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**Body and self in feminine psychology: As illustrated by delicate
self-mutilation and the eating disorders**

Cross, Lisa Warren, Ph.D.

City University of New York, 1990

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A

**BODY AND SELF IN FEMININE PSYCHOLOGY:
AS ILLUSTRATED BY DELICATE SELF-MUTILATION
AND THE EATING DISORDERS**

by

LISA W. CROSS

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, the City University of New York.

1990

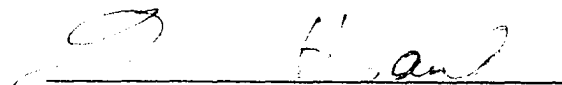
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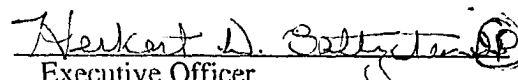
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Abstract

Body and Self in Feminine Psychology:

As Illustrated by Delicate Self Mutilation and the Eating Disorders

by Lisa W. Cross

Advisor: Professor Irving H. Paul

The following theory will be presented in this dissertation: women are at once more attuned to and alienated from their bodies than are men, by virtue of specific aspects of female reproductive anatomy and sexual maturation. Partially internal genitalia, menstruation, relatively abrupt changes in body contours at puberty, and pregnancy all contribute to an ambiguous, paradoxical, and discontinuous experience of the body for women. In addition, efforts by women to transform passive and diffuse experiences of their bodies into active, focal experiences have a significant impact on their object relations and psychopathology, as well as lending women special sources of wisdom and psychological strength.

I will test the explanatory power of this theory by examining its capacity to explain some unresolved questions raised by findings of other, empirical researchers. In specific, my hypothesis must satisfactorily explain the well-replicated finding of the preponderance of women in the eating disorders diagnostic category, and the newly-emerging finding of frequent co-incidence of delicate self-mutilation and eating disorders in the same patients.

Implicit in my theory is a dispute with some of the more facile feminist critiques of psychoanalytic theories of femininity. In my opinion many of these critiques are based on overly literal and simplistic interpretations of the key psychoanalytic concepts of feminine masochism, passivity, narcissism, and penis envy. I draw heavily on the theories of Judith Kestenberg and Helene Deutsch in my effort to breathe new life into these concepts and to revive their original depth and complexity.

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CHAPTER ONE

The motivation for this study originated in my work with a patient who displayed a particularly perplexing, fluid, and self-destructive form of symptomatology. Over time I came to see that her difficulties, which ranged from delicate self-mutilation to a mixed typed of eating disorder to various psychosomatic symptoms, had a kind of perverse rationality. There seemed, in fact, to be some kind of attempt at mastery of early physical and sexual traumas behind her apparent self-destructiveness.

My own ability to intuit the motives behind my patient's behavior led me to the possibility that she presented in distorted form certain trends of the normal feminine personality. It also seemed to me that the particular linkages I saw between my patient and healthy women could shed some light on the old dilemma of feminine masochism, which has received much attention lately from feminist critics of psychoanalysis. The concept of masochism in general, and the specific syndromes of self-mutilation and eating disorders, are problematic-- intellectually irritating-- because they seem so counter-intuitive. Why should such apparently distasteful behavior be so wholeheartedly embraced by my own (and other) patients? Just as perplexing is the question of why these disorders occur so much more frequently in women than in men, an issue that, surprisingly, is given short shrift in the relevant psychoanalytic literature.

All of these queries led me back to the early psychoanalytic thinkers on femininity, many of them now ridiculed, discredited, or merely unread. I became particularly interested in Helene Deutsch and her ideas on women's capacity to transform painful or otherwise problematic bodily experiences into creative acts of mastery over fear, confusion, and anxiety. I also found that Judith Kestenberg later elaborated on this notion and made it the central theme of her theory of femininity. Here, it seemed to me, was an indication of the ways in which the traditional psychoanalytic emphasis on sexual anatomy and functioning could be used to explain psychological strength in women-- not merely pathology. The supposed psychoanalytic slogan, "anatomy is destiny" much criticized as outmoded and anti-feminine, might in fact shed light on some of women's greatest psychological achievements, rather than necessitating a reductive, pathologized view of feminine development.

The central theory of this study is as follows: women are at once more attuned to and

alienated from their bodies than are men, by virtue of specific aspects of female reproductive anatomy and sexual maturation. Partially internal genitalia, menstruation, relatively abrupt changes in body contours at puberty, and pregnancy all contribute to an ambiguous, paradoxical, and discontinuous experience of the body for women. In addition, efforts by women to transform passive, diffuse experiences of the body to active, focal experiences have a significant impact on their object relations, psychopathology, and sources of wisdom and psychological strength.

The explanatory power of this theory will be tested against the two diagnostic syndromes mentioned above, which are found almost exclusively in women: eating disorders and delicate self-mutilation. These two disorders are particularly relevant to my hypothesis because they involve potent, intricate, and malignant bodily experiences. A study of these syndromes allows female attitudes towards the body to be seen in sharper relief, in a microcosmic and caricatured form, because there is such a parsimonious expression of multiple desires and prohibitions within one symptom, yet such an exaggerated flouting of natural physical needs. The scope of this study will not encompass the presentation of new etiological theories for the eating disorders and delicate self-mutilation; my discussion will, however, shed further light on the specific experiences of the body as a source of danger, comfort, transcendence and power intrinsic to these syndromes.

I should underline the fact that I do not in this dissertation test its theory in a directly empirical way-- by, for instance, making predictions of subjects' behavior and testing these predictions. Instead I test my theory in a more formal fashion, by examining its ability to explain unresolved questions in others' empirical findings, e.g., 1) the well replicated finding that eating disorders are far more common in women than men and 2) the newly emerging finding that delicate self-mutilation and eating disorders often coincide in the same patients.

Implicit in the theory presented above is a dispute with some of the more facile culturalist objections to psychoanalytic emphasis on the symbolic power of bodily experience: in particular, the feminist critiques of psychoanalytic theories of feminine development. In my opinion, many of these criticisms are based on overly literal and simplistic interpretations of the key concepts of women's penis envy, masochism, narcissism, and passivity. In this dissertation I will make an effort to breathe a little new life into these concepts, to revive some of their original depth and complexity and to add

to them new shades of meaning derived from recent psychoanalytic thinking on feminine development.

I do not intend to make, however, a sweeping dismissal of what are, indeed, massive cultural influences on feminine development. The scope of this dissertation, however, does not encompass the question of how cultural factors augment or vitiate the hypothesized symbolic meaning and influence of female sexual anatomy and maturation.

My theory will be developed in the following sequence: in Chapter 2 I shall briefly review the history of the concept of femininity in psychoanalytic thinking, discussing both the first proponents of the view of woman as an "homme manqué" (Jones, 1935), and both the early and modern critics of this view, who instead contend that femininity has a primary, rather than compensatory, status. The ideas of Helene Deutsch and Judith Kestenberg will be particularly emphasized.

In Chapter 3 I shall review the background research on eating disorders and delicate self-mutilation so as to lay out the issues which will be once again taken up in a later chapter, in the context of my hypothesis.

In Chapter 4 I shall give a full presentation of my theory, organized developmentally. Here I shall elaborate on the theme of how the presence of specifically female genitalia, secondary sexual characteristics, and reproductive maturation, rather than the absence of a penis, presents significant challenges to a girl's development. I shall trace the influence of these factors through the significant milestones of female sexual development: first genital sensations and masturbation, anatomical and functional changes of puberty, first experience of sexual intercourse, pregnancy and lactation.

In Chapter 5, as a test of my theory's explanatory power, I shall apply it to the two diagnostic categories of delicate self-mutilation and the eating disorders. In order to "pass" this test, so to speak, my theory should answer the very basic but rarely addressed question of why these disorders are more often present among women than among men, and should explain their frequent coexistence and similarities as syndromes.

In Chapter 6, I shall further flesh out my theory by presenting a new interpretation of the concepts of feminine masochism, passivity, and narcissism. In this context I shall discuss once again the views of Judith Kestenberg and Helene Deutsch, noting my in-

debtedness to their ideas but also my arguments with their positions. A summary statement of my integration of the two positions is as follows: I do not place at the core of the feminine dilemma the fact that a woman does not have a penis, that she is not a man; I do, however, in concert with the proponents of this latter view, consider the facts of a woman's anatomy to be central to her psychology. Women's sexual development presents paradoxes and challenges that men's sexual development does not, and I believe Deutsch is correct in stating that neurotic masochism and passivity are pitfalls that women must circumvent. In order to fully enjoy, embrace, and develop her femininity a woman must solve the riddles of her body without passive, masochistic submission to or blind denial of biological exigencies.

CHAPTER TWO

In this chapter I shall review the history of psychoanalytic thinking on femininity, with particular emphasis on the key concepts of penis envy, the feminine triad of narcissism, passivity, and masochism, and the controversy over primary femininity as opposed to innate bisexuality. I shall focus a good deal of my discussion on Helene Deutsch and Judith Kestenberg, whose ideas have particular relevance to my own theory.

Part One: Early Psychoanalytic Theories of Femininity: 1905 - 1945

Through the early 1940's most psychoanalytic thinkers, with a few important exceptions, support Freud's views that: 1) the central event in feminine development is the discovery of the lack of a penis, 2) that this anatomical difference between the sexes has long-lasting characterological consequences in the form of female penis envy, passivity, masochism, and narcissism, 3) and that true femininity is a late-developing phenomenon, arrived at only by a circuitous route via early, biologically-determined bisexuality, struggles to overcome masculine psychological trends, and gradually-evolving compromise-formations catalyzed by penis envy. Feminine development is thus seen as highly problematic, since it has to overcome foreign masculine influences; the theory of feminine development at this period in history is also problematic, because it remains an extrapolation from, a kind of step-child of, the theory of male development.

Sigmund Freud

Freud's theory on feminine development is often characterized as excessively biologically deterministic. Although he does place great emphasis on the anatomical differences between the sexes and on biological differences in levels of aggression, he also discusses (with little elaboration) the influence of cultural mores on sex differences, and (in far more detail) the complex and gradually evolving psychological effects of each sex's awareness of anatomical difference. Freud's desire to take into account all these factors, and his difficulties in reconciling them, is evident in the contradictions within his theory of feminine development. On the one hand the little girl, in her infancy, is described as having a "bisexual predisposition" (1933, p. 116), as a "little man" (*Ibid.*, page 118), manifesting a "masculine" sexuality focussing on the penis-like clitoris (1905; 1925) and possessing no awareness of the vagina (1931). (This shifting between the little girl's "bisexuality" and her "masculinity" is very curious; it betrays Freud's tendency to

fall back on the masculine developmental paradigm. At times it appears as if only women are hampered with the paradoxical state of bisexuality, men being quite naturally masculine.) On the other hand Freud insists that the little girl has some significant innate feminine characteristics: her aggression is subject to not only socially but “constitutionally imposed suppression” (1933, p. 116), thus she is biologically predisposed to the traits of masochism and narcissism, which are intimately linked with inhibition of assertiveness.

In his account of the first phase of the girl's development, then, Freud wavers between concepts of innate femininity and innate bisexuality, between an emphasis on constitutional factors and a stress on the effects of experience. His uncertainty on these points surfaces particularly in his discussions of the activity/passivity dichotomy; he is obviously tempted to set up a parallel here with the masculine/feminine dichotomy, yet recognizes that this equation would undermine his central concept of infantile bisexuality and oversimplify his theory of male and female development. As a result his writings are studded with passages vacillating on this issue, with no definitive outcome. (See 1905, p. 24; 1917, p. 327; 1923, p. 175; 1933, pp. 114 to 115.)

In the next phase of feminine development, which centers on the little girl's discovery of the boy's penis, Freud places greater emphasis on psychological experience: sexual-anatomical and other constitutional differences are now always considered within the context of object relations and compromise-formations. The object of the little girl's masculine, clitoral sexuality is initially the mother; but once she discovers that her mother's and her own sex-organ are “organically inferior” (1931, p. 200) to that of the male, she undergoes a shift in the aim and object of her sexuality (1931; 1933). Before I discuss Freud's description of this shift, however, it should be made clear that he gives surprisingly scanty reasons for why the clitoris is considered by little girls to be “inferior” to the penis. Freud seems content with emphasizing the greater size and the greater visual accessibility of the penis (1925), and with asserting (without evidence) that masturbation is less satisfying for the girl than for the boy (1933). In general he simply assumes the patent superiority of the male organ.

To return to the little girl's discovery of the penis, she is swiftly overcome with envy of the little boy and with angry disillusionment with her mother, who not only lacks a penis but also (supposedly) has deprived her daughter of one as well (1931; 1933). The little girl's considerable shame and self-contempt over what she assumes is the effects of castration causes her to relinquish her active, aggressive clitoral sexuality for a

passive, masochistic wish to receive the cherished penis of her father (1925; 1931). Although occasionally the vagina is prematurely sexually awakened at this time (1925), usually the little girl's sexuality is subject instead to a massive wave of repression (1905).

Although the girl finds a new source of sexual excitement at puberty --the vagina-- the increased libido of this phase forces her to confront re-awakened masculine, clitoral sexuality (1905). There is always the danger at this point that the girl, in seeking to eradicate this remnant of infantile sexuality, should annihilate all sexual feelings indiscriminately (1933). Ideally, however, her sexuality should undergo at puberty one final transformation: in zone, from clitoris to vagina, and the final resolution for her penis envy should come in the form of a child who replaces the missing penis.

It is not easy to give a clear and systematic account of the character traits--narcissism, masochism, and passivity-- which Freud believes to be essential components of femininity. His treatment of these concepts is quite circular, in that each one of them both explains and is explained by the others.

Female passivity, for Freud, is partly due to some unknown constitutional propensity for suppression of aggression (1933; 1940). It is not clear whether Freud is restating this point or providing an additional cause for women's passivity when he states that it is the lack of an active, aggressive sex organ that makes women less sadistic than men (1923). This biologically determined passivity is enhanced by the renunciation of active clitoral sexuality described above, in the face of the narcissistic blow of penis envy and the resulting choice of masochistic, passive vaginal sexuality.

Feminine narcissism and masochism seem in Freud's view somewhat derivative of the more primary passivity. Narcissism, in the general sense of taking the self as a libidinal object, evolves from the shift from active to passive, from external interests to internal focus, just described (1919). Narcissism, in the more specific sense of physical vanity and a propensity for physical shame, stems directly from penis envy (1940). The evolution of feminine masochism follows parallel lines, originating in biologically-determined suppression of aggression and reinforced by the oedipal choice of passive sexuality (1933). (Here Freud often carelessly equates passivity and masochism, in a clearly circular argument.) This peculiarly feminine and supposedly healthy form of masochism is differentiated by Freud from primary erotogenic masochism (one of the early "partial" sexual instincts which, unless subordinated to the

mature sexual aim of intercourse, evolves into a perversion) and moral masochism (in which pain is sought out in the form of, and in order to relieve, neurotic guilt) (1924a). Freud appears to believe that women often present a mixture of these forms of masochism: he suggests that women, by virtue of their excessive sexual guilt, are particularly prone to masochistic guilt (1919) and that common feminine sexual fantasies focus on pleasure in the pains of rape, castration, or childbirth --all of which sound quite close to perverse. Freud's overall metapsychology, in fact, requires the existence of these latter fantasies in women: given his profound commitment to the evolutionary perspective, he believes that behaviors which perpetuate the species must be wired in, so to speak, through an association with pleasure. As a result the pain women suffer through their reproductive functions must be linked up to the sensation of pleasure. For this reason Freud, and many of the psychoanalytic theorists of femininity who follow him, conflates endurance of pain with enjoyment of pain.

Freud's account of femininity, in summary, leaves the reader with an impression of the near-inevitability of stunted female development. The woman's sexuality is likely to remain on the level of a child's: "the child perhaps does not behave differently from the average uncultured woman in whom the same polymorphous-perverse disposition exists." (1905, p. 51). Her character development is largely based on reaction-formations and fantasies relatively unevolved from their origins in the Oedipal phase: "In girls the motive for the destruction of the Oedipus complex is lacking. Castration has already had its effect... [thus the influence of the Oedipus complex] may persist far into women's normal mental life." (1925, pp. 192-193). In fact, "If we ask an analyst what his experience has shown to be the mental structures least accessible to influence in his patients the answer will be: in a woman her wish for a penis." (1940, p. 51) The following passage from a late essay by Freud epitomizes the pessimistic view of femininity so prevalent at the time in psychoanalytic circles:

A man about thirty strikes us as a youthful, somewhat unformed individual, whom we expect to make powerful use of the possibilities for development opened up to him by analysis. A woman of the same age, however, often frightens us by her psychical rigidity and unchangeability. Her libido has taken up final positions and seems incapable of exchanging them for others. There are no paths open to further development; it is as though the whole process has run its course and remains thenceforward in susceptible to influence--as though, indeed, the difficult development to femininity had exhausted the possibilities of the person concerned. (1933, pp. 134-135)

Karl Abraham

Abraham's 1922 paper, "Manifestations of the female castration complex", was highly influential in setting down the themes of early psychoanalytic thinking on femininity. Freud's most important writings on this topic, published between 1925 and 1933, owe a significant debt to Abraham's published work and personal communications (Mitchell, 1973; 1975). Abraham emphasizes the inexorable effect of penis envy on later feminine passivity, masochism, and narcissism, and considers child bearing to be the sole symbolic substitute for the lost penis. Like Freud, he collapses any difference between women's experiences of physical pain and fantasied castration, on the one hand, and their actual enjoyment of these states, on the other. He also adds menstruation and defloration to the list of physical events which intensify women's "passive fantasies of mutilation" (1922, p. III). Abraham, more than Freud, emphasizes the sadistic and vengeful reactions of many women to penis envy.

Jeanne Lampl de Groot

Lampl de Groot's papers of the late 1920's and early 1930's also were influential on Freud's developing theory of femininity. Like Freud, she is careful to stress that masculinity and femininity, activity and passivity, are abstract dichotomies which bely the bisexual complexity of both women and men. For instance, she notes that the stereotypically feminine woman is too passive to take on the necessarily active role of mothering (1933). Lampl de Groot also, most likely influenced by Horney's papers of the 1920's, does not merely assume the natural superiority of penis to clitoris but instead details the little girl's envy for the exhibitionistic function of the penis in urination (1928) and for the fact that it is "bigger, stronger, and more visible" (1928, p. 185).

Marie Bonaparte

Bonaparte is one of the most pessimistic of the early psychoanalytic writers on femininity, repeatedly emphasizing what she terms the pervasive "dark background of female suffering" (1935, p. 245). She considers masochism particularly dangerous to women's psychological health, and states that women, in order to enjoy sex, must separate the experience of being passive from the expectation of pain. If the (in her view) inevitably passive feminine experience of sex is overly tainted with masochism women either become frigid-- fearful of sex-- or develop masochistic perversions (1934; 1953).

Both Lampl de Groot (1928) and Abraham (see Jones, 1953) disagree with Freud over the absence of early vaginal sensation; Horney and Jones underline their disagreement on this point with Freud by making it a focus of their dissenting theories of femininity.

Karen Horney

Horney's early writings on femininity, from 1924 to 1935, remain well within the orthodox psychoanalytic camp in emphasizing the psychological impact of sexual anatomical differences, with some intimations of her later stress on cultural factors. The anatomical difference she chooses to emphasize, however, is not (just) clitoris versus penis, but vagina versus penis. The little girl's experience of her body is not analogous to the little boy's; instead she has very early "cravings to take into [herself], to receive" (1933, p. 158) and wishes for a baby (1926) that directly stem from awareness of her vagina. Horney offers as evidence for this awareness mothers' and pediatricians' reports of early vaginal masturbation (1933) and little girls' fantasies of rape and internal bodily damage (1926; 1933). This primitive awareness of the vagina is often overlooked, partly because it is so easily repressed, out of both fear of mutilation and preference for the "more easily accessible" clitoris with its "lesser cathexis of anxiety" (1933, p. 160). Another reason why these early vaginal sensations are disregarded is the "masculine mode of thought" (1926, p. 59) in psychoanalysis, which sees women in terms of what they lack, e.g., a penis, rather than in terms of what they possess-- a vagina.

Using a similar argument, Horney gives a new slant to the concept of penis envy. First she adds several new reasons why the little girl sees the penis as preferable to her clitoris. First, boys are given greater exhibitionistic license in urinating (1924); thus they can more freely explore their genitals as well as check to see whether they are damaged in any way (1924; 1933). As a result boys find their genitals less a source of confusion and anxiety than do girls. In summary, penis envy is often due to girls' "restrictions as regards the possibility of gratifying certain instinct components [e.g., "urethral erotism, the scopophilic instinct, onanism" (1926, p. 63)] that are of the greatest importance in the pregenital period." (1924, p. 42). Horney makes an important distinction between this "primary form" of penis envy, which is oriented towards narcissistic erotic pleasure, and its later manifestations which are object-related, bound up with the longings and disappointments of the oedipal era (1926). (Horney makes other original contributions to the concept of penis envy, such as its function as cultural metaphor and its defensive

uses, which are not directly relevant to this discussion.)

Horney's treatment of the problem of masochism is very much at odds with the prevalent psychoanalytic view of the time. Unlike Freud, Abraham, Lampl de Groot, and Bonaparte, she questions the assumption that women's experience of physical pain necessarily leads to enjoyment of such pain (1935). At the most, she states, the normal feminine experiences of pain at menstruation, defloration, and childbirth can only contribute to a masochistic orientation. The claim that a necessary connection exists between these experiences and masochism is based on reasoning falsely from pathology to normality-- a fallacy to which psychoanalytic thinking is prone. Arguing by analogy, she asks whether a mountain climber is masochistic because he carries a knapsack; he can only be seen as such if his pain is understood not as a means but as an end.

Ernest Jones

Jones' concept of primary femininity is largely derived from Horney, but his polemical writing style is often more effective than hers in highlighting their objections to concept of the post-phallic, defensive origins of femininity.

there is more femininity in the young girl than analysts generally admit... (1935, p. 486)... her femininity develops progressively from the promptings of an instinctual constitution... In short, I do not see a woman in the way feminists do-- as un homme manqué, a permanently disappointed creature struggling to console herself with secondary substitutes alien to her true nature. (*Ibid.*, p. 495)

For Jones, as for Horney, the young girl's vaginal sensations and masturbation, her fantasies of vaginal intercourse, and her desires to give birth are all manifestations of a primary, irreducible femininity.

Jones combines these ideas with a notion derived from Melanie Klein's observation in young children of fears and fantasies of disembowelment: "aphanisis", fear of complete destruction of the sites of sexual pleasure. This fear is experienced by both sexes but has a more profound effect on the feminine psyche. The presence of a mysterious inner cavity is a major factor in female aphanisis; in fact,

I doubt whether Freud does not attach too much significance to the girl's concern about her external organs at the expense of her mortal fears about the inside of her body. (1935, p. 495)

For both Jones and Horney, castration fears focussed on the (external) clitoris largely serve as a mask for deeper anxieties about internal damage.

All of these early psychoanalytic thinkers struggle with the same questions: if women are so hampered by powerful innate masculine trends and inexorable characterological distortions due to penis envy, how can feminine psychological normality be explained or even defined? Are women, instead, doomed to intransigent frigidity, perverse masochism, or vengeful envy of men? Alternatively, is it possible that some bedrock of femininity exists from early on, which can be described in positive terms, rather than as a lack of masculine traits? Such a bedrock would make feminine development less problematic and would allow for a theory of femininity that is not just a pathologized offshoot of Freudian theory of male development.

In the next section we shall see how Helene Deutsch makes an ambitious attempt to create a full theory of feminine development, which integrates pathology and normality by explaining the origins of both women's strengths and their weaknesses. We shall also see how she is hampered in this attempt by her allegiances to a still "phallogentric" classical Freudian viewpoint which does not sufficiently describe the bedrock of femininity mentioned above.

Helene Deutsch

In her early writings (1925 to 1933) Deutsch follows the early psychoanalytic line of thinking on femininity by emphasizing the rigidity of feminine reaction-formations and the female proclivity for polymorphous perverse or inhibited sexuality. During this period her metapsychology, accordingly, remains rooted in classical libido theory. In the 1940's (and later), however, she increasingly stresses the feminine capacity for sublimation, for evolving complexly interwoven character traits far removed from their instinctual origins. She discusses at this time the tremendous importance for women of the impulse towards mastery, towards transforming passive experiences into active ones, and further clarifies the differences between normality and pathology in women. Deutsch is frequently caricatured by contemporary critics of psychoanalysis because this second phase in her thinking is often ignored.

In this latter phase Deutsch's writing stays close to phenomenological reality, is rich

in case material, and scrupulously avoids simplistic definitions of normal femininity. (This subtlety of her writing does at times, however, deteriorate into ambiguity and contradiction.) In my view, Deutsch presents the most complete and sophisticated account of femininity within the classical psychoanalytic framework.

The Question of Primary Femininity

Deutsch adheres, throughout her writings, to Freud's original view that the little girl is psychologically bisexual and that this fact is at the core of feminine development, normal and pathological.

But for the bisexual disposition of the human being, which is so adverse to the woman, but for the clitoris and its masculine striving, how simple and clear would be her way to an untroubled mastering of existence! (1925, p. 160)

... even in the most feminine manifestations of [women's] life-- menstruation, conception, pregnancy and parturition, they had a constant struggle with the never wholly effaced bisexuality of their nature. (1930, p. 196)

The little girl is seen as having no awareness of her vagina, except in special cases of early seduction (1930; 1945). Deutsch does, however, resist the tendency of many of the other early analysts, including Freud, to understand the girl's early bisexuality as almost pure masculinity.

Our view of the girl's early childhood rejects the psychoanalytic hypothesis that the young girl is in this period masculine. (1944, p. 280)

The little girl, like the little boy, shows her feminine side in activities such as maternal play (Ibid.).

In contrast to her ideas on bisexuality, Deutsch makes significant changes in her thinking on penis envy and feminine narcissism, masochism, and passivity between her papers of the 1920's and 1930's, and her 1944-45 book on femininity.

Penis Envy

Early on, Deutsch rather unreflectively assumes that the little girl naturally experiences her clitoris as inferior to the penis. At this point Deutsch feels little need to

give reasons for penis envy, beyond vague references to the clitoris' lesser amount of libido (1925).

In her 1944-45 volumes, however, Deutsch provides a far more satisfying explanation for penis envy and in fact reformulates the entire concept. The little girl envies the penis because

at a certain point of her development [e.g., the phallic period] she lacks an adequate organ for the outlet of inner excitations.... [The fact that] the boy has an organ which can actually be grasped and thus has the possibility of transferring psychological processes to material, real ones, creates an obscure feeling in the girl that he can manage his sadistic impulses, anxieties, and masturbation struggles better than she can master hers. (1944, pp. 319-320)

(Here we can detect an echo of Horney's view of penis envy.) In addition, the girl not only feels that she lacks an adequate organ for the discharge of active, phallic impulses, she also experiences a gap between the emergence of passive sexual impulses (after the renunciation of the clitoris) and awareness of an organ for their discharge (in adolescence).

Thus the little girl is for the second time confronted with organlessness: the first time she lacked an active organ, now she lacks a passive organ. It is only these two events together [rather than the mere lack of a penis] that produce her genital trauma. (1944, pp. 229-230)

Deutsch thus believes that most of her psychoanalytic contemporaries exaggerate the importance of penis envy as the only factor in the entire picture of feminine genital inhibition (1944).

The girl's desire to master, to discharge in a controlled fashion, her sexual tension and aggression is an instance of the "general human tendency to project inner dangers outside oneself in order to master them" (*Ibid.*, p. 320). As I shall soon discuss, this impulse towards mastery through a shift from internal experience to external reality is a key concept in Judith Kestenberg's more recent theory of femininity, as well in my own theory.

Masochism, Passivity, and Narcissism

Deutsch's early account of masochism parallels that of Freud, in that she is satisfied

with economic explanations of transfers of libidinal energy and assumes that women's naturally occurring experiences of pain must be accompanied by pleasure, according to the dictates of an evolutionary perspective.

The active-sadistic libido attached to the clitoris rebounds from the barricade of the subject's inner recognition of her lack of the penis... and, most frequently of all... is deflected in a regressive direction towards masochism. (1930, p. 199)

The girl's fantasy of castration, upon discovering the boy's penis, is incorporated into a central, organizing sexual fantasy of being raped/castrated by her father (*Ibid.*). In the interests of "the preservation of the race" the desire to procreate, with all its attendant pain, must be linked with the "pleasure-tendency of man's instincts" (1930, p. 205). Even the extreme pains of childbirth must contain the "acme of sexual pleasure", an "orgy" equivalent to orgasm (1925, pp. 153-154). In sum, each woman's life is dominated by the "masochistic triad [of] castration, rape, and parturition" (1930, p. 204).

Deutsch's early account of feminine passivity is similarly parallel to that of Freud. Despite innate bisexuality the girl is assumed to be less active from birth onwards; this tendency is further reinforced by the "rebound" to passive sexuality after the advent of penis envy (1925; 1930).

In her early writings Deutsch elaborates on Freud's concept of masochism by stressing, like Bonaparte, its potential dangers for the woman-- and here the concept of narcissism takes on a new and more dignified function. Deutsch understands narcissism as not only an excess of focus on the self and on physical vanity, but also as a healthy resistance of the woman's ego to excessive masochism, an insistence on keeping intact psychological and physical health (1930; 1932).

In my view, Deutsch's later account of feminine narcissism, passivity, and especially masochism is far more subtle than any previous discussion of these topics, whether in her own writings or those of other early psychoanalytic thinkers. An important shift in metapsychology allows for this new complexity of thinking. She now can make clearer distinctions between pathology and normality by drawing on Hartmann's new concepts of the conflict-free sphere of the ego, and the primary and secondary functions of autonomy (Hartmann, 1939). Deutsch now states that "we do not regard the processes of maturation as mere products of instinctual developments or as solutions of conflicts with these developments." (1944, p. 244). Thus her metapsychology now allows for the existence of

feminine character traits that are not crude reaction-formations, closely tied to infantile sexual impulses and fantasies, but are instead complex sublimatory structures.

The concept of feminine passivity takes on important new meaning, and a more mature and less pathological function, in 1944 when Deutsch states, "passivity does not mean activity or lack of sexual energy" (p. 280) or "inactivity, emptiness, and immobility" (p. 190). It is instead a "passive-receptive readiness" (*Ibid.*, p. 280), an "activity turned inward" (*Ibid.*, p. 190), and one of the elements of a rich inner life (*Ibid.*, p. 272).

In an amplification of her earlier views on narcissism, Deutsch adds to its positive functions a contribution, along with passivity, to the woman's "rich world of inner activity" (1944, p. 193). This world can develop only if the woman protects herself with a "narcissistic wall" (*Ibid.*) against the "masochistic forces of dangerous and painful giving" (1945, p. 105). She seems to be claiming here that women have more difficulty separating their own motives and experiences from those of others, in a somewhat similar fashion to her concept of the "as if" personality (1942); narcissistic trends can counter this tendency by serving psychological autonomy.

Of the three core feminine character traits masochism is given by Deutsch the most complex-- and sometimes most obscure-- treatment in her later writings. She vacillates between clearly differentiating normal feminine masochism from moral or perverse masochism, and at other times blurring the boundary between these concepts in such a way that women sound destined to enjoy physical and mental pain. On the one hand, feminine masochism is characterized as a kind of joyful subordination of one's own goals, desires, and interests to those of another person; it has none of the "cruelty, destructive drive, suffering and pain by which masochism manifests itself in perversions and neuroses." (1944, p. 191). In the same vein, normal feminine masochism consists of a state of "psychological preparation" (1944, page 177) for the physical pain women must endure in their sexual and reproductive functions, a capacity to tolerate, not necessarily enjoy, pain. Deutsch in this mind-set can reasonably take issue with Horney's (1926) criticisms:

I should like to defend my previous work against a misinterpretation. K. Horney contends that I regard feminine masochism as an "elemental power in feminine mental life" and that, according to my view, "what woman ultimately wants in intercourse is to be raped and violated; what she wants in mental life is to be humiliated." It is true that I consider masochism "an elemental power in feminine life" but in my previous

studies and in this one I have tried to show that one of woman's tasks is to govern this masochism, to steer it in the right paths, and thus to protect herself from those dangers that Horney thinks I consider woman's "normal lot". (1944, p. 278, note)

On the other hand, Deutsch often reverts to the trend of her earlier writings in statements such as, "The attraction of suffering is incomparably stronger for women than for men." (1944, p. 274). Here normal feminine masochism is not merely a capacity for endurance of pain, a striving towards mastery of pain, or an enjoyment of altruistic acts; it is, once again, enjoyment of pain.

Deutsch's description of childbirth (1945) best epitomizes her capacity to view women in a three-dimensional fashion, as capable of transcending, rather than merely capitulating to, the dilemmas posed by their bodies. Ideally, she states, a woman should give birth in such a way that neither self-destructively relinquishes self-determination and helplessly gives in to pain, nor willfully seeks to battle against the natural processes of her body. In Deutsch's terminology, the most "feminine" woman, in childbirth as in all other endeavors, seeks a constant balance, a natural interplay, between excessive passivity and masochism, on the one hand, and excessive narcissism and activity, on the other. Deutsch's thinking here is rich in evocative paradoxes: the woman who insists on medication that kills all pain is engaged in a kind of masked passivity, for she denies herself the opportunity to engage actively in the vicissitudes of childbirth. Such women, Deutsch notes, often experience childbirth as "uncreative" (p. 251), comparable to a "trauma" (p. 252), and therefore feel no emotional connection to their newborn child. They experience the child as something that happened to them, that did not come from them. The woman who, on the other hand, displays "normal masochism", who allows herself to experience some pain in childbirth and to master it actively, feels instead a "joy in accomplishment" afterwards (p. 248). One particular passage conveys Deutsch's understanding of these paradoxes most powerfully:

The woman has a feeling, which is intensified at the end of her pregnancy, that soon something will take place in her life that, in her subjective estimation, will change the order of the world, that something will come out of her and will exist only by her will, but that nevertheless this something represents a power over which she has no control. Whether she wants to or not, she who has created this new life must obey its power; its rule is expected, but invisible, implacable. It is inside her and yet it is unknown and irresistible. Because of these very qualities it necessarily produces fear. This knowledge of an event that will happen on a certain date, upon which one depends, and which, nevertheless, one cannot influence, this mixture of power and submission, has something fatal and inevitable about it, like death. (pp. 220-221)

Here Deutsch skillfully juxtaposes terms such as “submission” to, and lack of control over, “implacable” forces, with the opposite theme of women’s “power” and “will” to create. From this perspective women’s physical make-up does not render them merely incomplete replicas of men, but instead grants them special opportunities for gaining wisdom, in grappling with the inexorable forces of the body. Such a perspective is essential to a theory of femininity that neither denies differences between the sexes nor reduces such differences to inequality; I will come back to this point in a later chapter in discussing my hypothesis.

Despite Deutsch’s revision of the concepts of feminine narcissism, masochism, and passivity, and despite her eventual dismissal of penis envy as the crux of feminine character development, she is still in her later writings hampered by pathologizing terminology inherited from Freud. For instance, to describe as “normally masochistic” a woman who shows courage and psychological flexibility in grappling with the pain and anxieties of childbirth is either misleading or downright contradictory. This flaw in her writing goes deeper than terminology for, as we saw in her revised discussion of masochism, she cannot completely reconcile women’s strengths with their weaknesses, nor construct a theory of feminine pathology that fits comfortably into a broader theory of normal femininity. There is a curious tension in her discussions of penis envy which hints at the source of these conceptual difficulties. In these passages, she repeatedly depreciates the importance of penis envy in women and intimates that women have sources of strength and weakness which are different from those in men-- but then draws back from defining these latter factors. If Deutsch were not so wedded to the dogma of infantile bisexuality she would be able to live up to the promise of her later work by defining such primary sources of femininity.

The next body of literature to be discussed attempts to fulfill the promise of an autonomous theory of feminine normality and pathology by specifying the origins and characteristics of primary femininity. Although this is a more recent body of literature than that previously discussed, it still remains within the general framework of classical psychoanalytic theory by emphasizing the far-reaching psychological impact of sexual anatomy and function

Part Two: Modern Psychoanalytic Theories of Femininity

In this section I shall discuss the recent emphasis in psychoanalytic thinking on what

Robert Stoller (1977) calls "primary femininity": the toddler girl's sense of being female which is not, as the earlier Freudians would have it, a derivative sexual identity, secondary to and a defense against more basic masculine or bisexual trends. In the late 1940's an increasing number of psychoanalytic thinkers begin to assert that most, if not all, little girls possess an awareness of some kind of internal genital space (vaginal or vaginal/uterine), and that this awareness is at the core of their sense of being female (Greenacre, 1948, 1950; Kestenberg, 1956; Barnett, 1966; Fraiberg, 1972). As evidence for such a phenomenon, observational researchers note the high incidence, in the first three years of life, of masturbation centering not only on the clitoris but also the labia and vagina (Galenson, 1976; Kleeman, 1977). Rectal stimulation, such as from cleaning during diapering or from constipation, is also very likely to cause referred sensation in the nearby vagina (Greenacre, 1950). Little girls can infer, as well, the presence of some kind of inner space from the vaginal opening, based on their experience of other openings and orifices, such as the mouth and rectum (Kestenberg, 1956b; Barnett, 1966). Horney's and Jones' early contention that the presence of a genital inner space rather than the absence of a penis forms the foundation for femininity thus gains far greater credibility during this modern period. (See especially Erikson, 1968.)

Most of these writers, in addition, emphasize the problematic nature of this early female awareness of inner genital space: the confusion, anxiety, and shame associated with it, and its resulting relative ease of repression, in comparison with the boy's genital sensations. (This issue is often cited, in fact, as secondary evidence for the presence of early vaginal sensation, as explanation for previous denials of such sensation by patients and researchers.) More than any of these writers, Judith Kestenberg places this idea at the center of her developmental theory, and considers the girl's strivings to master these problematic factors to be a potentially constructive force which can catalyze development. In this section I shall particularly focus on her writings, with references to other modern psychoanalytic theorists where they amplify her points. (Citations are from Kestenberg, unless otherwise noted.) As we shall soon see, the time-honored concepts of female penis envy, masochism and passivity take on new meaning within Kestenberg's theoretical paradigm.

First Genital Sensations and Masturbation

Kestenberg believes that from the very beginning of life the girl's inner genital sensations have a significant "lack of localization and a refractoriness to verbal

description" (1968, p. 458). The female inner genital is both "enigmatic and inaccessible" in contrast to the boy's penis (1956a, p. 289). The little boy's feelings of sexual tension, although they also have a (partially) internal origin, within the groin, can be easily "externalized" onto the penis (1968). The boy's penis is visually accessible; urination and regular erections remind him of its presence, as does its stimulation by body movement (1956a; Moore, 1977; Greenacre, 1950). As Lampl de Groot and Horney pointed out years earlier, the boy is also given license to look at and touch his penis during urination; thus he can explore its contours and sensations, as well as reassure himself that it is intact and compare it with those of other boys. (See also Greenacre, 1950.) The little boy's erections, although often uncontrollable and unpredictable, are less anxiety-producing to him than the little girl's vague and diffuse genital sensations, because he can gain mastery over his penis in all these other ways.

The vagina, in contrast to the penis and other body orifices, cannot be deliberately filled or emptied by the little girl, so that she can learn its shape and function (Barnett, 1966). Even the girl's external genitals are confusing to her: their tissues are "irregular and changing" (1973, p. 89) and the clitoris disappears in a state of excitement. In general sexual tension emanating from the clitoris or vagina is usually experienced as mysterious in origin and quite unavailable to control, thus both frustrating and anxiety-producing.

Without localization, shape, or meaning, the vagina easily becomes a part of the body ready to become ego-alien and threatening from within....The characteristic fear attached to these flushes [of sexual excitement] is that they will sweep over the whole body, becoming intolerable, all-consuming, and dangerous to the body in toto. (1973, pp. 89-90)

In comparison to the penis, the vagina and clitoris lack "organ constancy"; they often in fact only exist, from a phenomenological point of view, when in states of excitement (1956b). This factor encourages anxiety about genital damage, which the manual and visual inaccessibility of her genitals does nothing to allay.

Kestenberg considers the visual inaccessibility of the girl's internal and, to some extent external, genitalia, and the unavailability to control of their sensations, to be critical factors in early, basic, feminine characterological passivity. The little girl's genital feelings do not naturally lead to active attempts to modulate them or to discover their origin and function (1956b; Moore, 1977).

The little girl's confusion and anxiety over genital sensation is exacerbated by the disgust and shame stimulated by the proximity of her genitals to the anus (1956b; Deutsch, 1944; Greenacre, 1948; Needles, 1968).

In sum, motives for, and ease of, repression of sexual experiences are more readily available to the little girl than to the little boy. Repression in turn exacerbates the ambiguous nature of her genital experience; it also produces a kind of psychological vacuum which is rapidly filled with fantasies. These fantasies further distort the girl's understanding of her body.

It is not surprising, then, that the little girl has a "far less accurate and differentiated appreciation of her genitals", with respect to labelling their different parts, than does the boy (Lerner, 1977, p. 279), and that she masturbates less directly, vigorously, and frequently than does her male peer (Kleeman, 1975; Galenson, 1976).

The Search for Mastery over Genital Sensation-- Sequential Phases of Externalization

According to Kestenberg, women throughout their lives seek to transform diffuse, passively experienced genital sensation of vague, internal location into "focal forms of discharge" involving external organs, objects or people. In the process, the experiential qualities of passivity, internality, and diffuseness are changed into activity, externality, and focus. This process, which Kestenberg terms "externalization", has broad and profound effects on feminine sexual development and object relations, and it progresses along clear-cut developmental lines. Two periods in this process of externalization are especially crucial and problematic; the "maternal" or "inner genital" phase, at two to three years of age (just preceding the phallic phase) and the pre-pubertal phase. During these two periods inner genital sensation is at its strongest, and the girl feels most pressed to externalize it. (In her later writings Kestenberg describes similar phases of strong inner genital sensation in boys, emanating from the rectum, testicles, and prostate. She believes that these experiences are less problematic for boys because it is far easier for them to externalize inner genital sensation onto the penis.)

During the first, toddler, phase of externalization, the little girl has inchoate experiences of "swelling, pulling, jitteriness, a 'funny feeling', heat, or pain" (1956b, p. 7). She searches for an "explorable object" (usually a doll) which can be the focus of these sensations-- which can be soothed and satisfied, manipulated and explored, unlike

her own genitals. The doll also is visible, tangible, and ever-present, in contrast to her genitals. This stage, according to Kestenberg, forms the core of the female maternal instinct, preceding heterosexual object choice (1956a; 1977).

The doll is not, however, a fully satisfactory object of externalization for the little girl; throughout her early childhood the pressure of diffuse inner genital sensation continues to erupt in the form of irritable nagging, teasing, and crying. She nags and teases another person-- at first, her mother-- as she feels nagged and teased herself by tantalizing, unreachable sexual excitement; in this way she also finds someone to soothe her as she cannot soothe herself. (Kestenberg feels that the adult female hysterical character is a pathological continuation of this early trend: such women, with their constant histrionic vivacity, "spread excitement", rather than satisfying or containing it [1956b].) In these attempts to actively discharge inner genital sensation the little girl in some measure paradoxically perpetuates her passivity through dependency on others.

the ego [has] given up its prerogative of mastery over the body and contents itself with the feeling of mastery over people who can provide satisfaction and thus effect relaxation. (1956b, pp. 6 -7)

Kestenberg attributes the little girl's advanced speech development and toilet-training to her dependency on her mother.

While the boy is still busy experimenting with his body and getting an intimate knowledge of it, the girl, frustrated in her efforts to master bodily sensation of the lower part of the body, is already more dependent on the mother than the boy and therefore more in need of communication and obedience. (1956b, p. 11)

The girl in her first three years also seeks to externalize inner genital tension onto psychosomatic symptoms such as rashes and stomach aches, which have a clear physical source and expression, and can thus be alleviated (1968; Greenacre, 1950).

During the phallic phase (around four years old) the little girl over-cathects the clitoris and denies the existence of the vagina, in another attempt to find an external, clear focus of genital sensation (1956b). To all the classically-cited motives for penis envy is added, at this stage, the girl's wish for the boy's greater opportunities for externalization. The boy at this age also feels pressure to channel inner genital sensation (from the groin and perineal-scrotal area) but does so with greater ease, into his penis (*Ibid.*).

As the little girl's penis envy and resulting disillusionment with her mother moves her

into the oedipal phase the father becomes an important object of externalization (1973). He is now the main representative of her elusive, tormenting, inner genital, and as such is teased, manipulated, and unconsciously blamed. This phase is precursor to later heterosexual sadomasochistic relationships:

[the oedipal phase girl's] sensation of something inflicted on oneself, an inability to discharge tension [is] identified with an aggressor, and a yearning for relaxation [is] identified with passive dependence. (1956b)

In this way a pattern may be set up of impotent reliance on an eternally frustrating male, and fantasies stimulated of master-slave relationships.

During the oedipal phase the vagina may be temporarily recathected in the form of fantasies of sexual intercourse with the father, following the phallic phase's overcathexis of the clitoris and preceding the latency phase's re-repression of such fantasies (1968).

All of these externalizing trends intensify during the pre-pubertal phase, when inner genital tension reaches its apogee. This period, which follows the relative calm of latency, begins with the functional and anatomical changes of puberty and ends when the girl is actually capable of reproduction. Teasing and manipulating of the opposite sex, bursts of diffuse emotionality such as giggling and irritability, and master-slave masturbation fantasies all increase at this time. Masochistic trends also are exacerbated, because pain and punishment can provide yet another focussed outlet for tension (1961).

As the girl moves into adolescence proper her menses become more regular and predictable; as a result, Kestenberg believes, menstruation becomes an important source of increased mastery over the body. Here she takes issue with the traditional psychoanalytic view that menarche has only a negative effect on feminine development. Menstrual cramps instead lend the ambiguous uterus a more specific locale and the vagina also gains greater definition as funnel for a visible discharge. Both these organs become more stable elements of the girl's body image at this time (1967b). In addition, the adolescent girl can learn the typical signs of her pre-menstrual and menstrual phases, as well as take effective steps to make herself more comfortable at these times. Kestenberg observes that the organizing effect of menstruation is such that even psychotic patients can discuss it in a more lucid way once they have reached menarche (1961).

Menarche can also, however, have disorganizing effects on female development. The menstrual flow can revive anal concerns over messiness and loss of control, and diminish the girl's sense of mastery over her body (1961). (See also Deutsch, 1944, Silberman, 1950, and Shopper, 1979.) The menses can also symbolically represent a lost of the inner genital, rather than consolidating their mental representation (1977). Finally, the menses can take on a pathologically masochistic externalizing function, encouraging the adolescent girl to find other, similar psychosomatic symptoms with which she can symbolically represent and soothe diffuse sexual tensions (1961).

Despite her belief that masochistic trends often crystallize around menstruation during adolescence, Kestenberg makes a sharp distinction between the pathways of normal and pathological masochism which open up at this time. In a 1961 paper she compares two research subjects, "Mrs. A" and "Mrs. B", with respect to their differing reactions to daily setbacks and difficulties. Mrs. A's children's illnesses, squabbles, and difficulties in school move her to "formulate questions and ideas as to how to make things better....[She] uses painful experiences to find direction and organization in her life." (1961, page 294). Mrs. B, in contrast, lapses into confused, helpless complaining when faced with the normal chaos of a household of children, and seems to enjoy her suffering per se, rather than enjoying any attempts to master it. Kestenberg characterizes Mrs. B's behavior as "masochistic pain on an instinctual level" and Mrs. A's approach as "the use of pain through mastery on the ego level" (*Ibid.*). The crucial differentiating characteristic here is the effect of suffering on ego function: Mrs. A. becomes disorganized, unable to cope; Mrs. B becomes more organized, making plans and predictions in order to solve her dilemmas. The two possible reactions to menarche described above, normal and pathological, also characterize these two forms of masochism.

For Kestenberg the adolescent boy's ejaculations are parallel in function to menstruation; they challenge his sense of bodily mastery in such a way that can lead to more anxiety and confusion or stimulate increased efforts to understand and control his body. Although the boy's ejaculations are not as predictable as the girl's menses, he can to some extent modulate them through masturbation and in this way learn their mode of functioning. In addition the boy's orgasms, much more than menstruation, further externalize groin and scrotal sensation to the visible penis. His body image attains even greater clarity, with the penis now the "core of the overall design of the male body" (Kestenberg, 1967a). (The simple but very important fact that ejaculations are physically

pleasurable and menstruation is not also makes this landmark of puberty less problematic for the boy.)

When the young woman has her first experience of sexual intercourse she has, for all foregoing reasons, generally less understanding of her own sexual functioning and anatomy than does the young man of his. Her still vague inner genital sensations, according to Kestenberg, must await the intruding presence of the penis to gain greater clarity. (This idea, by the way, is a familiar theme in psychoanalytic writings on femininity. Bonaparte [1953] and Deutsch [1944], among others, also subscribe to the "Sleeping Beauty" paradigm of female adult sexuality, according to which the vagina must be "awakened" by the penis.) The passivity that necessarily accompanies the continuing vagueness of her genital experience is counterbalanced by the male's activity and sharply focussed sensation (1956b). In most cases then, the man is the "teacher and organizer of female sexuality" (1968, p. 464). Kestenberg even goes so far as to say that the penis truly "creates" the vagina, since the vagina only gains clear mental representation once it is filled by the penis. The vagina and penis can become linked in one mental image as a result; this accounts for the frequent female fantasy of an internal penis (1956b).

In adolescence and young adulthood then, even after the first heterosexual experiences, female understanding of and control over genital sensation is still to a large extent vicarious, borrowed from the male. In a continuation of earlier trends she seeks to excite, tease, and manipulate his sexual feelings so that she gains a mastery over his body that she lacks with respect to her own (1973).

Pregnancy presents, for Kestenberg, the last developmental challenge of inner genital sensation since it involves powerful but often ambiguous experiences within. In child-bearing, however, women can attain their most powerful sense of mastery over inner genital experience.

The girl has to yield the exploring, fear-conquering activity on her vagina to the man. This she normally does in her role as the receptive passive partner in intercourse. [However,] the active manipulation and mastery of her infant substitute for her inability to develop actively a clear image of her inner genital. (1956a)

All the characteristics of the doll cherished by the little girl are present in the baby in an even more satisfying form: here is an aspect of the unknown space within, now become visible, tangible, explorable. The baby, in contrast to inner genital sensation, is

ever-present, and can be brought relief from bodily tension (1956b; 1968; 1977). (It should be noted that, although Kestenberg feels that the pressure to externalize sexual tension forms the core of the maternal instinct, she does recognize many other familiar and classic motives for childbearing, which are more rooted in object relational issues.)

There does exist a danger that the mother will over-sexualize her relationship with the baby as a result of the pressure towards externalization. As a result her handling of the baby can become seductive, obsessively exploratory and intrusive, and close to masturbatory: the baby becomes equivalent to a fetish (1956a; 1968).

The above example of pathological externalization illustrates Kestenberg's belief that the healthy woman must strike a balance between being content with only a vague understanding of her genitals and unfocussed, unsatisfied sexuality on the one hand, and making excessive attempts to externalize sexual tension, on the other. She must not, for instance, repress vaginal sensation in favor of the clitoris, transfer inner genital tension onto psychosomatic symptoms, nor infuse others with her own tension and then seek to control them in the ways she cannot control her own emotional lability. Some measure of externalization is unavoidable and even desirable, for even in adult women all of the genital areas, and in particular those completely internal, can lose cathexis and mental representation when not in a state of excitement (1956b). Even the healthy adult woman's mastery over her genital sensations is so tenuous that there "remains enough unrelieved, poorly localized excitement... to warrant repeated externalizations" (1973, p. 97).

Kestenberg sees wide-ranging implications in these continuing deficits in women's understanding of and control over their sexuality. Their ego functions are as a result very definitely compromised in comparison to men, although in some ways this outcome proves adaptive for what Kestenberg considers to be women's primary role of childrearing. Women's diffuse body image results in weak ego boundaries; on the more positive side this lends them flexibility and empathy; on the negative side, it leads to fears of ego dissolution and an excessive propensity for regression (1967b; 1968). In addition, women are less reality-directed than men because of their continuing preoccupation with problematic inner sensation (hence their "narcissism"); they are better at "intuition" of emotions than at "knowledge" of the external world (1956a).

Kestenberg repeatedly emphasizes, in light of the above feminine characteristics, that women can-- and should-- remain quite passive in their sexuality and identity-formation.

Above all, women must learn to be “teachable” and, as I have already discussed, their “natural teachers” are men (1968, p. 151). Kestenberg speaks critically of an eighteen year old female patient who “manipulated men rather than allowing them to teach her” (*Ibid.*, p. 119). Similarly, the young adult woman should “mold and organize her identity to fit the ego ideal and social aspirations of her love object”, whereas the young man’s “ego ideal and his actual place in society become the narcissistic core of his identity before he can safely invest his object-cathexis in a permanent relationship” (*Ibid.*, p. 149).

Summary and Critique of Kestenberg's Theory

I have already discussed, in part one of this chapter, the failure of early psychoanalytic thinkers to construct a theory of femininity that is not derived from and pejoratively compared to a theory of masculine development. In this most recent section I have summarized the ideas of a modern psychoanalytic thinker, Judith Kestenberg, who does truly embrace Harold Blum's (1977) notion that femininity has “its own primary developmental lines”. She traces these developmental lines out of their origins in a bodily experience that is peculiarly feminine and also quite problematic: diffuse, unlocalized, inaccessibly internal genital sensation. As she follows the vicissitudes of female responses to this bodily experience Kestenberg repeatedly stresses the concept of mastery: the female capacity to creatively transform experiences that are confusing, frustrating, or anxiety-producing into more clear-cut, comprehensible, and manageable states. As a result Kestenberg's viewpoint balances women's problematic bodily experiences with their capacity to develop, nonetheless, in a healthy and mature fashion. She tries to construct an integrated theory of femininity that can account for both normality and pathology according to the same basic explanatory principles. She does retain many of the old psychoanalytic concepts of femininity (penis envy, masochism, narcissism, and passivity) but recasts them in such a way that women are not seen in such a pathologized or phallogocentric fashion than is the case with more traditional psychoanalytic theories. The little girl does not envy the boy's penis because she has nothing where he has something; instead she has her own specifically female, although problematic, genital experience. Kestenberg attributes to women the capacity to transform passive genital experiences into situations in which they can gain some measure of active mastery. In clearly differentiating normal and pathological masochism, she allows for the possibility that women's painful or confusing genital sensations help them to learn to transcend pain, rather than necessarily direct them towards perverse enjoyment of pain.

Despite these significant achievements of Kestenberg's theory of femininity, she still falls into the old psychoanalytic habit of over-emphasizing women's passivity. For Kestenberg, women's ability to master their own bodily experience is almost always vicarious, attained through controlling parents and children, or through learning about their bodies from men. Her treatment of adolescent and adult femininity is particularly unsatisfactory in this regard. Although teenage girls and young women are less likely than their male peers to be knowledgeable about their own patterns of sexual response, they are not necessarily doomed, by virtue of their anatomy, to this state. There is nothing, for instance, that literally physically prevents them from masturbation, which is of such paramount importance to young men in purveying a sense of ownership of the body. In addition women can become more assertive and knowledgeable vis-à-vis their bodies-- for instance, in their relationships to obstetricians and gynecologists, by performing part of their own vaginal self-examinations. As I discussed in the previous section on Helene Deutsch, women also during childbirth have a unique opportunity to transform an "implacable" physical process, to which they must in one sense passively acquiesce, into a creative act that is in some more profound sense not at all passive.

Kestenberg is also rather too reductive in her universal application of the principle of feminine "externalization". Her explanation of sex differences in ego functioning largely on the basis of this concept is often unwieldy, as if she were trying to balance a large object on the head of a pin! Her reliance on rather hackneyed male-female dichotomies such as "emotional intuition of internal states/rational knowledge of the external world" betrays a simplistic epistemology, equating internal experience with the non-real, and external, perceptible "facts" as the real. Surely wisdom, for both men and women, requires an interplay of emotion, empathy, abstract understanding, and physical observation?

Despite these quarrels with Kestenberg, I believe that her basic theme of externalization has powerful explanatory value, and shall draw on it a great deal in stating my own hypothesis in Chapter 4. I will also in that chapter try to rectify some of the failings in Kestenberg's discussion of female adolescent and adult development.

CHAPTER THREE

In this chapter I shall review the research on, first, the eating disorders, and, second, delicate self-mutilation. The material presented here will provide the foundation for Chapter Five, in which I will discuss these syndromes in the context of my overall theoretical hypothesis.

Part One: The Eating Disorders

At the outset a distinction should be made between the older, originally more inclusive, term “anorexia nervosa” and the newer term of “bulimia”.

Anorexia nervosa's latest formal psychiatric definition (DSM-III R) is as follows: a disorder of no known physical cause in which there is lost at least fifteen per cent of body weight, or less than eighty-five per cent of average expectable body weight is not gained (as during the adolescent years), there is a significant distortion in body image in perceiving oneself as fat, and there is an intense dread and refusal of weight gain. Anorexia nervosa was first reported in the medical literature in 1689 by an English physician, Richard Morton, who described two cases, male and female, in their late teens (Silverman, 1988). The disorder was first designated a discrete syndrome by an English psychiatrist, William Gull, in 1874 (Bruch, 1973).

Bulimia was not recognized to be a separate diagnostic entity from anorexia until the late 1970's, and not formally recognized as such until 1980 in the DSM-III. (Gull in 1874 had in fact described bingeing symptoms in his anorexic cases.) There has been much controversy over bulimia's definition. The original DSM-III description was at once too broad and too specific: it did not distinguish between habitual and occasional bingeing, nor specify the presence of some form of purging; thus it incorporated under its rubric close to normal behavior. This first definition also explicitly excluded anorexic dieting, which is now widely recognized as often accompanying bingeing (Sours, 1974; Bruch, 1985; Kassett, Gwirtzman, Kaye, Brandt, & Jimerson, 1988). The newest DSM-III R definition does require the presence of purging (usually vomiting or laxative abuse) and/or dieting, and specifies at least two bingeing episodes a week; it also allows for a “residual” category, with some but not all of the criteria met. The newer definition in this way acknowledges recent researchers' general consensus that bulimia and anorexia form part

of a spectrum disorder (Boskind-Lodahl, 1976; Garfinkel & Garner, 1982).

An eating disorder can thus take the form of, first, a pure, "restricting" sub-type (as epitomized in the DSM-III R's "anorexia nervosa"), second, a mixed sub-type, in which bingeing, purging, and dieting co-exist, and, third, a less pathological type in which bingeing and purging exist but normal weight overall is maintained. (To avoid confusion, I shall, when specificity is possible, refer to "restrictors", "bulimic anorexics", and "normal weight bulimics" to characterize these three sub-types.) It has been recently suggested (Garfinkel & Garner, 1987; Hogan, 1983; Wilson, 1983, 1988; Johnson & Connors, 1987) that the two ends of the diagnostic spectrum -- "pure" bingers and restrictors-- have widely different ego and super-ego styles and family backgrounds. Bingers have weaker super-egos and thus tend to show more "externalizing" types of defensive behavior, such as projection and acting out. They are, accordingly, more prone to impulsive self-destructive acts, such as suicidal gestures, self-mutilation, drug and alcoholic binges, promiscuity, and stealing. They display affective disorders more frequently, show more mood lability in general, and are more frequently diagnosed as borderline. Life in their childhood homes is generally chaotic, with their families manifesting addictions, affect disorders, and self-destructive behavior. Restrictors have more rigid super-egos, are more inhibited in their behavior, and tend to use what Johnson and Connors (*Ibid.*) term "internalizing" defenses: isolation of affect, reaction-formation, and intellectualization. Their families of origin tend to be perfectionistic and over-controlled, with narcissistic disorders prevailing.

One of the two strongest demographic findings on the eating disorders is their correlation with socioeconomic status: large scale epidemiological studies in both Western Europe and the United States confirm that the overwhelming majority of these patients are middle or upper class (Garner, 1980; Boskind-White, 1985; Johnson & Connors, 1987).

The other most powerful demographic finding on the eating disorders is their gender specificity: women patients always outnumber men. Bruch (1979), for instance, in a review of 70 past cases of restrictors between 1942 and 1970, found a one to seven male-female ratio. Garner and Garfinkel (1982) found a 3.3 per cent male incidence in 221 restrictor and bulimic anorexic patients referred to their eating disorder unit between 1976 and 1981. Gesensway (1988) estimates that only 13 percent of college age bulimic anorexics and normal weight bulimics are male. These male cases all appear, in addition, to be the exceptions which prove the rule, as they are generally described as "feminine"

in personality. Crisp (1983) attributes "profound gender identity uncertainty" to his 40 cases of male eating disorders seen over a period of 20 years; Sours (1980), Mintz (1983), and Wilson (1988) all note in these cases a symbolic association of weight gain with feminization, and a problematic over-identification with the mother.

These important sex differences in incidence of eating disorders are given surprisingly short shrift in most of the relevant literature, in that theoretical explanations for them are usually sparse or non-existent. Psychodynamic thinkers are particularly unlikely to offer such explanations, perhaps because of certain unstated assumptions about women's problematic sexual development and natural propensity for masochistic behavior. (I shall take up this point again in Chapter 5.) The most common explanatory theories, when they are given, are cultural or bio-psychological. The first type of theory, in contrast to the second, is systematically developed by its proponents, who believe that modern women are subject to conflicting sex-role expectations to be both autonomous and self-effacing, ambitious and nurturing. As a result, women resort to one of the few acceptable, yet self-defeating, forms of competitive behavior: weight loss. This behavior symbolically expresses their conflicting wishes to be both nurtured (fed) and utterly independent (not in need of food) (Ohrbach, 1985; Boskind-Lodahl, 1985; Steiner-Adair, 1986). Most theorists, even those concerned mainly with intrapsychic factors, ascribe in some measure to this point of view; the apparent recent increase in incidence of eating disorders is very frequently explained in this fashion. The second, biopsychological, type of theory attributes women's increased vulnerability to the eating disorders to deeper conflicts over sexual maturation, as a result of earlier onset of puberty and more discontinuous pubertal body changes, in comparison to men (Crisp, 1967; Bruch, 1973; Garner & Garfinkel, 1982; Wilson, 1983). Other explanatory concepts include women's tendency to not actively express sexual and aggressive wishes (Oliner 1988) and Tabin's more elaborate theory of girls' difficulties with separation in the toddler years, when they are caught between psychological individuation and gender-identity formation, between identifying and disidentifying with their mothers (Tabin, 1985; Tabin & Tabin, 1988).

Johnson and Connors in their exhaustive 1987 review of the literature note that there is general agreement among researchers on age of onset for the eating disorders: during adolescence in the vast majority of cases. Garner and Garfinkel (1982) describe an average age of incidence between 12 and 25 years, with a bimodal distribution whose peaks are at 14 and 18 years. This latter finding may be due to a gradually emerging difference in age of onset between the more "restrictor" type of disorder (around

menarche) and the more bulimic type (around the time of graduation from high school). (Johnson, Stuckey, Lewis, & Schwartz, 1982; Mintz, 1983) Catalysts for the emergence of symptoms are usually described as experiences that signify maturation and separation from family (Johnson and Connors, 1987).

Incidence statistics for the eating disorders vary widely, partially on account of ambiguities and differences in nomenclature. In two of the best studies, anorexia- both bulimic and purely restricting- has been assigned a 7 per cent incidence among English adolescent girls and a 1 per cent incidence among English 16 to 18 year old girls in private schools (Schwartz, Barrett, & Saba [1985] citation of Lacey and Crisp studies). In their review of epidemiological findings Johnson and Connors (1987) report that studies using the DSM-III definition of bulimia cite statistics ranging from 5 per cent of college women to 20 percent of college seniors. Johnson and Connors conclude that the most carefully designed studies with clear symptom descriptions of bulimic anorexia and normal weight bulimia result in incidence statistics hovering around 8 per cent.

A frequent observation in the recent literature is that eating disorders are increasing in incidence, as a result of the cultural factor of intensified conflicts within the female sex role and the peculiar infectiousness of these symptoms in high schools and colleges (Boskind-Lodahl, 1985; Bruch, 1985; Lacey, 1985; Ohrbach, 1985).

The phenomenology of eating disorder symptoms emerges very clearly in the literature. Binging, dieting, vomiting, excessive use of laxatives, and over-zealous exercise all have a compulsive, addictive quality: the patient is overwhelmed with anxiety at the thought of relinquishing these behaviors and usually organizes her life around them in a secretive and ritualistic fashion (Crisp, 1983; Wooley & Wooley, 1985; Reiser, 1988). The symptoms also all have a cathartic, self-purifying quality, which modulates affective states of anxiety, anger, sexual tension, or dissociated "emptiness". Patients often note experiences of "smothering" or "swallowing" anger through gorging (Lacey, 1985), of rhythmic vomiting as a means of attaining a calm, somnolent state (Gesensway, 1988; Fairburn, 1985) or as a "stomach orgasm" (Swift & Letven, 1984), of dieting and compulsively exercising in order to "exorcise" anxiety and attain an elated state (Katz, 1985), or of purging in order to break through a feeling of inner deadness (Abraham and Beumont, 1982; Hogan, 1983; Bliss, 1986). The main controversy over the phenomenology of the eating disorders is the question of whether these patients experience hunger when they are dieting; at least one sub-group do not--probably the

most severe "restrictor" cases (Garner & Garfinkel, 1982; Wilson, 1983).

The quality of object relationships among eating disordered patients follows an easily recognizable pattern. Both within a given patient and across patients there is a vacillation between a grandiose insistence on ascetic self-sufficiency, on the one hand, and impulsive seeking out of emotional supplies, on the other hand (Crisp, 1976; Garfinkel & Garner, 1982; Johnson & Connors, 1987). When the second mode of relating is ascendant, intimacy is found in transient, superficial, sexual relationships and there is little capacity for frustration-tolerance. (This latter pattern is more common among bulimics, who binge on sex rather like the way they do on food.) The patient is often actually less interested in sex than in physical contact and comfort (Johnson & Connors, 1987), and in fact quite disgusted by her biological needs and functions (Wooley & Wooley, 1985). In the first mode of relating control over emotional and physical needs is rigidly upheld. In both cases the patient has a tremendous investment in controlling those around her, almost like fetishes (Sperling, 1978; Crisp, 1983), which results in powerful countertransference reactions. Therapists and hospital staff find themselves feeling emotions the patient has evicted from herself: impotence, neediness, and despair (Bruch, 1973; Sprince, 1988; Boris, 1988). They become locked into sadomasochistic battles for control, often focussed on the issue of forced feeding (Wilson, 1983). These patients' relationships with families, lovers, and friends are also sadomasochistically tinged, as they gain malevolent control over others through punishing their own bodies.

Psychological theories of etiology for the eating disorders have, not surprisingly, mirrored changing fashions in the field of psychiatry. Early theories focus on drive conflict, such as ambivalence over oral aggression or Oedipal fantasies of impregnation (Masserman, 1941; Moulton, 1942; Lorand, 1943). Later theories show the ensuing influence of ego psychology, family-systems theory, object-relations theory and self-psychology; in general, however, they all focus on the same core factors of separation problems, profound conflicts over autonomy, fears of sexual maturity, and difficulties with tension regulation.

Bruch (1973; 1979; 1985) has largely popularized the diagnosis of anorexia nervosa and her particular etiological theory still has much influence. She emphasizes three crucial ego deficits of her eating disorder patients (usually of the classic restrictor sub-type): perceptual and cognitive mis-readings of internal physical and affective states; very poor sense of personal effectiveness and excessive interpersonal compliance; and a

distorted body image. She attributes all these traits to unempathic parenting, in which the child's responses are inappropriately and confusingly interpreted by the adult, so that the child has no opportunity to discover an inner self and thus develop autonomous functioning. The result is an overly "good" child who conforms to her parents's stringent ethical principles and perfectionistic ambitions. Any conflict over sexuality or aggression is, according to Bruch, secondary to the basic ego deficits.

The family systems approach to the eating disorders [see especially Minuchin, Rosman, & Baker (1978) and Selvini-Palazzoli (1978)] stresses the patient's essential and rigidly-defined role in stabilizing family patterns-- particularly in mediating and deflecting marital conflict. Both of these theorists stress the "enmeshment" of these families, such that the child has no opportunity for autonomous action or experience (Minuchin et al) or feels the mother, and her food, to be a hostile, devouring introject (Selvini-Palazzoli).

Recent psychoanalytic approaches to the etiology of the eating disorders present in pure or amalgamated form the following types of theories: an object relations perspective (with emphasis on separation-individuation conflicts and borderline type of ego deficits such as poorly modulated aggression), a more classical, structural approach (with emphasis on oedipal impregnation fantasies) and a self-psychology approach (with emphasis on ego deficits in cohesion and stability of the self rather than in drive modulation). The cases presented in the psychoanalytic writings are very diverse in range of diagnostic severity and family pathology. I will present two etiologic theories which are both popular and prototypic of the field at present.

The first theory, that of Wilson and his colleagues (1983) is object-relational in approach, emphasizing profound conflicts over, and difficulty in modulating, oral aggression, which "contaminates" the preceding anal and oedipal phases. The parents of eating-disordered patients are described as infantilizing in two contradictory ways: both over-punitive and over-lax. In flight from a controlling mother, there is premature entry into an oedipal relationship with a sexually over-stimulating father. The organization of eating disorder symptoms is similar to that of phobias or psychosomatic symptoms, and often co-exists with the latter. Mechanisms of projection and displacement allow anxiety to be quite successfully avoided, because it is so efficiently bound up with one narrow realm of experience, e.g., eating.

The second theory, more self-psychological in approach, emphasizes the parent's use of the child's body as a fetish. (See Geist, 1985) The child's body becomes the parent's symbolic penis, a tool to "narcissistically repair [his or her] self-esteem" (Abraham [1924], cited in Schwartz [1988, p. 34]). This symbolic equation is the origin of the eating disordered patient's later fascination with maintaining a taut, narrow, muscular body. The internal experiences of the child are of no account to the parent, who instead is overpre-occupied with the child's physical appearance and bodily functions (Geist, 1985). The patient learns to treat her body as the parent did, such that it becomes a repository for both self-hatred and primitive grandiosity (Goodsitt, 1985). As a result of this mode of parenting there results certain profound ego deficits: the patient, no matter how articulate otherwise, cannot verbalize emotions, or regulate them thereby. Instead, affects are expressed in the form of bodily states; the body becomes "a primitive system of concrete symbolization" (Tabin, 1985, p. 213). Being thin is equated with being free, unfettered, and separate; constant physical activity imparts these experiences as well. Vomiting is equated with being pregnant or with ridding oneself of an intrusive psychological presence. Over-eating is equated with assuaging loneliness by filling up an empty space, or with controlling/destroying a malevolent other. This inability to symbolize emotion in the more abstract form of words explains the frequently-noted incapacity of these patients to produce fantasies or free associate in treatment (Bruch 1973; Wilson, 1983; Krueger, 1988).

Some of the most energetic and prolific empirical researchers on the eating disorders, such as Garner and Garfinkel (1982) and Johnson and Connors (1987), favor a multi-factorial, "risk factor" model of etiology, incorporating social pressures (such as the conflicting sex role expectations described above), a pre-existing vulnerability in affect-modulation which is perhaps biochemically-based, and enmeshed or chaotic family conditions.

Part Two: Delicate Self-Mutilation

In the 1960's there suddenly appear in the psychoanalytic and psychiatric literature many papers on patients who cut themselves without apparent suicidal intent (Offer & Barglow, 1960; Burnham, 1966; Graff & Mallin 1967; Grunebaum & Klerman, 1967; Rinzler & Shapiro, 1968; Kafka, 1969; Pao, 1969; Podvoll, 1969). Pao (1969) is the first of these writers to make a careful distinction between "delicate self-mutilation" ("superficial, delicate, carefully designed [repeated] incisions", p. 195) and "coarse

self-mutilation" (usually a "single, deep, and coarse incision close to vital points", [Ibid.]) In the spate of papers which follow it emerges that delicate self-mutilation sometimes takes the form of small burns, but most commonly involves cutting (Asch, 1971), is usually done on wrist or forearms (Rinzler & Shapiro, 1968; Novotny, 1972), and is often exacerbated in an epidemic-like fashion on psychiatric wards (Offer & Barglow, 1960; Graff & Mallin, 1967; Grunebaum & Klerman, 1967). Delicate self-mutilation is also found to happen more frequently among women, with studies citing female to male ratios from 2 to 1 to 20 to 1 (Offer & Barglow, 1960; Graff & Mallin, 1967; Pao, 1969; Novotny, 1972). These females are usually in their adolescence or early twenties (Rinzler & Shapiro, 1968; Rosenthal, Rinzler, Walsh, & Klausner, 1972) with age of symptom onset early to mid-adolescence (Pao, 1969; Novotny, 1972). The precipitant for onset is almost universally described as some kind of psychological abandonment, often by lover or therapist (Crabtree & Grossman, 1967; Podvoll, 1969; Asch, 1971).

The earliest account of this syndrome found in the psychiatric literature is that of Emerson in 1933 (detailed in Favazza, 1987), describing a 23 year old woman with a history of sexual abuse and profound sexual conflicts who cut herself for "relief". The uniformity of the delicate self-mutilation symptom picture leads Pattison and Kahan (1983) to designate it a discrete disorder, "deliberate self-harm syndrome". This syndrome consists of compulsive, recurrent, and direct attempts at self-harm with low lethality and no suicidal intent, and is believed by Pattison and Kahan to be associated often with DSM-III Axis II diagnoses of borderline or histrionic personality disorder. Pattison and Kahan allow "atypical cases" which are closer to the coarse self-mutilation category to be included under this rubric, which most of the other authors cited above do not.

Pao's "coarse self-mutilation" seems to be diagnostically, demographically, and symptomatically different from delicate self-mutilation. It generally occurs in psychotic populations-- often paranoid schizophrenic-- with grossly delusional religious ideation (Pao, 1969; Lester, 1972; Shore 1979; Lion & Conn, 1982; Favazza, 1987). It also seems to occur more frequently in older men (beyond their late twenties), in contrast to the preponderance of young female delicate self-mutilators (Pao, 1969; Pattison & Kahan, 1973).

Other disorders to be differentiated from delicate self-mutilation are the various modes of self-injurious behavior (usually head-banging or self-biting) associated with

neurological disorders e.g., Tourette's syndrome (Lion & Conn, 1982), autism (Cain, 1961, Green, 1967), Lesch-Nyhan disease (Carr, 1977; Lion & Conn, 1982), temporal lobe epilepsy (Lion & Conn, 1982) and severe mental retardation (Green, 1967; Lester, 1972).

One additional symptom picture is somewhat more difficult to differentiate from delicate self-mutilation than those mentioned above: self-cutting in jailed inmates. This behavior can be phenomenologically quite similar to that of delicate self-mutilation, in that small cuts are made in a state of psychological tension, with no pain experienced during the act and much relief felt after (Bach y Rita, 1974). The psychological underpinnings of the act, however, appear to be quite different: there is a stronger component of conscious motivation and secondary gain, such as transfer to a hospital ward or different cell block (Lion & Conn, 1982; Favazza, 1987) and the cutting seems to emerge also from the enforced inhibition of externally-directed aggression in very violent, particularly male, inmates (Bach y Rita, 1974; Favazza, 1987).

There does seem to be a continuum between young women who cut themselves only on psychiatric wards, as an expression of adolescent defiance, exhibitionistic female "machismo", and craving for excitement, and comparable young men who, although similar in personality structure, are more likely to end up incarcerated (Offer & Barglow, 1960; Grunebaum & Klerman, 1967; Bach y Rita & Veno, 1974).

Those who cut themselves only when incarcerated (in hospital or jail), whether out of redirected anger and secondary gain, or out of adolescent rebellion and histrionics, are very different in personality structure from "classic" delicate self-mutilators, as I shall discuss shortly.

Other factors also blur the definition of delicate self-mutilation. Many studies still combine coarse and delicate, single and recurrent, suicidal and non-suicidal acts of self-mutilation in their target group, and then cite equivalent sex ratios and later mean ages of onset as argument against the preponderance of delicate self-mutilation among young women. (See especially Clendenin and Murphy, 1971, and Weissman, 1975) Even setting aside such methodological blunders, delicate, non-suicidal self-mutilation itself can evolve, as the patient ages, into more gross and overtly suicidal acts of self-destruction (Pao, 1969; Novotny, 1972).

Nonetheless, those studies which carefully select out only recurrent, non-suicidal

delicate acts of self-cutting, not simply confined to the psychiatric ward, do repeatedly find the same demographic and personality characteristics. A core group emerges of classic delicate self-mutilators who are mostly female, usually in their teens and twenties, with borderline or histrionic personality characteristics, rather than psychotic or anti-social types of personalities. These patients have idiosyncratic relationships to their bodies and types of object relationships, and express a particular form of body symbolism in their self-cutting, not seen among other patients who cut themselves. In the following section I shall detail these psychodynamic peculiarities. (There is some evidence, as well, for a small sub-group of males within this core group, who are characterized as “effeminate”, or as struggling with powerful homosexual conflicts. [Pao, 1969; Asch, 1971; Novotny, 1972] Although little information is provided in the literature about these men, they do appear to experience sexual identity difficulties and alienation from their bodies similar to those of the female delicate self-cutters.)

The phenomenology of delicate self-mutilation is remarkably similar across cases and studies. The sequence of events begins with an intolerable sense of psychological and physical tension, often unspecified in content but at times explicitly sexual or angry (Kafka, 1967; Asch, 1971; Favazza, 1987). Very commonly this feeling of tension is accompanied by a dissociative experience-- feeling numb, empty, or unreal (Graff & Mallin, 1967; Pao, 1969; Rosenthal et al, 1972; Gardner & Cowdry, 1987). These feelings are followed by an addictively irresistible need to cut, or more rarely burn, oneself (Novotny, 1972; Siomopoulos, 1974; Pattison & Kahan, 1983). The cutting itself is performed in an intensely private, ritualistic fashion, which often has masturbatory overtones. Patients will, for instance, line up sharp instruments in a predetermined fashion, while sitting in a dark bedroom, with only one dim lamp or candle lit (Podvoll, 1969; Gardner & Gardner, 1975). The patient will rarely feel any pain during the cutting, although she sometimes does so afterwards (Simpson, 1973). Instead, there is a tremendous, quasi-physical sense of relief, which is erotic, cathartic, and soothing all at once. Characteristic comments from patients and therapists are as follows: “a voluptuous blood-bath...private and luxurious” (Kafka, 1969, pp. 209-210); “I felt the badness in me go out” (Grunebaum & Klerman, 1967, p. 529); “[she felt] something evil and tense within her, leaking away” (Simpson, 1973, p. 809); “[the blood felt] warm, comforting, and maternal” (Burnham & Giovacchini, 1969, p. 226). Alongside this sense of relief is a rapid disappearance of the dissociated state, and an intensified sense of being alive, real, in one's body, and physically separate and psychologically distinct from others (Kafka, 1969; Burnham & Giovacchini, 1969; Rinzler & Shapiro, 1969). Usually the patient stops

cutting at the sign of blood, which is an intensely pleasurable and fascinating sight (Asch, 1971; Rosenthal et al, 1972; Simpson, 1973).

The phenomenological descriptions of delicate self-mutilation available in the literature are so compelling that it is tempting to assume some kind of universal body symbolism and/or biochemical addictive tendency being tapped. Bleeding, and its less common relative, deliberate burning, are ancient and geographically widespread forms of physical healing and spiritual purification. Ackerknecht, in his classic text Medicine and Ethnology (1971), notes that, "bleeding is an almost universal trait in primitive medicine" (p. 99), encompassing Oceania, Central America, Pre-Columbian Peru, Brazil, Greece from the time of Hippocrates, and China from the fourth century B.C. (p. 99; see also Epler, 1980). In the modern period bleeding was particularly common in nineteenth century America and England, where it was mainly used for "feminine complaints" (Siddall, 1980). Siddall comments that contemporary accounts by patients express a "feeling of purification, mystery, and magic". (p. 102) upon being bled. Frazer in The Golden Bough (1890) describes numerous examples of bloodletting for purposes of initiation, propitiation, and spiritual rebirth in African, South American, and Pacific cultures. Coid, Allolio, and Rees (1983), Richardson and Zaleski (1986), and others have investigated a possible neurochemically-based addictive component to self-cutting, noting an increase in the body's natural opiates in habitual self-mutilators.

The object relations of the classic delicate self-cutters are also strikingly homogeneous. Three themes recur in the accounts of this syndrome. The first pattern of object relations commonly described is a driven, needy, at times indiscriminate seeking out of physical contact, as a way to relieve feelings of emptiness, loneliness, or inner deadness (Graff & Mallin, 1967; Rinzler & Shapiro, 1968; Asch, 1971; Carroll, Schaffer, Spensley, & Abramowitz, 1980). (This interpersonal trend alternates at times with an opposite, grandiose counterdependency [Burnham & Giovacchini, 1969; Kafka, 1969]). Sexual contact very frequently is only a means to this end, rather than pleasurable in and of itself (Graff & Mallin, 1967); often in fact sexual intercourse per se is explicitly feared (Rosenthal et al, 1972; Doctors, 1979; Favazza, 1987). The second theme of object relations is sadomasochism: researchers repeatedly note that these patients seek out sadistic men (Asch, 1971; Burnham & Giovacchini, 1969; Doctors, 1979; Favazza, 1987). Doctors, in fact, makes an explicit parallel between the delicate self-cutter's sadomasochistic relationship to her body and her relationships to others. In both arenas the patient seeks some form of emotional catharsis, as in the case of a girl who "sought to

be hit by someone, so that she could experience the release of tears" (p. 148) and had partially provoked several rape attempts. The third interpersonal trend noted is such patients' extraordinary facility in inducing powerful countertransference reactions in therapists and hospital staff. Such reactions include the experience of being a sadistic tormentor (Podvoll, 1969; Kafka, 1969), of taking on an omnipotent responsibility for the patient in the form of savior fantasies (Burnham, 1966; Podvoll, 1969; Zerbe, 1988), or becoming a container for the patient's deep loneliness and sense of helplessness (Grunebaum & Klerman, 1967). In all these cases these patients use projective identification in a particularly compelling way, such that they form mutually intense relationships in which they both control the other by encouraging him or her to act out their own disavowed feelings.

Etiological theories found in the literature on delicate self-mutilation are usually--and surprisingly-- not explicitly offered as explanations for the preponderance of females in this diagnostic category. As was the case with the eating disorders, this omission is probably due to unstated assumptions about feminine masochism and problematic sexual development. Phillips and Alkan (1961a) do try to explain the sex ratio with an unelaborated comment about women's greater propensity for directing aggression inwards; Graff and Mallin (1967) similarly, and rather simplistically, state in this context that females are culturally molded to be more passive than males, and are more often rejected by their mothers. Doctors (1979) seems to be the only researcher who offers a detailed, coherent explanation for the preponderance of female delicate self-cutters. Implicit in her discussion of these patients is her concept of an increased (in comparison to males) female propensity for inchoate sexual sensation, fears of bodily damage and thus of penetration of any sort, and feelings of lack of control over bodily functions. (Doctors invokes here the ideas of Barnett, Greenacre, Horney, and Kestenberg [see Chapter 2].) Delicate self-cutters in Doctors' view, cope with these body-related frustrations and anxieties by seeking active, counter-phobic methods through which they themselves bring about the pain, bodily penetration, and bleeding. (As I shall discuss in Chapter 4, my own theory of delicate self-mutilation, as well as of the eating disorders, owes a great deal to Doctors' ideas.)

Setting aside the perplexing question of the female quasi-monopoly on delicate self-mutilation, many of the etiological theories focus on a few central ego deficits which this symptom expresses and serves to ameliorate. It is often noted that these patients have great difficulty communicating feelings, irrespective of their verbal facility in other

areas (Offer & Barglow, 1960; Grunebaum & Klerman, 1967; Doctors, 1979). These patients thus feel shut into a state of “almost supreme loneliness and isolation” (Podvoll, 1969, p. 213). Partly as a result of this verbal incapacity, these patients also have difficulty modulating affect. As noted previously, they are prone to incommunicable, extreme states of tension which they cannot soothe, or opposite states of deadness or emptiness which they cannot enliven. These patients' frequent abuse of alcohol and drugs also testifies to their problems with affect-modulation (Graff & Mallin, 1967; Rinzler & Shapiro, 1968; Novotny, 1972; Grunebaum & Klerman, 1972; Coid et al, 1983). Walled off as they are in the world of their own bodies, with little ability to verbally communicate intolerable internal states, these patients resort to concrete body symbolism to express their emotions, soothe their tensions, enliven their numbness, and assuage their loneliness. The literature is filled with evocative and rather bizarre incidents in which these patients surround themselves with the reassuring presences of the concrete symbols of their self-cutting: razors, mirror shards, or bloody pieces of kleenex carefully secreted around the ward or their homes (Podvoll, 1969; Kwawer, 1980; Favazza, 1987). The patients' scars, blood, or instruments of cutting become “transitional objects”: comforting presences which represent aspects of the self but also have a semi-objective, external ontological status (Kafka, 1969; Kwawer, 1980). The patients' physical wounds are visibly apparent and can be literally tended in ways their emotional wounds cannot. As one patient puts it, “I like to see pain.” (Rosenthal et al, 1972, p. 1366). Other patients cleanse, powder, and bandage their wounds like “a mother changing a baby's diaper” (Favazza, 1987, p. 226).

Another common element in the etiologies offered for delicate self-mutilation is the patient's feelings of lack of control over bodily functions. Many writers describe their patients' distaste for menstruation and link self-cutting with an attempt to control the bleeding by actively causing, rather than passively experiencing, it (Asch, 1971; Rosenthal et al, 1972; Doctors, 1979; Kwawer, 1980; Favazza, 1987). It has also been hypothesized that self-cutting, as a metaphor for intercourse, can originate in a similarly counter-phobic approach to fears of sexual penetration (Novotny, 1972; Doctors, 1979). As a result of this preoccupation with self-control, these patients can seem surprisingly self-reliant: one patient has an “aura of self-containment, bodily omnipotence, and endurance of affliction” (Podvoll, 1969, p. 220); another, when she cuts herself, “suddenly retires into self-sufficiency” (Burnham & Giovacchini, 1969, p. 224).

Several authors link such difficulties with affect-modulation, abstract verbal

symbolism, and perceived control over bodily functions to broader difficulties in development. Asch (1971) believes that these patients are subject to "empty" or "dead" internal states because their mothers are distant and unresponsive. As a result the daughters are not able to form a separate, cohesive, and stable set of interests, values, and abilities which would result in a sense of being real, of having an inner self.; instead they are dependent on external models of behavior. Their personalities are vacant and "thrill-seeking"; their vast, unmodulated reserves of anger are eradicated with dissociative defenses, further exacerbating their sense of psychological emptiness. Other theories place great emphasis on these patients' bodily experiences as infants. Early experiences of physical and sexual abuse, severe medical illness and/or painful surgery instill a profound sense of alienation from the body, taking the form of dissociative states. Self-mutilation simultaneously "returns" the patient to her body and, in a counter-phobic fashion, imparts a perverse sense of control over the body because she herself brings about the physical injury (Kafka, 1969; Lower, 1971; Rosenthal et al, 1972; Simpson, 1981; Sackstedter, 1989a). Doctors (1979), in the most comprehensive explanatory theory extant on delicate self-mutilation, combines a sensitive and detailed account of the essential ego deficits with a genetic theory incorporating many of the above factors. She emphasizes the delicate self-mutilator's inability to tolerate or temper psychological and physical tension, or to express these states verbally, and the resulting counter-phobic tendency to "turn passively experienced diffuse distress into active, focal experiences [of a concrete, physical nature] designed to achieve a feeling of control over self" (p. 206). The extremely unempathic mothers of these patients are not able to soothe and give shape to their infants' inchoate states of distress; their daughters as a result move prematurely into overly intense oedipal relationships with their fathers. These girls also have more than the average number of experiences with injury and illness in early childhood. All these elements combine to produce difficulties with separation and self-soothing, alienation from the body, and unstable sexual identity, which are all intensified by adolescent sexual maturation and pressures to individuate. Since Doctors believes, as I discussed above, that even healthy girls have a propensity for unsatisfactory tension-regulation and for fears bodily damage, the above genetic factors make the future delicate self-cutters doubly at risk.

In this chapter I have summarized the literature on the two syndromes of delicate self-mutilation and eating disorders; the demographic, phenomenological, and and psychodynamic parallels between the two groups are by now probably quite apparent. In the next chapter (4) I shall outline my general developmental theory on women's

problematic relationship to their bodies. In Chapter 5 I shall return to the issue of these two perplexing disorder, use my theory to explain the parallels between them and to account for their preponderance in women, and discuss the insufficiencies in this regard of other theories.

CHAPTER FOUR

The sex organ of a man is simple and neat as a finger; it is readily visible and often exhibited to comrades with proud rivalry; but the feminine sex organ is mysterious even to the woman herself, concealed, mucous, and humid as it is; it bleeds each month; it is often sullied with body fluids; it has a secret and perilous life of its own.

-- Simone de Beauvoir, The Second Sex

Women watch themselves being looked at ...thus turn [themselves] into an object...[The woman] comes to consider the surveyor and the surveyed within her as the two constituent yet always distinct elements of her identity as a woman.

-- John Berger, Ways of Seeing

In this chapter I shall give a detailed account of my hypothesis by tracing the woman's relationship to her body through the phases of early childhood, adolescence, pregnancy and breastfeeding. As I have stated earlier, I do not consider the lack of a penis to be the central element in feminine psychology; I do, however, believe that woman's overall sex-specific reproductive anatomy and functioning are crucial to her emotional development. As so many critics of Freud's position have noted (see Karen Horney and Erik Erikson in particular), to posit that the lack of a penis is the core of feminine psychology ignores the potent symbolism of what women do possess, both anatomically and functionally. My essential argument is as follows: a woman finds her own body more esoteric than does a man, more mysterious in its workings, more subject to abrupt and profound transformation. As a result, women are at once more attuned to and alienated from their bodies than are men. A further paradox exists in the fact that a woman's body is experienced by her as both self and other, particularly during pregnancy but at other times as well.

I shall first discuss in this chapter the difficulties and pitfalls in the various phases of female development; here I will draw heavily on the psychoanalytic writers discussed in Chapter 2, particularly Judith Kestenberg. I should clarify at the outset, however, that my theory takes a somewhat different direction from that of Kestenberg. My ideas are very much influenced by her concept of the girl's externalization of undefined, unlocalized genital sensation, but I also find that she overextends this concept with insufficient atten-

tion to the theme of what I call "the other within": the paradox of containing within oneself the body, or part of the body, of another. I shall discuss this theme in feminine development in much more detail below.

I shall next outline in this chapter a comparison of these snares in the track of feminine development with some parallel, and not insignificant, crises faced by men. Finally I will examine the ways in which women can, and do, resolve the paradoxes in their body experience in such a way that furthers psychological growth.

Pitfalls in Female Development

In Chapter 2 I noted two important findings from psychoanalytic research on toddler girls. First, girls of this age are significantly less able to label the different parts of their genitalia than are boys (Lerner, 1977). Second, girls of this age masturbate less frequently and less directly than do boys (Kleeman, 1975, 1977; Galenson, 1976). Girls' decreased knowledge and exploration of their genitals, as evidenced in the above findings, originate to an important extent from the relative physical inaccessibility of their genitals. In contrast to boys, little girls cannot easily show off and compare their genitals; they are not given license to touch them during urination; they can less easily discover their contours because these are changeable, irregular, and partially internal (Lampl de Groot, 1924; Horney, 1924, 1928; Kestenberg, 1973). The girl's genitals may have a tenuous connection to her body image, coming into psychological focus only when aroused (Kestenberg, 1956b). As a result little girls find their genitals to be more of a source of confusion and anxiety than do boys. In addition, girls experience more frustration in their genital experiences: sexual sensation is inchoate, difficult to localize or satisfy (Kestenberg, 1956a; 1968). Under these circumstances it is not surprising that girls experience penis envy. Their absence of a penis does not only (or, in some circumstances, even significantly) indicate to them physical damage, a castration; it signifies the lack of an organ which could provide focussed and explorable sensation.

As I have already discussed, Kestenberg believes these ambiguous aspects of girls' genital experience to be so important that they spend much of their lives searching for objects and people onto which sexual sensation can be "externalized"; these symbolic substitutes for the genitals are more accessible to exploration and control. I feel that Kestenberg exaggerates the importance of externalization in early childhood: the little girl's attachment to her doll, her nagging and teasing of mother and father --these phe-

nomena seem to me more rooted in object relational issues of identification, love, and hate, rather than being transformations of genital sensation. (I do believe, however, that the adolescent girl's treatment of the opposite sex owes much to Kestenberg's process of externalization, as I shall later discuss.)

The transformations of puberty further complicate the girl's experience of her body. It now seems even more mysterious and uncontrollable, and a new problematic theme is introduced: the body as "other".

The girl's advance into puberty occurs earlier and more abruptly than the boy's. The American girl's average peak of pubertal development, for instance, takes place in the seventh grade, while that of the boy occurs one and a half to two years later (Schonfeld, 1969; Hill & Lynch, 1983). The girl's body changes in shape more than the boy's: a significantly decreased muscle-to-fat ratio adds breasts and transforms thighs and hips. These changes in physical contours have a profound effect on the girl's feelings and fantasies about her body. Body image is often fragmented: certain aspects of the body -- particularly, perhaps, the breasts-- can be perceived as ego-alien (Rosenbaum, 1979) and she often describes her body in terms of its parts (a pretty waist, an ugly nose) rather than as a whole (Striegel-Moore, Silberstein, & Rodin, 1986). Body image can also become more fluid, disrupted as it has been by abrupt change; this must be one factor in teenage girls' changeable views on their own physical attractiveness.

In interviews with 60 upper-middle class teenagers, Rosenbaum (1979) found that the girls described their bodies mainly in terms of appearance and physical attractiveness; the boys described their bodies in terms of function and physical effectiveness. This finding may be partially due to (besides important cultural factors) the girls' focus on their dramatically changed physical appearance and to a decreased muscle- to- fat ratio. The relatively taut and muscular body of latency has become softer, with a changed center of gravity; balance, speed, strength, and agility can all, at least temporarily, diminish. Feelings of physical vulnerability and a general lack of physical effectiveness can arise, as a result. Whatever the complex causes for the preoccupation with physical appearance commonly observed in teenage girls, this phenomenon signifies a further alienation from the body, an experience of the body as object rather than subject --despite a narcissistic intimacy with the body manifested in minute inspections of complexion, hair, figure, and clothes. Emphasis on the body's appearance necessarily involves an observer, a split between subject and object of perception. This alienation from the body evidences itself

very frequently in struggles with weight loss, extraordinarily common among American and Western European girls. Johnson and Connors (1987) review several large-scale epidemiological studies done in the United States, Great Britain, and Sweden, in which 43 to 56 percent of high school girls describe themselves as fat and 75 percent of these express distress at this.

I have already mentioned (Chapter 2) the common psychoanalytic observation that menarche can have a regressive effect on the teenager's sense of control over her body. Shopper (1979) points out that the use of so-called "sanitary napkins" and references to "soiling" in advertisements hints at the anal themes menstruation evokes --in girls and on Madison Avenue! He emphasizes that sanitary napkins, most commonly used by the younger adolescents, do not (unlike tampons) differentiate anus and vagina, covering both like a kind of diaper. Instruction in the use of these by one's mother also can stir up early memories of toilet-training. (Shopper raises the question of why tampons, invented in 1933, did not come into general use until the 1960's: fears of loss of virginity through this artificial form of penetration must be one factor, but also there must exist a more generalized fear of the unknown, the hidden cavity. In this connection he notes pharmaceutical companies' extraordinary sensitivity to the female unconscious, shown in the many diaphragm, tampon, and contraceptive jelly inserters on the market, all of which allow women to avoid placing their fingers in the vagina.) The menstrual pain felt by many teenage girls can also be experienced as a betrayal by the body, further undermining their sense of control over the physical self.

The findings on masturbation among adolescent girls are similar to those with toddlers: in comparison to her male counterpart, the teenage girl masturbates less frequently, and more indirectly (using a pillow between her legs instead of her hand, for instance) (Blos, 1962; Rosenbaum, 1979). Gagnon and Simon (1973) cite Kinsey's finding that around 50 percent of teenage girls first learn about orgasm in an interpersonal context; in strong contrast to boys, they rarely have spontaneous orgasms and are less likely to discover orgasm through masturbation. This finding has tremendous psychological importance: the discovery of masturbation is often a significant symbolic step towards psychological autonomy, in that the teenager is now much better able to soothe, to comfort himself (Chasseguet-Smirgel, 1976; Person, 1980, 1983; M.E. Laufer, 1982). Masturbation also signifies an increased understanding of one's body, and ability to master its needs. Conversely, discovering sexual pleasure and satisfaction through another person means that such mastery and understanding are still only vicarious, as Kestenberg would put it.

For many girls, a boy discovers their vagina and clitoris before they do themselves, and a boy knows more than they do about the workings of these organs. A sixteen year old girl interviewed by Rosenbaum (1979) seems to be metaphorically expressing this vicarious discovery of her own body through sex when she says,

I hope I will feel better, more whole [through sex]. I hope it will organize something.... would get me in touch with another, unexplored part of myself. I'd be more totally me. (p. 249)

When the vagina is not yet psychologically owned by the girl, the penis can be experienced as an "other within" in a more confusing way than is the case with a more experienced woman: the boundary between penis and vagina is even more vague, since the girl is not familiar with the contours of the vagina. Here the penis symbolically anticipates the fetus, the "other within" in an even more radical form.

Because of these symbolic meanings to intercourse, the avoidance of sex in some girls can be an effort towards psychological autonomy, an insistence on ownership of the body. For boys the very opposite is often the case; the discovery of sex is an exhilarating step towards adulthood and independence, perhaps partly because of its connotation of exploration into foreign and distant lands.

Regular trips to the gynecologist, for which no parallel exists among young men, can also contribute to the girl's sense that another person (in this case, once again, usually a man) has more direct knowledge about her genitals than she does herself.

I am in strong agreement with Kestenberg that certain important themes in adolescent girls' heterosexual relationships originate in their experiences of their own genital sensation as mysterious, frustrating, and unmanageable. Teenage girls often tease and frustrate their male counterparts in mildly sadistic ways; they also often enter into rather masochistic relationships in which they cling to unavailable, domineering, or somewhat abusive boys. (The immense popularity of "gothic" and "bodice-ripper" novels is testimony to the appeal of the angry, brooding, dark-browed hero.) Although these trends in teenage sexual relationships are to some extent due to the cultural emphasis on sexual passivity in girls, I believe that they also are expressions of girls' feelings of passivity vis-à-vis their own bodies, not just in relation to boys. A girl can achieve vicarious mastery over her own sexuality by learning to manipulate (so to speak!) a boy's passions, or by establishing moral superiority over a boy who psychologically abuses her but simultaneously de-

sires her. In the latter case her means of achieving mastery is more complex and indirect: she takes vicarious possession of his sexual power which he manifests sadistically, by (apparently) depriving her of power.

In pregnancy the paradox of the "other within" takes center stage (see Deutsch, 1945; Benedek, 1970; Pines, 1972; Turini, 1980). In addition, feelings of loss of bodily control from the toddler and adolescent periods are revived dramatically, increasing the rift between body and self.

Deutsch (1945) points out the recurrence of anal themes during pregnancy, manifested in the woman's feelings of fear and disgust at loss of control over bodily contents: her fantasies of breaking her waters on a crowded subway, her terror of losing control during labor. Adolescent anxiety over a suddenly transformed body is revived with the even more abrupt and extreme physical changes of pregnancy. (One indication of the extent of this physical transformation is the re-naming of one part of the body as it takes on a new function: the vagina becomes the "birth canal" [Kestenberg, 1968]). The adolescent preoccupation with external and internal physical changes also returns; yet this apparent intimacy with the workings of the body is countered by an increased sense of alienation from it. The analogue to adolescent gynecological visits is the now far more frequent trips to the obstetrician, who, once again, has more access than the woman to this new extension of her body. Very commonly the prospective mother feels that the obstetrician knows more about the fetus than she does (Turini, 1986); in the early months of pregnancy she may only be aware of the physical presence of the fetus when the doctor allows her to listen to its heartbeat through his stethoscope.

It is fascinating to observe that many women --particularly those seriously pursuing careers, it seems to me-- manage these fears of loss of bodily control by resorting to the old adolescent preoccupation with weight. Although most obstetricians nowadays emphasize the importance of significant weight gain to the health of the fetus, many women exercise and limit their weight gain to an injurious extent. In a pregnancy exercise group I noticed at the end of each class a cluster of women around one class-member, who had only gained ten pounds by her seventh month. The open envy and admiration of this group had an extraordinarily adolescent quality to it; the woman herself was rather bemused by all this attention since she was, not surprisingly, distressed by her lack of weight gain. In the repeated group discussions about labor the phrase "lose control" frequently recurred, and seemed to be more a source of anxiety than the actual pain of labor.

(See Pines [1972] for further discussion of fears of passivity among pregnant upper middle class working women.) Just as Deutsch described over forty years ago, many women show two opposite but related reactions to fears of loss of control during labor: they try to fight the pain and contractions, so as to maintain a stance of active control, and, as a result, must ironically end in resorting to a stance of passive submission --to premature and/or large doses of pain medication. The texts of various approaches to natural childbirth, despite their ideological differences, all emphasize the sense of active mastery paradoxically derived from "allowing the body to take over" (a process which is, of course, easier said than done!).

It is possible that the lengthy process of a normal labor allows a woman to differentiate gradually from the child within her, step by step with each contraction. Deutsch (1945) makes reference to the alienation some women initially feel from their newborn if they have been fully anesthetized during the labor, and this often seems to be the case with Caesarean births as well: a feeling of, "Where did that come from? That's not the baby who was inside me.". In both cases the woman has not taken part in a gradual, active process which allows her to take possession of her baby while simultaneously differentiating herself from it.

In lactation the breasts take on a completely new function, just as did the vagina previously. The baby, although no longer within the mother, is still biologically connected to her -- "eating her up", so to speak. Are the breasts the mother's or the baby's? The breastfeeding mother's frequent lack of interest in sex may be due not only to low estrogen production but also to a wish to have her body to herself.

Parallel Difficulties in Male Development

In the previous section I outlined the potentially problematic areas in development for the girl, as she grows with and into her body. Before discussing the ways in which these developmental crises can further emotional growth, I will briefly address the main difficulties which boys face in coming to terms with their physical selves.

Little boys face an opposite problem to that of girls in relation to their genitals: if anything the penis can be felt to be too obtrusive, rather than not obtrusive enough. Sudden erections, which occur from birth onwards (Francis & Marcus, 1975), can make the little boy feel that part of his body is outside his control, moved by mysterious forces,

not quite part of the self. The fact that the penis is not safely hidden within folds of skin or inside the body, like the girl's genitals, can make it seem more vulnerable. The changeable position of the testicles, which can fully retract up until the age of around six years, can also stimulate fears of genital damage (Bell, 1961, 1965). Retraction of the testicles can cause them to be less than solidly integrated into the body scheme, analogous to the clitoris.

At puberty the rapid growth spurt can lead to feelings of physical weakness, as a result of (usually temporary) decreased muscle- to-body-mass ratio. In the same studies cited by Johnson and Connors (1987) in which teenage girls were found to be anxiously preoccupied with being fat, around 75 percent of the teenage boys were concerned about being overly thin and thus physically weak. (See Striegel-Moore et al, 1986 for further studies confirming this finding.) During puberty also spontaneous erections -- and spontaneous ejaculations-- cause most boys to feel that the penis "has a mind of its own".

Thus, in summary, there are many opportunities across the developmental span for boys to feel that aspects of their bodies are mysterious, contrary, and anxiety-producing. Nonetheless, the obtrusiveness of the boy's genitals seems to me to be of paramount importance in allowing him to "own" his physical self. Despite the confusing and embarrassing behavior of the penis, the boy can gradually learn about its workings because he has complete and direct physical access to it. In addition, the shocking behavior of the penis at puberty --e.g., spontaneous ejaculation-- is nonetheless very pleasurable, in contrast to the parallel essential harbinger of female puberty, menstruation. Even the feelings of physical awkwardness and weakness due to the adolescent growth spurt are usually rectified by a hormonally-stimulated jump in muscle development, when the boy's strength suddenly increases up to 100 percent (Schonfeld, 1969).

Paradox in Female Anatomy and Function as Stimulus to Development

How, then, can the growing girl come to terms with all these mysterious, hidden, and seemingly alien aspects of her physical self? Is she doomed to sexual and psychological passivity, to being a Sleeping Beauty who must await the arrival of her Prince? As we have already seen in Chapter 2, even the more revisionist mainstream psychoanalytic thinkers, such as Deutsch and Kestenberg, end in believing that this is the case. Certainly one can envision ways in which girls can be encouraged to overcome the ambiguous or

unmanageable aspects of her body. Mothers of little girls, for instance, can help them learn to label the specific parts of their genitals, and this teaching can be reinforced during adolescence. Adolescent girls can be encouraged to be athletically active, so that they can gain a sense of their bodies as smoothly functioning and under their control. Impossible standards of physical beauty tend to lose importance when the body feels good and works well: not surprisingly, Rosenbaum (1979) found that athletically active teenage girls had significantly better body images than their more sedentary peers. Not all the paradoxical aspects of the female body can be overcome in this fashion, however. All girls grow up knowing that they can, and perhaps will, contain another living being inside them, and that this being will only separate itself from them through a wrenchingly painful physical process, a process which conjures up terror of bodily damage in even the most mature (or well-analyzed!) woman. Here, I think, Helene Deutsch's comments on childbirth are most helpful. The only way a woman can feel she truly owns her body is by embracing its paradoxes and profound physical transformations, rather than in all cases seeking to overcome them. In some fashion the hidden aspects of the genitals in early childhood, the radical body changes of adolescence, the penis as "the other within" during intercourse, all prepare the woman for pregnancy and childbirth. If she allows her body concept to remain somewhat fluid, so that it can incorporate massive transformation and the presence of (in some sense) alien elements, and if she repeatedly allows the body to take control, but without passive, masochistic submission, she is then better prepared for the psychological crisis of childbearing. Perhaps, also, lessons well learnt in the physical arena can translate into a broader wisdom, one which can teach the woman when to give in to and when to resist the needs and wishes of another person, just as she did with the demands of her body. This broader wisdom can also help her face the even greater physical and psychological crisis of illness, old age, and death, when accepting the limitations of one's body --and in extension, one's self-- becomes a crucial issue.

CHAPTER FIVE

These patients, bound within the seemingly inescapable opposition of master-slave, enact these oppositions on the surface of the body.

-- Jill Montgomery, "The return of masochistic behavior in the absence of the analyst"

"Take, eat; this is my body.", and he took the cup... saying, "Drink ye all of it, for this is my blood."

-- New Testament, Matthew, 26: 26-27

Bottle-fed baby, disgusted when I think of one; injection, the idea that there is something flowing into me, horrible! Integer, integra, integrum [whole; undivided] comes to mind. Untouched. A man is more untouched than a woman. He is inviolate; he does not have to be pregnant. A man remains himself, does not have to assimilate, renounce; only women have to do that.

-- Helmut Thoma, Anorexia Nervosa (fragment of session with anorexic patient)

In this chapter I shall test the capacity of my hypothesis to shed light on three unresolved issues related to eating disorders and delicate self-mutilation in women: co-occurrence of these disorders in many patients, demographic and phenomenological similarities between these disorders, and the preponderance of women within these diagnostic categories. I will argue that delicate self-mutilation and the eating disorders occur more frequently in women because they present, in an exaggerated form, the normal girl's attempt at coming to terms with the discontinuous, ambiguous, and seemingly recalcitrant aspects of her physical development, as described in the previous chapter. These two symptom complexes address similar psychological issues and draw on similar feelings, fantasies, and strivings related to the body. As a result they are demographically and phenomenologically similar, and frequently co-exist in the same patient.

In addition, just as I have discussed the effect of the normal girl's attempts at mastery over her body on her relationships to others, I will describe how similar struggles with the physical self evolve into the eating disorder and delicate self-mutilating patients' modes of relating to others --those attitudes which cause so much perplexity, fury, and despair in the families, friends, and therapists of these patients.

Part One: Co-existence of Eating Disorders and Delicate Self-Mutilation; Demographic and Phenomenological Similarities

The co-incidence of delicate self-mutilation and eating disorders is very frequently noted in the literature; few writers, however, show any interest in explaining this phenomenon. Pao (1969), Podvoll (1969), Asch, (1971), Novotny (1972), Rosenthal et al (1972), and Siomopoulos (1974) all parenthetically note the occurrence of fasting, vomiting, bingeing, "weight problems", or "eating disorders" in their delicate self-mutilation patients. Favazza (1987) after an extensive literature review on self-mutilation concludes that "as many as fifty percent of female chronic self-mutilators have a history of anorexia nervosa or bulimia." (p. 206). I myself have found it almost impossible to discover a delicate self-mutilation case study in the literature that does not cite an eating disorder history; the reverse case, anorexics who show delicate self-mutilation, is not as common in terms of percentages. Writers on the bulimic sub-type of eating disorder are particularly likely to discuss the existence of "impulsive" or "self-destructive" acts, including delicate self-mutilation, among their patients (Johnson & Connors, 1987; Wilson, 1988). Favazza (1987) and Johnson & Connors (*Ibid.*) observe that delicate self-mutilation can evolve into an eating disorder, and vice versa.

A historical link between the two syndromes can in fact be found in medieval Europe. Recently several historians have been debating possible parallels between modern eating disorders and the ascetic practices of certain Catholic "holy women" in the thirteenth to fifteenth centuries (Bell, 1985; Bynum, 1987; Brumberg, 1988). This latter phenomenon, quite widespread and notorious at the time, involved extensive fasting and vomiting (spontaneous or induced), accompanied by sleeplessness, cessation of menses, and constant, restless activity. There are also reports of "surreptitious and compulsive gorging" among these women (Bynum, 1987, p. 135). (Women who claimed to survive without eating, supposedly through divine intervention, in fact existed up until the late nineteenth century, as Brumberg [1988] documents.) Although these historians' disputes focus on self-mortifying eating practices, these women's flagellations, cutting, gouging, and burning of their bodies is also well-documented, as is their spontaneous display of Jesus' five wounds from the crucifixion ("stigmata"). In some cases the self-injury was carried out as punishment for breaking a fast. Ascetic eating practices have been claimed to exist among the so-called "desert fathers"-- early Christian male ascetics-- of the third and fourth centuries, but these were rare cases, if not completely apocryphal (Bynum, 1987). What Bell terms the "holy anorexics" of the medieval period, however, were uni-

versally female and were commonplace (and well-documented) enough that they are considered by modern historians to be an important element in the religious temper of the times. The showing of the stigmata is also an overwhelmingly feminine phenomenon: Bynum (*Ibid.*) finds only two cases of holy men who are reported to show all five stigmata and very few cases of men who display stigmata at all. In addition, the female stigmata bled "periodically", usually every Friday (to commemorate the crucifixion); male stigmata did not recur on a regular basis. Here we have many of the familiar features of the self-mutilation and eating disorder syndromes: self-purification through mortification of the body; amenorrhea and menstrual symbolism; hyperactivity; all correlated with fasting, purging, self-cutting, and even bingeing. It is, of course, very dangerous to try to establish parallels between two historical periods which are so divergent in value-systems: these holy women of the medieval period had, for instance, much social prestige and even political power, in contrast to the impotent self-destruction of modern anorexics and self-cutters. Despite this caveat, the fact that distorted eating practices and self-cutting co-existed in a period so distant in time and alien in value-systems to our own (when, for instance, famine was common and slenderness not an aesthetic ideal) does suggest an intrinsic psychological link between the two phenomena. (Later in this chapter I shall return to this question, in discussing the merits of the cultural explanation for the eating disorders.)

As should already be apparent from the review of literature in Chapter 3, there are many parallels between delicate self-mutilation and the eating disorders with respect to age and circumstances of onset, phenomenology, and gender links. Both disorders usually arise in adolescence, are precipitated by separations (such as camp, boarding school, or break-up with boyfriend), and appear with far greater frequency among girls than among boys, with male patients of either category having obvious homosexual characteristics. The phenomenological similarities between the disorders are almost completely neglected in the relevant literature, yet are especially striking. Bingeing, purging, dieting, and self-cutting have a powerfully addictive, compulsive quality (as Wilson [1988] is one of the few to point out). They are all also highly ritualized behaviors, often conducted in secret. One self-cutting patient (Grunebaum & Klerman, 1967) uses a metaphor which coincidentally describes the cathartic and purifying aspect of both types of symptoms: "[Self-cutting] is like vomiting; you feel sick and spit out the badness." (p. 529). Pao (1969) and Burnham and Giovacchini (1969), similarly, point out the soothing function of self-cutting, bingeing, and purging; the patients themselves attest to the sexual undertones to their symptoms: the "stomach orgasm" of vomiting, the "voluptuous blood-bath" of self-muti-

lation. (See Chapter 3.) Another recurring theme in the literature is the use of these symptomatic acts to dispel feelings of deadness, emptiness, and unreality. Johnson and Connors (1987) comment on a study (Mitchell, Boutacoff, Hatsukami, & Pyle, 1986) which finds a 40 percent frequency of self-cutting in laxative-abusing bulimics:

[pain with diarrhea] has an integrating function similar to other forms of self-mutilating behavior, [so that the patient] can feel alive and in touch with reality. (p. 149)

Explanations in the literature for the coexistence and phenomenological/demographic similarities of delicate self-mutilation and eating disorders are usually vague and cursory: the two syndromes are said to arise, for instance, from sexual confusion (French & Nelson, 1972) or from an underlying hysterical personality disorder and rejection of femininity (Simpson, 1973). More specific explanations, on varying levels of abstraction, cite the common factors of need for self-punishment (Burnham & Giovacchini, 1969; Johnson & Connors, 1987); soothing the pain of abandonment (Burnham & Giovacchini, 1969; Pao, 1969); avoidance of depersonalized states (Johnson & Connors, 1987); inability to establish an identity separate from mother at puberty (Asch, 1971); unmodulated aggression and primitive super-ego functioning (Wilson, 1988). Such explanations are still far too broad in scope, since they could be used to account for the links among a wide variety of psychiatric disorders. They do not take into account the many, very specific similarities between delicate self-mutilation and the eating disorders, notably the parallel struggles with the body and parallel attempts to shift emotional difficulties onto the physical plane, yet also to transcend physicality altogether.

Favazza (1987) to my knowledge is the only writer to emphasize the coexistence of eating disorders and delicate self-mutilation, stating he has been much impressed by this phenomenon in his extensive practice with delicate self-mutilators. However, perhaps because he has not been struck by the phenomenological parallels between eating disorders and delicate self-mutilation specifically, he accounts for their coexistence by subsuming them under the (in my view) overly-broad category of "Delicate Self-Harm Syndrome" which includes psychotic cases and falls into an even broader class of self-injurious behaviors, such as heavy cigarette smoking, chronic alcoholism, and the refusal of essential medical treatments. To my mind this is taking the continuum theory too far: eating disorders and delicate self-mutilation are far more similar to each other, psychodynamically and symptomatically, than they are to any of these other disorders. The following section, I hope, will make this point more cogently.

Part Two: Underlying Psychodynamic Parallels between
Delicate Self-Mutilation and the Eating Disorders

In the following section I will discuss the means by which eating disorder and delicate self-mutilating patients negotiate the same challenges and paradoxes of the body that are faced by the healthy adolescent girl. Parallel difficulties in meeting these developmental challenges is, I believe, the explanation for the frequent co-incidence of these disorders, for their phenomenological and demographic similarities, and for the fact that they both are far more likely to appear in females than in males.

These two psychiatric illnesses, as bizarre and self-destructive as they appear, are nonetheless attempts to own the body, to feel it to be self (not other), known (not uncharted and unpredictable), and impenetrable (not invaded or controlled from the outside). As should become clear from my discussion, this struggle, ironically, backfires in such a way that perpetuates and often exacerbates the original struggles with the physical self.

We know far less about these patients' feelings about the body in early childhood -- how they come to terms with Kestenberg's "unlocalized genital sensation" and with partially internal genitals-- than we know about their adolescent struggles with the body. The former question, of course, involves far more speculative reconstruction of the past. As I described in Chapter 3, there has certainly been much emphasis in the literature on early difficulties with soothing all physical tension, rather than sexual feelings in particular. (See Bruch, 1973, Geist, 1985, Goodsitt, 1985, Sugarman & Kurash, 1982, Schwartz, 1988; Krueger, 1989 on eating disorders; Grunebaum & Klerman, 1969, Kafka, 1969, Lower, 1971, Rosenthal et al, 1972, Atwood, 1981, Simpson, 1981, Favazza, 1987 on delicate self-mutilation.) Early problems in localizing and identifying physical tensions in general is considered by Bruch to be an essential factor in the eating disorders; Doctors (1979) makes a similar point about delicate self-mutilation. Although these themes of early difficulties in localizing, naming, and modulating bodily tensions recur in the literature on both disorders, there is little theoretical reference to these difficulties with sexual tension in particular. Schwartz (1988), in a review of psychoanalytic literature on bulimia, does cite the normal young girl's use of "eating and oral sensation to localize and detoxify enigmatic and confusing vaginal sensation", but does not specify what form this might take in the childhood of a bulimic. Doctors (*Ibid.*), as far as I know, is the only researcher to systematically apply Kestenberg's concepts of unlocalizable genital sensation (and

its externalization) to delicate self-mutilation. As I noted in Chapter 3, Doctors believes that this symptom is a transformation of vague, passively experienced discomfort-- often specifically sexual tension-- into "an active focal experience", a manifestation of a pathological counter-phobic personality trend which originates in early childhood. Among her evidence for this theory are these patients' infant-like experiences of "intolerable, diffuse distress" (p. 213), their continuing reliance on transitional-object-type furry animals and toys, and their memories of mothers who were notably unempathic and thus did not help their daughters organize and relieve distress.

More direct evidence for an early rupture between body and self in these two disorders lies in the intriguing fact that both are often linked to a history of physical or sexual abuse, painful illness, or major surgery. In Chapter 3 I noted that this type of history has been observed from the very start of modern research on delicate self-mutilation. Recently this has become an issue in eating disorder research as well: for the past five years several authors have been debating the possible increased incidence of sexual abuse among these patients. (See Calam and Slade, 1989, for a review article on this topic.) Such early experiences of physical pain and malevolent or medical physical intrusions must make the body seem like an enemy alien, and indeed encourage willful detachment from a body which brings such distress. In addition, important early experiences of physical pain could establish a prototype for externalization, along the lines of Kestenberg's theory of female masochism. The patient comes to seek out physical pain because it is a more clear-cut, controllable experience than sexual tension-- and because pain deliberately sought out constitutes a counter-phobic triumph over previous, passive experiences of pain. Doctors (*Ibid.*) believes that this latter mechanism is at work among her delicate self-mutilating patients, all of whom have prominent histories of early physical illness and injury, and who seem in some measure to seek out physical attacks from parents and boys during adolescence. Finally, early experiences of severe physical distress can stimulate such hatred for the body that the self is driven to retaliate against the body experienced as an other. (See Sackstedter's [1989a] and Montgomery's [1989] treatments of sexual masochism.) All the above is still largely speculative; it is hard to believe, however, that the tremendous enmity between psyche and soma that exists among eating disorder and delicate self-mutilating patients does not have origins in early childhood.

Less questionable is the assertion that, by adolescence, alienation from the body -- particularly the sexual body-- is crucial to the full-blown presence of an eating disorder and/or delicate self-mutilation. These patients (and their therapists) provide dozens of

examples, in word and in act, of their massive discomfort with the esoteric, changeable, and ego-alien aspects of their bodies, as they undergo the radical transformations of adolescence.

Virtually every researcher on the eating disorders has pointed out their patients' discomfort with the normal increase in body fat at puberty. (See, for instance, Crisp, 1983; Wilson, 1983; Brooks-Gunn, 1988.) These patients attempt to stabilize a shifting body image by dieting or purging themselves back to the old familiar pre-pubertal body. These efforts, however, often only further de-stabilize body image by causing wide variations in weight (Wooley & Wooley, 1985). The rapid shifts between a protruding stomach and a sense of fullness (due to bingeing or constipation) and a flatter stomach and sense of emptiness (due to vomiting or laxative abuse) also destabilize body image. Pubertal fat becomes a potent and complex metaphor, symbolizing emotional and physical weakness--indulgence in all fleshly pleasures-- and foreshadowing the even more extreme changes of pregnancy. The manic pursuit of exercise and of a lean, taut body, so commonly seen among restrictor anorexics (Bruch, 1973; Krueger, 1988), purveys a grandiose sense of physical lightness (almost as if flying), of freedom, of invincibility (Steiner-Adair, 1986). Breasts, stomach, and rounded hips only impede one's flight.

Breasts, stomachs, and thighs are such objects of hatred that, as one 12 year old anorexic put it, "I'd like to get a knife and cut off the flesh, just like that." (Mintz, 1983, p. 340; see also Gesensway [1988] and Wilson [1988] for similar observations.). This extraordinary image suggests an implicit fantasy shared by eating disorder patients and delicate self-mutilators: it seems very likely that both, literally or figuratively, seek to pare off fat, to mortify the flesh.

Delicate self-mutilators-- in a striking parallel with the eating disorders-- often suffer from body image disturbances. Doctors (1979) notes her patients' "frequent and intense shifts of feeling concerning body image... sudden feelings that they are ugly, fat, disgusting..." (p. 202). Rinzler and Shapiro (1968) note the same type of body image distortions in their self-cutting patients.

The psychiatric literature is also replete with references to the eating disorder patient's distaste for menarche. As Mintz (1983) evocatively puts it, menarche "re-opens old wounds" (p 336). Many writers in fact believe that amenorrhea is one of the crucial aims of these patients' attempts at weight loss; this wish can be so powerful that menstru-

ation often stops before significant weight loss, for no apparent biological reason (Hogan, 1983; Wilson, 1983; Fairburn & Garner, 1988; Tabin & Tabin, 1988). Menstruation threatens the eating disorder patient's all-important need for dominion over her body, stirring up as it does memories of loss of bowel control (Mintz, 1983). Menarche may revive, for a vulnerable adolescent, the confusing question of what is inside and what is outside, what is me and what is not-me, that she first confronted during the toilet-training period. Menstruation can also become a prototype for tension-discharge, just as Kestenberg suggested. In fact, Johnson and Connors (1987), in a study of the incidence of bulimic symptoms, found that 62 percent of their 316 subjects binged one to ten days prior to menstruation, while none binged during it; apparently menstruation itself performed the requisite tension-discharge function.

In his exhaustive review of research on delicate self-mutilation Favazza (1987) reports a common "disgust over menarche, menstruation, and intercourse" (p. 203). (See also Nelson and Grunebaum, 1971) A recurrent theme in the literature is the transformation of the passively-experienced "injury" of menstruation into the actively sought injury of self-cutting (Asch, 1971; Rosenthal et al, 1972; Doctors, 1979; Favazza, 1987). One of Favazza's patients even holds the belief that she can divert blood from the vagina by cutting herself. Doctors' (1979) careful in-depth study of 5 delicate self-mutilators shows a symbolic equation of menstrual blood and faeces in all of her teenage female patients, with one patient even referring to sanitary napkins as "diapers". Menarche for these girls stirred up the same regressive anal concerns found in eating disorder patients. It is interesting to note that some delicate self-mutilating patients seem to be different from at least the bulimic eating disorder patients in that they cut themselves during menstruation, as well as before or after (Rosenthal et al, 1972. Here, perhaps, the important issue is to control the flow of blood, rather than making use of menstruation as an alternative form of psychosomatic discharge.

For girls who have only a tenuous sense of ownership over their bodies the experience of sexual intercourse can take on the character of psychological invasion and masochistic submission. Writers on the eating disorders with very few exceptions emphasize the sexual conflicts in these patients. The desire to be thin is equivalent to the desire to have an asexual, latency-age body (Bruch, 1973; Wilson, 1983). I would argue that such wishes do not solely arise out of problematic oedipal yearnings or fears of emotional separation from the mother, as is commonly asserted in the literature; the avoidance of mature sexuality also involves an insistence on ownership over one's body. Oliner (1988)

makes the point that the penis can be experienced as equivalent to food, both representing a psychological intrusion of the "other" (To take the extreme case, force-feeding of the toddler, or of the hospitalized anorexic, can be the equivalent of an oral rape.) Zakin's (1989) comparative Rorschach study of 35 binge eaters (20 of whom also vomited at least once a week) and 20 normal subjects found that Rorschach body penetration scores had between .3 and .43 correlations with well-standardized tests of eating disorders. The body penetration measure, states the author, "reflects the degree to which body boundaries are experienced as fluid and easily penetrated or violated" (p. 413). (In fact, the eating disorder patient's preoccupation with semi-mechanically controlling her bowels may be, in part, an attempt to eradicate what seems like a foreign presence, an intrusion from within.)

As I discussed in Chapter 3, the actual sexual behavior of eating disorder patients is usually either completely abstaining (in the case of restrictors) or compulsively indiscriminate (generally a bulimic trait). In the abstainers the desire to defend against psychological invasion is more direct and clear-cut; in the transitory, often sadomasochistic sexual encounters of the bulimic there seems to be a more complex set of motives in operation, including a counterphobic trend. Since this type of girl tends to believe that pain and of powerlessness are integral parts of her bodily experience, she seeks them out so as to keep them under her control. Here also we can see the "full-empty" imagery that so preoccupies the eating disorder patient. Emptiness --a stomach without food or a vagina without a penis-- can be literally experienced by the restrictor as lightness, freedom, psychological autonomy, or it can evoke in the bulimic loneliness, neediness, an inner void. In the latter case, "fullness"-- e.g. sex-- is sought out in a frantic, indiscriminate fashion whenever the gaping "hole" of loneliness is felt. These sexual encounters do not succeed in assuaging the loneliness, however, partly because the sexual feelings and acts are experienced in a dissociated way (Lower, 1971; Hogan, 1983); body and self are estranged.

These same themes pervade the sexual conflicts and behavior of the delicate self-mutilator. As I mentioned in Chapter 3, these patients also manifest extremes of sexual behavior: complete and fearful abstention or indiscriminate sexual encounters with sadomasochistic overtones. Once again, counterphobic trends and full-empty imagery can be discerned in these opposite but linked types of behavior. Many writers describe the delicate self-mutilator's unconscious equation of sexual intercourse and being cut (Novotny, 1972; Rosenthal et al, 1972; Doctors, 1979). Doctors believes that her patients pursue sexual encounters so as to master their fears of physical pain and damage, just as I have ar-

gued is the case with “promiscuous” eating disorder patients. Doctors supports her contention by underlining the fact that her patients all began to have sex four to six months after menarche (although this was not necessarily socially acceptable behavior in their cultural milieu), as if the pain and blood of menstruation triggered counter-phobic sexual behavior. The feelings of emptiness so often described as preceding self-mutilation can also precipitate frenzied attempts at sexual contact, so as to feel “filled up” (Rinzler & Shapiro, 1968; Novotny, 1972).

The dramatic physical changes of adolescence and the first sexual experiences foreshadow possible future pregnancy- a premonition definitely laden with anxious fantasies for the eating disorder patient and, more inferentially, for the delicate self-mutilating patient. Conflicted wishes to be pregnant are noted repeatedly in eating disorder case histories (Sperling, 1978; Sours, 1980; Hogan, 1983; Mintz, 1988), as the patient symbolically enacts gestation or expulsion of the fetus through vomiting, diarrhea, and rapid weight gain or loss. Reiser (1988) gives an account of a patient who equated diarrhea (due to laxative abuse) with miscarriage. (See Sperling [1978] and Mintz [1988] for similar case accounts.) Hamburg (1989) cites a patient who consciously associates bingeing with being pregnant (both incorporating the experience of being “filled up”) and purging with abortion. The preoccupation of these patients with full-empty experiences and with separating out self and non-self, inside and outside, comes up again in this context. Food, faeces, menstrual blood, the penis, and finally the fetus can all be experienced as the “other” within, an internal presence whose continuity with the self is ambiguous.

One actually pregnant bulimic patient experienced this state as one of “fullness” and thus “self-sufficiency” (Gesensway, 1988). She contained all she needed within her, and felt dependent on no one, just as some patients feel during or after a binge. Another patient (in this case, significantly, anorexic), whose eating disorder began after an abortion, commented that, “After the pregnancy and abortion I am so particular about what goes inside me-- into any part of my body. I don’t want anything foreign inside me.” (Mogul, 1989, p. 79.) Here food seems to be equated to the fetus, both creating an experience of a malevolent inner presence, in contrast to the previous case. Similarly, Selvini-Palazzoli (1978) argues that fears of pregnancy among eating disorder patients are not fears of sexuality per se, but of psychological invasion by another. Pregnancy can in fact exacerbate, or suddenly and dramatically, improve an eating disorder (Kalucy, Gilchrist, Mc Farlane, & Mc Farlane, 1985; Lacey, 1985; Gesensway, 1988; Goldman, 1988; Lemberg & Phillips, 1989; Mogul, 1989). The effect of a pregnancy in such cases may be due to whether the

fetus is experienced as a hostile, ego-alien invader (perhaps most often in restrictor cases), or a comfortingly ever-present being, more integral to the self and more worthy of nurturance (perhaps more likely among bulimics). The patients who have the latter experience may be those who Gesensway (1988) describes as improving with pregnancy but deteriorating once again during weaning, when the baby is perceived as more separate from the self.

Evidence pertaining to fantasies of pregnancy among delicate self-mutilators is quite sparse, except in the perhaps veiled form of recurring feelings of emptiness, almost universally experienced before the cutting takes place. Asch (1971), in the only study of pregnancy among delicate self-mutilators known to me, believes that these patients seek out pregnancy in order to fill up a sensed inner void. He notes, however, that his patients sought abortions when they felt the movements of the fetus. Perhaps the fetus' independent actions transformed these patients' experience of it from a benign extension of the self to an alien, hostile presence, as I speculated in the case of Gesenway's bulimic patient.

Certain themes constantly echo through the accounts of body experience among eating disorder and delicate self-mutilation patients. Both types of patients seek an ascetic transcendence of and omnipotent control over the body.

Christian imagery of attaining the status of pure spirit, for instance, recurs in eating disorder case histories. Wooley and Wooley's (1985) patient draws a cross as a symbol of her cure, of becoming "purely spiritual". Hogan's (1983) patient consciously identifies with Christ, and recounts fantasies imbued with the themes of quasi-mystical "will" and "power". Wilson's (1983) patient bluntly states that she wishes to have no body whatsoever; body fat is imagined to vaporize slowly in a purification of the self. Fried and Vandereycken (1989) describe quite eloquently this characteristic attitude:

Many patients, in a narcissistic blending of ascetic practices and mystic fantasies, idealized the image of a sylph-like figure that is floating in the air as a weightless ballerina, detached from the gravity of an earthly body. (p.370)

This extraordinarily powerful wish for, and sense of, detachment from the physical realm contributes to the common delusion among severe anorexics that radical weight loss will not bring death: the body will die, but not the core self. One of Bruch's (1973) patients puts this very clearly:

I have denied my body, I have pretended it did not exist, it was not worth anything. I did let it disintegrate as if 'myself' and 'it' were different-- like two separate people. I was in my body--but severed from it. (p. 279)

(Note once again the drastic cutting imagery here in an eating disorder, not self-mutilating, patient.)

Almost every writer on the eating disorders is struck by the paramount importance for these patients of a sense of control, displaced from the environment to a ruthless dominion over their own bodies (see Bruch, 1973; Wilson, 1983; Geist, 1985.). They seek control over almost every bodily function, such that each calorie of food ingested must be cancelled out in a rigid schedule of exercise and/or purging.

The delicate self-mutilator is similarly determined to transcend and control the realm of physical existence through mortification of the body. Many such patients are in fact so successful in this striving that their therapists are impressed in spite of themselves. These patients elicit such descriptions as, "an aura of...bodily omnipotence and endurance of affliction." (Podvoll, 1969, p. 220); "proud...[manifesting] the ultimate control" (Burnham & Giovacchini, 1969, p. 228). In Chapter Three I noted the common view of these patients that their cutting purifies them, releases the evil "dybbuk", as one put it (Asch, 1971, p. 614). Podvoll's (1969) patients viewed their self-cutting as all that is "honest, authentic, pure, disciplined" (p. 219). The perverse sense of control elicited from self-cutting can be seen in this quote from an anonymous caller into a talk show on delicate self-mutilation: "I used to slit my wrist. I did it because it gave me a sense of power, like I controlled my own destiny." (Donahue, transcript number 10165, p. 18). (See also Kafka [1969] for similar quotes from patients.)

All these patients, in their attempts to master and rise above physical need and sensation become, ironically, only more obsessed with such concerns, as the body slips more and more out of their control. Their continuing preoccupation with the body is betrayed, for example, in the care given to make-up, clothes, and hair, as Gardner and Gardner (1975) and Doctors (1979) point out in reference to self-cutting; these authors in fact believe that their patients' scars have some kind of narcissistic, decorative function. Kafka's (1969) self-cutting patient treats her body as "a constant object of erotic fascination" (p. 208). Other authors have pointed out the bizarre contrast between the anorexic's well-groomed hair, chic and tight-fitting clothes, and her grotesquely emaciated body

(Bruch, 1973; Chernin, 1981). In all these cases there is a distorted narcissism, a perverse sense of beauty in the proud display of livid scars and protruding bones. This preoccupation with the physical self takes a more ego-alien form when the self-cutting or abnormal eating habits become addictive. These acts which originally were aimed at erasing the existence of the body and at establishing self-control, now take control themselves. The world narrows to an obsessive preoccupation with the body and its products-- blood-stained kleenex and containers of blood stored in closets (Kwawer, 1980), or vomit in drawers (Wilson, 1983)-- and with thoughts of the next meal, the next purge, the next self-cutting. Every plan for the day revolves around finding an opportunity to (usually secretly) carry out these rituals. The eating disorder patient scrutinizes her body for areas of fat; the self-cutter minutely supervises the healing of her scabs (Favazza, 1987). Instead of vaporizing, leaving the self free and unencumbered, the body becomes an albatross, an ever-present enemy.

In these patients the body and the self have a paradoxical relationship that is both intimate and estranged. As a result these patients feel painfully dissociated-- yet not liberated-- from their bodies. In eating disorder patients this often takes the form of feeling split into different selves or physical parts. (One of Hogan's [1983] patients "scolds" parts of her body she judges to be too fat.) It is frequently asserted that eating disorder patients have these splits in self-concept or body-concept because of unassimilated and malevolent introjects (c.f. Selvini-Palazzoli, 1978, Hogan, 1983, and Wilson, 1983). I would argue that another cause is an abnormal division of body and self-- an estrangement which is primary (not a metaphor for warring internal objects) and is due to an incapacity to come to terms with the more mysterious and changeable aspects of the female body. Self-mutilating patients' estrangement from their bodies is most evident in the radically dissociated states which precede the self-cutting: the self is often experienced as hovering above or standing at a distance from the body (Rosenthal et al, 1972).

In sum, the relationship between self and body in these two disorders is fundamentally sadomasochistic. Sadist and masochist are always psychologically entwined: the sadist feels both intense yearning and contempt for his victim; the masochist fears, yet depends upon and covertly controls the sadist. Self and body, in the eating disorders and in delicate self-mutilation, are similarly entwined yet mutually hateful. The self alternates roles with the body, sometimes oppressor, sometimes the oppressed. The patient herself is "both proud punisher and victim" (Burnham and Giovacchini, 1969, p. 226).

This internal sadomasochistic relationship has an exact parallel in these patients' interpersonal relationships. I have already discussed their panicky yet rageful struggles for control with family and therapists, their intense neediness and rebellious counterdependency. (See Chapter 3.) Internal and external sadomasochism are linked through the common element of the body: other people are manipulated as if extensions of the body, and functions or parts of the body are tyrannized as if unruly persons.

When relationships with others become too fraught with sadomasochistic overtones the body can always revert from oppressor to its previous status as a faithful companion, trustworthy and obedient when family, lovers, friends, and therapists are not. Here the body functions as a transitional object, in Winnicott's (1953) sense: a soothing presence that has an intermediate existential status, in between self and other. This function served by the body is particularly noted by the writers on delicate self-mutilation. Kafka (1969) states that one of his patients feels her blood to be a kind of "security blanket": she can always resort to its warm and comforting presence and feels as a result self-sufficient, in need of no one. Kwawer (1980) notes that his patient gazes at remnants of her blood, on kleenex or in a container, so as to soothe herself. Both these authors explicitly refer to their patients' blood and bodies as transitional objects. It is not surprising, then, that these patients are described as giving the impression of "self-containment" (Podvoll, 1969) and "omnipotent self-sufficiency" (Burnham & Giovacchini, 1969). The transfer of control from the environment to the body is explicit in one of these patients' explanation for her self-cutting: "When you're powerless over your environment you have control over yourself." (Donahue Show, transcript number 10165, p. 18).

Eating disorder patients very commonly have these same feelings about food: it is always available to them as a soothing presence and can be controlled in a way that people cannot (Bruch, 1973; Wilson, 1983; Krueger, 1988).

During the binge itself, she felt pleasure, sometimes euphoria. She experienced a magical omnipotence, in which she could have, for a moment, whatever she wanted, entirely within her control. (Krueger, 1988, p. 62)

The grandiose insistence on self-sufficiency is of course related, in restrictor eating disorder patients, to their belief that they have transcended their need for food; in these patients, however, just as with the bulimics, there is a substitution of thinking about, making, and eating food (however small the quantity) for interpersonal relationships. Food can purvey this sense of containing all one's needs within, by virtue of its transitional sta-

tus as intermediary between self and other.

To summarize my views on the eating disorders and delicate self-mutilation, I have hypothesized that these patients have more difficulty resolving the paradoxes of the body confronted by healthy females. All women must come to terms with the esoteric-- hidden, changeable, and unruly-- aspects of their reproductive anatomy and functioning; in so doing they (ideally) develop a sense of ownership over the body, despite its invasion or inhabitation by the "other". However, instead of embracing the paradoxes the body presents, these particular patients try to erase all contradictions and ambiguities. Ownership of the body is distorted into ruthless tyranny over and mortification of the body.

I have speculated that early experiences of physical or sexual abuse, severe pain or invasive medical procedures, may help create a developmental deficit, a psychological chasm between body and self. This rift becomes widened for defensive purposes perhaps already in early childhood but certainly by adolescence, when the patient seeks excessive control over unruly emotion, sexual sensation, and sudden bodily changes (as well as over friends, lovers, and family) by tyrannizing the body. The body itself is temporarily transformed from enemy into ally, and the solution seems simple and efficient: self-cutting, dieting, bingeing, or purging solve every emotional dilemma; psychological conflict is neatly packaged. When this type of patient feels overrun by others and by her own, seemingly unmanageable, needs, she always has recourse to the body, her whipping boy and her solace. In a kind of internal projection all psychological problems become physical ones and emotional experience is concretized. Thinness is self-sufficiency, bleeding is emotional catharsis, bingeing is the assuaging of loneliness, purging is the moral purification of the self; there is no sense of metaphorical bodily expression in these patients. The body of course comes to resent its taskmaster, in a way very much similar to the development of an addiction. (It is no coincidence that these patients show a high rate of drug and alcohol abuse, as I noted in Chapter 3.) The more the addict attempts to control his emotional world with drugs or alcohol the more substance-dependent and out of control he becomes. Similarly, the body of the eating disorder or self-cutting patient escapes from control and persecutes in its turn: vomiting leads to remorseless hunger; over-use of laxatives leads to intransigent constipation and laxative addiction; weight loss leads to an escalating compulsion to lose even more weight. What began as an attempt to resolve the paradox of a body that feels alien to the self, now founders in deeper paradox, as body and self constantly shift roles of victim and victimizer, master and slave.

Part Three: Competing Theories on the Preponderance of
Women Manifesting Eating Disorders and/or Delicate Self-Mutilation

In the case of the coexistence of and similarities (both symptomatic and psychodynamic) between the eating disorders and delicate self-mutilation, I have already shown that few authors have indeed discovered this issue, and that when they have their explanations are scanty or superficial. The often-invoked concept of women's tendency to turn anger against the self and thus against the body does not hold up in face of men's significantly higher incidence of brutal and fatal attacks on their own bodies. In the case of the preponderance of women in the eating disorder or delicate self-mutilation category there are, however, some serious competitors to my theory, from both the psychoanalytic and the "culturalist" schools.

In the case of delicate self-mutilation Doctors (1979) presents (not completely explicitly) a precise explanation for the gender link, rather than simply attributing it to the feminine propensity to turn anger against the self-- the over-broad explanation favored by other researchers. As I noted in chapter 3, Doctors invokes several psychoanalytic writers on early vaginal sensation-- Kestenberg, in particular-- in order to postulate that girls have more difficulty with localizing, identifying, and thus satisfying, sexual excitement. Since Doctors believes that delicate self-mutilation is first and foremost a disorder of self-soothing, an attempt to focus and control inchoate sensation, girls are more liable to it because of their inherent deficiencies in this area. I am fully in agreement with Doctors on this point and find her theory to be elegant, comprehensive, and concise. I would, however, like to take her point (and Kestenberg's) much further, by emphasizing the many ways in which girls find their bodies to be confusing and recalcitrant: with respect to not only unlocalizable genital sensation, the ambiguous contours of the female genitalia, and the sense of loss of bodily control in menstruation, but also all the paradoxes of what I have called "the other within" (the penis or the baby). (In this regard Doctors more strongly emphasizes the object-relational aspects of delicate self-mutilation; I stress much more these patients' struggles with the body, not only with real people and internalized objects.)

In the case of the eating disorders the question of the predominance of women has received somewhat more attention than it has in the delicate self-mutilation literature. As I have previously noted, most psychoanalytic theorists however give this very salient issue

short shrift. Thoma (1967), for instance, in his lengthy and clinically detailed book on the eating disorders devotes exactly two sentences-- throw-away lines in the middle of a paragraph-- to the glaringly obvious question of why all of his patients are female. Psychoanalytic explanations generally take the form of one-sentence references to the more abrupt and earlier onset of puberty among girls than among boys (Crisp, 1967; Bruch, 1973; Garner & Garfinkel, 1982; Wilson, 1983; see Sours, 1980, for a slightly more elaborated and quite eloquent account) and the contradictory sex-role expectations brought to bear on adolescent girls in modern culture (Wilson, 1983; Bruch, 1985). I am obviously very much in sympathy with the first explanation (and in fact to some extent in concert with the second, as I shall later discuss) but not with its lack of elaboration with respect to the specific psychological consequences of each transformation of puberty. Psychoanalytic writers in fact often devote more time to explanations external to their theories (e.g., discussions of cultural factors) than they do to psychoanalytic explanations per se. For instance, Wilson's (1983) psychoanalytic explanation for the large number of female anorexics is as follows:

In comparison to males, females must undergo more complicated physical and emotional changes (Freud, 1932; Blum, 1976); they are subject to the combined pressures of the maternal ego ideal, greater dependency needs, and oedipal and pre-oedipal envy, all of which contribute to the universal female fear of being fat. (p. 23)

After this cursory discussion of a very complicated issue Wilson then spends a page and a half on the aspects of modern culture which encourage eating disorders among women. Wilson is obviously relying here, as do the other psychoanalytic writers on the eating disorders, on his audience's presumed belief in the universal feminine propensity to turn anger against the self, and thus against the body. (Even if Wilson had explicitly invoked women's turning anger against the self as explanation for the greater number of female eating disorder patients, his position would still be weak, for how could he then explain men's higher incidence of successful suicide, an act of aggression against the body par excellence? (See Neuringer & Lettieri [1982]; Kushner [1989].) He also relies on his audience's belief that female adolescence is more problematic than male adolescence, because of penis envy and greater difficulties in separating from the mother.

Tabin and Tabin (1985; 1988) are the only psychoanalytic theorists (to my knowledge) who try to rectify this deficiency in the literature on the eating disorders. As they put it,

None of the models of the psychological etiology of [anorexia and bulimia] provide explanations of the sex ratios and sex-specific manifestations of the disorders one

would hope might be provided by a complete theory. (1988, p. 175)

Tabin and Tabin go on to discuss their own quite elaborate and carefully thought-out theory for the predominance of female eating disorder cases. Their ideas are somewhat similar to Wilson's, in that they emphasize the greater difficulties of girls in individuating from their mothers, but project this issue back from adolescence to the period of one and a half to three years, when, they argue, the seeds of eating disorders are sown. During this early period female separation-individuation is more problematic than male because the entwined issues of gender identity, psychological autonomy, and oedipal sexuality make the little girl feel torn between separating from her mother and becoming a sexual being, on the one hand, and incurring the rivalrous rage of the parent she depends on the most, on the other hand. This dilemma becomes encapsulated in the metaphor of eating, since dependency on the mother at this age is still tied up with the act of feeding. For boys as well these three great themes of early childhood are intertwined, but boys do not fear their mothers' (the primary caretakers') rivalry and rage, because boys' rival instead is the father. Boys may however fear engulfment by the mother, drawn to her as they are by early oedipal longings, and recoil from the gender confusion which results; this is, in fact, the dilemma of the eating disordered boy.

There are some important flaws in Tabin and Tabin's theory, despite its detailed presentation. Most significantly, one must ask why the girl's fear of her mother's rivalrous rage should be a more powerful and damaging a force than the boy's fear of his mother's capacity to engulf and destroy the his budding masculinity? Several authors have pointed out that men have more gender identity problems than do women (such as transvestism and transsexuality) precisely because they must very early disidentify from the primary caretaker in order to establish a gender identity (Greenson, 1968; Stoller, 1972; 1973; Person, 1975, 1980). Why do these difficulties with gender identity in men not more often take the form of eating disorders, which certainly involves a good deal of gender ambivalence as a syndrome? I would argue that girls indeed do have more difficulty with dependency on their mothers (although not with gender identity) than do boys, and they express this by becoming embattled with their bodies-- because their bodies have been more mysterious, changeable, and recalcitrant than have boys', from early on in life. Hence, eating disorders (as well as delicate self-mutilation) are far more common in females.

I shall now turn to the cultural (rather than intrapsychic) explanations for the female preponderance of eating disorders, many of whose exponents present carefully thorough-

ly executed and eloquent arguments (Chernin, 1981; Boskind-White, 1985; Ohrbach, 1985; Steiner-Adair, 1986). The basic outline of their position is as follows: during the modern period there is lip-service paid to equality between the sexes; nonetheless girls at puberty are presented with contradictory cultural exhortations to be autonomous, yet non-threatening; achievement-oriented, yet self-denying; sexually liberated yet "pure". Confronted with this dilemma some adolescent girls embody (and also parody) their predicament in an emaciated body, asexual and infantile, without any physical needs or normal physical functions. Their deliberate loss of curvaceousness also expresses their desire to be male. Women address this dilemma within the narrow confines of the body because they are implicitly discouraged from entering the broader male arenas of work and politics. All the natural adolescent ideals and ambitions become channeled into one narrow, sterile pursuit: losing weight.

This position, although I believe it has a good deal of validity, does not appear to explain the existence of severely distorted eating habits among the "holy women" of medieval Europe, as described by Bell (1985) and Bynum (1987). These women lived in a time when sex roles were more clear-cut than at present-- and when, in fact, thinness was in no way an aesthetic cultural ideal. The fact that these women displayed similar eating habits as present-day anorexics and bulimics (extreme fasting, purging, and even at times binging) argues for the possibility that there is a cause more profound than cultural factors at work, a cause rooted in biological realities.

In summary, extant psychodynamic theories do not sufficiently explain the striking preponderance of female eating disorder patients, and the theories which depend on cultural explanations for this phenomenon do not account for the appearance of eating disorder-type behavior in a different cultural milieu from our own. I should add that I in no way discount the role of cultural factors and object relational issues in the etiology of the eating disorders-- and also of delicate self-mutilation. Certainly, for instance, women's continued and to some extent acculturated discomfort with expressing anger, needs for control, and perfectionist strivings in a direct, active way predisposes them to expressing these within the circumscribed arena of the body. The relatively high incidence of female hysterical conversion symptoms and psychogenic invalidism of the Victorian period is another case in point. As for early object relational factors, I have a strong suspicion that a parent's fetishistic focus on the infant's bodily functions and physical appearance (with little interest in the infant's emotional states), or massively unempathic responses to the infant's bodily needs and somatic signals, can foster the kind of early psyche-soma split

that results later in an eating disorder or in delicate self-mutilation.

Once again, however, I am arguing that such theories are not sufficient to explain the etiology of eating disorders and delicate self-mutilation, and in particular their coexistence and high incidence in women. I believe that we must add to the explanatory factors of problematic early object relations and of culturally-defined sex roles, the sudden transformations, dilemmas and ambiguities presented by female anatomy and function across the developmental span.

CHAPTER SIX

Part One: Female Narcissism, Masochism, and Passivity Revisited

Early on in this study I mentioned that one of the conceptual problems I sought to address through my theory of the self-body relationship in women was the reinterpretation and rehabilitation of the rather unpopular psychoanalytic concepts of innate feminine narcissism, masochism, and passivity. Helene Deutsch's reliance on these concepts has especially come under a great deal of criticism from feminist revisionists of psychoanalytic theory. (See Friedan, 1963; Greer, 1970.) Although I am very much in sympathy with the efforts of such writers in the last two decades to disentangle the dross of masculine bias from the genuine and enduring riches of psychoanalytic theory, I also believe that Deutsch especially has been caricatured and misconstrued-- to some extent because she herself writes ambivalently about certain core issues of feminine psychology. In the following section I shall discuss, relying on Deutsch's writings as well as on Judith Kestenberg's, those aspects of the core concepts of narcissism, masochism, and passivity which I believe should be retained, and those which should be jettisoned.

As should be apparent from my discussions of normal and pathological adolescent development in girls, I do believe that there is a passive feminine tendency which has its roots in sexual anatomy and function, in the experiences of being entered, explored, or inhabited by the "other". Although these experiences can of course evolve into a self-destructive characterological trend--for example, the impotence the eating disorder patient feels vis-à-vis her own body-- I think that Deutsch is very right to emphasize the paradoxical activity that can reside within passivity. Most pertinent is Deutsch's case of the woman who is able to allow her body to "take over" during childbirth-- a "letting-go" which requires no small amount of effort! (It is this kind of subtlety of reasoning which has been completely overlooked by Deutsch's modern critics.) In an extension of these ideas, I have argued earlier in this paper that women can attain a certain kind of wisdom in avoiding the modern insistence on omnipotent control over the body, a wisdom that allows her peaceful acceptance of the inescapable effects of age and illness. Kestenberg takes this trend of thinking still further, in her idea that much constructive mastery arises from originally passive experiences, from efforts to "externalize", localize, and satisfy ambiguous genital sensation. Both Deutsch and Kestenberg, however, still stress over-

much woman's propensity for psychological impotence. Kestenberg for instance still insists that a healthy adult woman's mastery over her body remains largely vicarious; as I described in Chapter 2, she believes that only the man performs "the exploring, fear-conquering activity on [the woman's] vagina". The woman herself cannot explore and learn about her genitals; she must await knowledge of her own body as an indirect mode of self-exploration. Deutsch generally underemphasizes the active aspects of women's apparent passivity.

In the case of the concept of narcissism both Deutsch and Kestenberg are quite even-handed in discussing both the healthy and pathological aspects to this feminine trend. I have already discussed my agreement with Kestenberg that this tendency arises out of a girl's positive efforts to scrutinize and understand the more mysterious and changeable aspects of her body, to make it a subject rather than an object to be admired, desired, or criticized by others. I also agree with Deutsch's views on another constructive aspect of narcissism: its role in rectifying what can be an "excessive masochism", a "dangerous and painful giving" to others. Many of Deutsch's critics, perhaps misled by the pejorative connotations of the term, have overlooked this idea that narcissism can help a woman hold on to her self, to not capitulate overmuch to the demands of others. I have also discussed how narcissism can be distorted in the eating disorders into a sterile fascination with a body which only becomes more alien as the girl increasingly seeks to control its workings, so that the body becomes an object and no longer a subject.

Feminine masochism has been in the history of psychoanalytic theory the most embattled, and most complex, of these three core concepts of femininity. Although it is nowadays an unpopular view, I do agree with Deutsch, Kestenberg, and other traditional psychoanalytic thinkers that there is a feminine tendency towards masochism that is not totally based on internalization of a demeaned social role, and that is linked to universal feminine experiences of the body. The symbolically powerful signal of sexual maturity (e.g., menstrual blood and discomfort), the anticipation and/or experience of labor pain, and the experience of being subject to indefinable, unappeasable sexual tension-- all these events predispose women to masochistic attitudes towards their bodies and other people. I find particularly thought-provoking and original Kestenberg's idea that the common yet mysterious phenomenon of mildly sadomasochistic male-female relationships in adolescence is related to the teenage girl's sense of being at the mercy of frustratingly inchoate sexual feelings, arising from an area of her body of which she has little knowledge. The adolescent girl transforms this experience into one in which she is instead at the mercy of

a boy, but also holds him in her thrall through his desire for her; overall she feels a peculiar sense of superiority at her own martyred state. I have described an exaggerated form of this phenomenon in the case of eating disorder and delicate self-mutilating patients, who have blatantly sadomasochistic relationships with both their bodies and other people. These patients are angrily controlling in their relationships, yet they also are assailed by despairing impotence and-- in yet another paradoxical twist-- they cherish secret and grandiose feelings of martyrdom. There is a clue here to the continuing enigma of masochism, in fact. This much-debated form of pathology is not only an expiation of guilt, a pursuit of sexual satisfaction, or a distorted expression of anger; it can also be-- perhaps especially so for women-- a prideful assertion of power, of moral and physical transcendence.

Both Deutsch and Kestenberg make valuable contributions to the notion of feminine masochism as a constructive phenomenon. Kestenberg's definition of healthy masochism as the enjoyment of mastery over pain, as pleasure in a physical or psychological challenge, seems to me very useful, as does Deutsch's concept of normal masochism as the capacity to endure pain. (Here the term masochism is really genuinely misleading and overly pejorative, however.) Erikson has similarly, and eloquently, spoken of the female capacity "to stand and understand pain" (1968, p. 275). I might reiterate here the wisdom of Deutsch's hypothetical woman in labor who knows how to accept pain without embracing it, how to struggle with pain without denying it.

My main disagreement with the classical position on masochism is of those occasions when it is transformed from a complex theory (which takes into account the kind of paradoxes described above) into a simplistic equation: naturally-occurring experiences of physical pain cause women to seek out pain. Unfortunately it is not always the more misguided of critics of psychoanalysis who fall back on this simple formula, but psychoanalytic theorists themselves who do as well, at times.

Part Two: Implications for Further Research

The theory I have set out in this dissertation has a variety of empirical applications. One testable hypothesis is the following: do certain (previously non-symptomatic) women develop what might be termed sub-clinical eating disorders while pregnant, in wrestling with feelings of loss of bodily control and of intrusion by a foreign body? The group that may be most at risk-- professional, achievement-oriented women working in

male-dominated professions, who may be ambivalent about their physical femininity-- could be followed across the three trimesters of pregnancy and at least three months after birth, with repeated administrations of the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983), the Rorschach, Draw-A-Person test, and a semi-structured interview. Fisher and Cleveland's body barrier and penetration scores (Fisher & Cleveland, 1958; Fisher, 1970) could be used in scoring the Rorschach, and correlations made between these scores and the Eating Disorders Inventory. Changes on all these measures before and after quickening, and before and after birth would also be very interesting to look for.

The Rorschach in fact may be a very useful instrument for studying normal pregnancy. (See, for example, Mc Connell & Daston, 1961.) It is possible, for instance, that the variable and ambiguous body concept I have argued is common during pregnancy may demonstrate itself in an unusually large number of x-ray and anatomy responses. The theme of the "other within" may emerge in an unusually large number of percepts featuring mirrors, twins, and symbiotically or parasitically related beings, themes otherwise expected to be found in the protocols of narcissistic or borderline patients (Krohn & Mayman, 1974). The Rorschachs of apparently normal pregnant women could also be directly compared with those of borderline patients, for possible structural (rather than content) differences. (This last approach would constitute an empirical test of Bibring's (1959) well-known assertion that psychologically healthy pregnant women temporarily manifest borderline characteristics.)

These aspects of the Rorschach (barrier and penetration scores; x-ray, anatomy, mirror, and symbiotic/parasitic percepts) could be used to further examine problematic body concept issues among eating disorder patients. (See Strober & Goldenberg, 1981; Piran, 1988; Zakin, 1989, for examples of such studies.) Comparisons could then be made between the protocols of eating disorder patients on the one hand, and of pregnant women with and without sub-clinical eating disorders, on the other hand.

Part Three: Concluding Comments

My emphasis on the psychological impact of feminine anatomy and functioning could, despite all my disclaimers, be seen as a return to the biologically deterministic and pejorative views of women presented in some of the early psychoanalytic writings. Because of this possible distortion of my views I want to clarify my position even further. Rather than consigning women necessarily to a fate of narcissistic absorption, psycholog-

ical impotence, and addiction to pain, I in fact believe that the same vicissitudes of their bodies which can encourage such a fate, can alternatively result in special opportunities for the gaining of wisdom. A woman who comes to terms with a body that is at times unpredictable, alien to her, and out of her control can more easily accept the process of aging, illness, and death, and may be able to avoid the grandiose assertion of utter control over one's fate and one's environment which has been a failing of the modern age. Such a woman is also perhaps more able to maintain a close identification with her children while simultaneously being able to relinquish her power over them: like her own body they are both part of herself yet also "other". This last quality is one that is often cited by psychoanalytic thinkers as the feminine capacity for empathy, due to "weakness of ego boundaries" and a greater facility for "regression in the service of the ego". (See Greenacre, 1948; Kestenberg, 1956a, 1967b, 1968; Lerner, 1977.) This type of back-handed complimentary language betrays a definition of emotional maturity which is limited and somewhat masculine in bias, emphasizing control, phallic activity, and psychological separateness. A new and more subtle brand of feminist criticism of psychoanalysis (see Chodorow, 1978, 1989; Gilligan, 1982; Notman, Zilbach, Baker-Miller, & Nadelson, 1986) makes the point that women should be seen as following a separate "developmental line" from men, one which emphasizes connection as much or more than separateness and can differentiate immature passivity and masochism from a mature capacity to need and give.

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