mothering during the symbiotic phase, and the marked and significant disturbance in the pleasure economy from birth between mother and child (Novick & Novick, 1987) have frustrated the child’s basic need to be noticed and responded to. The unresponsiveness, distractedness, and aloofness of the mothers to the child’s real needs, and their externalization of the unwanted onto the child, is crucial to the development of pathology in their children. The many interferences with the establishment of the infant—mother preprogrammed empathic relationship include the failure of mirroring experiences, seen as both a negative impingement and trauma (Winnicott, 1965); the disruption of cohesiveness, self-regulation, continuity, self-harmony, and self-definition; and the “development of premature defenses, which crystallize into a false self” (p. 117). Although, these patients are intelligent, verbally advanced children who achieve academic success and display athletic interest, Lerner claims that their successes bring little sense of gratification. Some of the features of Lerner’s patients are hypervigilance, feelings of vulnerability, a fragile self-esteem, a tendency to comply with the expectations of others, and accommodation without emotional investment. In addition, patients showed feelings of being nongenuine and unreal, perceiving the world as cold, empty, and unngiving; defects in their cohesiveness, strength and harmony of the self; attempts to disown responsibility for thoughts, acts, and impulses; and depressed and masochistic behavior. These symptoms are similar to other symptoms we have described.

In the Novicks’ (1972) Hampstead study on masochistic boys and their depression, obsessiveness, and self-destructive (mutilating) behavior, one can also see a number of similarities between this group and the anorectics. Lane and Goeltz (1998),
in discussing the Novick's work with these children, point out their fears of annihilation, feelings of being picked on, wish for punishment, inability to assert themselves, and denial of pleasure. They are attached to pain and suffering, with compensatory feelings of entitlement, fantasies of being in total control, and fulfillment of revenge motives in fantasy. Other similarities include gender problems, bisexual experiences in fantasy, and difficulties in object relations.

If we pursue the self-destructive, self-mutilation theme and shift to the work of Asch (1971), and his study of anhedonic girls between the ages of 14 and 21, who complain about a propensity for cutting, scratching, and slashing themselves, he tells us that this self-destructive symptom, "like anorexia," occurs many more times in girls than boys and that these anhedonic girls have a proclivity toward eating disturbances. These girls reportedly felt empty or dead, suffered recurrent episodes of depersonalization, and displayed primitive forms of depression (anhedonia). They had histories of eating disorders, feelings of intense loneliness and boredom, an inability to concentrate, with periods of promiscuity and a usual history of drug use. They floated from one relationship to another, without sustaining them. They showed little affect except for severe anxiety, and appeared detached and dreamy, childish, and incapable of aggression, except in fantasy. They appeared passive and submissive, suffered specific outbursts of violence and destructive rage, and were attracted to sadistic men who exploited them. They turned their own sadistic thoughts against themselves. Separation of any kind produced severe pain and depression as they needed to maintain contact and closeness with their objects. Self-mutilation was not uncommon, with a failure to establish stable object consistency. They needed objects to avoid separation anxiety, to regulate self-esteem, and provide reality for them.

The mothers of these girls are said to have been distant, unresponsive to their daughter's needs, and preoccupied. They had difficulty responding in the first two years of the patient's life, and some had postpartum reactions. Fathers were unavailable or preoccupied when available. As mentioned, they are extremely vulnerable to separation anxiety, are terrified by their aggression, and attempt to cover it up.
We have been aware for some time that those patients who engage in self-mutilation often have a history of eating disorders. The first attempt to categorize self-mutilation behavior was by Karl Menninger in 1938. He designated three categories: religious (culturally sanctioned), neurotic, and psychotic. The most common form of pathological self-mutilation is multiple episodic cutting with low lethality. Asch (1971) described the mothers of his cutters and slashers as preoccupied, unresponsive, distant and unable to involve themselves with their daughters, and the fathers as absent, unavailable, or preoccupied. Favazza and Conterio (1989) presented data on 290 female self-mutilators who skin cut on at least 50 occasions. They state that the typical subject is a 28-year-old Caucasian woman who has self-cut since 14 years of age. Seventy-five percent of the subjects utilized multiple methods of self-mutilation including skin cutting (72%), burning (35%), hitting (30%), interfering with healing (22%), hair-pulling (10%) and bone breaking (8%). Sixty-one percent of the subjects admitted that they currently had or at some time in the past had an eating disorder, including anorexia (15%), bulimia (22%), both (13%), or obesity (11%), with 13% having had inpatient treatment for an eating disorder with the average age of onset being 16 years.

In comparing their self-mutilation with eating disorders, Favazza and Conterio (1989) claim that the childhood history of their subjects is "quite similar" to that of the eating disorder samples. Sixty-five percent claim they were sexually or physically abused at an early age. Lack of affection, rage, and double-bind communications were claimed to be common family experiences. Cross (1993) followed up on Pao's (1969) distinction between delicate self-mutilation (superficial, carefully designed repeated incisions, small burns) and coarse self-mutilation (single deep incision close to vital parts). She quotes Favazza (1987) who claimed that "as many as 50 percent of female chronic self-mutilators have a history of anorexia or bulimia." Both conditions are described as "involuntary, potent, intricate, and malignant bodily experiences" (p. 42), and as having similar demographical and phenomenological landmarks. Both occur more frequently in women than men. In each syndrome, the patient feels a "compulsive, almost addictive need to cut, binge, purge, or diet" (p.
and the act is usually performed “secretively, in a semi-mas- turbatory fashion” (p. 50).

Lane and Goeltz (1998) also emphasize the autoerotic nature of the symptoms of both bulimia and wrist-cutting.

There is a frantic search to feel, to seek excitement, to act out in some manner, while convincing themselves and others of their emptiness and deadness. They must do something to rid themselves of the depersonalization, to release or discharge tension, and to experience a sense of relief and relaxation. This need to be soothed, held, and comforted is attained by the impulse to cut, which also discharges the sought-after excitement while focusing on the body and its sensations (self-soothing) in the service of individuation. This autoerotic sexualization is seen in its transitional meaning through an elaborate ritual (razor, towel, turning down the lights, soft music, comments made about its exciting nature, such as “pure pleasure,” and “having fun by myself” (Hull & Lane, 1988, p. 87) leading to the release of tension and usually ending by going off to sleep. The self-soothing activity (cutting or stuffing oneself) is viewed as a reunion with mother (p. 268).

Suyemoto (1998) in her lengthy paper proposes several explanatory models of self-mutilation, one of which is the sexual model of the drive category. This model proposes that the act of self-mutilation brings about sexual gratification while at the same time one punishes oneself for the act. This behavior is conceptualized as expressing an unconscious wish to destroy the genitals, which are seen as the source of the urges. The act itself may be an avoidance of direct sexual action or feelings by substitution, or an attempt to control sexuality or sexual motivation. The absence of self-mutilation prior to puberty suggests the connection between it and sexual development (menstruation). Suyemoto (1998) draws on Freudian theory to explain how the repression of sexual urges and conflicts can lead to their being acted out in symptomatic behavior with, “little conscious awareness of the sexual nature of the self-mutilation” (p. 541). She never directly states that the act of self-mutilation is a substitute for masturbation or an autoerotic act, although it is suggested.

Suyemoto (1998) points out that there is a high correlation between early sexual abuse and self-mutilation. Cutting the soma may be a way to displace mental pain and anguish onto the body,
to concretize it in this way, so that the pain can be more easily managed. Or perhaps adolescent sexual development and motivation rekindle earlier sexual dysfunction and traumas, along with the revival of oedipal wishes and sexual and aggressive fantasies which “overwhelm” the young person. Self-mutilation may be a way to “purify” the body from sexual impulses. A negative reaction to the menarche and menstruation is seen as the turning point for these girls, with empirical findings showing no self-mutilation before menstruation, that 65% of the sample report negative reactions to menstruation, and that 60% of self-mutilating acts recur during menstruation (Rosenthal, Rinzler, Wallsh, & Klausner, 1972). Self-mutilation may be a way of dealing with conflict centering around the acceptance of menstruation and femininity in general. Self-mutilation may cause bleeding, in a displacement from the genitals, and shows the need to be in control, thus turning the passive into the active, and possibly explaining the greater frequency of self-mutilation in women (related to menarche). Asch (1988) felt that masochistic self-mutilating individuals are preoccupied with the need to be in control of their pain and unpleasurable relationships.

ETIOLOGY

Anorexia is claimed to have overdetermined causation. The latest definition of eating disorders include disturbances in early object relations, particularly in the family system, ego functioning, body image, and personality development in general. Mushatt (1982–1983) felt too much emphasis was being placed on sexual conflicts, particularly oedipal, making it a too narrow and limited view of anorexia. Mushatt believed the disorder was “best understood within the framework of the process of separation of self from object,” the struggle to achieve a sense of “separateness and individuality” (p. 257). He defined anorexia nervosa as “an expression of ego defective development arising from varying degrees of failure to resolve the process of developing a sense of individuality” (p. 258). Such problems may involve the enmeshment of mother and daughter, so that boundaries are blurred and self-other differentiation is confused. The child views herself as an extension of the mother, revealing both se-
vere dependency on her, while desperately attempting to separate from her, wanting no similarities to her, particularly her narcissism. The anorectic may defend her strong narcissistic entitlement, her desire to have all of her mother and consequently the world all for herself, by behaving "differently," not wanting anything. This may be exhibited by a refusal of closeness or intimacy.

Fear of loss of control over sexual and aggressive conflicts as expressions of the patient's struggle to resolve the separation/individuation impasse may lead to regression and the use of primitive oral and anal defenses. There may be a conflict between the wish for and fear of incorporation/or fusing with the omnipotent mother. The desire for closeness may unconsciously be equated with total merging or incorporation by the object. The anorectic symptoms may stem from vengeful, matricidal wishes "to get back" at mother through emotional and motile constriction and the closing of openings. Fear of voraciousness and insatiability, and the narcissistic rage associated with such fantasies, is a theory offered by Savitt (1980). Food is associated with mother, and in anorexia it can be the expression of the wish not to grow, and to continue to be taken care of like a child. It represents repudiation and denial of the demands of puberty and mature sexuality. Chasseguet-Smirgel (1995) sees eating problems as an enactment of pseudodevelopment, to control maternal dependency conflicts, particularly at the time of puberty. Menstruation is interrupted in a flight from adult female responsibilities. There may also be a denial of oral impregnation fantasies. In yet another view (Cross, 1995), this emotional regression (anorexia) gives the young woman control over bodily functions and turns the passive into the active. She achieves mastery and control over anal pleasures. An internal sense of control and identity is fostered through defiant and oppositional behavior.

It is easy to regress to a preoccupation with food, as food and eating are so much a part of infant life. By having symptoms the anorectic girl proves mother is not perfect. There is a strong wish not to give her laurels, but rather to unconsciously expose her imperfections, by an overinvestment in eating and food. The need for the false self causes the child to keep in all negative
feelings. The use of laxatives and the shedding of fat helps get rid of the unwanted mother, good feelings having never been associated with food or eating. The anorectic symptoms permit acting out in passive-aggressive or anal ways, that is, “indirectly” rather than directly. Fixation at or regression to a symbiotic position exaggerates the anorectic’s narcissism, ambivalence, control, and magical thinking.

SUMMARY

In summary, both self-mutilators and eating-disordered individuals come from dysfunctional homes with a very controlling mother and usually absent father. They often have a history of trauma. They are depressed and obsessive, attached to their mothers, who discourage attempts at emancipation. The symptoms serve the purpose of keeping them as little girls with negative feelings toward menstruation, sexual maturity, development, and femininity in general. These symptoms comprise self-destructive behavior in the service of removing sexual thoughts, temptation, and activities. Favazza (1987) included both eating disorders and self-mutilation in his “deliberate self-harm syndrome.” The symptoms, whether they be anorexic, bulimic, or a form of self-mutilation are seen as “autoerotic in nature and a substitute for normal masturbation” (Hull & Lane, 1988). Eating disorders and delicate self-mutilation are said to have “a cathartic, self-purifying function in that they modulate states of anxiety, sexual tension, anger or dissociated emptiness, and they bring about a tremendous quasi-physical sense of relief” (Cross, 1993, p. 50). These patients’ use of substitutes prevents maturation and growth as women, causing regression to pregenital phases with the use of pregenital defenses, and the demise of the demands of puberty and mature sexuality.

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Center for Psychological Studies
Nova Southeastern University
3301 College Avenue
Maltz Psychology Bldg.
Fort Lauderdale, FL 33314-7796

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