THE PARADOXICAL FEMININE

Eating Disorders Beyond Gender

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This thesis distils from a mass of research the patterns of expressions and etiological factors in eating disorders. Drawing on a diversity of research fields - epidemiology, historical accounts, femininity theories, clinical and social psychology, neuroscience, and object relations models -, I have found that intrusion, as the overwhelming experience of invasion of receptivity in the primal mother-child dyad, is the fundamental psychological factor in the etiology of eating disorders and that this factor transcends gender. Through articulating what I have coined the male 'homosexual exception' in disorders that mostly affect women, I have shown that *both men and women are susceptible to eating disorders in proportion to their vulnerability to fears of intrusion into receptivity*. To arrive at this conclusion, I have made use of, and transcended, stereotypes of gender through which eating disorders have been seen to be essentially diseases of the female, in connection with female receptive anatomy and development, and their increase among males, in particular homosexual males, has been either overlooked or a mystery. In helping refine the intrusion thesis beyond a notion of receptivity exclusively linked to female anatomy, my interpretation of the particular vulnerability of women and of a subgroup of male homosexuals to eating disorders has allowed transcending stereotypes of sexual orientation from which my study originated.

CONTENTS

INTRODUCTION

This work is an attempt to understand the gender dimension of eating disorders. It examines and questions the facts and assumptions that underlie the dominant feminine paradigm associated with eating pathology and the extent to which gender is relevant to these disorders. Using extensive interdisciplinary research literature, I have discovered what I call the ‘homosexual exception’ and demonstrated two conclusions that follow from it: 1) that ‘intrusion, as the overwhelming experience of invasion of receptivity’, constitutes the fundamental psychological factor in the etiology of eating disorders; 2) that it transcends sex and gender.

OVERVIEW OF THE ARGUMENT

In this section I outline the context, scope, frame of reference, and objective of my research on the gender and intrusion dimensions of eating disorders. I briefly introduce the interdisciplinary methodology through which I articulate and provide evidence for my theory of intrusion and the original contribution thus made to psychoanalytic theory. To end, I define core concepts as I use them in this thesis.

The integration of disparate literatures, which my interdisciplinary approach entails, has represented a complex and challenging undertaking. Some of the difficulties are described below. One has to do with keeping in focus the ultimate psychoanalytic frame of reference of this thesis. This is thoroughly addressed in the section on methodology and sources preceding Part I of this work. In that section I show how bringing together various literatures is critical to the main theoretical moves that structure the thesis.

The field of eating disorders is complex and theories of its predicaments are multiple and seemingly conflicting. Two leading object relations models (my psychoanalytic focus), which both use intrusion as a frame of reference to explain eating disorders, attest to this complexity. Marilyn Lawrence's model links eating pathologies to femaleness on the basis that women's receptive anatomy and psychology make them particularly vulnerable to psychic forms of intrusion, which in

their concrete expression are experienced as physical intrusions in the form of food (Lawrence, 2001, 2002, 2008). The focus is on the female, constitutional, dimension in the disorder. Ignoring the gender dimension, Gianna Williams' model does not address the question of female particular vulnerability to intrusion (1997a, 1997b, 2004a, 2004b)[1]. It emphasizes, instead, the external origin of intrusion, in the form of projections of parental anxieties, and its interpersonal, dyadic, dimension, expressed in incapacitation in 'receiving' anything, including food, from 'another'. An external dimension of intrusion implies that males and females are both, theoretically, on the receiving end of parental projections. While Williams does not articulate this particular point in her intrusion theory, her work includes a significant number of male case studies.

My research has focused on pushing Lawrence's and Williams' object relations theories and their apparent contradiction to a deeper level by asking whether a leading etiological factor, intrusion, underlay male as well as female eating disorders. The positive answer my work brings to this question suggests that stereotypes of gender, implicit in conceptualizations of intrusion on the grounds of female receptive anatomy and psychology, have impeded a generalization of the notion of intrusion to both men and women.

[1] My references to Williams include both her personal writings (1997a, 1997b) and her edited work with P. Williams, J. Desmarais & Ravenscroft, K. (Williams et al 2004a, 2004b).

From the correlation and distillation of a mass of research on femininity[2] theories, psychoanalysis, and psychology, I have been able to confirm my thesis that '*intrusion, as the overwhelming experience of invasion of receptivity', is the fundamental etiological factor in eating disorders, and that this factor transcends gender and sex.* I have reached this conclusion through articulating what I call the 'homosexual exception' - the particular vulnerability of male homosexuals, as opposed to men in general, to pathologies that by and large affect women. From a dual angle on eating disorders and male homosexuality, and their coincidence with certain aspects of femininity in connection with receptivity, I have shown that women and men are susceptible to eating disorders in proportion to their susceptibility to anxieties of intrusion. In this regard, intrusion, understood in terms of receptivity, constitutes the structural psychological component, on a continuum between external and constitutional factors, in the femininity/intrusion/receptivity equation of these pathologies. Along the way, I have been able to show that the two leading object relations models on intrusion are compatible. I have defined the continuum between external and internal factors with reference to the social sciences currently acknowledged model of biopsychosocial etiology of eating disorders.

[2] For the sake of clarity, concepts such as 'femininity', 'intrusion', 'receptivity', 'homosexual exception', 'biopsychosocial', which I start introducing in this section, are further defined under a separate subsection below on core concepts as used in this work.

An extensive research on the psychoanalytic literature on eating disorders has yielded little relevance to the issue my work attempts to deal with. I have found no work that seeks to get to an etiological level at which gender stereotyping is transcended and a fundamental etiological factor can be linked to eating disorders whether they are found in males or females. In order to address this lacuna I have looked outside the psychoanalytic field into an interdisciplinary literature on eating disorders, bringing object relations models on intrusion together with femininity theories, historical accounts, and studies from various branches of psychology. These literatures have not been probed together before. I bring to bear a range of large-scale, non-psychoanalytic research, not just to expand the research base, but to strengthen an object relations theory of intrusion by showing how it establishes a fundamental, gender-indifferent etiological base to eating disorders, adding thereby to the robustness of the overall findings in psychoanalytic theory. I sought to bring these literatures together in support of my thesis without diluting the specifically psychoanalytic vocabulary and models, which form the core of my research.

While this work has strong gender identity implications, its principal interest is in the relationship between femininity and eating disorders at a level that transcends gender identity. It does not pretend to define femininity. If anything, it uses the word in its stereotypical manner only to anchor it in the research under review, with the aim of

showing that it can be transcended, and that it should be transcended in order to ground theories of eating disorders on more solid ground. It values the metaphor of 'intrusion, as the overwhelming experience of invasion of receptivity', as relevant to explaining eating disorders in women, but attempts to go beyond a notion of intrusion as exclusively linked to female receptive anatomy. The metaphor is critical to eating disorders, *in and beyond their unique gender lopsidedness.*

The interdisciplinary methodology in this work derives from my research questions and from the critical exception, male homosexuality, which they revealed in the feminine paradigm of eating disorders. The thesis integrates in a hopefully novel way constructs and findings from femininity theories and various branches of psychology - epidemiology/taxonomy, history of the disease, developmental, clinical, social/cultural, and neuropsychological - with a psychoanalytic object relational frame of reference, in its focus on anxieties of intrusion. The theoretical selection of intrusion as a primary problematic in eating pathology derives from the conceptual worth of introjective and projective processes in explaining dynamics of taking in/receiving and expelling as expressed in restrictive, binging and purging behaviors.

My initial interest in femininity in eating disorders stemmed from a series of questions - why women, and why a Western and apparently modern pathology? This first set of questions called for reflection on aspects pertaining to contextuality,

temporality and anatomic predetermination, which in turn invoked further questioning of the biological and cultural dimensions of these disorders, beyond my prime psychoanalytic perspective and interest. Such questions have of course been asked time and again but have so far only found partial answers, in relation perhaps with their sole consideration within individual fields of research. Their examination across disciplines helps broaden our understanding of their complexity. My examination does not try to cover all these massive questions. It aims to gather from other disciplines what might shed new light on eating disorders, a field that seems bogged down in the psychoanalytic literature - something I realized in discovering the lacuna on the relationship between eating disorders, intrusion and gender.

Another set of questions and aspects of methodology arose in connection with the surprising finding I came across when exploring the vast literature on eating disorders. The discovery is about an exception in the nearly exclusive feminine landscape of eating disorders - the fact that a significant number of male homosexuals are vulnerable to these pathologies. This exception, which had apparently gone unnoticed by psychoanalysis, represented a turning point in my research, which it brought together in a way I had not expected. Beyond representing a noticeable challenge to the feminine paradigm of eating disorders, the vulnerability of male homosexuals emerged as a powerful conceptual instrument to investigate the intrusion

and femininity hypotheses and their ultimate relevance (or lack thereof) to female receptive anatomy in these pathologies.

This exception in the feminine landscape of eating disorders appeared particularly relevant since evidence points towards what I describe as a gender-related paradigm of research on sexual orientation and gender, regardless whether the paradigm is a social construction or not. Findings revealed that, despite gradual refinements and modifications over the past decades, conceptualizations and measurements of sexual orientation have been consistently expressed in terms of attributes of femininity or masculinity. This overlap - more accurately confusion, as I demonstrate in my work - of questions of gender, sexual orientation, and eating pathology presented a unique opportunity to explore aspects of femininity in these disorders.

The thesis does not aim to redefine the ‘feminine’ or the ‘masculine’, but seeks to understand the relationship between femininity, intrusion and eating disorders, beyond questions of gender identity. My scrutiny of the homosexual exception is anchored in the same interest. It is based on the fact that men, whose anatomy does not match a notion of receptivity in the way female anatomy does, nevertheless experience a disorder of receptivity when suffering from eating disorders. The stereotypes of male/female with respect to receptivity, which have been carried out into psychoanalytic

research, end up proving a powerful case. Men, who, psychologically, experience themselves as vulnerable to receptivity, suffer eating disorders. Men, who do not experience themselves as vulnerable in this way, do not. And the same holds for women. Therefore, anatomy turns out not to be the crucial factor in eating disorders; rather it is vulnerability to the invasion of receptivity. Anatomy is nevertheless still shown to play an important, though not decisive part, in that women, whose anatomy does fit more closely with anxieties about receptivity, suffer from eating disorders substantially more than men.

The discovery of an exception that pertains to sexual orientation and the inscription of this exception in stereotypes of gender, not to mention their exploration in the context of pathology, is a difficult minefield to navigate. The question of an appropriate terminology, bound to vary over time, space and across disciplines, is complex and delicate and the risk of improper wording probably inescapable. But this exception has constituted a critical breakthrough in my work. It signaled a contradiction of the feminine paradigm. It emerged as a methodological conceptual instrument of investigation. Most importantly, its exploration allowed putting forward a universal theory of intrusion, as the overwhelming experience of invasion of receptivity that is not restricted to one gender.

It is this universal notion of intrusion, which allows breaking free from the way gender stereotypes may have overdetermined a psychoanalytic reading of eating disorders. While reflection on stereotypes around femininity (and sexual orientation) has certainly broadened our understanding of eating disorders, an overemphasis on socially influenced sex roles can, on the other hand, limit our ability to address their complexity. This work makes use of stereotypes of gender and sexual orientation in eating disorders to transcend them by teasing out invariants, which turn out to be intrusion and receptivity: in my universal understanding of intrusion, men and women who are vulnerable to anxieties of invasion of receptivity are more prone to eating disorders. The interdisciplinary approach has helped me establish this theory.

The integration of research across disciplines raises the question of the extent to which constructs from one discipline can be equated to those from another. For instance, considering their respective emphases on internal and external worlds and dynamics, are we referring to similar phenomena when we speak about intrusion and control - two essential concepts in this work - in psychoanalysis and in psychology? My choice of an integrative approach indicates my conviction that such correspondences, without of course constituting exact matches, are meaningful. Correspondences between paradigms are the crux of my interdisciplinary methodology, the foundation on which the thesis is based. They expand the perspective of individual disciplines beyond

mere confirmations or contradictions. They open unexpected avenues of reflection and research. They unsettle and qualify well-established constructs, which tend to be self-evident within each discipline, but dismissed or ignored by others. The discovery in the psychological literature of homosexuality as a significant risk factor for eating disorders in males - a finding that was then made use of to broaden a psychoanalytic understanding in its gender dimension - is an example of the benefit of interdisciplinary dialogue. In Chapter VII I discuss in a specific way the question of correspondences between the constructs of intrusion and control in psychoanalysis and psychology. I identify and describe psychological instruments, which measure over-protective behaviors that reflect subjects' perceived parental control, over-concern about their security, intrusion, and over-involvement. The notions of control and intrusion as measured in these instruments sufficiently match their counterparts in psychoanalysis. I also describe in the chapter processes of internalization that are particularly relevant to establishing bridges between external and internal worlds.

Core Concepts as used in this work

a) By 'intrusion', I mean the experience of an imposed and overwhelming disruption of one's sense of security in identity or sense of self, whether the source of that interruption is shown to originate in the external world - for example, in the parents; or in the internal world, as a fantasy based on insatiability. One dimension of this experience is a loss of control of oneself to an internal object, whether that object was originally outside, as a parent, or inside.

b) By ‘receptivity’, I mean the capacity to take into one’s internal world what comes from the other’s internal world, or from a fantasy, in a way that does not threaten one’s sense of security in identity or sense of self. In the extreme, I mean intrusion as the complement of insecure or endangered receptivity. I have condensed the link between ‘intrusion’ and ‘receptivity’ in the expression ‘intrusion as the overwheming experience of invasion of receptivity’.

c) By ‘femininity’, my intention is not to define what femininity is. In using the word, I intentionally reproduce its specific usage, and the stereotypes it conveys, in the psychological and psychoanalytic literature on eating disorders to go beyond gender stereotypes. A typical example is my exploration of feminine vulnerability to intrusion into receptivity, which makes use of gender stereotypes about female receptive anatomy to transcend them through a gender-indifferent theory of intrusion that extends the notion of receptivity to both men and women.

d) By ‘homosexual exception’, I mean no more than men who have sexual relations with other men. In the first instance, I refer to a statistical fact - the particular vulnerability of male homosexuals, among men, to disorders of eating that by and large affect the female population. In the last instance, going beyond stereotypes, I refer to a subgroup of homosexual males who compare with women with eating disorders with respect to receptivity - more specifically, to vulnerability to intrusion into receptivity. It is this subgroup of men with matched receptivity to receptive women with eating disorders that shows higher occurences in these disorders.

e) By ‘biopsychosocial’, I refer to the multifactorial - biological, psychological, and cultural - etiology model of eating disorders that currently dominates social sciences. While in my thesis intrusion is the ultimate factor of etiology in eating disorders - both among other psychological phenomena and among biological and cultural factors -, I confer particular significance to biopsychosocial dynamics to explain the contemporay surge in eating disorders and its matching increased incidence in populations that are vulnerable to intrusion into receptivity - namely women and homosexual men.

SYNOPSIS

In this section I present the structure of the thesis and the content of its chapters.

The work is divided in three parts, preceded by a section on methodology and sources. Part I provides the framework for conducting my exploration in both its psychoanalytic and psychological dimensions. I then examine each dimension in Part II and Part III respectively.

In four chapters seeking to capture the complex interweaving of historical, cultural, taxonomic, and metaphorical considerations that will guide my exploration, Part I sets the stage for an examination of femininity as linked to intrusion in eating disorders.

From a twin critique of contemporary nosology and epidemiology, Chapter I offers a broad outlook on the landscape of eating disorders in the 20th and 21st centuries. Quite remarkable amongst the findings brought about by this overview is the male homosexual exception in eating disorders, which, beyond the breach it creates in an otherwise uniquely female-biased psychopathology (Lock, 2009), provides a critical test of the intrusion hypothesis on which psychoanalysis has established a feminine foundation of eating disorders.

Chapter I asks challenging questions around the gender dimension of eating disorders, thereby providing an essential background for a reflection on the nature of femininity and its relation to intrusion. The rise in recent statistics on these pathologies in males, particularly homosexual men, raises for instance the question of how one should ultimately interpret such an increase. Does it reflect genuine changing trends and rates of prevalence? Or is it just the result of changes in classification, criteria of diagnosis, methods and tools of computation, samples of population, or even expectations by health providers or researchers? Similarly, the identification of male homosexuality as a major risk factor in the development of eating disorders, the homosexual exception, begs the question of whether a corresponding phenomenon characterizes the relationship between homosexuality in women and pathologies of eating. In other words, do same-sex relations affect eating behaviors in women in the same way they do in men? Finally, differences in diagnosis between male and female patients with eating disorders bring up the question of the extent to which these pathologies are similar, and if they are, the implications such similarity has in terms of biological[3] determinism.

The chapter's questions on the upsurge in male eating pathology, men's homosexuality as a major risk factor, and the relevance of biological determinism, and

[3] Unless otherwise specified, I will be using the words biological and biology in the broad sense, that is as encompassing aspects pertaining to anatomy, genetics, hormones, neuroscience, etc…

some answers they receive in the chapter - in particular the identification of male homosexuality as a parameter to investigate the nature of femininity and intrusion in these disorders -, inscribe this research from the onset within the nature/nurture debate on the actual contribution of sexes, sexual orientation, biological vulnerability, and environmental contexts to the femininity/intrusion/receptivity equation of eating pathology.

Chapter II takes us back in history and into the debate over the existence of some element of continuity between historical and contemporary forms of eating disorders, which the familiar categorization of these pathologies as a modern phenomenon has called upon. Do syndromes of self-starvation, bingeing, or binge purging from the past bear any semblance with modern forms of anorexia and bulimia?

The question is not rhetorical. It does bear implications at many practical levels - including in setting the parameters that help determine the nature and essence of these diseases. Indeed, the chapter allows introducing the hypothesis of intrusion as the core problematic in eating disorders through the proposition that eating, at once archaic and object-related, lends itself to metaphorical dynamics of intrusion that involve the object. The proposition is made possible on the basis of the identification in the chapter of some form of historical continuity between anorexia, bulimia and their precursors around control-related themes of assertion, protest, and superiority. When considered

against a psychodynamic conceptualization of interconnectedness between the two poles of eating pathology, with anorexic control a defense against bulimic desire for the object (Shipton, 2004), the notion of control is extended to intrusion - hence the inference of intrusion as the fundamental problematic. An overlap of control and intrusion and ensuing consequences on intrusion's supremacy are verified in Chapter VII.

Chapter II therefore explores various arguments in favor or against vertical (across time) and horizontal (interconnectedness of the two poles of anorexia and bulimia) continuity. Of particular importance in this respect are arguments around imbalances in the available body of historical evidence on anorexia and bulimia; symptom inconsistencies across time, principally in bulimia; and diagnostic fluidity between the two emblematic categories of eating disorders. Again, in ultimately assigning a certain degree of historical continuity and taxonomic interconnectedness to eating disorders, the chapter's main contribution is the proposition that intrusion constitutes the core problematic in these pathologies.

Chapter III in Part I touches on biological and metaphorical questions, which a consideration of the female body - difficult to eschew when examining questions of femininity in eating pathologies - invites. The chapter presents theories, which view the

feminine specificity of eating disorders as linked in one way or another to female anatomy, biology and development.

In these theories, the female body can be the mother's and/or the daughter's. Chasseguet-Smirgel (1993) for instance sees feminine specificity in the fact that the girl's body is identified with, and projected onto, her mother's. For Self-Psychology (Sands, 1989, 2003; De Groot and Rodin, 1994), it is body similarity between daughter and mother, which plays a role in the preeminence of these disorders among women. Beyond identifications, projections and similarities, feminine specificity has been metaphorically linked - in Lawrence (2001, 2002, 2008), Cross (1993) and Russell (1992) - to the receptivity of the female body.

An examination of these theories reveals a critical relationship between the status of objects and the weight granted to the female body. For instance, Cross depicts symbolism as inherent in the female body and its paradoxes, and eating disorders as a pathological externalization of female anatomy - leaving therefore no fundamental place or role for objects in her theory of femininity. In contrast, other models that emphasize issues of containment, dependence or autonomy and their expression via the body in eating disorders inherently implicate one or another form of dynamics with the object. Chasseguet-Smirgel sees these disorders as involving autarchic fantasies with anal and autoerotic components - fantasies that embody a denial of the need for the object.

Russell alludes, obliquely, to objects in his depiction of bulimic behaviors as caricatured enactments of cultural stereotypes of containment - in relation with female receptive anatomy -, conveyed through the gaze of parents. Lawrence's and Williams' respective emphases on introjective processes and containing functions implicate objects in a more direct, though quite distinct, manner. Internal objects reflect fairly similar models of inner world dynamics in the two theories, which nevertheless differ fundamentally on the origin of intrusion and the role external objects play in its development. For Lawrence, intrusion more than often emanates from the subject and is therefore of a more innate nature; for Williams it frequently represents aggressions or projections of anxieties on the part of parents, consequently implying stronger environmental components. Finally, parental objects in Self-Psychology are both primary conveyors of cultural norms that reinforce biological givens, including physical similarity with the mother, and actual pathogenic agents, by omission or commission. The relative contribution of female anatomy/biology/development and objects in the different theories presented in Chapter III underscores, once again, their inscription in the wider nature/nurture debate.

The chapter eventually links each model to one of three problematics capturing the fundamental nature of difficulties behind feminine specificity in eating disorders: {1) control, or lack thereof (Cross and Chasseguet-Smirgel); (2) intrusion and containment (Lawrence, Williams and Russell); and (3) dependency/neediness and their attendant

identity issues (Self-Psychology with Sands, and De Groot and Rodin). Assuming that both objects and body, but not necessarily the female body, are critical to the development and maintenance of eating disorders, I revisit the intrusion hypothesis, proposing that, as a metaphor for the most archaic impulse associated with the object, the incorporation of food, intrusion constitutes the primary problematic, one that encompasses those of control and dependency/neediness/identity. More specifically, I suggest viewing intrusion as intended to control both objects and states of dependence/neediness as expressed in problems of identity. Theoretically, I found intrusion's supremacy on Williams' use of projective identification in the context of weaning: to evade painful experiences of dependence on, and loss of, the object, the infant forces in fantasy parts of its ego inside the object, to control it and erase any differentiation from it (Williams et al (eds), 2004a).

Finally, the chapter signals that, in the dynamics of body and objects that underlie eating disorders, the body is not necessarily the female body. Based on the only model (Williams'), which among all others does not deal with female anatomy, biology or development, let alone with feminine specificity in eating disorders, this qualification is fundamental. Indeed, Williams' work randomly examines the occurrence of these pathologies in the two sexes, therefore suggesting a conceptualization that applies indifferently to men and women. As such, it grants psychoanalytic empirical and

theoretical support to my thesis of intrusion in eating disorders as feminine in essence - because of its connection with receptivity - but transcending sexes - through extending the notion of receptivity beyond the female receptive anatomy.

Setting aside the question of gender, Chapter IV, the last in Part I, ponders over factors behind the important surge in the past decades in eating disorders. Bearing in mind the widely recognized biopsychosocial model of etiology in social sciences, the chapter proposes the object relations paradigm of the mother-infant dyad (the frame of reference of this work) as a prism that captures the interplay between culture, biology (in terms of the body) and psychology, which may explain the recent increase.

In the first part of the chapter I suggest, following Orbach (2009), that the cultural component in the biopsychosocial equation pertains to a worldwide engulfing atmosphere of images, which mirrors, in its effect on individuals, psychological phenomena that occur in the context of problematic early interactions in the mother-infant dyad.

In the second part, Chapter IV provides evidence from neuroscience in support of the mother-infant paradigm of object-relations and of the crucial importance for early child development of dyadic channels of communication - in particular visual-facial channels, which have been shown to be relevant to the culture of images. Beyond substantiating dyadic dynamics, neuroscience underscores the corporeal dimension of

two-person unconscious communications, validating in this sense the notion of embodied minds. This integrates the biological (corporal) component in the biopsychosocial equation of eating disorders.

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Having introduced the female receptive body as a suitable metaphorical[4] channel for expressing the dynamics of intrusion at work in eating, and suggested that the coincidence of the female body metaphor with the symbolism of food and eating may explain the feminine specificity of eating disorders, I proceed in Part II to explore the concept of intrusion from a psychoanalytic theoretical perspective, including in its relevance to femininity in eating disorders.

Part II consists of two chapters - Chapter V, which provides the background for a conceptualization of intrusion in psychoanalysis - its origin in Freud and Abraham and its unfolding in the object relations tradition; and Chapter VI, which looks at the concept in its application by Lawrence and Williams in the context of eating pathology.

In its examination of the psychoanalytic foundation of intrusion, Chapter V shows that intrusive phenomena, which I have suggested find their quintessential

[4] My use of the concept of 'metaphor' is so far general and does not refer to the psychoanalytical opposition between concreteness and aptitude for symbolization, which constitutes a major conceptual reference in this thesis. I will establish the distinction whenever necessary in the rest of the work.

expression in eating disorders, are rooted in the body and alimentary experiences, and are best captured in the concepts of pathological introjection and projection. From an object relations perspective on the inner world, the pathway to pathology for introjective and projective processes, which otherwise are core to normal psychological development, is depicted in terms of failures in the interrelated phenomena of triangulation, differentiation and symbolization. These failures lead to concreteness of thought whereby symbols are confused with the objects they are meant to symbolize.

The first part of the chapter traces the conceptual support to the corporal dimension of intrusion - one that allows a preliminary delineation of inner and outer spaces through the dynamics of introjection and projection - back to Freud and Abraham. In Freud, oral incorporation and its attendant aspects of pleasure and unpleasure represent a first expression of the opposition between introjection and projection, internal and external (Laplanche and Pontalis, 1973): "…The original pleasure-ego wants to introject into itself everything that is good and to eject from itself everything that is bad. What is bad, what is alien to the ego and what is external are, to begin with, identical" (Freud, 1925b, 237). In Abraham (1924), the identification of a first anal stage whose aim is to destroy through expulsion - an expansion on Freud's notion of an oral impulse to spit out what is bad - sets the psychological phenomenon of projection in the context of anal excretions.

After situating the corporal dimension of intrusion within Freud's and Abraham's conceptual framework of incorporation and expulsion, Chapter V introduces Klein's momentous elaboration on the subject - a contribution that not only emphasizes the critical position of objects in the dynamics of introjection and projection, but also puts forward female receptive anatomy and stronger introjective impulses (1928, 1932) as significant components of impingement.

Object relations elaborations on introjective and projective processes provide the foundations on which Lawrence and Williams base their respective conceptualizations of intrusion in eating disorders. A common core for both models is the critical status of objects in dynamics of introjection/projection (Klein, 1932) and the 'container-contained' relationship (Bion, 1962a). Divergences proceed from particular emphases on one or the other theory, or aspect of a theory. Lawrence's femininity theory, including a cycle of intrusion mostly originating in subjects, is grounded in Klein's perspective on feminine psychology as connected to female receptive anatomy and to stronger introjective impulses in women. Williams' emphasis on the interpersonal - two-persons, two-ways - dynamic nature of the dyadic relationship in Bion's 'container-contained' relationship allocates a more balanced share between constitutional factors and externally originating influences [the latter couched in psychological terms, as per Lawrence's depiction (2001)]. Her reversal of the relationship into 'receptacle-foreign-body'

dynamics has significant theoretical implications in terms of locating intrusion in parental projections of anxieties.

Further object relations elaborations contribute to the development of the notion of mental space, which explains intrusive phenomena in eating disorders in terms of concreteness of thought and impairment in the capacity to receive from another. Mental space refers to the mapping of inner Oedipal constellations in their interrelated aspects of symbolization, triangulation and differentiation. Failures in triangulation and differentiation - the recognition in one's inner unconscious world of three as distinct positions as possible: the subject's, the primary object's and the third's - imply failures in symbolization as expressed in concreteness of thought and incapacity to receive.

Klein's symbol formation (1930) and Bion's '-K' link (not knowing) (1962a) are relevant to the notion of a 'ubiquitous *intrusive internal* object' in Lawrence and, through her reversal of the 'container-contained' relationship, to Williams' concept of a '*projecting internal* object'. Segal's symbolic equations (1957) - symbols felt by the ego to be the original object as opposed to representing it - are particularly meaningful to Lawrence's description of concreteness as the splitting of the feeding maternal function upon eating and its equating with food. Britton's third position (1989, 1992, 2004) and Birksted-Breen's 'penis-as-link' (1996) expand on Segal's preliminary notion of a tripartite mental space. They respectively provide novel perspectives on the significance

to symbolization of the paternal function and of the recognition of sexual difference. Their contributions inform both Lawrence's and Williams' models.

Having established in Chapter V the psychoanalytical foundations for a consideration of intrusion as failures in symbolization and their expression in concreteness, Chapter VI sets to examine the concept in the specific context of Lawrence's and Williams' respective models on eating disorders.

The chapter shows how Lawrence's and Williams' theories proceed from a similar Kleinian frame of reference that emphasizes introjective processes - more specifically disturbances in these processes, which grant a quality of invasiveness to all phenomena of incorporation and taking in. The two works also describe a globally similar inner picture of faltering triangulation, symbolization, and differentiation, and an ensuing concreteness of thought when food or eating functions are literally conflated with the object and its qualities, desired and/or rejected, instead of representing it. This is conceptualized by Lawrence as the incapacity to discriminate between what is, and what is not, intrusive, and by Williams as impairment in the ability to 'receive from another'.

Although the absence of an internal Oedipal triangle constitutes the bedrock on which symbolization stumbles in the two theories, and despite the fact that they both

consider intrusion as core to eating disorders, Lawrence's and Williams' models of eating disorders nevertheless diverge on a number of important aspects.

They differ for instance on the fundamental question of where intrusion originates from and the mechanisms it involves - a difference that impacts other aspects of the theories. For Lawrence, intrusion is mostly initiated in the infant's own intrusiveness into the mother and, further on, into the parental couple. This prompts its bouncing back onto the child through his/her anticipation and dread of retaliation. A -K *intrusive object* is instated, which attacks the link between the internal parents and compromises triangulation, therefore corrupting meaning and preventing discrimination in the intrusive quality of objects and their concrete substitutes. In contrast, Williams sees intrusion as more than often originating in parental projections, mostly anxieties but also aggressions, which are experienced as inimical foreign bodies through the reversal of the 'container-contained' relationship into a 'receptacle-foreign-body' one - the omega function, the obverse of Bion's alpha-function of digesting emotional experience and making it available for thinking. A *projecting object* is consequently introjected, which attacks the paternal function and the parental couple and undermines triangulation. There ensues disorganization in meaning, which leads, in a context of dependence on the object, to impairment in the capacity to receive from others. It is important to point out that, through its Bionian focus, Williams' model does not rule out

dysfunctions originating in the infant. Instead, it stresses the interpersonal - two-persons, two-ways - dynamic nature of the dyadic relationship, locating aptitude for receptivity in both mother and child.

Williams' greater emphasis on external reality and actual parents underscores another important divergence in the two models: the status of real fathers in the dynamics of eating pathologies. For Lawrence, the absence or irrelevance of fathers, as revealed in the representations of anorexic girls, almost always reproduces the failed internal Oedipal triangle and seldom corresponds to reality. It is the internal father, not necessarily the actual one, who is absent or irrelevant. Denying him his place aims at denying separateness between daughter and mother, between self and object. For Williams, as reflected in the many examples of actual paternal deficiencies presented in her work, both internal and external fathers are relevant and attacks on the paternal function often mirror actual paternal deficiencies. More specifically, the paternal function or third element - the guarantor or facilitator of differentiation and symbolization -, although a "function and not necessarily a person", can be carried out "by the mother herself or the actual father or is the provision of a boundary between mother and child" (Williams et al (eds.), 2004b, xxi).

The other momentous difference between the two models is that Lawrence's offers insight into the feminine specificity of eating disorders whereas Williams' allows

transcending it, thus lending meaning to the occurrence of these disorders in males. Lawrence's specificity is based on the Kleinian premise that female receptive anatomy and development predispose women to anxieties of intrusion. When compounded by constitutionally excessive introjective tendencies and by failures in maternal containment, women's susceptibility to these anxieties leads to anorexia. As for Williams, she does not address the question of feminine specificity in eating disorders, disregarding altogether any role female anatomy and development may have in these pathologies. Laying more emphasis, in a Bionian way, on the interpersonal, two-fold receptacle configuration that dynamics of introjection and projection entail, and, farther than Bion, on the parental end of this configuration, her model suggests alternative channels of metaphorical receptivity that transcend gender.

Defenses erected against anxieties of intrusion are also emphasized in a different manner in the two models. For Lawrence, they are phallic fantasies of completeness and omnipotence, the caricature of structure and thought, revealed in the manic erasing of symbols of womanhood in female anorexics. For Williams, they are of a more tangible, functional nature - defining two prototypes of protection against massive projections as well as corresponding categories of eating disordered patients: the 'no-entry' patient, typically the anorexic, who develops a kind of impervious shell;

and the more ‘porous’ bulimic patient who deals with parental projections he/she has allowed in by alternating absorption and expulsion.

In the last instance, it seems relevant to describe most differences in the two models in terms of the nature/nurture dynamics. Accordingly, each model would stand for a distinct etiology representing a greater weight of one component over the other. Lawrence’s model would cover eating disorders characterized by a greater constitutional component, with excessive introjective mechanisms in the lead, particularly in the case of women. Williams’ would cover eating disorders arising in the context of massive projections by parents, both mothers and fathers, potentially unfolding across generations - the latter incidentally presenting an alternative to biological explanations of transmission. In this sense the two models are not mutually exclusive and Chapter V concludes by suggesting their possible reconciliation: whilst the theory emphasizing innate dispositions, Lawrence’s, symbolically explains the feminine specificity of eating disorders, the one focusing on environmental failures, Williams’, extends the metaphor of intrusion to explain eating disorders in both women and men.

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After building the rationale for a conceptualization of eating disorders and their feminine specificity in terms of intrusion (Part I) and exploring the latter's psychoanalytic theoretical background, in general and in eating disorders (Part II), Part III establishes bridges between Lawrence's and Williams' object relations models, on the one hand, and psychological frames of reference, on the other. This is done in two final chapters based on findings from the psychological literature - Chapter VII, which looks into the parental dimension of intrusion, and Chapter VIII, which explores it in the light of sexes, gender and sexual orientation.

A major contribution of Chapter VII is the identification of psychological measurements of parental behaviors, the Parental Bonding Instrument (PBI) (Parker el al, 1979) and the Egna Minnen Betrsffande Uppfostran (EMBU) (Perris el al, 1980) - in Swedish, 'my memories of upbringing'. Although the frame of reference of the two tests is not psychoanalytic, the chapter shows that correspondences with psychoanalytic models are sufficient to make them relevant to the confirmation of my thesis that intrusion, understood as the overwhelming invasion of receptivity, is the fundamental factor of etiology in eating disorders, and that it transcends gender.

An overlap of intrusion and control is inherent in the design of the two tests. Combined with assumptions of historical continuity and interconnectedness of anorexia and builimia around control-related issues, this validates the intrusion hypothesis - the

first building block in my elaboration of a universal intrusion theory that applies to the two sexes (Chapter II).

PBI and EMBU findings also establish a definite and dominant link between patterns of intrusive parenting in both mothers and fathers and the development of eating pathology in offspring. This confirms the hypothesis of intrusion's supremacy over other problematics, adding another component in the construction of the intrusion thesis of eating disorders (Chapter III). Moreover, PBI and EMBU findings reveal the irruption of actual fathers in disorders that often have been considered as belonging to the exclusive realm of the mother. This, amongst other results, vindicates William's model, contradicts Lawrence's, and underscores the relevance for eating disorders of combined parental dynamics as opposed to individual maternal or paternal patterns of parenting.

Revisiting the nature/nurture pervasive aspects of this research, the chapter brings up the biological dimension of eating disorders, which, if impossible to circumvent, does not provide either an absolute and exclusive etiological response. In weighing the relative contributions of environment and biology, which broadly correspond to Williams and Lawrence's respective models, the chapter shows that a biological foundation of eating pathology is to be understood within an interactive etiological model that also entails parental influences. This is in line with an integrative

approach of early development, which puts forward the epigenetic principle of a continuing dialectic between developing organisms and their fluctuating environment (Schore, 1994). It also is in agreement with the biopsychosocial understanding of eating disorders in its comprehensive incorporation of constitutional, psychological, and environmental etiologies. It finally validates my proposition that Lawrence's and Williams' models are not mutually exclusive but fall rather on a continuum.

In addition to instruments measuring the dual phenomenon of intrusion and control, the chapter refers to internal working models in Attachment theory and schemas in Schema theory. These sets of concepts are useful at two levels. They first describe mechanisms whereby intrusion is internalized and perpetuated, thus providing complementary pathways to biological etiology in the transmission of intrusion-related phenomena in eating disorders - in individuals, within families and across generations. They also reveal tensions between low care, abandonment, rejection, underprotection, on the one hand, and control, overprotection, overinvolvement and intrusion, on the other. Such ubiquity of intrusion in psychological findings (PBI, EMBU, schemas and internal working models) refines and details my thesis of intrusion as the organizing problematic around which other predicaments and anxieties revolve (intrusion's supremacy).

In examining parental and constitutional contributions to intrusion-related phenomena in eating disorders, Chapter VII left out one critical aspect of biology that is particularly relevant to an exploration of the nature of femininity in these pathologies - the sex of patients and their sexual orientation, considering that male homosexuality and bisexuality are specific risk factors for diseases that otherwise mainly affect women. Chapter VIII continues the exploration with this perspective in mind, probing into the homosexual exception and using it as a conceptual tool to understand parameters of femininity and masculinity, in general and in eating disorders.

The chapter considers various sets of studies, which identify the respective contributions of biology and environment - both cultural and parental - to sexual orientation and, further on, to gender-related traits**.** Reference is made once again to the multifactorial, biopsychosexual paradigm of behavior, which currently dominates social science - in this instance, an interactional model (Byne and Parsons, 1993) whereby genes or hormones do not define sexual orientation as such, but influence specific personality traits in ways that impact how individuals and their environment interact.

A first insight into the components of sexual orientation comes with my assessment of research on the role of biology as presented in a comprehensive review by Mustanski et al (2002) on the subject. It acknowledges the significance of biological factors but does not support their exclusive contribution.

Turning then to the cultural components of sexual orientation, Chapter VIII identifies and pursues various avenues of relevance to intrusion and femininity in their relationship to eating disorders. To start with, an examination of research on sexual orientation and gender over a period of three quarters of a century shows the field's inability to depict homosexuality beyond popular stereotypes on the femininity of homosexual men and masculinity of lesbians.

A first set of studies on the relationship between gender-traits and eating disorders in both heterosexual males and females indicate that eating pathology is generally positively associated with femininity and negatively associated with masculinity. This is referred to in the psychological literature as the femininity hypothesis of eating disorders.

Another layer of complexity is introduced by studies that bring in the equation of eating disorders the dual components of sexual orientation and gender traits. These studies reveal dialectical dynamics between homosexual subcultures and the broader culture of society - with subcultures not necessarily abiding by stereotypes imposed by mainstream culture, and results showing differences between males and females. With the assumption that gender traits reflect cultural stereotypes about feminine and masculine behaviors whereas sexual orientation expresses the ideals of the male homosexaul and lesbian subcultures, the predominance of one over the other in the

context of eating disorders is understood as an indicator of whether in these disorders gender trumps sexual orientation or if things happen the other way round. Findings show that amongst homosexual males, the male homosexual subculture trumps masculinity. Results are less consistent in the case of lesbians: some studies show that they are less concerned with body weight and shape, and diet or binge less frequently than heterosexual women, a reflection of the lesbian subculture; other studies indicate instead that gender trumps sexual orientation as the lesbian subculture has been insufficient to reverse pervasive cultural messages on female attractiveness as related to slenderness.

Despite these inconsistencies, Chapter VIII ultimately makes an argument in favor of a femininity theory of eating disorders - femininity as a factor in the etiology of these disorders - that applies to both men and women. It furthermore draws attention to the critical relevance of degrees of femininity in exacerbating susceptibility to eating disorders, a finding revealed when femininity scores are considered against a background of sexual orientation. As noted earlier, my reference to a femininity theory conveys meanings, and related stereotypes, which femininity bears in the psychological literature. It does not aim to define femininity per se, but, to the contrary, uses gender stereotypes to transcend them through a universal theory of eating disorders that applies to women and men.

A further elaboration, crucial because it establishes the pivot around which intrusion, femininity and eating disorders are ultimately articulated, is brought about by two findings, both pertaining to the depiction and measurement in positive or negative terms of control patterns and gender traits. This is an instance where the depiction of feminine traits in positive and negative terms allows me to use cultural gender stereotypes, as conveyed in the psychological literature, to transcend them. The first finding reveals the substantial weight of negative forms of control in negative feminine traits. Bearing in mind the overlap of intrusion and control, proposed in Chapter II, developed in Chapter III, and confirmed in Chapter VII, the finding of an important level of negative control in negative femininity invites the key theme of intrusion into the gender equation of eating disorders. The second finding establishes correspondences between negative feminine traits and symptoms that are characteristic of eating disorders in both females and males.

At this point, Chapter VIII puts forward a general equation featuring intrusion, femininity and eating disorders, the penultimate point in my exploration of the psychological literature on eating disorders: (1) if issues of control overlap with issues of intrusion (Chapters II, III, and VII); (2) if the weight of negative control in negative femininity is substantial (Chapter VIII); (3) if, finally, stereotypic negative forms of control and femininity match up symptoms that characterize eating disorders in both females

and males (Chapter VIII); then, this work's thesis would be supported. *The psychological phenomenon of intrusion, understood in its feminine dimension of receptivity, is the fundamental etiological factor in eating disorders; as such it transcends sex and gender.*

Chapter VIII finally addresses one ambiguous and yet unanswered area in my intrusion/femininity theory: is there, in the femininity of homosexual men, an intrusive component that would explain, beyond biological and socio-cultural factors, this population's vulnerability to eating disorders?

Answering this question brings back to the fore the theme of parental intrusions, which in the context of sexual orientation, is fraught with the danger of ideology because of the implicit or explicit pathologization of homosexuals and their parents. Chapter VIII therefore discusses the ideological complexities, including their implications on academic work, of inscribing male homosexuality within an Oedipal constellation that entails over-involved mothers and absent or irrelevant fathers.

The chapter presents findings that challenge the consistency of such a constellation in the male homosexual population in general. It identifies however a subgroup of male homosexuals whose parents' behaviors, both mothers and fathers, are characterized by low care and high intrusion. These patterns of parental dynamics overlap with those typical of offspring with eating disorders. Seen from this perspective,

the vulnerability of male homosexuals to disorders that usually affect women would only concern a specific subgroup of homosexual men with intrusive parents. Future studies on intrusive parenting in homosexual men suffering eating disorders are needed to verify this inference.

When combined with a femininity hypothesis of male homosexuality (featuring measurable, if stereotypical, high levels of femininity) and of eating disorders (femininity as a factor in these pathologies), this final set of findings supports an integration of the psychological (intrusion) and cultural dimensions of femininity in eating disorders, without ruling out its biological givens.

From a twin perspective on eating disorders and male homosexuality, and their coincidence with some aspects of femininity (in connection with introjectivity and receptivity), Chapter VIII has established that intrusion, as the overwhelming experience of invasion of receptivity, constitutes the structural psychological component, together with cultural and biological ones, in the feminine presentation of these disorders. This is in line with current interactional models of behaviors, whether they are gender-related or connected to sexual orientation. As the psychological component in eating disorders, intrusion - with its receptive/feminine complement - is located within, yet distinctly from, the two poles of culture and biology. Neither cultural, nor biological, but at the interface between the two, intrusion (into receptivity) has been shown to be the invariant in eating

disorders. The conceptualization extends the receptivity metaphor beyond the female body.

METHODOLOGY AND SOURCES

AN INTERDISCIPLINARY APPROACH TO STRENGTHEN PSYCHOANALYTIC THEORY

As I established the rationale for an interdisciplinary approach to the question of gender imbalance in eating disorders, I argued that such an approach addresses the complexity of these disorders beyond a mere expansion of the research base, and beyond the perspectives of individual disciplines, including my own psychoanalytic angle. Its merit, I argued, is manifest at two levels: 1) it makes stronger an object relations theory of intrusion by demonstrating how it establishes an elemental, gender-free etiological foundation to eating pathology; 2) it strengthens the solidity of overall findings for psychoanalytic theory.

The interdisciplinary approach nevertheless presents some difficulties. One is the problem of establishing correspondences between constructs, including concepts such as intrusion, from various disciplines. I discuss these difficulties in Chapter VII. Another important challenge is the need, when navigating from one discipline to another, to keep in focus the ultimate psychoanalytic frame of reference of this work. It is this challenge, which I hope to address in this section on methodology and sources.

In describing the database on which I build my research, my main objective is to highlight the critical procedures that I adopt to make my main theoretical moves, and put forward, then substantiate, a universal, gender-free intrusion theory of eating disorders. These critical procedures are made possible thanks to the unprecedented manner in which various literatures are brought together with the two object relations models on intrusion - an undertaking, which is implied in my choice of an interdisciplinary approach.

The following review is structured thematically, on the basis of the contributions, which different disciplines, models and sources bring to an intrusion thesis that proposes intrusion as the overwhelming experience of invasion of receptivity. Sources that are not directly relevant to the formulation and/or substantiation of my universal, gender-free intrusion thesis are discussed in the text[5].

The three focal themes in my exploration of eating disorders are: A/ gender imbalance, by which I mean the remarkable higher prevalence rates of eating disorders in women; B/ intrusion and receptivity; and C/ the relevance of gender attributes. The disciplines, models, or sources, which contribute, individually or collectively, to one or

[5] I discuss in individual chapters areas that are not directly relevant to the 'intrusion, as the experience of invasion of receptivity' thesis. These broadly include: the literature on the relevance of neuroscience to the mother-infant paradigm and to the biopsychosocial argument (Chapter IV); and the literature further contributing to the biopsychosocial argument - in particular, research on biological factors in eating pathologies (Chapter VII) and in sexual orientation (Chapter VIII). As for the theoretical foundation on which the two intrusion models under consideration are based, it is developed in Chapter V.

another theme consist of historical accounts, femininity theories, object relations models on intrusion, and various branches of psychology.

In the following presentation, I start by indicating the relevance of various literatures to the theme under consideration as well as cross-references to other themes and literatures. I then refer in more detail to findings or aspects of particular interest, linking them to their respective sources. I end by summing up, under the titles 'The Contribution to the Thesis', the chief contribution of specific literatures to the formulation and/or substantiation of my proposed universal, gender-free theory of intrusion in eating disorders. In general, all sources and disciplines provide context, facts and rationale for the formulation of the thesis. The psychological literature additionally presents evidence in support of the thesis.

THEME A: GENDER IMBALANCE IN EATING DISORDERS

The unique gender imbalance in eating disorders, which motivated my initial interest in exploring aspects of femininity in these pathologies, has received attention from the following perspectives: studies on epidemiology/taxonomy, historical accounts, femininity theories, and object relational models on intrusion. Essential contributions to Theme A are summed up as follows. Epidemiology/taxonomy studies reveal changing trends in favor of higher prevalence rates among men, in particular homosexuals (the

so-called ‘homosexual exception’. Historical accounts provide context and perspective for this work’s challenge of the notion that eating disorders are a strictly feminine pathology. Femininity theories and object relations models on intrusion are the foundations on which I base: 1/ my fundamental theoretical departure from feminine exclusivity; and, deriving from it, 2/ my proposition that intrusion is the core problematic of eating disorders that encompasses other problematics and difficulties. The literature contributing to Theme B on intrusion and receptivity provides additional theoretical perspectives, as well as confirmation, to the intrusion thesis. The literature contributing to Theme C on the relevance of gender traits substantiates, through using the ‘homosexual exception’ as a research tool, the universal gender-free intrusion thesis.

The Psychology Literature (Epidemiology/Taxonomy)

Studies on epidemiology/taxonomy identify trends and inconsistencies and set the context and the rationale for researching the question of gender imbalance in eating disorders. They also reveal homosexuality as a specific risk factor for eating disorders in men - *this homosexual exception constitutes a stepping-stone to conduct my research.*

In recent years, epidemiological studies have gone beyond the confirmation of what remains a predominantly feminine pathology (American Psychiatric Association, 1973, 1980, 1987, 1994, 2000, 2013) to reveal what may represent changing trends in

prevalence rates among men (Hudson et al, 2007; Domine, 2009; Lock 2009; Preti et al, 2009). Such a change has been, and remains, difficult to confirm categorically for the very reason that, with the assumption that women constitute the high-risk group in eating disorders, studies on time trends incidence - which are in significant increase since the second half of the 20th century (Keel, 2005) - have generally reflected female tendencies (Hoek & Van Hoeken, 2003; Currin et al, 2005; Van Son et al, 2006; Zachrisson et al, 2008).

Uncertainties regarding changing trends in male prevalence rates are attributed to underreporting that results, amongst other reasons, from discrepancies in methods of classification. For example, the likelihood of changing trends is greater when partial syndromes are considered, as opposed to full syndromes, and community samples, as opposed to clinical samples[6] (Wolraich et al, 1996; Woodside et al, 2001; Muise el al, 2003).

Other classification difficulties contributing to underreporting are explained in reference to the prevailing feminine paradigm. Because eating disorders are thought to be feminine pathologies, men with these disorders are less likely to perceive/label their eating behaviors as problematic; or report compensatory conducts; or seek treatment. Similarly, screening criteria to detect eating disorders are not adapted to

[6] Partial syndromes do not display the full array of symptoms as listed in conventional taxonomy. Community samples refer to studies in which participants are recruited from a specific community (for instance, college students). In clinical samples, participants are recruited from clinical settings and are more likely to have more, or more severe, symptoms.

men, neither are expectations of healthcare providers geared towards anticipating male cases. (Carlat & Camargo, 1991; Braun et al, 1999; Ross and Ivis, 1999; Domine et al, 2009; Lock, 2009).

The literature on similarities and divergences in eating disorders suggests a globally homogeneous syndrome in the two sexes. Divergences do exist however. Those pertaining to symptom intensity - for instance women scoring higher than men on the drive for thinness or body dissatisfaction scales - do not fundamentally challenge the overall picture of homogeneity. Those pertaining to differences in symptoms or risk factors - in particular, male homosexuality as a specific risk factor - are critical to this work because of their explicit discrimination between men and women.

Comparative studies that confirm similarities in a direct manner include: Crisp et al (1986), Olivardia et al (1995), Geist et al, (1999), Striegel-Moore et al (1999). Other studies, which refer incidentally to such similarities include: Carlat et al (1997), Ross and Ivis (1999), Miotto et al (2003), Ricciardelli and McCabe (2004) Domine et al (2009).

Studies that reveal divergences in symptom intensity include: Crisp et al (1986), Carlat and Camargo (1991), Carlat et al (1997), Braun et al (1999), Geist et al (1999), Bramon-Bosch et al (2000), Joiner et al (2000), Muise et al (2003), Ricciardelli and McCabe (2004).

Studies that reveal differences in symptoms or risk factors - the major challenge to an overall picture of homogeneity between men and women - come under the two headings of differentials in body image preoccupations (Andersen, 1984; Ricciardelli and McCabe, 2004) and homosexuality as a specific risk factor (Schneider and Agras, 1987; Carlat and Camargo, 1991; Carlat et al, 1997; Bramon-Bosch et al, 2000; Russell and Keel, 2002; Austin et al, 2004; Ackard et al, 2008).

The Contribution to the Thesis

While the epidemiological and taxonomic literature on eating disorders in the 20th and 21st centuries continues to show an exceptional gender bias toward women, it also suggests that men are increasingly affected by these disorders. In this regard, the identification of homosexuality as a specific risk factor for men has opened up an interesting area of investigation in what was otherwise an inconsistency in the femininity theory, which had previously been brought about by the rise in eating disorders in men. When combined with correspondences that have been established in the literature between sexual orientation and gender traits, male homosexuality has emerged as a new conceptual tool to research the question of sexes and gender in eating disorders - this is developed below under the theme of the relevance of gender attributes to eating disorders (Theme C). My discovery of the homosexual exception has opened the space for a whole new area of investigation.

Historical Accounts

Historical accounts provide some perspective on the question of gender imbalance in eating disorders - a perspective that supports this work's conceptualization of eating pathology as not structurally limited to one gender.

A review of the historical literature on precursors of anorexia and bulimia does not signal a gender imbalance in either direction (Stein and Laakso, 1988; Habermas, 1989; Habermas and Beveridge, A., 1992; Bemporad, 1996; Crichton, 1996).

The Contribution to the Thesis

Though tentative and limited - female to male ratios in historical documents on eating disorders are lacking for reasons pertaining to terminology, classification, and anachronism - the contribution of historical accounts to the theme of gender imbalance is nevertheless important. It offers a general background against which the debate over the contemporary dimension, including its gender aspect as highlighted by recent changes in epidemiology/taxonomy, can be considered. Two works, which were published at the turning point of the major outbreak of eating disorders and of significant changes in taxonomy (in particular with regard to bulimia), encapsulate the relevance of a historical dimension to this debate. Chernin's work (1985) was probably the first to bring attention to the fact that the anorexic's body was most of the time female. Earlier, Bruch's (1973) landmark book on eating disorders does not refer to the notion of gender. This indicates that gender imbalance was not a central concern before the mid-eighties. It seems to me that awareness of, and focus on, the gender component of eating disorders may have paralleled the increase in recent years in these pathologies[7].

The psychological literature - on parenting, schemas and attachment (Theme B on intrusion and receptivity); and, on gender traits, sexual orientation, and their relation to

[7] The surge, which I link in Chapter IV to a biopsychosocial understanding of these complex disorders, may have acted as a catalyst in boosting the recently documented gender imbalance. In my conclusion I state that the biopsychosocial configuration, with 'intrusion as the experience of invasion of receptivity' as its psychological component, explains why women are more prone to eating disorders. I also suggest that the same tripartite organization, in its intrusion component again, suggests a tentative explanation for the higher susceptibility of male homosexuals to these disorders.

eating disorders (Theme C on the relevance of gender traits) - brings support to a gender-free thesis of eating disorders.

Femininity Theories and Object Relational Models on Intrusion

This third field of knowledge provides models and counter-models of feminine specificity from which I proceed to build a gender-free intrusion theory of eating disorders that specifies 'intrusion as the experience of invasion of receptivity'. This understanding of intrusion transcends a notion of receptivity that is exclusively associated to female receptive anatomy.

Femininity theories, including one object relations model on intrusion (Lawrence's), view the particular vulnerability of women to eating disorders as connected to the receptivity of female anatomy, to female development, and to related dynamics with the maternal object. A second object relations theory on intrusion (Williams'), which altogether ignores the question of feminine vulnerability to eating disorders, provides a counter-model to femininity explanations.

Transcending a notion of receptivity that is exclusively linked to female anatomy and development does not preclude the relevance of various femininity theories - including the specific focus each one places on particular phenomena over others - to a solid gender-free intrusion theory that adequately addresses the complexity of eating pathologies. It is on this basis that I put forward a working hypothesis that grants a

supreme position to intrusion among other problematics and difficulties - namely control, dependency/neediness, and their related expressions in identity issues. I explain the rationale for intrusion's supremacy over other problematics through Williams' use of projective identification in her intrusion model on eating disorders.

In this section, I describe the particular emphasis, which individual femininity theories and object relations models put on themes of intrusion, control, dependency and neediness. A particular attention is given to the object relations focus as one that constitutes the pivot of the intrusion argument in my work. I will therefore briefly mention the distinct merit of each model for my theory, with a special emphasis on Lawrence's and Williams' object relations intrusion models. Detailed accounts of relevant aspects in all theories are found in Chapters III, V, and VI.

A first model by Chasseguet-Smirgel (1993) establishes feminine specificity in connection with dialectics of alienation between a girl, her mother and their two bodies. In her perspective, eating disorders represent an escape from the dictates of feminine biology. Such dictates, and defenses against them, feature body/mind dynamics of alienation and passivity that are kept alive through identificatory and projective mechanisms involving the mother and her body. The model highlights the importance of autarchic fantasies and their anal and autoerotic components. Chasseguet-Smirgel

offers a uniquely expressive picture of the autarchic mode of functioning of anorexics in terms of the struggles they fight to control dependency on the maternal object.

Another model, by Cross (1993), emphasizes dialectics of alienation with the female body. Alienation in this model does not however involve the maternal object and is intrinsic to female anatomy and development: power over the body is a rebellion against the paradoxical way women relate to a body experienced at once as mysterious (the object of constant narcissistic scrutiny) and changeable (changes to which they are passively subjected). Eating disorders therefore are efforts to transform passively experienced, vague and internal genital sensations into focalized expressions - which are then externalized, projected onto organs and object relations -, and self-inflicted (active) emaciation constitutes a defense against anxieties of passivity. Although the model could be critiqued for its foreclosure of dynamics with the object, it nevertheless presents a remarkable insight into anatomic and developmental aspects as expressed in struggles eating disordered women fight to control their body. While it occupies a secondary position vis-à-vis control and passivity, the problematic of intrusion is also an important component of Cross' model.

If the two preceding models on feminine specificity lay emphasis on dialectics of control over the body, involving (Chasseguet-Smirgel) or foreclosing (Cross) the object, Self-Psychology (De Groot and Rodin, 1994; Sands, 1989, 2003) views the

concretization of neediness in the body in these pathologies as a specifically feminine recourse to deal with unmet developmental strivings and dependency needs. A biopsychosocial etiological model highlights consequences in terms of identity-related disturbances. In the model, biological givens (including similarity with mother) and early challenges in feminine development combine with cultural and familial hurdles to create deficits in identity that are reflected in issues around differentiation, neediness, lack of agency and unawareness of affect. From this perspective, eating disorders are self-soothing strategies, which aim at resolving these difficulties through the substitution of food for the mother. The substitution denies the shortcomings and failures of an idealized maternal object. The mother's significance as a primary object, although reinforced because of physical similarity, is not intrinsic but connected to ongoing practices of maternal mothering. Although Self-Psychology is not my frame of reference, its all-encompassing approach is the closest to the integrative perspective adopted in this work. Its contribution to dependency, neediness, and identity issues as interrelated phenomena is illuminating.

Russell's (1992) intrusion model proposes that bulimia is a metaphor representing a stereotypically feminine resort to stuffing - a caricature of expected containment -, and purging - a caricature of rejecting that expectation. In his model, the influence of the female body is mediated by culture and the function of

introjective/projective processes is principally one of discrimination between subject and object through attraction (taking in) and repulsion (ridding). Russell's model creates a bridge between Self-Psychology's greater integration of the cultural dimension of eating disorders and an object relational focus on phenomena of introjection and projection - my theoretical background as featured in the following opposed, but nevertheless compatible, two models on intrusion.

Lawrence's (2001, 2002, 2008) view on female anatomy and development as important aspects of feminine specificity in anorexia is articulated around three main aspects/phenomena of intrusion: (1) dominant anxieties resonate with the reality of sexual difference - mirroring female sexual constitution, the feminine character is open and inclined to introject, but also closed and terrorized of being projected into; (2) excessive introjective tendencies are in operation, which involve the projection of strong aggression onto the mother's body and equally powerful expectations and fears of retaliation; and, (3) maternal containment of anxieties of intrusion fails. (Klein, 1928, 1932) Cycles of intrusion mostly originate in the subject. Intrusive phenomena, in connection with concreteness of thought, reflect inability to discriminate between what is and what is not intrusive in what the anorexic girl takes in: psychic introjection occurs upon eating as some aspects of the mother function (feeding) are split and equated with food. Beyond the question of feminine specificity per se, Lawrence's model carries

structural consequences on a conceptualization of eating disorders in terms of intrusion. It emphasizes constitutional dispositions, mitigates external influences, and consecrates the maternal paradigm of eating disorders.

In contrast, in emphasizing a vicarious maternal (parental) apparatus of receptivity that operates through 'container-contained' dynamics (Bion, 1962a), Williams' (1997a, 1997b, 2004a, 2004b) model extends channels of metaphorical receptivity beyond female anatomy and gender. Cycles of intrusion in disorders of eating and other pathologies mostly originate in the object, when children are bombarded with parental projections (anxieties or aggressions), which they experience as intrusive alien objects. A projecting object is internalized that reverses the 'container-contained' dynamics into a 'receptacle-foreign-body' relationship. The capacity to receive, stay with, think of, and digest unbearable thoughts and emotions/sufferings is impaired, and thoughts and emotions are concretely transformed into and through bodily processes. Anorexics develop 'no entry' defenses, impervious shields, to block out parental, alien anxieties; bulimics allow them in and are then compelled to expel them.

Of supreme significance to impairment in receiving is the context of dependence and loss around weaning in which it unfolds and consequences thereof on differentiation from the object through projective identification (Klein, 1946). To evade

excruciating experiences of dependence on and loss of the object, parts of the ego are forced in fantasy inside the object in order to control it and erase and deny any differentiation. Fusing with the object, being inside it rather than with it, protects against feeling the risk and pain of neediness and separation (Williams et al (eds.), 2004a). Consequences, however, are dismal in terms of identity loss, blurring of boundaries, and diminished capacity for tolerating limits and frustrations (Quagliata, 2004). It is on the basis of Williams' use of projective identification in her intrusion model of eating disorders that I put forward the working hypothesis of intrusion's supremacy over other problematics, namely control and dependence/neediness and their related identity issues, which are emphasized in the femininity theories under consideration. Intrusion's supremacy in my hypothesis specifies *intrusion as aiming to control objects and or states and emotions, in a context of overwhelming dependency on an overbearing internal object both desperately needed and dreaded, and consequences thereof on issues of identity.* In this generic formula, dependence refers to the fantasy of being forced, beyond one's capacity, to control what gets in the body and mind, including eating.

As mentioned above I have specifically developed the two object relations models for their central contribution to the intrusion hypothesis. Williams' model in particular has significant implications in terms of a conceptual shift away from an

exclusively feminine and maternal paradigm of eating disorders. It also grants a far greater weight to external influences (couched in psychological terms), while acknowledging an infant's contribution to a dyadic misfit. These implications ultimately lead to a universal and more comprehensive account of these disorders.

Before wrapping up on contributions from femininity theories and object relations intrusion models to the articulation of a universal, gender-free intrusion theory of eating disorders, I will refer briefly to a last psychodynamic hypothesis, put forward by Shipton (2004), which occupies a key position in my theoretical reasoning. There are two reasons why I did not include it in the section on object relations models. One is that it belongs more in the section on the relevance of historical accounts to Theme B on intrusion and receptivity: it provides a psychodynamic rationale for the notion of interconnectedness of anorexia and bulimia, which, combined with an assumption of historical continuity in anorexia, allows extending the notion of control to intrusion - a preliminary introduction of intrusion in the equation of eating disorders. The other reason is that the hypothesis stands as a simple proposition, which Shipton does not elaborate on. This hypothesis is nevertheless critical and deserves being developed, a step I take in this work in Chapter II.

The Contribution to the Thesis

Williams' model presents a powerful counter model to feminine specificity in eating disorders - a counter model that nevertheless allows integrating phenomena and issues emphasized in femininity theories relevant to these pathologies. I take it further in this thesis.

In shifting focus to vicarious channels of receptivity, maternal or paternal, and to impairment in the capacity to receive resulting from parental intrusions (projections) - as theoretically allowed by the reversal of Bion's concept of 'container-contained' - Williams' model establishes a foundation on which I develop a universal, gender-free notion of 'intrusion as the experience of invasion of receptivity' that transcends female anatomy and psychology.

As significantly, Williams' model provides the backbone for my working hypothesis of intrusion's supremacy over other phenomena emphasized in femininity theories of eating disorders. My hypothesis underscores intrusion as the most elemental, archaic impulse involving the object via dynamics of introjection and projection - concretely expressed through and around eating, in the prototypic context of weaning. Projective identification (parts of the ego are forced in fantasy inside the object in order to control it and erase and deny any differentiation) is critical in allowing intrusion's theoretical subsuming of other problematics. This comes in addition to the theoretical worth of introjection and projection in explaining dynamics of taking in/receiving and expelling as conveyed through restrictive, binging and purging behaviors. My treatment of intrusion's supremacy in the context of the contributions of femininity and object relations theories to the gender specificity of eating disorders overlaps with Theme B on intrusion and receptivity.

Intrusion's supreme standing among other problematics is substantiated in the psychological literature on parenting, schemas and attachment under Theme B on intrusion and receptivity. Evidence of a gender-free perspective on intrusion is provided under the psychological literature on gender traits, sexual orientation and their relation to eating disorders (Theme B on the relevance of gender traits). Both literatures vindicate Williams' model of parental projections (intrusions) as applying to either sex.

THEME B: INTRUSION AND RECEPTIVITY IN EATING DISORDERS

In this section I introduce the literature, historical accounts and psychological sources, which I build on to articulate and then confirm the intrusion hypothesis of eating disorders, the second major theme of this work.

Historical Accounts

Historical accounts cast a light on social and historical contexts as a crucial dimension of eating disorders. They allow me to contradict a common view that anorexia has origins in the past while bulimia is a modern disease. More specifically, they allow the pooling of observations over a substantial period with the postulate that anorexia and bulimia are dynamically interconnected - with anorexic control defending against bulimic hunger for the object (Shipton). This is important considering the introjective phenomena, and its intrusion offshoot, which underlie these dynamics and imply an intimate relationship between control and intrusion. This in turn introduces intrusion as a problematic of eating disorders, an important step in the elaboration of my thesis.

Reviews of historical accounts offer interesting insight into the prehistory of anorexia (Habermas and Beveridge, 1992; and Bemporad, 1996) and of bulimia (Stein and Laakso, 1988; Parry-Jones and Parry-Jones, 1991; Crichton, 1996; Ziolko, 1996).

Habermas (1989) presents a comparative perspective on forerunners of the two syndromes.

On Anorexia

Exploring intellectual histories of concepts, histories of syndromes and the reconstruction of cultural influences on a syndrome, Habermas and Beveridge (1992) present two cases of anorexia, which underwent a retrospective rediagnosis. They reconstruct the intellectual and institutional context that allowed the rediagnosis. Their work casts a light on the link between religiously motivated forms of self-starvation and secular manifestations of fasting in anorexia as identified by medical writers. It reveals in particular dynamics of institutional influence between the Church and the medical establishment, which reflect changing spiritual or pathological meanings borne by the anorexic syndrome at different times in history.

Bemporad (1996) covers historical references on self-starvation, recent publications on the history of eating disorders, and articles describing cases of eating disorders in the past. His summary of the prehistory of anorexia before its formal medical identification at the end of the 19th century allows establishing the existence of a self-starvation syndrome since ancient times. It links its frequency, manifestations, and possible motivation to particular political, social and cultural contexts and events.

On Bulimia

In their review of some of the historical mentions of bulimia in the medical literature of the previous 300 years, Stein and Laakso (1988) argue against the common characterization of bulimia as a modern syndrome, considering that the depiction results from increased rates of prevalence and changes in the criteria constituting the syndrome. They point to historical evidence, which suggests that earlier conceptualizations of the term describe both a symptom and a discrete syndrome. They show that despite the fact that the diagnosis and use of the notion of bulimia have been variable in history, its basic dramatic characteristic has remained constant.

Exploring the etymology of the term in a range of printed works dating from the fifteenth to the eighteenth centuries; describing and discussing the symptomatology, etiology and treatment of twelve reported cases between the seventeenth and nineteenth centuries, Parry Jones and Parry Jones (1991) show that bulimia, as pathological voracity, has been consistently described over centuries. Considering these historical findings against the modern syndrome of bulimia nervosa, they conclude that the symptom of bulimia has occurred for centuries in conjunction with a variety of other symptoms and signs, forming accepted syndromes whose interpretation has been influenced by contemporary social and cultural factors and evolving medical knowledge.

Crichton (1996) looks into the cases of Emperors Claudius and Vitellius in the context of Romans' eating habits and their attitudes towards these habits during the first two centuries A.D. His extensive search of contemporary Latin literary and historical sources and prominent medical sources suggests that the variant of binging and self-induced vomiting, as revealed in the two cases, was practiced intermittently by some individuals of the wealthy elite and was not representative of the vast majority of Romans, which appeared to have reasonable and healthy eating habits. The study suggests that bulimia nervosa is by no means an entirely unprecedented phenomenon.

Ziolko (1996) reviews historical references to bulimia from the first recorded report (2,500 years ago) to the 1970s. Underscoring the many changes the concept of bulimia underwent over time, from monosymptomatic to polymorphous clinical pictures, he argues against the notion of a new disorder.

Comparing Anorexia versus Bulimia

Tracking the history of weight concerns, binge eating and purging strategies, Habermas (1989) critically reassesses British, American, German and Italian historical medical reports on forerunners of anorexia and bulimia, alerting to the problem of retrospective diagnosing and examining factors that may have influenced the history of medical writing on eating disorders. He articulates the main tenets on which a distinction

between the modernity of bulimia nervosa and the historical breadth of anorexia nervosa are based: in anorexia, weight concerns as a new phenomenon has superseded traditional ascetic motivation; in bulimia, the combination of food reversal methods - motivated by weight concerns (as a new phenomenon) - with binge eating has been known since ancient times.

The Contribution to the Thesis

A historical perspective on precursors of anorexia and bulimia illuminates social and cultural influences on the specific expression and meaning, which these complex pathologies acquire at different times and in different contexts. Most importantly, it provides a preliminary formulation of my thesis that 'intrusion, as the experience of invasion of receptivity', is the fundamental psychological factor in the etiology of eating disorders.

My critique of historical accounts on forerunners of eating disorders in the above reviews suggests a certain level of historical continuity for anorexia around control-related themes (assertion, protest, and superiority), which, considered in combination with Shipton's object relations assumption of interconnectedness between anorexia and bulimia, extends the notion of control to intrusion. This extension or overlap introduces intrusion as a problematic in eating disorders.

Shipton's (2004) psychodynamic link between anorexia and bulimia on which I base the link between control and intrusion is presented in her concise and practical introduction to therapeutic work with eating disordered populations in the social context of the 20th and 21st centuries. She posits the interconnectedness of anorexia and bulimia on a daunting, insatiable appetite for the object - with anorexic control a defense against bulimic desires and impulses. Considering that underlying bulimic urges to incorporate the object are introjective processes and their intrusion offshoot, I infer that dynamics of anorexic control over bulimic impulses always imply intrusion. This allows proposing an overlap of control and intrusion.

Beyond Shipton's psychodynamic link, the notion of interconnectedness is confirmed by contemporary nosological crossovers between anorexia and bulimia, and by taxonomic fluctuations in successive versions of the DSM. Furthermore, the historical perspective reflects a similar taxonomic complexity through the distinctions it highlights between

core/contextual symptoms and full-blown/partial syndromes in the two forerunners of anorexia and bulimia.

The intrusion hypothesis, in both its overlapping component with control and supreme position over other eating disorders problematics (Theme A on gender imbalance, in particular femininity theories and object relations models on intrusion), is confirmed in the following psychology literature.

The Psychology Literature (Studies on Perceived Parenting, Schemas, Attachment)

Psychological studies on parenting, schemas, attachment, and their relationship, substantiate the intrusion theory. This is done through: 1/ the validation of an overlap between intrusion and control, which extends the notion of control to intrusion - thus introducing the latter as a problematic in eating disorders (Theme B, in particular historical accounts); and, 2/ the identification of a predominant pattern of intrusive parenting in subjects suffering eating disorders (Theme A, in particular femininity theories and object relations models on intrusion) - thus confirming intrusion's central position among other problematic, and providing particular support to Williams' model of parental projection of anxieties.

These findings and the conclusions I draw from them consequently allow integrating psychological results with a number of psychoanalytic postulates of my work. In Chapter VII I make it clear that correspondences between the notions of control and intrusion as used in the psychological and psychoanalytic literatures are sufficient to support my thesis. Among arguments justifying correspondences between the two

constructs in the two paradigms, I cite in particular the process of internalization as used in Williams' model of eating disorders and in attachment and schema theories to explain how controlling and intrusive parenting behaviors are reflected through internal experiences of control and intrusion.

Two sets of psychological tests measuring the relationship between parenting patterns and backgrounds and the development of eating disorders in offspring are relevant to the intrusion hypothesis.

A first set provides reliable measures of overlapping phenomena of control and intrusion in perceptions of early parenting. The two tests are the Parental Bonding Instrument (PBI) (Parker el al, 1979) and the Egna Minnen Betrsffande Uppfostran (EMBU) (Perris el al, 1980) - in Swedish, 'my memories of upbringing'. The overall validity and reliability of retrospective perceptions of early parenting has been generally acknowledged (Gilbert and Perris, 2000; Panfilis et al, 2003). The tests are discussed at length in Chapter VII.

The overlap of intrusion and control, which allows extending the notion of control to intrusion - a first step in the articulation of the intrusion thesis (Chapter II) - is inherent in the design of the two tests: protection scores in both tests assess parental behaviors, which are defined via subscales of control, overprotection, and intrusive contact. The convergent validity of PBI and EMBU tests is documented in a study in three

independent samples of community subjects, psychiatric patients, and eating disordered patients and their parents (Arrindell et al, 1998).

On the other hand, PBI and EMBU findings show a definite link between eating disorders and a predominant and stable pattern of intrusive/controlling parenting, the 'Parental Affectionless Control Dynamic' - whether eating disorders are considered aggregately or in subgroups of anorexic, bulimic, or binge eating patients. This provides evidence for the thesis that intrusion encompasses other problematics of control, dependence/neediness and related expressions in problems of identity (Chapters III, & VI). Findings also highlight the significant role fathers play in the development and maintenance of these pathologies.

PBI and EMBU studies of relevance include: Gomez (1984), Pole et al (1988), Steiger et al (1989), Calam et al (1990), Fichter and Noegel (1990), Palmer et al (1990), Russell et al (1992), Sordelli et al (1996), Fichter et al (1993), Fichter and Quadflieg (1996), Fowler and Bulik (1997), Murray and Waller (2000), Panfilis et al (2003), Meyer and Gillings (2004), Katena et al (2004), Turner et al (2005), Laporte and Guttman (2007), Canetti et al (2008), McEwen & Flouri (2009). Relevant EMBU results are found in: Esparon and Yellowlees (1992), Castro et al (2000), Ihle et al (2005), Rojo-Moreno (2006).

The second set of tests measures two constructs: 1/ schemas in Schema theory (Young, 1990; Young et al, 2003), and, 2/ internal working models in Attachment theory (Bowlby, 1969, 1973, 1980; Pietromonaco and Feldman Barrett, 2000). The two constructs are important because they reveal mechanisms of internalization and transmission of psychological phenomena in an individual's life, within families, and across generalizations. As such, they help explain the link between external and internal experiences.

Both schemas and internal working models describe comparable mental phenomena, respectively beliefs and mental representations, about self, others and relations that emerge in childhood and endure over life. A main distinction between them centers on content. In schemas, content changes according to contexts and disorders. In internal working models, it remains consistent, centering on attachment patterns and attendant anxieties.

In eating disorders, schemas and internal working models suggest complementary or alternative pathways to biological explanations for the perpetuation of intrusive-related phenomena. A core belief, shame, mediates the relationship between perceptions of parenting and the development of eating disorders. Insecure attachment, and its attendant anxieties, is characteristic of patients suffering from these disorders. Both shame and insecure attachment feature enduring tensions between low care,

abandonment, rejection, underprotection, on the one hand, and control, overprotection, overinvolvement and intrusion, on the other. Insecure attachment specifically underscores the anxiety component underlying these tensions. Most significantly, these tensions match those characteristic of control and intrusion as identified in PBI and EMBU findings on eating disorders and refer to the overwhelming and excruciating experience of dependence on an internal object both desperately needed and dreaded. Finally, findings present evidence of transgenerational transmission of eating disorders through the perpetuation of attachment and parenting styles.

Studies on attachment in eating disorders include Armstrong and Roth (1989), O'Kearney (1996), Ward and Ramsay (2000), Jones et al (2006), Canetti et al (2008) (PBI), and Tereno et al (2008) (EMBU).

Studies dealing with shame in eating disorders include Murray and Waller (2000), Turner et al (2005), Jones et al (2006), and Goss and Allen (2009).

The Contribution to the Thesis

The literature on parenting (PBI and EMBU), schemas, and internal working models establishes a bridge between the paradigm of psychology and object relations models on intrusion in eating disorders. In validating a number of working hypotheses put forward in this work, it eventually confirms the thesis that intrusion is the fundamental etiological factor in eating disorders. The psychological literature confirms in particular:

1. The hypothesis of an overlap of control and intrusion. The hypothesis, which I inferred from the combination of assumptions of historical continuity and psychodynamic interconnectedness of anorexia and bulimia around control-related

issues [Shipton's view of anorexic control as defending against bulimic appetite for the object], had extended the notion of control to intrusion. Its confirmation, as inherent in PBI and EMBU tests, validates the introduction of intrusion as a factor in eating pathology. Point 2 below validates intrusion as the fundamental psychological factor of etiology in eating disorders.

2. The hypothesis of intrusion's supreme standing among other problematics: *intrusion aims to control objects and/or states and emotions, in a context of overwhelming dependency on an overbearing internal object, both desperately needed and dreaded - and consequences thereof on issues of identity.* The hypothesis derived from my positioning of Williams' critical theory on intrusion - and its specific usage of projective identification - as a counter-model to all femininity theories of eating disorders. Its confirmation, through the identification of a predominant pattern of 'Parental Affectionless Control Dynamic' that underlies all forms of eating disorders, validates the thesis that 'intrusion, as the experience of invasion of receptivity', is the fundamental psychological factor in the etiology of eating disorders.

3. Beyond, and underlying my two hypotheses above, Shipton's and Williams respective object relations propositions: 1/ on anorexic control as aiming to control bulimic appetite for the object; and 2/ on projective identification - in a context of weaning, and to evade painful experiences of dependence on, and loss of the object, the infant forces in fantasy parts of its ego inside the object, to control it and to erase any differentiation from it.

4. Following from the identification of a predominant pattern of 'Parental Affectionless Control Dynamic" (point 2 above), the significance of parental projections/intrusions to eating disorders. This supports Williams' model of parental projections of anxieties onto children over Lawrence's view of a mostly constitutional etiology. The relevance of Williams' object relations model of parental intrusions further applies to all points below.

5. Both fathers and mothers are relevant to the development of eating pathology. This constitutes a qualification of the maternal paradigm of eating disorders.

6. The significance of actual fathers - they are not the mere projections of offspring (as in Lawrence's model); their intrusions are documented - to the development and maintenance of eating pathologies.

7. The additive/compensatory dimension of parental dynamics. When both parents are intrusive, the damaging impact on offspring is exacerbated. When one parent does not behave in an intrusive manner, harmful effects on offspring are mitigated.

8. The intergenerational transmission of intrusion-related phenomena and anxieties in eating disorders as an alternative or complementary channel to biological/constitutional perpetuation (Lawrence).
9. An integrated etiological model of eating disorders on a continuum between innate, constitutional (Lawrence) and environmental/parental (Williams) influences. The model corresponds to the current biopsychosocial view of these disorders. It establishes multiple biological, cultural, and psychological contributions to the etiology of eating disorders. In my thesis, offspring perceptions of intrusive parenting stand for the psychological component in the biopsychosocial formula. Whether intrusions originate internally or externally, the overwhelming experience of invasion of receptivity is nevertheless the same.

THEME C: THE RELEVANCE OF GENDER ATTRIBUTES TO EATING DISORDERS

The last major theme, the gender specificity of eating disorders, is the crux and the culminating point of this work. It probes into the notion of intrusion in the psychological literature - this time against the backdrop of gender, sexes, and sexual orientation. Theme C brings ultimate support to the thesis that intrusion, as the overwhelming experience of invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders, and that it transcends sexes. This includes explaining the homosexual exception through restricting the vulnerability of male homosexuals to eating disorders to a subgroup whose intrusive parenting matches that of female patients with these disorders.

The male homosexual exception, which was revealed in epidemiological/taxonomic studies (Theme A on gender imbalance), is put to use as a

conceptual tool to test, *together,* the femininity and intrusion hypotheses of eating disorders. This joint consideration of the intrusion and femininity hypotheses constitutes an elaboration on findings - and conclusions that follow from them - that were gathered under Theme B (intrusion and receptivity). The latter findings and conclusions substantiated the first segment of my thesis that 'intrusion, as the overwhelming experience of invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders'. Tested together, the intrusion and femininity hypotheses provide evidence for the second segment of the thesis: 'intrusion is universal, and it transcends gender'.

I will restate what I say in different places in this work concerning my reference to notions of femininity and homosexuality as deliberately reproducing - with the aim of transcending them - their respective usage, and stereotypes thus conveyed, in the literatures under consideration. In using stereotypes of gender and sexual orientation, as carried through the literatures on eating disorders, Theme C allows going beyond these stereotypes via the substantiation of a gender-indifferent intrusion theory of these pathologies.

The Psychology Literature (Studies on Gender Traits, Sexual Orientation, and their Relation to Eating Disorders)

The substantiation of a universal thesis of intrusion in its application to the two sexes in eating disorders has involved a number of steps, and a gradual expansion of my scope of research: from studies focusing on the relationship between sexual orientation and gender attributes; to studies on the relationship between femininity and eating disorders; to studies investigating eating pathology, gender and sexual orientation together; to studies allowing to bring together the femininity and intrusion hypotheses; and, finally, to studies addressing the relevance of intrusive parenting to male homosexuality.

The first set of psychological findings sheds a light on the relevance of sexual orientation to this work. This is in reference to the so-called gender-related paradigm of research on sexual orientation. Despite evolution over time in their conceptualization and measurement, studies on sexual orientation in relation to attributes of femininity and masculinity have consistently established a link between the two: from bipolarity [either/or, unidimensional, masculinity (M) or feminity (F) scales]; to two-dimensionality [independently assessing (M) as instrumentality (I) and (F) as expressiveness (E), in both men and women]; to gender diagnosticity [calibrating (M) and (F) against cultural standards, in conjunction with (I) and (E)] (Lippa and Connelly, 1990; Sandfort, 2005; Lippa, 2005; Lippa, 2008). Whether a construct or not, research has not been able to

describe the relationship between sexual orientation and gender traits beyond popular stereotypes on the femininity of homosexual men and masculinity of lesbians (Woodhill and Samuels, 2003).

Mirroring findings that show a relationship between sexual orientation and gender traits are studies establishing a relationship between eating disorders and femininity. In women, eating pathology has a positive relationship with femininity and a negative one with masculinity. In both heterosexual men and women, eating disorders are associated with high identification with feminine traits (Hawkins II et al, 1983; Paxton & Sculthorpe, 1991; Wichstrom, 1995; Murnen and Smolak, 1997; Lakkis et al, 1999).

An expansion of the scope of research comes with studies investigating the three parameters together (sexual orientation, eating disorders, and gender traits). It reveals dialectical dynamics between homosexual subcultures and the broader culture of society: male homosexual subcultures emphasize looks, style and slenderness - identified as feminine characteristics; the broader culture reflects society's stereotypes of femininity and masculinity. Results show a higher susceptibility to eating disorders in homosexual men in connection with the male homosexual subculture and its display of feminine characteristics. In homosexual males with eating disorders, the male homosexual subculture trumps gender (norms of masculinity) (Lakkis et al (1999).

The above associations (eating disorders and femininity; eating disorders, femininity, and male homosexuality) argue in favor of a femininity theory of eating disorders - femininity as a factor in the etiology of these disorders - that applies to both men and women, including male homosexuals. Quite significantly, the femininity hypothesis is highlighted when viewed against a background of sexual orientation: in general, lesbians are less, and homosexual men more, vulnerable to eating disorders, and individual degrees of femininity in each group appear to aggravate such propensities (Meyer et al, 2001).

A further expansion of my research links together the femininity and intrusion hypotheses. This brings support to a theory of eating disorders, which centers on aspects of receptivity that are common to both femininity and intrusion and apply to the two sexes. This shared space between femininity and intrusion, which is epitomized in the notion of 'intrusion as the overwhelming experience of invasion of receptivity', is revealed through two sets of tests and results.

One measures and establishes correspondences between negative femininity and negative styles of control. Negative femininity measures two clusters of characteristics, which cover subordination of self to others and verbal passive aggressiveness and their symptomatic expression in low self-esteem and neuroticism (depression and anxiety). Negative styles of control refer to having too little control,

being indecisive, timid, and dependent (Spence et al, 1979; Woodhill and Samuels, 2003).

The other set reveals the coincidence of negative femininity and its yielding style of control with symptoms that are characteristic of eating disorders in both men and women (Lakkis et al, 1999; Williams and Ricciardelli, 2001, 2003).

I combine the previous two results [a significant weight of negative control in negative femininity, and a correspondence of negative feminine traits and control styles with symptoms of eating pathology in the two sexes] with the earlier finding of an overlap of intrusion and control (Theme B, the section on intrusive parenting in the psychology literature). The integration of negative control/intrusion and negative femininity with eating disorders symptoms in the two sexes supports a gender-free femininity theory of eating disorders, which emphasizes aspects of receptivity that are common to both femininity and intrusion. In brief, (1) if control overlaps with intrusion; (2) if the weight of negative control in negative femininity is substantial; finally, (3) if negative feminine traits and control styles correspond to eating disorders symptoms in males and females; then a gender-free femininity theory of eating disorders centering on intrusion can be inferred. This establishes the relationship between intrusion and femininity in men and women with eating disorders.

Bearing in mind that I have documented a relationship between eating disorders and male homosexuality, which underscores the relevance of femininity to this relationship; considering that I have established an association, in terms of receptivity, between intrusion and femininity in eating disorders in the two sexes - my next and final theoretical move concerns the outstanding intrusive component in the intrusion/femininity equation of eating disorders in homosexual males with these pathologies. This ultimate theoretical move allows me to restrict the vulnerability of male homosexuals to eating disorders to a subgroup whose intrusive parenting corresponds to that of female patients with these disorders. This conclusion is reached through the examination of two sets of studies.

The first set explores parenting patterns and male homosexuality independently from their relationship to eating disorders. These studies contradict the predominance of a typical parental constellation that has been commonly associated with male homosexuality. A homogeneous, monolithic parental configuration featuring a close-binding, dominant mother and an irrelevant/rejecting father does not do justice to the complexity governing the relationship between parenting and sexual orientation in men.

Instead, and this is quite significant to the question under consideration, a second set of findings shows that, among many parenting patterns, one in particular represents a direct match of the ‘Parental Affectionless Protection Dynamic’ - intrusive

control and low care, by both mother and father - that I have shown to be typical of parenting in males and females with eating disorders.

This important coincidence allows extrapolating these findings on intrusive parenting in a subgroup of male homosexuals to the category of homosexual men suffering from eating disorders. This leads to the conclusion that, as in women with eating disorders, vulnerability to the psychological phenomenon of intrusion is the leading etiological factor in the development of these disorders in male homosexuals. The shared space between femininity and intrusion, which is epitomized in the notion of ‘intrusion as the overwhelming experience of invasion of receptivity’, applies to male homosexuality.

The following studies have explored the relationship between parenting and male homosexuality: (Freund and Pinkava, 1959; West, 1959; Bieber et al, 1962; Bene, 1965; Nash and Hayes, 1965; Apperson and Mcadoo, 1968; Evans, 1969; Moran and Abe, 1969; Roberston, 1972; Thompson et al, 1973; Stephan, 1973; Freund, 1974; Siegelman, 1974; Buhrich and McConaghy, 1978; Koenig, 1979; Zuger, 1980; Mallen, 1983; Sipova and Brzek, 1983; Skeen and Robinson, 1984; van den Aardweg, 1984; Newcomb, 1985; Milic and Crowne, 1986; Friedman, 1996; Ridge and Feeney, 1998; Corliss et al, 2002; Kiatkowski , 2010; Wilson et al, 2011).

The Contribution to the Thesis

Theme C (the relevance of gender attributes to eating disorders) brings together the paradigms of psychology and object relations on intrusion in eating disorders, this time from the perspective of gender, sexual orientation, and their relationship to one another and to intrusive parenting. Significant contributions to Theme C come through the exploitation of the 'homosexual exception', which was revealed in epidemiologic and taxonomic sources (Theme A on gender imbalance), as a tool of research. An integration of findings from Theme C with those from Theme B (intrusion and receptivity) brings ultimate confirmation to a gender-free intrusion thesis of eating disorders that conceptualizes 'intrusion as the overwhelming experience of invasion of receptivity'. It also explains the relationship between the homosexual exception and eating disorders.

Setting the rationale and the parameters for an exploration of aspects of femininity and male homosexuality in conjunction with eating disorders, Theme C has in particular:

1. Confirmed overlapping aspects of control and femininity and their coincidence with symptoms of eating pathology in both males and females.

   Combined with an overlap between control and intrusion (Theme B on intrusion and receptivity), this overlap of control, femininity and symptoms of eating pathology in males and females gives initial support to a gender-free intrusion thesis of eating disorders. A relationship between intrusive parenting and eating disorders in a subgroup of male homosexuals as inferred in point 3 below provides additional support to the thesis.

2. Established a relationship between femininity, male homosexuality, and eating disorders whereby in male homosexual subcultures, sexual orientation trumps gender: in these subcultures, alignment with feminine stereotypes concerning slenderness influences the development of eating disorders; the relationship involves a component of intensity - the more feminine male homosexuals are, the more prone to eating disorders.

   Viewed against this work's conclusion that, while intrusion constitutes the fundamental psychological factor in the etiology of eating disorders, biopsychosocial dynamics explain the contemporary surge of these disorders in women and in male homosexuals, this relationship between femininity, male homosexuality, and eating disorders sheds light on the cultural aspect of the biopsychosocial dynamics.

3. Inferred a relationship between intrusive parenting and eating disorders in a subgroup of male homosexuals whose intrusive parenting corresponds to the one found in patients with eating disorders - the 'Parental Affectionless Protection Dynamic', which is characterized by intrusive control and low care by both fathers and mothers.

   The inference brings further support to the gender-free intrusion theory.

4. The combination of all points above has allowed integrating the intrusion and femininity hypotheses of eating disorders to confirm that intrusion, in its feminine/receptive dimension - in other words, 'intrusion as the overwhelming experience of invasion of receptivity - is the fundamental problematic in eating disorders and that it transcends gender. As such, the complementary couple intrusion/receptivity constitutes the invariant factor in the equation of eating disorders.

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The interdisciplinary approach adopted in this work forced on me the constant challenge of sailing across various literatures and fields of knowledge without losing track of my ultimate psychoanalytic perspective on eating disorders. The present section on methodology and sources has hopefully addressed this challenge. Bringing various non-psychoanalytic disciplines and bodies of literature together with the two object relations models on intrusion has led to my main theoretical moves towards articulating and substantiating a conceptualization of both intrusion and femininity in terms of receptivity, and, beyond it, a gender-free intrusion thesis of eating disorders.

The critical theoretical steps described in this section provide a backbone against which all parts and chapters in this thesis can be read.

PART I

SETTING THE STAGE

CHAPTER I

THE CONTEMPORARY LANDSCAPE OF EATING DISORDERS

CHANGING TRENDS

Eating disorders are mental disorders acknowledged within the fields of psychology, social work, nutrition and medicine. Until recently, and as reflected in their eminent position in the 4th edition of the Diagnostic and statistical manual of mental disorders (DSM-IV-TR) (American Psychiatric Association, 2000)[8], Anorexia nervosa and Bulimia nervosa have attracted most attention in the research and clinical work on these pathologies (Keel, 2005). Of late however, increased interest has been directed towards a third, looser, category of the DSM-IV-TR, namely Eating disorders not otherwise specified. The rising interest in partial criteria - beyond full-blown forms of anorexia and bulimia - has corresponded with an increased attention to expressions of

[8] Changes in the latest, 5th, edition of the Diagnostic and statistical manual of mental disorders (DSM-V) classification of eating disorders are indicated whenever relevant (American Psychiatric Association, 2013).

disordered eating in the general population - beyond clinical cases. These parallel developments have had a considerable impact on shaping more recent perspectives on eating disorders, including in their gender dimension.

This chapter captures the dynamics, meaning, and implications of what can be described as the changing landscape of eating disorders in the 20th and 21st centuries. In addition to revealing increases in male cases, the exploration of the epidemiological field of these disorders casts a light on two other findings, which are critical in directing the course of this work. A first one is what represents an exception in an otherwise globally similar picture of eating disorders in women and men, that is, homosexuality as a specific risk factor for these disorders in males. This male homosexual exception opens avenues into investigating its potential, though stereotypic, connection with femininity - femininity itself representing another, difficult to circumvent, stereotypic assumption in disorders that mainly affect women[9]. The second finding indicates that eating disorders involve a combination of intricately entangled biological, psychological, and cultural components - beyond the distinct emphases of individual disciplines and despite the obvious flaw of an all-inclusive perspective.

In the first part of the chapter, I present and discuss the DSM-IV-TR categories. In the second part, I look into the asymmetrical gender epidemiology of eating

[9] Stereotypes pertaining to homosexuality and femininity are examined in Chapter VIII.

disorders, asking challenging questions about recent changes in the landscape of these pathologies, in particular in relation to the homosexual exception.

CONTEMPORARY NOSOLOGY (DSM-IV-TR)

Anorexia Nervosa

The four diagnostic criteria for Anorexia nervosa as presented in the DSM-IV-TR are:

> A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
> B. Intense fear of gaining weight or becoming fat, even though underweight.
> C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
> D. In postmenarcheal females, amenorrhea[10], i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration)" (American Psychiatric Association, 544-545).

The manual differentiates between two subtypes of anorexia based on the presence or absence of regular binge eating or purging during an ongoing episode. There is first the restricting type of anorexia (ANR), in which weight loss is attained primarily through dieting, fasting, or excessive exercise. There is also the binge-

[10] The central amenorrhea diagnostic criterion has been eliminated from the DSM-V while other core criteria have on the whole remained unchanged (American Psychiatric Association, 2013).

eating/purging type of anorexia (ANBP), which consists of regular engagement in binge eating or purging (or both).

A number of features and disorders are associated with anorexia in the DSM-IV-TR:

- Depressive symptoms such as depressed mood, social withdrawal, irritability, insomnia, and diminished interest in sex. Many of the depressive features may be secondary to the consequences of semi starvation.
- Obsessive-compulsive features, in connection or not with food - the latter include preoccupation with thoughts of food, the collection of recipes or hoarding of food.
- Other features include fears about eating in public, feelings of ineptitude, a powerful need to **control** one's environment, rigid thinking, restricted social spontaneity, **perfectionism**, and excessively inhibited initiative and emotional expression. Individuals with ANBP are more prone than those with ANR to have **impulse-control** issues, over-consume alcohol and drugs, show more mood lability, be sexually active, have a greater rate of suicide attempts, and have a personality disturbance corresponding to borderline personality disorder criteria.

Other facts concerning Anorexia nervosa in the DSM-IV-TR include:

- **More than 90% per of cases, which seldom begin before puberty, are females.**
- The lifetime prevalence among females is around 0.5%.

- **Subthreshold cases (EDNOS) are more commonly encountered.**
- In males, the prevalence rate is about one-tenth that in females.
- **The incidence seems to have increased in recent decades.**
- Course and outcome are extremely variable - from recovery after a single episode, to fluctuating patterns of weight gain followed by relapse, to a chronically deteriorating course over many years.
- **Within the first five years of onset, a significant number of individuals with the restricting type (ANR) develop binge eating, signaling a change to the binge eating/purging subtype. A constant change in clinical presentation such as weight gain with the presence of binge eating and purging may eventually warrant a change in diagnosis to Bulimia nervosa.**
- The long-term mortality rate is over 10%, with death mostly resulting from starvation, suicide, or electrolyte imbalance.

I would like to emphasize some aspects (in bold above[11]) that are crucial to themes and theses developed in this work. Starting with the significant fluidity mentioned in the point before the last, it constitutes an argument in favor of a classification of anorexia and bulimia along a continuum rather than as discrete categories (Chapter II). This interconnectedness of anorexia and bulimia is central to a

[11] See also bold sections below.

psychodynamic view of eating disorders as centering on an avid and scary appetite for the object, with anorexic restrictions deployed to defend against bulimic desires and urges (Shipton, 2004). There is also the related question of control, which, in its endurance across history, provides a cautious case for a continuity theory for both anorexia and bulimia (Chapter II) - in contrast with the view that these pathologies, in particular the latter, are a strictly modern phenomenon. The ubiquity of control in history is particularly significant in view of its overlapping with intrusion, posited in Chapter II and substantiated in Chapter VII. Such coincidence, which represents a thread running throughout this work's examination of eating pathology, allows extending control's pervasiveness to intrusion - a critical step in elaborating the argument that intrusion is the core problematic of eating. A last object of relevance is of course the striking female preeminence in disorders of eating, the fundament of my interrogation on the relationship between these ailments and femininity.

Bulimia Nervosa

The five diagnostic criteria for Bulimia nervosa in the DSM-IV-TR are:

> A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
> (1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

> (2) A sense of lack of **control** over eating during the episode (e.g., a feeling that one cannot stop eating or **control** what or how much one is eating)
> B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
> C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months[12].
> D. Self-evaluation is unduly influenced by body shape and weight.
> E. The disturbance does not occur exclusively during episodes of anorexia nervosa" (American Psychiatric Association, 2000, 549-550).

As with anorexia, there are two subtypes of bulimia, based in this case on the presence or absence of a regular use of purging methods to offset binge eating during an ongoing episode: the purging type of bulimia, which describes regular engagement in self-induced vomiting or the misuse of laxatives, diuretics, or enemas; and the non-purging type, which describes other inappropriate compensatory behaviors, such as fasting or excessive exercise, but no regular self-induced vomiting or misuse of laxatives, diuretics, or enemas.

[12] A slightly lower threshold - the required minimum average frequency of binge eating and compensatory behaviors have been reduced from twice to once weekly - is the main difference between DSM-IV-TR and DSM-V diagnostic criteria for bulimia (American Psychiatric Association, 2000, 2013).

Features and disorders that are associated in the DSM-IV-TR with bulimia include:

- A typically normal weight range, with some cases slightly underweight or overweight.
- An increased frequency in: depressive symptoms, such as low self-esteem, or mood disorders; anxiety symptoms, such as fear of social situations, or anxiety disorders; substance abuse or dependence, involving in particular alcohol or stimulants; and features that meet criteria for one or more personality disorders, mostly borderline personality disorder. Individuals with the purging type of bulimia show more symptoms of depression and greater concern with shape and weight than those with the non-purging type.

Other facts concerning Bulimia nervosa in the DSM-IV-TR include:

- Lifetime prevalence among women is about 1% to 3%.
- **The rate of occurrence among males is about one-tenth that among females.**
- The age of onset is usually late adolescence or early adult life, **often during or following an episode of dieting**, with disordered eating behaviors persisting for at least several years in a high percentage of clinic samples.
- The course may be chronic or intermittent, with phases of remission alternating with recurrences of binge eating.

In addition to what was said in the section on anorexia with regard to interconnectedness and continuity, control, and intrusion, it is conceivable to envision symptoms or syndromes that are co-morbid with anorexia and bulimia as belonging on either side of **control** coping strategies - pathologically rigid (obsessive-compulsive types) or loose (impulsive, borderline types).

Eating Disorders Not Otherwise Specified (EDNOS)

Finally, **the DSM-IV-TR Eating disorders not otherwise specified category includes disorders of eating that do not match each and every criterion for either anorexia or bulimia.** Examples include:

> 1. For females, all of the criteria for anorexia nervosa are met except that the individual has regular menses.
> 2. All of the criteria for anorexia nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
> 3. All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
> 4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
> 5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
> 6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors

> characteristic of bulimia nervosa (American Psychiatric Association, 2000, 550).

In addition to providing further support to the classification of anorexia and bulimia on a continuum, Eating disorders not otherwise specified have a direct impact on epidemiological indicators, including from the perspective of gender. This is mostly apparent in the way an inclusion of EDNOS may affect prevalence rates amongst the male population, a question that will be extensively dealt with in the second part of this chapter.

The Cultural Dimension of Anorexia Nervosa and Bulimia Nervosa

Cautiously mentioning the lack of systematic research on the frequency of anorexia in other cultures, the DSM-IV-TR nevertheless indicates that the disorder seems far more widespread in industrialized societies. These societies, the manual explains, are characterized by abundance of food and by their linking of attractiveness with slenderness, especially in the case of females. The DSM-IV-TR does not exclude however cultural variations in the articulation of motivations for food restrictions - for instance distaste for food or epigastric discomfort -, and therefore in alternative manifestations of anorexia in non-Western societies. Referring to a similar scarcity in studies on the prevalence of bulimia in other cultures, the manual establishes that the disorder occurs with roughly similar frequencies in most industrialized countries.

In my work, I consider such variations in pathological eating behaviors as manifest cultural expressions of a more latent and universal phenomenon at work in eating disorders: the dynamic and painful negotiation of relations with the object through the unconscious and concrete identification of the latter with food and eating functions.

INSIGHT IN THE LOPSIDED GENDER EPIDEMIOLOGY OF EATING DISORDERS

Statistics in the 20th and 21st centuries are eloquent: women are by far the principal victims of eating disorders. However, a closer look at epidemiological studies reveals layers of complexity underneath the generally accepted 90% figure of female predominance. Indeed, an overview of the landscape of eating pathology signals some apparent changes over the past few decades, raising questions on the meaning of such seemingly shifting trends. As issues relating to sexual orientation and femininity/masculinity subtly emerge from a reflection on the asymmetrical gender distribution of eating pathology, they in turn prompt the critical question of their significance in each sex. In the last instance, the question arises of whether it is sex per se, as opposed to femininity or masculinity, whatever biological, cultural, or psychological connotations gender traits convey, which is actually at stake.

A striking impression when looking at the psychological literature on eating disorders is the overwhelming and often-contradictory nature of findings and the

difficulty to identify and confirm general trends in the field. This is certainly due to the complexity of this particular family of diseases, but it also is undoubtedly the reflection of wide differences in the methodological and taxonomical choices of individual studies. The disparities encompass categories and sub-categories of diseases as well as methods of computation and thresholds of inclusion. Some examples of the difficulties are the differential symptomatology in women and men, the extension of research from clinical to non-clinical populations, and the introduction of atypical and partial eating disorders categories - categories that fit with the Eating disorders not otherwise specified subgroup mentioned above. These difficulties indicate the need for a qualification of conventional figures on the gender distribution of eating disorders. The recent literature reveals that, when partial yet clinically significant criteria are taken into consideration, prevalence rates for males exceed those habitually cited.

Do changes in prevalence rates reflect changes in trends, with more men becoming victims of eating disorders? Would this then constitute the confirmation for a cultural explanation of eating disorders? Or would such changes only indicate differences in categories and methodology, differences that would therefore account for a so far underestimated population? Would this in turn mean that something, beyond the cultural, is inherent in the affected individual - for instance, a constitutional given? Or would it mean that eating-disordered patients, both male and female, are particularly

vulnerable to intrusion into receptivity - vulnerability that is nevertheless heightened in women because of the receptive nature of female anatomy -, the core psychoanalytic hypothesis in this work? In the next sections I start addressing these overlapping and fundamental questions.

Is There an Objective Increase of Eating Disorders In Males?

Recent studies on eating pathology indicate a higher across-the board prevalence rate among men than previously encountered, with particularly significant statistics for atypical forms of eating disorders and specific types and subtypes of Bulimia nervosa and Binge eating.

In an account of what he describes as the uniquely lopsided epidemiological gender profile of eating disorders, Lock points to changing trends in the landscape of eating pathology. Indeed, although eating disorders remain predominantly a female disease, male abnormal eating behaviors seem to be on the rise: between 10% and 20% of anorexia and bulimia cases and up to 40% of Binge eating disorder cases are now found among males (Lock, 2009). Other studies suggest similar upward tendencies. A 2009 epidemiological study in six European countries (Preti et al, 2009) found that lifetime estimated prevalence rates were 3-8 times higher in women than

they were in men for all eating disorders. A 2007 study (Hudson, 2007) showed that lifetime prevalence was consistently 1¾ to 3 times higher among women than men for Anorexia nervosa, Bulimia nervosa, and Binge eating disorder, 3 times higher among men than women for subthreshold Binge eating disorder, and approximately equal among women and men for any binge eating. All these figures at the least exceed the DSM-IV-TR aggregate figure of over 90% female prevalence - a percentage still frequently quoted in the literature.

Traditionally cited female preponderance is particularly qualified if one expands the categories of criteria to include partial syndromes, a direction recommended and adopted in a number of studies. For instance, Carlat et al (1997) suggest that atypical eating disorders might be a particular problem in males. In their review of the literature on eating disorders in male adolescents and young adults, Muise et al (2003) signal a strong developmental component to these disorders: a spectrum of subclinical disordered behaviors, widespread in boyhood and adolescence; and full-blown Anorexia nervosa, Bulimia nervosa, and Binge eating disorder in adulthood. Furthermore, the review shows variable but consistent results of higher female prevalence rates when DSM-IV criteria for these three disorders are applied to adolescent males. In contrast, when partial criteria are considered, far more widespread eating problem behaviors are revealed in young males. Extrapolating to the adult male population, Muise et al (2003)

indicate that less strict definitions of Anorexia nervosa and Bulimia nervosa imply higher prevalence rates for men. They also refer to the newer DSM-PC classification by Worlraich et al. (1996)[13] as allowing the description of pathological eating patterns in terms of a spectrum of behaviors that require psychiatric or medical attention. They recommend in particular keeping a close watch on the 'dieting and body image' as well as 'purging-binge-eating' symptoms. Woodside et al (2001) in turn show how partial syndromes in men, although scarcer in clinical population samples, are more common than the full syndrome in nonclinical samples. Comparing the incidence of anorexia in men and women, they find a female/male ratio of 2:1 when including a partial syndrome (participants met the weight criteria for anorexia but not the full criteria). In the case of bulimia they find a female/male ratio of 2.9:1 when they include a partial syndrome (two of three of either binge-eating, lack of control of eating, or compensatory behaviors).

Other factors may contribute to the underestimation of male cases in traditional statistics on eating disorders: men are less likely to seek treatment for disorders that are socially perceived as feminine (Braun et al, 1999; Dominé et al, 2009) and, more specifically, there are female/male differences in self-reporting of compensatory behaviors (Ross and Ivis, 1999); because they have different self-perceptions than girls,

[13] The Diagnostic and statistical manual for primary care (DSM-PC) (Wolraich et al., 1996) includes two categories, in addition to the DSM-IV partial criteria (American Psychiatric Association, 1994): (1) Dieting and body image behaviors and (2) Purging-binge-eating behaviors.

boys are not necessarily aware that their disordered eating is problematic (Dominé et al, 2009), and, in particular, women are more likely than men to label eating large amounts of food as binges (Carlat and Camargo, 1991); screening criteria are not always adapted to men - an obvious example is the menstruation criterion (amenorrhea), which singles out Anorexia nervosa as the only psychiatric diagnosis with different thresholds by gender (Lock, 2009); furthermore, screening instruments that are sensitive among female subjects often fail to identify male patients (Carlat and Camargo,1991); finally, healthcare providers, who have internalized the paradigm of eating disorders as a female pathology, do not naturally expect or investigate possibilities of eating disturbances in males (McVittie et al, 2005).

Going back to the original question, are changing trends in male eating pathology real or do they simply reflect changes in classification, computing and screening methods, perception and expectation? I found it difficult to categorically confirm any objective increases, as there are no studies that provide time trends incidences[14] for eating disorders in men. One study by Braun et al (1999), although it does not provide such incidences, does support the hypothesis of an actual increase. The study, which compares males and females admitted to the inpatient eating disorders service at The New York Hospital, Cornell, between 1984 and 1997, establishes that males constitute

[14] As women constitute the high-risk group in eating disorders, studies on time trends incidence have globally reflected female tendencies and do not provide significant information on male trends (Hoek & van Hoeken, 2003; Currin et al, 2005; Van Son et al, 2006; Zachrisson et al, 2008).

an increasing percentage of first admissions during these years. The fact that the study uses DSM-IV criteria, as opposed to the more inclusive ones mentioned above, could arguably signal even more increasing tendencies. A positive confirmation of actual increases nevertheless remains problematic.

Bearing in mind the preceding remarks on the underestimation of male cases in conventional prevalence rates and, despite limitations imposed by existing statistics, Dominé et al's (2009) recent and challenging alternative findings of 50% adolescent boys reporting some eating disorder-related concern and 20% reporting at least one disordered eating behavior are worth consideration (Lock, 2009). These results, founded on a large community health survey[15], provide I believe a reasonable starting point to understand the seemingly changing landscape of eating disorders - whether increases have actually occurred or are just increasingly accounted for.

Gender Similarities and Differences

Underlying most comparative figures and studies on eating disorders, irrespective of prevalence rates across genders, is a fundamental question, which relates to the nature of these disorders in each sex and the extent to which they are

[15] The percentage of males identified in clinic-based case series is generally significantly smaller than in community-based samples. As a consequence the latter offer a more accurate representation of prevalence rates (Braun et al, 1999).

comparable. Carlat et al (1997) have suggested that evidence for an overall similarity would support a more biologically based view of a discrete and relatively invariant disease entity. Conversely, if men with eating disorders were different from healthy men, a psychological and/or cultural etiological view would then be validated. I show below how difficult it is to draw the different paradigms apart. The intricacy of biological, psychological, and cultural components is well rendered in the biopsychosocial model of etiology, which I refer to, to eventually explain the contemporary surge in eating disorders, in particular in women and in male homosexuals.

There is general agreement that eating disorders present a great deal of similarity across genders (Muise et al, 2003). I list here some of the similarities that appear in the literature. Males and females with Anorexia nervosa are comparable in age of onset (17.1 years for males and 17.3 years for females) and presentation (20 years) (Crisp et al, 1986); they also are similar with regard to physical variables (percent ideal body weight, body mass index (BMI), and highest weight), illness features, and psychiatric comorbidity (depressive disorders, anxiety disorders, personality disorders, and substance abuse) (Crisp et al, 1986; Olivardia et al, 1995; Carlat et al, 1997; Geist et al, 1999; Striegel-Moore et al, 1999); likewise, males and females with Bulimia nervosa show comparable illness features and suffer from similar comorbid psychiatric

disorders[16] - including again major depression, substance abuse, anxiety disorders, and personality disorders (Carlat et al, 1997); the onset of body dissatisfaction occurs in early adolescence regardless of gender; more generally, psychosocial damages - including neglect, abuse, and trauma - increase risks for eating disorders in both males and females; the association of bulimic behaviors with impulsive personality traits and behaviors - in particular substance use, smoking, sexual risk taking, and aggressiveness - affects both men and women, and significant rates of dieting, binge eating, and purging behaviors are identified in adolescent males as well as females (Ross and Ivis, 1999; Dominé et al, 2009); also, BMI, negative affect, self-esteem, perfectionism, drug use, perceived pressure to lose weight from parents and peers, and participation in sports that focus on leanness are closely associated with eating disorders in both genders (Ricciardelli and McCabe, 2004); as for aggressiveness, a positive correlation between aggression and eating disorders scores exists equally in male and female populations (Miotto et al, 2003).

[16] Braun et al's (1999, 420-421) gender comorbidity comparisons based on eating disorder admissions at The New York Hospital, Cornell, between 1984 and 1997, are particularly relevant in this respect: "Axis I comorbidity was quite common, with mood disorders diagnosed in a majority of the sample (60.9% of males and 56% of females). Anxiety disorders were present in close to one half (43.5% of males and 52.2% of females). Alcohol or substance abuse or dependence was diagnosed in 30.4% of males and 39% of females). No significant differences between the men and women were found in any of the Axis I data. Only 16.7% of males and 11.1% of females had no Axis I or II comorbidity. No significant differences between the male and female groups were noted in the presence of Cluster A (paranoid, schizoid, schizotypal), Cluster B (antisocial, borderline, histrionic, narcissistic), or Cluster C (avoidant, dependent, obsessive-compulsive, passive-aggressive) personality disorders. There was no difference in the total number of Axis II disorders (including Personality Disorder Not Otherwise Specified, (PD-NOS)) for males and females or in the percentage of patients diagnosed with at least one personality disorder (50% of males and 66.7% of females)".

A few studies present some conflicting results, which somehow qualify an unequivocal affirmation of similarity in eating disorders between men and women. In order to look closer into these contradictions and assess their significance, I propose to organize them in two categories within a continuum/discrete dichotomy model.

On a continuum, gender differences, which are mainly expressed in intensity of symptoms or rates of prevalence, are revealed: in anorexic females scoring higher than men on the drive for thinness and body dissatisfaction scales[17] (Geist et al, 1999) - a finding replicated in female adolescents with chronic bulimic symptoms, although their bulimic male counterparts scored higher on the perfectionism and interpersonal distrust scales (Joiner et al, 2000); in involvement in sports presenting a slightly greater risk factor for eating disorders in men (Braun et al, 1999; Muise et al, 2003); more specifically, in anorexic males more likely to be pre-morbidly athletic, particularly joggers, than women (50% of males versus 24% of females) (Crisp et al, 1986); in females reporting, more than males, the use of exercise for weight control - and a correlation of weight-control-intended exercise with disordered-eating symptoms and low self-esteem found more in women (Ricciardelli and McCabe, 2004); in later age of onset in Bulimia nervosa for males (between 18 and 26 years) than for females (between 15 and 18) and more significant delays in men between age of presentation

[17] The authors however advise caution in drawing conclusions from this finding, considering that "… we cannot interpret the clinical meaning of the statistical difference in drive for thinness and body dissatisfaction until appropriate age- and sex-matched norms are developed" between adolescent males and females (Geist et al, 1999, 377).

(26.9 years) and age of onset (Carlat et al, 1997); in pre-morbid obesity occurring more often in men with Bulimia nervosa than in women (Carlat and Camargo, 1991; Carlat et al, 1997; Braun et al, 1999; in the particular prevalence of atypical disorders amongst men, with 32% of eating disordered males meeting the criteria for Eating disorders not otherwise specified, as opposed to 10% of women (Carlat et al, 1997); and, in psychiatric comorbidity and rates of suicidal behavior being much more elevated in eating disordered males (66.7% and 50%, respectively) than females (13% and 23%, respectively) (Bramon-Bosch et al, 2000).

As for discrete gender characteristics and risk factors, they seem to be limited to differing types of body image preoccupations among anorexics, with adolescent males showing concern about idealized masculine shapes as opposed to anxieties in women about weight or clothing size (Andersen, 1984). Indeed several correlates of the pursuit of muscularity are a masculine version of those linked with eating disorders: socio-cultural pressures to gain weight and muscles rather than lose weight, peer popularity, as well as the attractiveness of “power” over “leanness” sports (Ricciardelli and McCabe, 2004).

It is possible to conclude from the preceding overview that, whether they are expressed in terms of intensity/frequency or quality, discrepancies in eating disorders between men and women hardly challenge the widespread recognition of an overall

similarity (Braun et al, 1999). Whether such similarity implies a biological basis for these pathologies as opposed to a psychosocial etiology (Carlat et al, 1997) is however not as easy to extrapolate. This point will be discussed later on in the chapter.

The Homosexual Exception In Men with Eating Disorders

Beyond the broader picture of similarity, there exists one marked area of difference in eating disorders between men and women. This is the sphere of sexual orientation, with homosexuality and bisexuality constituting a specific risk factor for eating disorders in males - an exception in an otherwise globally comparable set of symptoms and risk factors in the two sexes. This specific risk factor is central to my thesis because it allows me to put forward my distinctive thesis, according to which eating disorders are not related to gender itself but to intrusion into vulnerability to receptivity, regardless of gender, and the control of intrusion. Although sexual orientation may also be relevant in women with eating disorders (Lock and Steiner, 1999) - in fact, homosexuality seems to act as a protective factor in women (Carlat et al, 1997; Lakkis and Ricciardelli, 1999) -, same sex relationships are far more common among eating disordered men, with male patients reporting being homosexual eight times more often than female patients (Bramon-Bosch et al, 2000). As for the male

population per se, Schneider and Agras (1987) find that 2.1% of homosexual men have an eating disorder in comparison with only 0.3% of heterosexual men.

There are a number of studies, a majority according to Russell and Keel's (2002) review, which confirm a significant association between male homosexuality and eating disorders. In a study on 135 males with eating disordered behaviors treated at Massachusetts General Hospital between 1980 and 1994, Carlat et al. (1997) found that 41% were heterosexual, 27% homosexual or bisexual (in comparison, the prevalence of homosexuality in females with undifferentiated eating disorders is 2%), and 32% asexual. Among those with a recorded interest in sex, 60% were heterosexual and 40% homosexual or bisexual. Of the 39 asexual subjects, 22 were aware of a specific sexual orientation: of these patients, 73% were heterosexual and 27% homosexual or bisexual. Homosexuality/bisexuality was significantly more common among bulimic patients, whereas asexuality was rare in bulimia but common in both anorexia and Eating disorders not otherwise defined. Overall, the results showed that homosexuality and bisexuality, which have prevalence rates of 1% to 6% in the general male population, constitute indeed a specific risk factor for eating disorders in general and for Bulimia nervosa in particular (Carlat and Camargo, 1991; Carlat et al, 1997). Austin et al (2004) also revealed comparable outcomes in the adolescent population, with homosexual/bisexual boys having greater chances of engaging in bingeing than

heterosexual boys. More specifically, Ackard et al (2008) established that the use of any disordered eating behaviors is revealed by 39.4% of sexually active adolescent males reporting only female sex partners, 53.4% reporting only male sex partners, and 56.4% reporting both female and male sex partners.

The Psychological Literature on Eating Disorders - Current Directions and Underlying Questions

A gender perspective on current findings in the area of eating pathology shows that:

1. Despite an ongoing female predominance in prevalence rates, eating disorders in males seem to occur more often than traditionally depicted.

2. It is not clear, and hard to verify at this point, whether the detection of greater male vulnerability to eating pathology reflects changing trends and rates of prevalence, or, whether it is merely the result of changes in classification (in particular, the inclusion of partial categories of eating disorders), criteria of diagnosis, measuring tools, or expectations by healthcare providers.

3. Homosexuality appears to be a major risk factor for eating disorders in men and, although this is not as clear, a protective one in women.

4. Overall - beyond the homosexual exception in men, and of course the feminine preeminence per se - there is general agreement that gender similarities prevail over differences in eating disorders.

5. The conceptualization of eating pathology etiology is difficult; a widespread view is that eating disorders involve a combination of intertwined biological, cultural, and psychological components - which social sciences describe in terms of a biopsychosocial model of etiology.

Bearing this blurred picture in mind, it is important to distinguish between the first two points, which I set as assumptions, and the last three, which, in the questions they pose, underlie the scope of this work.

Assuming that eating disorders are more prevalent in the male population than traditionally thought - and therefore leaving aside the currently unanswerable question of actual increases - serves in fact two purposes. Factoring in cases that may have been left out by inadequate instruments of measurement and more rigid taxonomic and diagnostic criteria is to start with more realistic. It allows taking into account diverse manifestations of eating disorders in the general population - although the danger then becomes of course one of over-inclusion and over-pathologizing. Also, the assumption of a more important (or growing) eating disordered male population than conventionally accepted allows a thorough investigation of differences and similarities, in addition to,

perhaps, helping solve the certainly true but nevertheless nebulous biopsychosocial formula of etiology.

As for the last three findings, underlying them are some more or less implicit and overlapping questions, which inform the dynamics that govern eating disorders as revealed in the psychological literature.

A first question is whether eating disorders are different in men (differences across sexes) or whether men with eating disorders are different (differences within the male population). As already indicated, the general trend in the literature reflects the latter view: men with eating disorders are different from healthy ones and these differences are to a large extent equivalent, sometimes with variations in degrees, and with the critical exception of homosexuality, to those found in women with eating disorders.

A related question concerns the gender typicality of the disorders: the nature of their relation, since they principally occur in women, with something that has to do with femininity - in practical terms, is there a correlation between eating disorders and aspects of femininity, in both men and women? The question underscores the need to revisit the notion of receptivity beyond its association with female anatomy.

Also implicit are myriad questions expressly concerning homosexuality - beyond its generally established identification as a key risk factor in male eating pathology and

its less clear role in female eating disorders. For instance, is homosexuality in men a purely specific risk factor for eating disorders, or, could it be viewed as a more general risk for psychopathology (Russell and Keel, 2002)? As a general risk factor, homosexuality could increase risks for any psychiatric disorder - for example, in cases when social condemnation of homosexuality causes anxiety and suffering, which in turn result in distress over one's sexual orientation, poor self-esteem, depression and, in some cases, disorders of eating. As a specific risk factor, homosexuality could be associated with traits, such as femininity, that specifically increase risks for eating disorders - Murnen and Smolak (1997) have demonstrated an increased identification with feminine gender role in females with eating disorders, and the question begs as to whether a similar identification characterizes homosexual men with eating disorders.

These questions overlap with more general ones centering on the opposition between biology and culture (Carlat et al, 1997). For example, does homosexuality place males in a sub-cultural system which values appearances in a way similar to that of the larger culture in women? Or do neurological, hormonal, or genetic factors predispose homosexual men to react in conventionally perceived feminine ways to the pressures of life, hence increasing their risk for eating disorders? Finally, how does this opposition between biology and culture interlock with the psychoanalytic problematic

under scrutiny in this work: susceptibility to intrusion and corresponding defensive reactions to such vulnerability.

Another set of questions relates to the nature of the relationship between eating disorders and comorbid manifestations, whether in the form of psychiatric syndromes or as mere, discrete symptoms. Beyond comparisons between men and women, interrogations of this sort are linked to aspects of precedence and antecedence (which is the most important and which comes first?) and present a lot of difficulty. Although answering them may prove challenging, and beyond the scope of this work, keeping them in mind may provide some insight in the entwined dynamics of control and intrusion, which are central to my exploration of the relationship between eating disorders and femininity.

Finally, inherent in all questions above is the classification of phenomena in the elusive discrete versus connected, and nurture versus nature, categories.

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The above overview of nosological and epidemiological aspects of eating disorders in the 20th and 21st centuries underscores the shifting dimension of these disorders as well as the questions and challenges such fluidity entails. The chapter

suggests that anorexia and bulimia are interconnected on the basis of taxonomic variability and crossovers between the two poles of eating disorders. When psychodynamically articulated in terms of anorexic control of bulimic hunger for the object (Shipton, 2004), interconnectedness presents a first step in the elaboration of my thesis that intrusion, as the overwhelming experience of invasion of receptivity, constitutes the fundamental psychological factor in the etiology of eating disorders, and that this factor transcends gender (Chapter II). Chapter I also identifies the homosexual exception as a striking phenomenon in the context of an overwhelmingly female ailment. Considered against the gender-related paradigm of research on sexual orientation, in particular the fact that male homosexuality has been consistently associated with feminine traits, this exception is made use of as an instrument to investigate the feminine element in eating disorders (Chapter VIII).

By situating the scope of nosological and epidemiological investigation in the 20th and 21st centuries, this chapter has hinted at the modern identity of eating pathologies. In a retrospective on precursors of anorexia and bulimia across history, the next chapter examines the extent to which these disorders are recent ailments. Answering the question will bear significance not only on the status of anorexia and bulimia in relation to one another and across time, but also in laying the ground for the introduction of

intrusion as a ubiquitous problematic that carries connotations of femininity in eating disorders.

CHAPTER II

A HISTORICAL PERSPECTIVE ON EATING DISORDERS

THE CASE FOR SOME FORM OF HISTORICAL CONTINUITY

The social context and meaning of a disease is often critical to its understanding and it is difficult to argue against the fact that culture and socioeconomic factors shape the experience, expression, and understanding of any ailment (Keel, 2005). Eating disorders are no exception in this respect.

There is little doubt that a strong relationship exists between the contemporary surge in these pathologies and pervasive modern societal messages and media images of slenderness as beauty. Chapter IV deals with this specific angle, suggesting the object relations paradigm of the mother-infant dyad as a prism to understand how the psychological, the cultural and the biological interact to propel eating and other bodily disorders at the epidemic level witnessed over the past decades. Such integration is in

agreement with the currently acknowledged biopsychosocial etiology of eating pathology. Back to social and cultural aspects per se, although eating disorders have swelled in a spectacular way since the middle of the twentieth century, it is also true that not everyone today is anorexic or bulimic (Shipton, 2004).

Similarly, it is quite conceivable that peaks and lows in rates of anorexia are over determined by macro economic trends and contexts - anorexic cases do subside or disappear (or go unreported?) during cataclysmic situations such as wars, famines and plagues (Henn et al., 2013) and seem to be on the rise in times of prosperity, in particular in recent times under the sway of consumerism. However, it is also a fact that not all individuals turn ascetically away from eating during times of abundance - the significant contemporary surge in obesity testifies to this.

The widespread view that eating disorders are a Western and modern ailment, while aptly underscoring the unquestionable workings of historical, social, and cultural contexts in the expression and perception (both individual and societal) of mental health symptoms (yesterday's hysteria and today's anorexia), should not preclude an examination of what may constitute a pre-history of these disorders. Such pre-history has the potential to reveal what endures in eating disorders, beyond contexts and times. In this respect, I will argue that there is something particular about eating - its primal/archaic and at once object/relational/social dimension -, which lends itself in a

unique way to the expression of psychosocial power relations and distress. There lies what I think is perennial in eating disorders.

Having presented in Chapter I the contemporary nosological yardsticks of eating disorders and explored their dynamic and complex epidemiology in recent times, I will now envisage them against the backdrop of history. Before this journey back in time, it is important to warn against the challenges such an exploration of links between modern and past forms of eating disorders is bound to pose. The interpretation of historical accounts from the perspective of contemporary classification is fraught with uncountable difficulties, not the least that of anachronism.

In this chapter, I identify some elements of historical continuity, which suggest that issues of control represent an enduring problematic in eating disorders. When considered against two assumptions - the interrelatedness of anorexia and bulimia, and an overlap of control with intrusion - the ubiquity of control can be extended to intrusion, therefore introducing the latter in the equation of eating disorders. Interrelatedness between the two poles of eating pathology is supported by contemporary taxonomy[18] (Chapter I) and articulated in psychodynamic terms as unappeasable hunger for the object - with anorexic control a defense against bulimic impulses (Shipton, 2004). The coincidence between control and intrusion is founded on another psychodynamic

[18] This is despite the classification of anorexia and bulimia as discrete categories.

assumption, which suggests that intrusion aims at controlling objects and/or states and emotions. The assumption, based on Williams' model of eating disorders, in particular her use of projective identification (Chapter VI), is put forward in the next chapter on femininity theories of eating disorders.

I start with a review of what for some constitute the historical forerunners of modern forms of anorexia and bulimia. Through a critical evaluation of these cases, I then try to identify elements of continuity that support the notion of an enduring problematic of control that pertains to the object. This eventually allows me to introduce intrusion in the equation of eating disorders.

PRECURSORS OF ANOREXIA NERVOSA AND BULIMIA NERVOSA

Syndromes of Self-Starvation

The following section on syndromes of self-starvation in history prior to the formal medical identification of Anorexia nervosa towards the end of the 19th century is largely based on Bemporad's 1996 review "Self-Starvation Through the Ages: Reflections on the Pre-History of Anorexia". Bemporad's review situates self-starving syndromes in their historical and social contexts - as interpreted in historical references to self-starvation, in recent publications on the history of eating disorders, and in articles describing cases of eating disorders in the past. I end the section with Habermas and

Beveridge's (1992) identification of paradigmatic milestones towards a secularization of fasting between the 15th and 20th centuries.

Prolonged and lethal forms of self-starvation are absent in classical Greek and Egyptian cultures. Fasting in these civilizations was limited in time, meant at different times and in different instances as self-punishment for transgressions against deities, pleas to invoke godly intercessions, or means towards trance-like states and divine enlightenment. It did not aim at depriving one's corporeal self.

With the exportation to the Mediterranean of Eastern religions and philosophies in the form of Gnostic sects, early forms of asceticism were introduced around the 4th century in the Hellenistic and Roman cultures of antiquity. Gnosticism sought intuitive knowledge in withdrawal from the material world and liberation of the soul from its corporeal subjection through austerity and extreme self-control. Prolonged fasting, which often led to death, was one such expression of early Christianity asceticism as personified in *male* hermits like Hilarion (4th century) and Saint Simeon Stylites (5th century). The first recorded young *female* casualty of self-starvation also goes back to the early Christian era: Blessila (late 4th century) died at twenty, victim of her brother Eustochium spiritual teachings of abstinence and prayer to a group of wealthy Roman women. The burgeoning of ascetic cults during this period has been interpreted against

a social backdrop of hedonism and materialism that lacked ethical and spiritual dimensions.

Conversely, the disappearance (or perhaps, inadequate recording) of self-imposed cases of starvation between the 5th and 10th centuries has been linked to the Dark Ages and their share of barbarian invasions, plagues, climatic deteriorations, and famines. Rare cases of female self-starvation - Bemporad mentions three such cases - have nonetheless been identified during that period, alternately bearing the meaning of satanic possession, to be dealt with through exorcism, or sainthood, interestingly expressing desires of liberation from the physical and social predicament of womanhood. St. Wilgefortis (lived sometime between the 7th and 9th centuries), also known in France and the Iberian Peninsula as St. Liberata, is a good example of the latter. She had vowed to remain a virgin and live a life exclusively dedicated to the service of God. To oppose an impending marriage her father had arranged for her, she refused nourishment to the point of losing beauty and feminine forms and became covered with hair all over her body[19]. Crucified as punishment by her father, she called for all to remember "the passion that encumbers all women" (Bemporad, 1996, 221).

The case of St. Wilgefortis in the Dark Ages is the precursor to a mini epidemic of self-imposed starvation in the late Middle Ages and early Renaissance. Also rejecting

[19] This is known as *hypertrichosis lanuginose* in contemporary terminology, a symptom associated with Anorexia nervosa.

an arranged marriage, St. Margaret of Hungary (13th century) engaged in intensive fasting and strenuous menial work, excelled in her studies, and barely slept[20]. She died of self-starvation at age twenty-eight and was canonized five years after her death. St. Catherine of Siena's is presented in Bemporad's review as a paradigmatic example among 261 cases of holy self-starvation between 1200 and 1600 AD that bore resemblance with modern anorexia. Born in 1347, the 24th child of her mother, she had a twin sister who died in infancy. Unlike St. Catherine who was the only one amongst all 24 siblings to be nursed by the mother, the prematurely deceased twin sister had been sent to a wet nurse. When Catherine was close to puberty, an older sister, who mentored her and held her in particular affection, deliberately fasted to reform her philandering husband (a reforming endeavor that proved successful). At the death of this other sister in childbirth, Catherine, who was fifteen, underwent a radical psychological transformation, withdrawing from and rejecting the mundane world, eating little and praying a lot. Opposing her parents' will to force her in wedlock, and affected by the loss of yet another sibling, she intensified her religiosity and asceticism - she cut her hair, devoted lengthy moments to meditation, secretly practiced self-flagellation in imitation of Christ's passion, slept very little (on sharp sticks), bound her body with a tight iron chain, and worked tirelessly for the poor and the sick. Forcing herself to vomit

[20] These behaviors and symptoms are in line with modern forms of anorexia.

the little amounts of food she ingested, she eventually died from malnutrition at age thirty-two[21].

Holy cases of female starvation in the Renaissance have been interpreted as underlying a desire for superiority over one's peers - a superiority initially sanctioned by the church - in combination with a wish to escape arranged marriages, childbirth, and childrearing. Through ignoring and torturing their body, women were rebelling against female social roles whilst at the same time securing a sense of ascendancy as belonging amongst God's elect[22].

The period following the Renaissance witnessed a decline in cases of holy anorexia. The decline has been interpreted in the context of mounting opposition by the church to claims of direct divine communication that characterized religious syndromes of self-starvation. Under the Inquisition, for instance, holy anorexics were demoted from sanctity to heresy. The decline has also been explained in terms of the general impoverishment that accompanied the subsiding of the Renaissance, and a parallel upsurge in male domination[23], whether amongst lay people or in the church - another reference to the relevance of economic and social backgrounds to these syndromes.

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[21] It is worth remarking that St Catherine's case as described in Bemporad's account displays both restrictive and compensatory eating behaviors - an overlap that evokes the fluidity of contemporary classification on the relationship between anorexia and bulimia and consequences thereof on their interconnectedness along a continuum. Questions of fluidity and interconnectedness are developed in the later part of the chapter.

[22] Chapter VII shows that, although free from sacred connotations, modern presentations of anorexia express comparable resistance to authority and pride over eating behavior.

[23] Bemporad (1996) points out that although women during early Renaissance had remained constrained by arranged marriages and expectations to bear numerous offspring (to offset high rates of death in infancy and childhood), they had nevertheless come closer to equality with men in education.

The 17th and 18th centuries show successive shifts in the meanings granted to self-starving women - from possession by the devil, to deception to gain fame or financial benefits, ultimately to physical and mental illness. Self-starving women typically became the object of visits by delegations of priests, doctors, or politicians. Besides, as their public notoriety expanded thanks to increased accessibility in societies to printed material, their example started spreading to affect rich and poor, Protestants and Catholics.

The paradigmatic passage from religious/supernatural powers (whether sacred or satanic) to scientific/medical etiologies is attributed to John Reynolds'[24] (17th Century) rebuttal of Martha Taylor's case of anorexia as a sign of miraculous sustenance by angels. Neither god nor devil would waste favor or powers on such menial a person argued Reynolds, who instead proposed a medical model to explain Taylor's anorexic behavior. Bemporad suggests that, in addition to confirming a shift towards medical interpretations, the publication between 1685 and 1770 of nine doctoral theses on anorexia also indicates the persistence of anorexic behavior - "despite the fact that the affected individual was considered sick at best, and a fraud at worst" (1996, 224). Bemporad signals that most of these dissertations ascribed at least a minor role to emotional factors in anorexia.

[24] This is described in Brumberg, J.J. (1988). *Fasting girls: The history of anorexia nervosa*. New York: Penguin Books, and cited in Bemporad, 1996.

The first comprehensive and modern description of Anorexia nervosa goes back to Richard Morton's[25] account of two cases, one male and one female, of self-starvation. The two cases came as part of his 1689 treatise on various types of consumption and not as distinct pathologies. The female patient died, but the 18-year-old boy apparently recovered.

In the 19th century, medical accounts become more precise as the clustering of symptoms allowed the emergence of differential diagnoses. Categorization for instance established the difference between food rejection, as part of a complex of hysterical symptoms, and restriction, as pure and primary anorexia in its perennial presentation. Another type of self-starvation listed under the category of sitophobia (Greek for grain), an intense terror of food, was identified among psychiatric asylums inmates. In these cases, the refusal to eat because of beliefs that food was poisoned or because a divine order forced the person not to eat was considered a secondary problem within a more serious psychiatric disorder. "Chlorosis", yet another form of eating disorder described in 1800, included, in addition to lack of appetite, symptoms such as diminished energy, headaches, shortness of breath, and amenorrhea. The illness became known as chloro-anemia or simple anemia after 1870 and essentially vanished after World War I. A major

[25] "Morton describes a 'nervous atrophy' or a wasting away of the body, without concomitant fever, cough or shortness of breath but accompanied by a want of appetite and bad digestion, leading to the "falling away of flesh every day more and more. Among the causes of this condition, Morton mentions violent passions of the mind, intemperate drinking, and unwholesome air, which destroy the tone of the nerves throughout the body" (Brumberg, 1988, cited in Bemporad, 1996, 225).

division may have actually existed between chloro-anorexia (true anorexia) and chloro-anemia (a nutritional deficiency or a consequence of gastric ulcers or inflammation) - the former affecting more affluent girls whose loss of appetite, social depression, pica[26], and amenorrhea constituted the main symptoms, with anemia arising as a secondary feature only later in the disorder; the latter affecting older, working class women who did not show anorexia, pica, or psychological symptoms, but suffered from severe anemia.

It is in 1873 that Gull [27] and Lasègue[28] formally distinguished, within a few months of one another, Anorexia nervosa from other diseases involving a component of self-starvation, therefore setting the groundwork for what still constitutes overall a valid and relevant description of anorexia - refusal to eat, onset in adolescence or early adulthood, restlessness, amenorrhea[29], and absence of concern over one's deteriorating condition.

According to Bemporad, later accounts of Anorexia nervosa include, successively:

- the assumption of a psychogenic origin of the disorder, as opposed to an organic one - an assumption based on the fact that recovery did occur when patients could be

[26] Pica is the continuous craving and compulsive eating of nonfood substances.
[27] Gull, W.W, (1873). Anorexia nervosa. In: Kaufman, M.R. and Herman, R. (Eds.) *Evolution of psychosomatic concepts,* 107-127. New York: International Universities Press, 1964..Cited in Bemporad, 1996.
[28] Lasègue, E.C. (1873) On hysterical anorexia. In: Kaufman, M.R. and Herman, R. (Eds.) *Evolution of psychosomatic concepts,* 143-155, New York: International Universities Press, 1964. Cited in Bemporad 1996.
[29] As mentioned earlier, amenorrhea is no longer included as a diagnostic criterion in the DSM-V (American Psychiatric Association, 2013).

convinced to eat and on autopsy results that did not reveal organic pathology (until 1919),

- its classification as a pituitary dysfunction (until the 1940s),

- a renewed rebuttal of the organic origin, based on the distinction between anorexia and pituitary atrophy, and a return to psychiatric explanations (ca 1948),

- classical psychoanalytic interpretations focusing on unconscious fantasies of oral impregnation (1940s) - in relation with: oral fixation, difficulties in the transition through puberty because of poor adaptive capability, and, after puberty, restrictions in affect, obsessive thinking and repressions of sexual wishes - and the anorexic behavior as guilt over, and defense against such fantasies,

- object-relation psychodynamic perspectives (1960s onward), in the US[30], emphasizing a mother's interferences with her daughter's individuation and the anorexic's ensuing failure to differentiate her body from the image of the maternal object

- in a context of social and psychological pubertal demands that increase the sense of weakness and helplessness, the anorectic experience as a mono-symptomatic psychosis in which the body, identified with the bad maternal object, is endowed with malicious powers and therefore must be controlled through starvation and exercise; and the anorectic terror as dread of the body rather than fear of eating,

[30] My precision.

- finally, and in parallel, familial models emphasizing the anorexic's sense of helplessness and ineffectiveness as well as disturbances in body image and perception
- in the context of adolescence with its requirement of psychological separation, and in connection with the absence of an independent sense of self and a robot-like compliance to the dictates of the family, primary anorexia as an extreme attempt to control the body (and the family, through illness) to compensate for an equally extreme lack of psychological control.

It is interesting at this point to refer to Habermas and Beveridge's (1992) proposition that differences in fasting purposes by individual fasters as well as differences in their interpretation by contemporaries (ambient culture and close circles, but also observing institutions such as the church or the medical establishment) constitute useful criteria to identify paradigmatic changes towards the secularization of fasting between the late 15th and 20th centuries - the so-called "transition from *miraculum* to *spectaculum* and then to disease"[31]. Based on these two criteria, Habermas and Beveridge link three types of anorexia to three periods of history:

1. The ascetic-mystical type in the late Middle Ages, which bears some similarities in intensive fasting, striving, and over-activity with modern forms of anorexia. This model

[31] Meyer, J.-E. and Feldmann, T. (Eds.) (1965). *Anorexia nervosa. Stuttgart: Thieme*, 1-14. Cited in Habermas and Beveridge. (1992, 432).

was interpreted in a religious way by the individual as well as by close circles and lay or religious observers/institutions.

2. Fasting girls between the 16th and 19th centuries: they were usually passive, commonly bed-ridden because of illness, and they presented many hysterical symptoms - features that do not match modern Anorexia nervosa. The interpretation of these cases held a position halfway between the religious and the secular: on the one hand, it was doctors who reported them; on the other, most affected individuals and their immediate circles continued to view these phenomena as religious - notwithstanding some residual skepticism, as simulation was not altogether dismissed and a tension between natural versus miraculous explanations was characteristic.

3. Modern anorexics since the middle of the 19th century: they do not pretend to fast. Those affected, their entourage, and the medical establishment, all have a secular interpretation of the phenomenon.

Binge Eating and Binge-Purge Syndromes

There seems to be general agreement that syndromes of self-starvation as those depicted in Bemporad (1996) and Habermas and Beveridge's (1992) reveal reasonable continuity with modern forms of the disease. In contrast, there is much less unanimity over whether recorded phenomena of binge eating and bingeing-purging are precursors

of Bulimia nervosa in its contemporary presentation. In fact, a commonly held view is that Bulimia nervosa is a recent disorder that emerged around the 1970's (Keel, 2005). Some authors have nonetheless challenged this contention, attributing the wide belief that Bulimia nervosa is a recent disorder to increases in prevalence rates and variations in categories of symptoms - for instance, Stein and Laakso (1988) point out that in the early 1970's the concept of bulimia was free of any reference to purging, which, since the late 1970's, has become however one of its most popular connotations. I discuss later and in parallel the question of continuity in anorexia and bulimia. Before I do so I will present some accounts of recorded historical cases that bear reasonable resemblance with modern forms of Bulimia nervosa. They are mentioned in the works of Stein and Laakso (1988), Habermas, (1989), Parry-Jones and Parry-Jones (1991), Crichton (1996), and Ziolko (1996).

A first expression of harmful compulsive eating is found in the mythical story of Erysichthon, punished with unstoppable eating for sacrilegiously cutting Demeter's oak tree, and allusions to ravenous and unbridled hunger appear in Greek comic poetry of the 4th and 5th centuries BC (Aristophanes and Timocles) (Ziolko, 1996).

The earliest clinical records of excessive and unbearable hunger - *megas limos, magna fames, fames bovina* - go back to the 4th-century BC Greek physician Diocles of Karystos. Commenting on ravenous hunger, Plutarch (1st-2nd centuries AD) establishes

a distinction between *bulimos* and hunger, indicating that the former is a disorder of the stomach that causes fainting and could be alleviated with a few bites of bread (consequently, it could not be imputed to lack of nourishment). Other 1st-century medical reports in Rome also describe patients who eat incessantly, day and night - for instance, a servant who ate bread for extended periods of time without any other visible change. In fact, during the first five centuries AD, lexicographers have consistently documented cases of *bulimos* (Ziolko, 1996).

As for binge-purge syndromes, they are traced back to Roman emperors Claudius and Vitellius (1st century AD), whose binging and self-induced vomiting Crichton situates in a historical and cultural context where such practices were neither totally alien, nor as widespread as commonly assumed: "Although gluttony is a favorite theme of Latin poets, instances of binging and vomiting are very rare" (Crichton, 1996, 205). As such, and on account of their uncontrollable dimension, he considers that they qualify as pathological: "Claudius and Vitellius are, to my knowledge, the earliest well-documented historical figures who regularly binged and vomited; they exhibit what could be described as an historical variant of Bulimia nervosa" (219)[32]. Among the multiple meanings he gave to bulimia, the physician and philosopher Galen (2nd century) includes kynorexia - constant eating and vomiting as a consequence of the great

[32] Disagreeing on this point, Ziolko considers that "during this era there is no evidence of a connection between kynorexia [constant eating and vomiting] and this luxuriating, willful play of gluttonous eating and vomiting as is sometimes suggested today" (1996, 352).

amounts eaten. In a later 6th century description, kynorexia is referenced as a total loss of control in restricting one's voracious appetite - in contrast with the complete lack of appetite exhibited in anorexia -, followed by compulsive vomiting (Ziolko, 1996).

A pathology characterized by overeating and self-inflicted vomiting was known in Arab medicine as suggested by Avicenna's (8th century) warning that excessive self-vomiting (as opposed to moderate and controlled one to offset the bad effects of overeating) was harmful for the stomach, thorax and the teeth, and that the habit of overeating and then procuring emesis (vomiting) typically lead to chronic diseases (Keel, 2005, 24).

Noting that, starting in 1000 AD, the meaning of *bulimos* as an uncommon, colossal, permanent, and insatiable hunger gains popularity, Ziolko (1996) remarks that almost all authors who have described *bulimos* between the 16th and 19th centuries have also referred to kynorexia (constant eating and vomiting). Although some of the sources maintained a strict distinction between *bulimos* and kynorexia[33], eventually "the aspect of one and the same disorder became dominant and both concepts were referred to together (for some time connected by 'and' or 'or')… Thus, kynorexia and bulimia are associated", concludes Ziolko (1996, 351).

[33] Or also between bulimia, as insatiable hunger and the retention of what has been ingested, and *fames canina*, characterized by vomiting after ingestion (Ziolko, 1996).

Considering that St. Catherine of Siena (14th century) and St. Veronica (17th/18th centuries) both fit into the category of (female) holy fasting, Keel (2005) points out that they could actually be included under the DSM-IV-TR diagnosis of ANBP (the binge-eating/purging type of anorexia) - along with excessive fasting, minimal sleep, and extreme activity, the former engaged in self-induced vomiting, the latter in binge eating (and also vomiting, although not necessarily self-induced, when forced to eat). Ziolko (1996) reports the case of an early 17th century nun who, inflicted with canine appetite (*fames canina*), vomited all the food she ate, was once more taken over by hunger, only to vomit again what she had ingested.

If atypical, one account of "secular" binge-purge cycles during the same period (17th century) features a 50-year-old man who every year went into cycles of twenty days of uncontrollable eating and vomiting, followed by twenty days of fasting. The rest of the year, he ate normally (Parry-Jones & Parry-Jones, 1991; Ziolko, 1996; Keel, 2005). In the middle of the 18th century, after a fever, a young man ate more than 200 lb of food in six days, never reached satiety as he constantly vomited, and eventually died extremely emaciated. Later in the century, another patient with canine appetite who ingested 379 lb of solid and fluid food within six days, but was emaciated because of vomiting, was however successfully cured (Ziolko, 1996).

Stein and Laakso (1988) present an interesting review of medical and other encyclopedic references on bulimia over a period of three hundred years, from the beginning of the 18th century until the official recognition of Bulimia nervosa as a distinct disorder in the 1970's. They note that between 1708 and 1824 bulimia appears to occupy more reference space than anorexia in general medical texts, tracing the earliest original English reference back to two medical dictionaries of the beginning of the 18th century. While both dictionaries describe the disorder in terms of an extraordinary appetite, one includes the additional symptom of a "defection of the spirits"[34], which the authors interpret as a sign of depression. Another dictionary of the same period discusses bulimia as a chronic condition that sometimes involves fainting fits and/or vomiting following the ingestion of considerable quantities of food. A later mid-18th century medicinal dictionary entry allocates two oversized pages to a discussion of *boulimus,* which includes a detailed summary of symptoms. Establishing a distinction with similar conditions resulting from worms, ulcers and normal pregnancies, the entry also discriminates between patients who experience vomiting after eating large amounts of food and those who don't - i.e. a distinction between true *boulimus* and its complicated variation that involves vomiting, *caninus appetitus*[35](207). Another

[34] Blankaart, S. (1708) *The Physical Dictionary* London: S. Crouch and J. Sprint. Cited in Stein and Laakso (1988, 207).

[35] "In the caninus appetitus, there is a desire after much food and great quantities are eaten, which, oppressing the stomach, are again discharged by vomit. The patient thus being relieved, his appetite returns, which, having gratified, he finds himself obliged to ease his stomach again, like a dog, by vomiting.

reference from the late 18th century distinguishes between three forms of bulimia: pure hunger, hunger terminated by vomiting, and hunger associated with fainting. Finally, the *Encyclopedia Britannica'*s entry of 1797[36] describes *bulimy* "as a disease in which the patient is affected with an insatiable and perpetual desire of eating; and unless indulged, he often falls into fainting fits"[37].

According to Stein and Laakso's review (1988), 19th-century references reflect sustained interest in bulimia as symptom or diagnostic concern. References during that period also reveal the recognition of a relationship between Anorexia nervosa and bulimic symptoms. Stein and Laakso mention in particular Gull who documents how "within the matrix of anorexia symptoms, patients occasionally evidence an extremely voracious appetite; temporarily deviating quite markedly from their pursuit of thinness" (205) - an observation that in their view justifies the rationale of bulimia as a subtype of Anorexia nervosa. As for the diagnostic importance of bulimia in the 19th century, bulimia is both considered a symptom within another disorder (in pica for example) or a distinct syndrome such as hyperorexia (excessive appetite). An 1869 entry in a French medical encyclopedia establishes for instance a differential diagnosis whereby 'boulimie' - i.e. food as a principal obsession; hunger persisting after huge amounts of

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In the true boulimis, there is a ravenous hunger and eating, but instead of vomiting, the patient suffers from lipothomy (fainting spells)". James, R. (1743) *A medicinal dictionary*. London: T. Osborne. Cited in Stein and Laakso (1988, 207).

[36] *Encyclopedia Britannica* (1797) Edinburgh: A. Bell & Macfarguhar. Cited in Stein and Laakso (1988, 206).

[37] *Encyclopedia Britannica* (1797) Edinburgh: A. Bell & Macfarguhar. Cited in Stein and Laakso (1988, 206).

food have distended the stomach and rendered ingestion impossible; torpor following a binge; and extreme hunger resuming after a few hours - is not to be confused with the adolescent's immense appetite, abdominal disorders, inadequate nutrition, tapeworm, or convalescence following typhoid. The same entry also distinguishes between two subtypes of bulimia: *cynorexia,* which involves vomiting; and *lycorexia,* with transit through the digestive system and out of the anus particularly fast due to quick intestinal contractions. In addition to an extensive description of numerous symptoms affecting bulimics, the entry finally argues that most cases are wrongly attributed to medical disorders and should instead be considered as functional problems resulting from specific nervous disorders (Stein and Laakso, 1988).

Between the 1930's and 1970's, Stein and Laakso note a diminution in references on bulimia as exemplified in its omission in the American Psychiatric Association's *One Hundred Years of American Psychiatry (*1944). They add that existing entries on bulimia during that period do not exceed two sentences. The authors refer however to thorough accounts of two cases, which involve features that remarkably match contemporary concepts of bulimia. The first in 1944 is Ellen West's famous case of Anorexia nervosa (Mendell and Lyons, 1958), which gave way to conflicting diagnoses by eminent experts of the period. West displayed a spectrum of weight loss strategies - diet restriction, laxative use, and vomiting - with episodic

bingeing. She furthermore felt severe helplessness in her struggle with obsessions, her ambivalence over intimacy, and her highly fluctuating mood. The second case in 1954, Laura, who plausibly met DSM-III (American Psychiatric Association, 1980) criteria of borderline personality disorders, also suffered from severe bouts of depression and an overpowering compulsion to eat anything in sight, incessantly and until exhaustion - she sometimes ended up sleeping two days and nights after a binge. Her binges were always preceded by an immense sensation of emptiness and sometimes followed by vomiting and ensuing feelings of drunkenness. In the account, Laura's fashionable slenderness was attributed to the ascetic regiment she followed - a likely reference to restrictive dieting.

Eventually, it is only in 1979 that Bulimia nervosa was identified by Russell as a new and distinct binge-purge disorder (Russell, 1979; Stein and Laakso, 1988; Keel, 2005).

CONTINUITY AND CONTINUUM

The above review and the contemporary nosological and epidemiological scene presented in the previous chapter raise the question of whether a connection exists between eating disorders, often viewed as modern pathologies, and pre-historic forms of anorexia and bulimia. In this section I argue that both anorexia and bulimia show

some aspects of historical continuity, which allows a conceptualization of the two pathologies around enduring issues of control that involve the object. The conceptualization ultimately introduces the notion of intrusion in the eating disorders conundrum.

The concept of continuity in eating disorders is complex and involves multiple levels of interaction, broadly defined in terms of time, space, intensity, and the relationship of classes of disorders with one another. These layers of interaction are articulated around a number of questions. Do modern forms of eating disorders bear continuity with seemingly comparable syndromes in history and across cultures? In a more specific way, does a single answer apply to the two emblematic categories of anorexia and bulimia, or is historical/spatial continuity relevant to one but not necessarily the other? In other words are the two disorders discrete, as suggested by psychiatric categories, or do they lay on a continuum, as also suggested by their conspicuous nosological overlap and fluidity - including in the frequently reported evolution, crossover, of anorexia into bulimia? Again, these various questions are interrelated and will be treated as such.

I mentioned earlier that, in contrast with a consensus that modern anorexia is reasonably connected to historical syndromes of self-starvation, there is disagreement among scholars over the existence of ‘pre-historical’ forms of bulimia. Proponents of

discontinuity for the latter syndrome have based their arguments on what they consider an important discrepancy in the mass of recorded evidence for the two syndromes, which they claim is more important in the case of anorexia, as well as on historical inconsistencies in criteria of inclusion, which they say are more characteristic of bulimia. As for advocates of continuity such as Stein and Laakso (1988), they consider the cases they have documented as speaking for a historical continuity of bulimia.

While considering binge-purging syndromes as exclusive to modern times does not do justice to historical references evoked in the above review, it is difficult to ignore the arguments put forward by the proponents of discontinuity. After presenting and discussing these arguments, I show how, by aligning bulimia on anorexia as two antithetic impulses towards the object (Shipton, 2004) - an alignment supported by the taxonomical fluidity revealed in Chapter I -, it becomes possible to consider the former disorder as having reasonably comparable precursors in history.

The Mass of Evidence Argument

The above review is not comprehensive and does not allow a definite answer about the volume of available evidence for each syndrome. On the other hand, it does not point toward a particularly remarkable dearth of historical accounts on bulimia. In any case, even if forerunners of today's bulimia are rare in comparison to their anorexic

equivalents, it is not clear whether this scarcity is the result or the cause of the late classification of Bulimia nervosa as a distinct disease (Keel, 2005) - with the official recognition of anorexia a century older than that of bulimia, the body of research on the former was bound to be larger[38]. Also, the paucity of literature on precursors of bulimia, again if the characterization applies, could also be attributed to difficulties in spotting bulimics. Indeed, in the absence of conspicuous signs, such as emaciation in anorexia, "bulimia nervosa may have existed but eluded detection"[39] (Keel, 2005, 30). Moreover, while anorexic motivations can be easily idealized - sacredness, protest against oppressive authority -, it seems difficult to romanticize bulimic drives, whether in their gluttony or purging aspects. It is worth mentioning in this respect the often-secret dimension of bulimic conducts and the shame that characterizes those who carry them (Chapter VII). To conclude, all the above factors may well contribute to a diminished visibility of bulimic behaviors, which would have necessarily impacted the volume of available historical references on these syndromes.

The Symptom Consistency Argument

As for the argument of symptom consistency across time, there is no doubt that there exists a difficulty that is specific to bulimia, which has to do with the complexity of

[38] Keel (2005) is nevertheless among those who argue against a historical depth in bulimia.
[39] Keel (2005) suggests however that signs of purging would have been noticeable in the absence of modern sanitary systems.

determining which pre-historic bulimic symptom or syndrome actually represents an antecedent of present day bulimia as a binge-purge disorder. This nosological difficulty is further complicated by the terminological confusion transpiring in historical accounts and encyclopedic entries - in some, bulimia refers only to the abnormally excessive absorption of food; in others, it also includes vomiting.

It is around the modern criterion of weight phobia that the differential in symptom consistency between anorexia and bulimia is particularly focused, justifying in turn their divergent historical status in the literature. For instance, noting that, when leaving the diagnostic yardstick of "fear of getting fat" out, anorexics are found as frequently in Western and non-Western cultures, not to mention historical cases of self-starvation, Keel (2005) infers that, in anorexia, similarities [intentional self-starvation, recovery in some cases and death in others, and a population of mainly adolescent girls and young adult women] far outweigh inconsistencies [weight concerns (as opposed to moral superiority[40]), attention seeking, and fear of the danger of food to the body]. In contrast, the binge purge syndrome, which, she notes, always occurs in contexts of exposure to Western influence (whether in Western or non-Western countries), consistently involves weight concerns. Keel consequently considers the binge purge syndrome as a

[40] It is important to point out however that, although it finds its expression in other, non-sacred ways, moral superiority is not absent from today's anorexic picture.

modern/Western, culture-bound[41] phenomenon, her case for discontinuity, whereas she views the syndrome of self-starvation as predating contemporary forms of Anorexia nervosa, her argument for continuity.

Like Keel (2005), although in a different and probably more complex manner, Habermas' (1989, 1992; Habermas and Beveridge 1992) take on weight concerns underscores the modern criterion's discriminatory position vis-à-vis continuity in anorexia and bulimia. While Keel's angle emphasizes the cultural aspect, Habermas' approach provides particular insight into the internal workings and dynamics of the contemporary symptom of weight phobia with other symptoms. In anorexia, the terror of becoming overweight, the new symptom in history, supersedes ascetic motivations for self-starvation, the symptom of the past. In bulimia, it is the combination of weight concerns with food reversal methods that is pivotal in changing a long-existing binge eating symptom into the modern binge-purge disorder.

There is I believe an inherent contradiction and arbitrariness in basing the continuity argument that discriminates between anorexia and bulimia on the existence or absence of the weight concerns criterion - its presence creating the modern/Western category of bulimia as a binge-purging syndrome, whilst its absence is considered irrelevant to the category of anorexia. Habermas himself alludes to the contradiction in

[41] Following Prince's definition of a culture-bound syndrome as "a collection of signs and symptoms (excluding notions of cause), which is restricted to a limited number of cultures primarily by reason of certain of their psychosocial features" (1985, 201). Cited in Keel (2005, 13).

remarking that, should this symptom, which constitutes a critical diagnostic criterion for both disorders in contemporary nosology, be taken into account to identify anorexic and bulimic syndromes in the past, then both eating disorders would be considered new from a historical point of view (Habermas, 1992). Extrapolating on Habermas' insight on the dynamic articulation of symptoms in eating disorders and pushing the above contradiction a little further, I will now put forward the case for some form of continuity for all categories of eating disorders.

The Fluidity of Eating Disorders

Habermas' (1989) perspective not only offers a good example of how past cases and contemporary classification can be linked in a meaningful way, it also highlights both the transient, contextual nature of some symptoms and the dynamic, fluid nature of eating disorders. This fluid dimension, I will argue, can paradoxically reverse, or at least qualify, a categorical affirmation of the modernity of bulimia - in its binge-purge form and as recognized in contemporary Western or Westernized contexts.

My argument is two-fold, in reference to a first distinction between core and contextual symptoms and a second one between full-blown and partial syndromes. Both distinctions are important in highlighting the ease with which contemporary taxonomic categories can be and have been, as a matter of fact, upset - in its sections on

taxonomy and epidemiology, Chapter I has often touched on this blurring of categories. There is for instance the fact that while purging was not a criterion in the DSM-III classification, it gained access to the status of core symptom in the DSM-IV-TR (American Psychiatric Association, 2000) - the very symptom, which in its combination with bingeing defines the so-called modern syndrome. There is also the non-purging subtype of bulimia in the DSM-IV-TR, which seems to refer precisely to the unacknowledged past forms of the disorder. The frequent crossover from anorexia to bulimia as well as the open-ended symptom combinations allowed by the category of Eating disorders not otherwise specified offer yet other examples of muddled classification. In a more prospective way, there is no doubt that should amenorrhea[42] no longer be considered a symptom of anorexia, on the ground that it automatically excludes males from the pool of diagnostic investigation, this would immediately have an effect on prevalence rates among men. In a more general way, occurrence rates would undoubtedly be impacted at many different levels if partial criteria were considered instead of full-fledged forms of pathologies. These few examples speak for a certain degree of fluidity that allows thinking of bulimia as interconnected with anorexia - a fluidity, which I think rules out a rigidly divergent historical course for each disorder.

[42] The DSM-V has actually excluded amenorrhea as a criterion and it will be interesting to check prevalence rates among men in the future in relation to this exclusion (American Psychiatric Association, 2013).

The Interconnectedness of Anorexia and Bulimia around a Problematic of Control

In an apparent contradiction of interconnectedness, contemporary taxonomy, along with arguments of discontinuity in the case of bulimia and continuity in that of anorexia, seems to suggest a conceptualization of the two disorders as discrete categories. There is no doubt that such a conceptualization presents advantages. It enhances for instance tools of research by allowing clearer distinctions. It also has a major clinical impact - both in terms of identifying the purely physical ailments that result from each disorder and permitting the prescription of medication for their treatment [for instance osteoporosis, increased blood cholesterol, and loss of gray matter in the brain in anorexia; esophageal tear, enlargement of and tear in the stomach, and lung infection in bulimia (Keel, 2005)].

The approach I suggest is to a certain extent intermediary between perspectives that view anorexia and bulimia as discrete categories and those that assume they exist on a continuum. Indeed, without thinking in terms of a continuum that "flattens out a complex interacting set of issues and defences" (Shipton, 2004, 26), the overlap and fluidity in contemporary nosological categories do point out to what I set, following Shipton, as a working hypothesis: the interconnectedness of anorexia and bulimia as "linked to a frightening, voracious appetite for the object", with anorexic control a defense against bulimic desires and impulses (Shipton, 2004, 29). This hypothesis is

based on an object relation view inspired by Klein and Bion. Of course, it would be ludicrous, and probably anachronistic to try and find substantiation for such a symbolic meaning in the literature on historical precursors of eating disorders. However, it might be interesting to look at evidence from the past from the perspective of what Shipton describes as a constellation of common issues that lies under the surface of any eating disorder and centers on “themes of self-assertion, protest, defiance, spiritual superiority and self-realization (that) all crop up in explanations about anorexia in contemporary approaches” (Shipton, 2004, 14). Considering that introjective processes, which underlie impulses to incorporate the object, generate derivatives in the form of intrusion, it becomes possible to posit that phenomena of intrusion are implied in dynamics of anorexic control to defend against bulimic urges of incorporation. This allows extending the notion of control to intrusion, a first theoretical move in the articulation of the thesis that intrusion, as the overwhelming experience of invasion of receptivity, constitutes the fundamental psychological factor in the etiology of eating disorders.

A further step towards articulating the intrusion theory is provided in Chapter III in my other working hypothesis, which subsumes various eating disorders difficulties under the supremacy of intrusion through the proposition that intrusion aims at controlling objects and/or states and emotions. The psychodynamic proposition derives from Williams’ object relations model of eating disorders and its use of projective

identification (Chapter VI) to explain how, to avoid painful experiences of dependence and loss of the object, parts of the ego are forced in fantasy in the object in order to control it.

The function of eating and the body (ies)[43] it inevitably involves provide propitious primal arenas for struggles with need and desire in relation to the object - to curb it or release it; to control it or submit to it. At different times in history, in different social and cultural contexts, the object of desire may assume, through displacement and transference, different forms, but the dialectic of the self with the other - played out in the act of eating and involving symbolically and dynamically related control/intrusion issues - may ultimately be the same.

This is well illustrated in the enduring theme of rebellion against authority and the status of women as well as the burdens of womanhood, which anorexia seems to have conveyed across time from St Wilgefortis, St Margaret of Hungary, and St Catherine of Siena through to contemporary feminist and other interpretations of eating disorders in terms of a power struggle - in some sense, the feminine anorexic body as an arena where the sacred and the 'feminist' meet. In this context, I would like to evoke what could appear on the surface as a contradictory position and trajectory of bulimia and anorexia, and for which I suggest an alternative explanation around the issue of control.

[43] See Chapter III on how eating disordered girls identify their body with their mother's body.

I have mentioned earlier, in the context of the mass of evidence argument, an inherent difficulty to an open or public visibility of bulimic behaviors - they are not avowable, let alone idealizable, unlike anorexic comportments, which can carry sacred connotations, and therefore appeal to both subjects and their entourage. This is epitomized in the understandable absence in historical accounts on bulimia of any religious meaning of the phenomenon[44] - whether attributed by fasters themselves, their community, or observing/commenting lay and religious institutions. Unless mentioned in the context of self-starvation syndromes, and, with the exception of the recognition by the end of the 19th century of a psychological component in both bulimia and anorexia, precursors of bulimia have in fact been described and explained mainly in terms of natural causes - physiological/medical and/or as curiosities. This fundamental difference in historical accounts on forerunners of anorexia and bulimia, which would support their status as discrete entities, can however be understood in an opposite way. If one accepts that anorexia and bulimia are dynamically interrelated, with anorexia in a way the antithesis of bulimia, one might recognize here the opposition between praiseworthy control and hard to confess lack of control, an opposition that underlies the respective anorexic and bulimic stands, and, further on, the “religious” as structure and the “non-religious” as

[44] As per Habermas and Beveridge’s (1992) classification mentioned above.

lack or loss of structure. In addition to a kind of horizontal continuity between anorexia and bulimia, a level of historical continuity in the former is then extended to the latter.

To conclude, answering the question of continuity in eating disorders is certainly difficult. Although this is true in particular in the case of bulimia, over which scholars are divided, it also applies to anorexia, which has triggered far less academic controversy. The core and enduring symptom of self-starvation has been invoked to support the view of continuity in anorexia, while the association of bingeing with purging, which defines the modern syndrome of bulimia, has been deemed inconsistent, leading some to consider it as a modern Western disorder.

The complexity of the question arises from many directions. The inscription of any disease in historical and cultural contexts is an important element, bound to influence the expression of symptoms in specific yet transient ways. This makes the challenge of determining which symptom is core and stable and which is contextual and fleeting a complex task. This is further complicated by the danger of anachronism any retrospective assessment and classification entails, but also because of the blurring of categories that contemporary taxonomy reveals. Not only are symptoms fleeting, so are categories in successive manuals, and categories within manuals.

Insight into the meaning of eating disorders across time and space may nevertheless be possible if one posits the interconnectedness of anorexia and bulimia,

which the fluidity in categories allows, and considers their underlying mechanisms of restricting, engulfing and expelling as reflecting enduring dynamics of control that pertain to the object. In positing an overlap of control with intrusion on the grounds that intrusion aims to control objects and/or states of emotions (Chapter III), it becomes possible to invite intrusion in the equation of eating disorders. The overlap is substantiated in Chapter VII.

Before moving to the third part of this background survey, which will examine theories on the feminine specificity of eating disorders, I would like to make a final comment on one aspect of continuity that concerns the female/male ratio in these disorders in the past. The question is after all at the center of this work. In the absence of a systematic computation of gender distribution in historical accounts, not to mention the taxonomic challenge this would pose, it is impossible to confront the asymmetry in contemporary statistics on male/female prevalence rates with any tangible evidence from the past. Cautiously looking back at the non-comprehensive historical review above, and notwithstanding the well-documented phenomenon of holy anorexia among females in the late Middle Ages and early Renaissance, it does not however present a striking case for female preponderance in history. In this respect, it is worth mentioning Bordo's (1993) reference to the little use of the concept of gender in Bruch's (1973) landmark work on eating disorders in as late as the 1970's. In fact, Shipton remarks that

Chernin (1985) was the first to point out that “the anorexic’s body was almost always a female body” (Shipton, 2004, 12). Although it is impossible to conclude on this issue, it is worth keeping this observation in mind when reflecting on the question of eating pathology in men.

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Chapter II has established a reasonable level of continuity between modern categories of anorexia and bulimia and historical syndromes of self-starvation and binging/purging - a continuity founded on enduring themes of control and on a conceptual assumption of dynamic interconnectedness between bulimic impulses towards the object and anorexic defenses to counter them. The chapter has accordingly put forward the hypothesis of an overlap between intrusion and control as relevant to introducing the former in the equation of eating disorders. The hypothesis, which is further developed in Chapter III through the subsuming of all eating disorder difficulties under the supremacy of intrusion, is verified in Chapter VII.

CHAPTER III

FEMALE BODY AND DEVELOPMENT

Having presented the contemporary nosology and epidemiological landscape of eating disorders (Chapter I) and probed into their historical dimension (Chapter II), I introduce and examine in this chapter female anatomical and developmental aspects that have been invoked to explain feminine specificity in these pathologies.

The first chapter in Part I established the homosexual exception as a parameter of exploration of the female landscape of eating disorders. This proceeded from the discovery that research on sexual orientation and gender traits has consistently described male homosexuality in terms of femininity. The second chapter introduced intrusion as a general problematic in these pathologies: through the proposition that eating, at once archaic and object-related, lends itself to metaphorical[45] dynamics of intrusion; and through the extension of notions of control to intrusion via the interconnectedness of anorexia and bulimia (anorexic control of bulimic hunger for the object). The association of control and intrusion is substantiated in Chapter VII.

[45] Here again, 'metaphorical' is used in its general sense and does not refer to the psychoanalytical opposition between concreteness and aptitude for symbolization.

The present chapter proposes the female body, in its receptive connotation, as another metaphorical channel for expressing the dynamics of intrusion at work in eating. Together with the homosexual exception, the coincidence of the female body metaphor with food and eating symbolism provides a background to reflect on, and go beyond, receptivity in its exclusive feminine specificity in eating disorders.

A review of the literature on the nature of the relationship between eating disorders and femininity highlights the crucial role feminine development has been seen to play in these disorders. It also shows how issues of female development more than often overlap with questions concerning the female body in its dynamics with objects - with feminine specificity linked to the distinct status each theory confers to the body, the object, and their relationship.

I have identified three broad perspectives on the relationship between eating disorders and femininity in the studies under review. A first one focuses on control, or lack of it, on the body and its functions. Two authors, Chasseguet-Smirgel (1993) and Cross (1993), emphasize this angle. Another point of view highlights themes of intrusion and/or containment. It is represented by Lawrence (2001, 2002, 2008), Williams (1997a, 1997b; Williams et al (eds.) 2004a, 2004b), and Russell (1992). Finally, in a looser manner, a self-psychology approach implicates an array of issues pertaining to identity and neediness/dependency. De Groot and Rodin (1994), and Sands (1989, 2003)

represent this perspective.

In the first part of the chapter, I present the theoretical contribution of individual authors. In the second part, I show how specific problematics of control, intrusion/containment, as well as difficulties around identity, neediness and dependency derive from particular conceptions of the body, the object, and their interaction. Underscoring its all-encompassing dimension, I eventually choose intrusion over other problematics and difficulties.

THEORIES ON THE FEMININE SPECIFICITY OF EATING DISORDERS

Chasseguet-Smirgel: The Body as Mother

Feminine Specificity: The Girl's Body Is Identified With, And Projected Onto, The Mother's Body

In an article on eating disorders and femininity, Chasseguet-Smirgel puts forward that, in certain cases and at a specific moment in female development, around puberty, eating disorders represent an escape from the dictates of feminine biology. She looks at the question of eating disorders from a philosophical/religious perspective of opposition between body and mind - a dualism embodied in Gnostic heresies that view the body as an instrument of the devil to subdue the soul (Chasseguet-Smirgel, 1993). In this respect, her approach establishes a bridge with historical cases presented in Chapter II. For her, feminine specificity in eating disorders is articulated around the persona and

body of the mother and transmitted through the psychological processes of identification and projection. More specifically, dynamics of alienation and passivity, which she considers characteristic of eating disorders, are kept alive through identificatory and projective mechanisms that involve the mother. Chasseguet-Smirgel describes them as follows.

At puberty, young girls become constrained by a body and a biological order they cannot control - in particular, dramatic changes in the body make it similar to that of the mother and, as a result, re-actualize early life issues of differentiation/separation and of integration of the corporal and psychical egos. The identification of the girl's pubertal body with that of the mother constitutes a distinctive element in the divergent developmental courses girls and boys engage in. Whereas boys struggle early on in life to disengage from maternal femininity as a means to develop their identity, a similar and as crucial process of intrapsychic separation and identity development - though deferred and using other channels - also occurs in girls. Chasseguet-Smirgel (1993) elaborates on this concept of protofemininity, borrowed from Stoller (1976, 1985; Stoller and and Herdt, 1982; Stoller et al, 1976), situating the delayed process of disengagement from maternal femininity at the time of puberty and identifying eating disorders, which she considers a reflection of separation/differentiation and integration issues (Chasseguet-Smirgel, 1993), as a major channel for its expression.

Projective mechanisms are critical to Chasseguet-Smirgel's view on the feminine specificity of eating disorders. The mother and her body are recipients of projections, which she describes using Laufer and Laufer's (1984) observations on the significance of passivity in the problematic of adolescent patients. According to Laufer and Laufer, these patients experience their body as a theater for incessant, overwhelming and painful fantasies and emotions. They live such experiences as a passive surrender to regressive urges against which they defend by projecting hatred of their body onto the mother - with an ensuing impression of submission to her. It is precisely such passivity, in its feminine version, which for Chasseguet-Smirgel is at the center of the projective mechanisms that incriminate the mother and her body in eating disorders.

Chasseguet-Smirgel therefore places the feminine body at the center of the symbolism linking femininity to eating disorders. The feminine body represents the body of the mother. Not only is it alien, it also is forced on the self in a persecutory way - imposed from outside through the biological order she represents. It must therefore be fought and subjugated. Control and power, and corresponding issues of passivity, are inherent in Chasseguet-Smirgel's body symbolism, and the mother is its centerpiece.

Autarchic Fantasies And Their Anal And Autoerotic Components

Another essential aspect of Chasseguet-Smirgel's theory is her suggestion that autarchic designs underlie eating disorders. Applying Meltzer's views to eating disorders - the rectum as a source of food and the unconscious relationship existing between food and feces -, she suggests that anorexia and bulimia involve an autarchic fantasy in which one feeds on one's own feces and is therefore self-sufficient. Although the autarchic dimension is more discernible in bulimia, it also applies in her view to anorexia through the dynamic relationship that governs the two ends of the eating disorders spectrum - anorexia representing a victory over bulimia. Here is another case for interconnectedness between the two emblematic poles of eating disorders as discussed in Chapter II. A suitcase full of food hidden under the bed, a fridge, an underground food storage where a patient hides to eat, all these elements derived from the experiences and fantasies of patients or from movies, represent for Chasseguet-Smirgel extensions of the body, unending rectums. Similarly, a patient eating what she picks from her nose, or another one dreaming she is in a hospital where the feces of patients are recycled into food represent autarchic fantasies of eating in endless cycles what has been rejected.

Autarchic fantasies involve anal and autoerotic components. The anal dimension is clear in the fantasies just described and is particularly detectable in bulimia.

Chasseguet-Smirgel indeed considers that anal masturbation fantasies - displaced in the form of compulsive digging out of one's ears to remove ear wax or picking one's nose, as well as the furious pressing, scratching and bleeding of one's spots or skin growths - are enacted in bulimia. Characterized by heinous and murderous feelings, such bulimic/anal enactments are extremely persecutory and therefore guilt creating. Another anal component is the quasi-conscious and concrete trash and excremental representations of the body as expressed in the deeds, words and fantasies of bulimic patients - yet another allusion to Gnostic representations of the body.

All Chasseguet-Smirgel's patients who endured eating disorders at adolescence had also suffered from autoerotic deviations early on in infancy - pulling one's hair, hitting one's head, etc. Linking autoeroticism and self-sufficiency, Chasseguet-Smirgel premises sound autonomy and positive autoeroticism on a good relationship with the object. Only when an infant has successfully interiorized a good relation with the mother can he/she engage in normal autoerotic activities and gradually gain autonomy from her. In contrast, negative autoeroticism does not proceed from the relation with the object, but develops instead in substitution for, and sometimes against, this relation. The outcome in such cases is false independence. For Chasseguet-Smirgel, the precocious and desperate search for autoerotic satisfaction aimed at masking feelings of void and loneliness is a way of compensating for lack of maternal narcissistic input

early in life. An example of linkage between negative autoeroticism and self-sufficiency, particularly pertinent to her problematic of eating disorders, is merycism - the pathology of ruminating: in an inversion of the phenomenon described by Freud (1920a) in the reel game, the infant manipulates bolus in a sort of caricatured rejection of dependence (Chasseguet-Smirgel, 1993).

Cross: The Paradoxes of the Female Body

In her work on body and self in feminine development through the study of the often coexisting eating disorders and delicate self-mutilation syndrome, Cross (1993) suggests that in both disorders, as in fasting Christian holy women (Chapter II), power over the body is a rebellion against the paradoxical way women experience their body: mysterious, subject to change, and both self and other. From her perspective, the anorexics' strivings to counter the normative view of the female body as mysterious and invaded by lover or child are nothing but a way to try and own their body, perceive it as self (not other), known (not enigmatic and unpredictable), and impenetrable (not invaded and controlled from the outside).

A Symbolism Inherent in the Female Body and Functions

For Cross, the weight of female sexual anatomy and function on women's object relations and on their psychological strengths and weaknesses is paramount - it finds expression in their endeavor to make sense of, restrain, and negotiate the vicissitudes of their body. Partially internal genitalia, menstruation, changes in body at puberty and during pregnancy - all these female anatomic attributes contribute to what she considers an ambiguous, paradoxical, and discontinuous body experience. On the one hand, the female body as the object of intense, constant, and narcissistic scrutiny and intimacy; on the other, passivity to, and alienation from, a changing and uncontrollable body, experienced as object rather than subject. In other words, women as both more alienated from, and more attuned to, their body.

Relatively inaccessible genitals, insubstantial connections between genitals and body image and, inchoate, difficult to localize and satisfy sexual sensations, these defining characteristics of the female body and sexuality operate as early as toddlerhood and have many repercussions, which Cross defines in opposition to those affecting toddler boys: little girls know less, and explore less, their genitals; genitals are for them a greater source of confusion and anxiety; and their genital experiences are more frustrating. The dramatic metamorphoses brought about by puberty (earlier occurrence, and greater significance and abruptness), and further on in pregnancy,

revive toddler themes of loss of bodily control - further accentuating their experience of the body as mysterious and uncontrollable and as split from the self.

In contrasting the developmental course of females and males, Cross does acknowledge the important challenges boys must also face as their body experience undergoes mysterious, contrary, and anxiety-provoking phenomena. Because of some fundamental differences, these challenges are not however as constraining as they are for girls: the obtrusiveness of their genitals, which allows them to own their physical self; the pleasurable sensations they experience in an otherwise uncontrolled behavior of the penis at puberty - in contrast to the unpleasant signal of female puberty, menstruation; and the feeling of physical effectiveness they derive from muscle development at adolescence - as opposed to the decrease in muscle-to-fat ratio, and corresponding feelings of physical ineffectiveness, which girls undergo during the process of hip, breast and thigh development.

Also confronting girls at puberty and again during pregnancy and breastfeeding is the way they experience their body as ‘other’ - another female pubertal developmental challenge, in addition to the quandary of an enigmatic and unruly body. During puberty, alienation from the body is manifest in a number of ways. First, in the fragmented body image of adolescents who often experience and describe their body in terms of parts (pretty waist, ugly nose) - parts that, furthermore, are sometimes plainly perceived as

ego-alien (breasts in particular). Second, in the fluidity of body image that results from the rapid succession of dramatic bodily changes. Third, in orgasms which, because they are often vicariously experienced and seldom result from direct masturbation, do not contribute to a sense of ownership of the body and of sexual pleasure. Finally, in experiencing the penis as an 'other' within, which symbolically predates the fetus within. Of course, the 'other' within becomes supreme in pregnancy, but also in lactation, when breasts can be felt as belonging to the baby rather than to the mother.

Eating Disorders: The Pathological Externalization of Female Anatomy

In her work, Cross often refers to Kestenberg's (1975) 'prototype' of externalization. Conceptually, if implicitly, the prototype underlies her emphasis on the impact of female anatomy and development on women's object relations and psychology as well as on the relationship between eating disorders and femininity. It provides at any rate a model around which female physical attributes of interiority, changeability, and otherness mentioned above can be articulated, and their projected/externalized manifestation, both normal and pathological, apprehended.

Cross proposes that women's tendency toward externalization is a reflection of their efforts to transform vague and internal genital sensations, experienced in diffuse and passive ways, into focalized expressions, which are discharged, externalized on

organs, objects and people. In its positive version, the prototype of externalization provides for a normal course in feminine development. In its pathological version however, patients seek physical pain because it constitutes a more definite and controllable experience than sexual tension, and because intentional pain constitutes a counter-phobic victory over previous, passive experiences of pain. Cross proposes that pathological externalization is particularly relevant to understand delicate self-mutilation and eating disorders - in both disorders patients had generally suffered from early difficulties in localizing, identifying and soothing sexual feelings, in addition to having specifically experienced some sort of abuse (sexual or physical), painful illness, or invasive surgery. Elaborating on the proposition that self-mutilating patients transform diffuse affect and sensation into localized, clear-cut physical injuries - their defense against fears of being passive victims to pain, bodily penetration, and bleeding by actively inflicting these states on the self -, she suggests a similar phenomenon takes place in eating disorders through self-inflicted emaciation and the suffering it entails.

Lawrence[46]: Female Anatomy and Development - An Orientation towards Introjection

Female anatomy and development are crucial to Lawrence's (2001, 2002, 2008) understanding of anorexia as a phenomenon centered on intrusion. Proceeding from

[46] As central to my thesis, the work of Lawrence and Williams is treated separately in Chapter VI. Sections devoted to the two authors here have been developed to the extent that they allow comparisons with other theories on the feminine specificity of eating disorders under examination in this chapter.

Klein's (1928, 1932) theory that girls have an innate knowledge of the receptive nature of their genitalia and stronger introjective tendencies than boys, she suggests that the feminine character mirrors female sexual constitution - open and inclined to introjection, but also closed and afraid to be projected into and invaded. In her words, "dominant trends and anxieties resonate with the reality of sexual difference" (2002, 841). From Lawrence's perspective, anxieties of intrusion, in correspondence with introjective tendencies, are specifically feminine.

Lawrence suggests that in anorexia, anxieties of invasion are particularly excessive. This is in connection with a girl's violent envy of the primitive maternal object and her projection of aggression onto the mother's interiors (Klein, 1928, 1932; Lawrence, 2002). The fiercer a girl's fantasized attacks on the inside of the mother's body, the more powerful her dread of invasion through retaliation. The problematic of intrusion in eating disorders is therefore rooted in a girl's own intrusiveness in her mother, regardless of her actual experience of being intruded upon. In situating the origin of intrusion in daughters, Lawrence does not dismiss altogether the relevance of mothers to this problematic. Her emphasis however is on maternal failure in the containment of anxieties of intrusion. As for the phenomenon of intrusion per se, she explains it in terms of an inability to discriminate between what is and what is not intrusive, the result of failed internal triangulation and symbolization.

Williams: Introjective and Projective Processes, Independently from Feminine Specificity

Williams' (1997a, 1997b; Williams et al (eds.) 2004a, 2004b) inclusion in this chapter is arguable - she does not propose a theory to explain feminine specificity in eating disorders, let alone one that implicates the female body or functions. Bodies, though not necessarily female bodies, are implicit in the theoretical background in which she grounds her work - like Lawrence, a Kleinian frame of reference that emphasizes introjective processes expressed in a problematic of intrusion. Most significantly and in contrast with Lawrence, she does not view perceptions of intrusiveness as fantasies triggered by the patient's own projections but as originating mostly in parents. Indeed, reversing Bion's 'container-contained' function (1962a) into a 'receptacle-foreign-body' function, she suggests that it is the latter that operates in eating disorders - not only are infantile anxieties not contained, infants are actually the recipients of powerful parental projections, which they experience as intrusive objects. As a consequence, Williams' work randomly presents cases of eating disorders pertaining to the two sexes. As significantly, the dynamics of intrusion it describes implicate both mothers and fathers.

Russell: Caricatured Stereotypes of Female Anatomy

Feminine anatomy, expressed in introjective tendencies, does matter in Russell's (1992) understanding of eating disorders. For him however, symbolic anatomic

expressions are not absolute and feminine specificity is relative and contextual. Russell views bulimia as a metaphor illustrating the stereotypically feminine as well as a perversion, which he defines as fascination with something also regarded as repulsive. Stereotype - masculine projection and feminine introjection - and perversion/fascination are intertwined in the proposition he makes that “we take interest in that which contains what we get rid of, and interest in the contents tacitly assumed to have been put into that container...” This entwinement is for him the essence of sexual interest - “... a fascination with the fate of what we have gotten rid of, and an inclination to reappropriate it” (101).

On stereotypes, Russell posits that feminine and masculine development are respectively rooted in the psychological prototypes of introjection and projection and their related clusters of characteristics - a feminine tendency to nurture, nourish and contain, based on introjective impulses, and a masculine tendency to aggressively penetrate, appropriate and control the other, based on projective impulses. These prototypes however are not rigidly assigned to one sex as opposed to the other but are originally indiscriminately available to all human beings. Positing that the discovery of one’s anatomy and gender is always vicarious - it is through the eyes of the other that girls and boys discover their genitals and physical differences -, Russell turns the causality relationship between anatomy and femininity or masculinity upside down.

Accordingly, sex role expectations take precedence over the discovery of sexual differences and it is conformity to such expectations, which in turn shapes the psychological prototypes of introjection and projection.

In addition to the prototype of introjection, the foundation on which experiencing oneself as a container is based, identification with the mother and her containing function is crucial to Russell's understanding of the feminine position. It is worth noting in this respect that Russell takes exception to Stoller's notion of proto or primary femininity discussed in the context of Chasseguet-Smirgel's theory, considering that in both sexes "although we are all psychologically androgynous, we are first of all male, if the male prototype is this active controlling of the universe, including taking in and also getting rid of experience. It seems to me we all start off with this (what is to become the ground for the) masculine stance, and then subsequently come to identify with that - the feminine - which contains us ... (W)hat is primary is masculinity, and from this evolves a capacity to identify, and then, in agreement with Stoller, the first identification (and symbiotic relationship) is with the feminine" (Russell, 1992, 102).

On perversion, Russell defines bulimia as a caricature of femininity, in the same way exhibitionism constitutes a distortion of masculinity. Such feminine and masculine perversions combine fascination, anger and repulsion over expectations of one's sex role. Seen from this perspective, bulimics literally stuff themselves, a caricature of

expected containment, and purge themselves, a caricature of rejecting this expectation. As parodies, attraction and revulsion to the containing function nevertheless both express a rejection of female anatomic constraints, reinforced as they are through the 'other', and through culture.

Self-Psychology: Biological Givens, Including Physical Similarity with Mother, and Arrests In Female Development

Looking into the relationship between femininity and eating pathology from the biopsychosocial perspective, Self-Psychology presents a comprehensive approach of the various dynamics operating in these disorders. It first describes biological givens, including the mother/daughter gender similarity and its developmental implications in terms of identification with a containing function and relatedness. It also refers to aspects of culture and parental failures (both parents) that further impact feminine psychological development in the form of identity-related disturbances - feelings of emptiness, unawareness of emotions or internal states, a sense of ineffectiveness and lack of agency - and disavowed and intolerable states of neediness, which women with eating disorders attempt to deal with and regulate through their body.

The work of three authors - De Groot and Rodin (1994), and Sands (1989, 2003) - broadly represents a self-psychology perspective on the relationship between eating disorders and femininity.

De Groot And Rodin

De Groot and Rodin situate the gender specificity of eating disorders at the level of arrests in female psychological development and in terms of disturbances in the sense of self. Three areas of female development, which they view as essential to the construction of a sound identity, are problematic in eating disorders - differentiation, affectivity and the sense of agency. They suggest that such a "constellation of disturbances" (312), which originates in biology and is reinforced by culture - the tacit encouragement of relatedness in girls and of activity, exploration and mastery in boys - and by parental dysfunctions - the failure of mothers and fathers to recognize and adequately react to the unique and distinct emotional state of their daughters - contributes to women's vulnerability to eating disorders. I would like to refer in particular to their discussion of biological factors and differentiation.

De Groot and Rodin point to biological givens such as neuroendocrine factors, gender differences in physical activity, and a greater inner capacity for empathy in female infants, all of which contribute to a lower sense of agency and effectiveness in girls. Equally significant is the biologically rooted psychological component of gender similarity between mother and daughter and its compounding impact on processes of differentiation - differentiation is easier in the development of boys as male identity is consolidated through separation from the mother, whereas female identity is based on

ongoing identification with, and relatedness to, the mother. Besides, in enhancing relatedness, the similarity factor accounts for further complexities in a girl's affectivity - because relatedness is often based on the mother's emotions and feelings rather than the daughter's, easier access to maternal emotional life can interfere with a girl's awareness of her own emotions and inner states. Finally, difficulties in differentiation from a physically similar mother in female eating disordered patients are further complicated by paternal absence - whether real or emotional - or, by seductive fathers. Typically, fathers of bulimics are absent and fathers of anorexics use their daughters to enhance their own image and needs.

Sands

Sands (1989) attributes women's greater susceptibility to eating pathology to difficulties in early female development, which express states of neediness and deficits in identity around issues of differentiation. Disordered eating aims at resolving these difficulties through the substitution of food for the mother. She situates these struggles in the context of Kohut's (1971) mirroring and idealizing processes - the admiration and confirmation of a child's sense of specialness and greatness, and a child's need to merge with the calmness and power of an admired one.

Feminine specificity goes back to what Sands (1989) describes as lack of

idealizable figures in the early life of little girls. Although boys and girls are similarly confronted to two developmental phases of disillusionment with the mother - when their acknowledgement of an increasing separateness leads to a breach in both the child's grandiosity and it's mother's omnipotence; and when they discover the secondary status in society of their so far revered mother -, disillusionment is more traumatic for girls than it is for boys, because mothers remain their primary idealization figure, whereas boys can turn onto fathers in their quest for alternative ones. Such disruption in female idealization processes leads to functional deficits in tension regulation, which in turn necessitate recourse to self-soothing mechanisms in the form of eating disorders.

In eating disorders the concretization of neediness in the body represents a specifically feminine recourse that fulfills self-regulatory functions. It is through her identification with the containing function of the mother that the eating disordered patient uses her body to concretize her unmet developmental strivings and dependency needs. Such likeliness for women to use their bodies to convey their disavowed and intolerable states of need is in contrast with men's propensity to instead experience the 'other' in this way. As for the self-regulatory functions served through the concretization of needs in the body, they include: distancing from, non-implication in, the situation of need; the body as 'not-me' (Sands, 1989, 2003), which, although evoking otherness, pertains to denial more than alienation; an easier management and domination of needs; finally,

through displacing neediness on the body, the bond with the needed idealized other is preserved - “since I don’t have needs and desires, you are not failing to meet them” (Sands, 2003, 105).

Beyond difficulties inherent in normal female development, cultural attitudes are critical in thwarting mirroring strivings in girls. In particular, society and family fail to adequately validate and admire female exhibitionist needs, except in areas of physical appearance and care for others. Furthermore, whenever these developmental strivings are perceived to be in conflict with the needs of others, they are checked and their expression - in excitement, motor-mindedness, and aggressiveness - restricted. Symbolic implications are significant in this respect, especially in relation to ensuing inclinations to later use the body as a channel to express exhibitionist concerns (Sands 1989, 2003).

Finally, specific parental behaviors combine with cultural factors to further impede feminine development. Such parental dysfunctions, mothers’ or fathers’, affect daughters at various levels. For instance, chronic parental unattunement exacerbates feminine vulnerability to the disruption of idealization processes (Sands, 2003). Little girls, who are used as narcissistic extensions by their usually female primary caretaker, present another example. Eating disorders in their case are a way to acquire an identity separate from that of the mother and a means to differentiate without separating

(Sands, 1989, 2003). Other examples implicating family behaviors or situations include the pathological focus of parents on body parts, which reinforces the use of the body as a channel of expression; and the narcissistic vulnerability of mothers, particularly their self-devaluation, which further thwarts the idealizing needs of girls (Sands, 1989).

PROBLEMATICS BEHIND FEMININE SPECIFICITY IN EATING DISORDERS AND THEIR INTEGRATION

With the exception of Williams'[47], all theories presented above emphasize feminine development and the female body, in a way or another, to explain feminine specificity in eating disorders. In all theories, with the qualified exception this time of both Williams' and Cross'[48], the representation of the female body involves critical dynamics with the maternal object and/or her body. Identification with, control over/by, intrusion into/by, differentiation/separation from, and dependence on/neediness of the mother/her body - these dynamics find a symbolic expression in and through the girl's body, in particular bodily functions pertaining to eating. Whilst the dynamics just evoked mostly overlap, each theory emphasizes one predicament over the others, thus establishing hierarchies whereby one core problematic subsumes other peripheral though related difficulties.

In this section, I identify the core problematic behind each theory, or set of

[47] As mentioned earlier, Williams does not develop a theory of the feminine specificity of eating disorders.
[48] Again, Williams' model, which involves dynamics with the maternal object, is not concerned with the female body or feminine specificity per se. Cross' theory on the other hand, while focusing on female anatomy and development does not feature the maternal object and dynamics that involve it.

theories, revealing the way feminine specificity, or lack thereof, is related to the standing individual models grant to bodies, objects, and their relationship. I eventually choose intrusion as the ultimate predicament, which encompasses all difficulties in eating pathologies. A predicament, which in my thesis is defining in eating disorders - *regardless of sexes and despite the fact that it is especially likely to be expressed in women, because of the receptivity of female bodies and of anxieties associated with female development.* The intrusion hypothesis is based on the conceptual value of introjective and projective processes and of projective identification. Introjective and projective processes are reflected in dynamics of taking in/receiving and expelling as revealed in restrictive, binging and purging conducts. Projective identification, as used in William's object relations model of eating disorders, specifically underscores my subsuming of all problematics under the supremacy of intrusion. The psychoanalytic background to my intrusion hypothesis, in particular Williams' integration of projective identification in her model, is presented in Part II.

Lack of Control of The Body: Chasseguet-Smirgel and Cross

Chasseguet-Smirgel's and Cross' inclusion under the same heading is justified by their unexpected convergence in emphasizing the question of control over the feminine body and functions as critical to understand the relationship between eating

disorders and femininity. Although Cross also highlights a problematic of intrusion along that of control, I will at this point only discuss the latter, considering, in line with her own position, that it subsumes the former.

The problematic of control, which brings to the fore the question of its enduring dimension in eating disorders across history and consequences thereof on a continuum view of these diseases (Chapter II), is also interesting because it is premised on a dialectical conception of the body-mind relationship. This dualism bears philosophical and religious undertones in the two theories. For Chasseguet-Smirgel (1993), the conflict and opposition between body and mind is epitomized in Gnostic heresies that consider the body an instrument of the devil aimed at subjugating the human soul. She tracks the idea of a soul distinct from the body back to the experience of the new born engaged in the task of integrating its corporal and psychical selves. Opposition between body and mind/self is also at the center of Cross' work (1993). This is indicated in the title of her article, 'Body and Self in Feminine Development', and in the parallels she also draws with ascetic practices and symptoms of fasting Christian holy women up to the 19th century - intensive fasting and vomiting, compulsive gorging, restless activity, sleeplessness, and cessation of menses, as well as flagellations, cutting, gouging and burning of one's body.

In the two theories the body-mind opposition constitutes one amongst many

underlying, sometimes overlapping, sets of opposition - the couples feminine/masculine, passive/active, mysterious/known, self/other, merger/differentiation, and alienated/attuned. I would like to examine and elaborate on some of these couples of opposites.

Starting with the generic opposition between body and mind, Chasseguet-Smirgel describes the basic fantasy underlying the body-mind conflict in eating disorders as a body expanding at the expense of the mind or self upon injection of food. It seems to me that such a metaphor of the conflict transcends gender and applies to both female and male bodies, therefore representing a universal predicament in eating disorders. I believe this universality finds confirmation in her argument about autarchic phenomena as well as in her detection of autoerotic and anal components in eating disordered patients. For that reason, and although she does not articulate the distinction, I think it is possible to identify two levels of body symbolism in Chasseguet Smirgel: a general level in which the body, irrespective of gender, is implicitly implicated; and another, specifically involving the feminine body. In both cases, it must be noted, eating disorders represent a rebellion against bodily needs and the dictates of biology as well as against the maternal object.

In contrast, Cross situates the conflict between body and mind/self in eating disorders solely in the area of female development, its deviance to be more accurate,

therefore implicitly suggesting that these disorders are by nature feminine. By premising her argument on what she considers the paradoxes of normal feminine development - simultaneous alienation from and attunement to the body, and body as both self and other - she clearly emphasizes the intrinsic and structural dual nature of the feminine condition. Locked up in an ineluctable master-slave opposition, eating disordered patients repetitively enact these oppositions as paradoxes on the surface of their body, desperately trying to transform passively experienced sensations and pains into ones over which they have active power and control.

Another related aspect of Chasseguet-Smirgel's and Cross' treatment of the body-mind opposition in eating disorders is their particular attention to the splitting nature of the ailment as well as to issues of otherness/alienation (the body as other) and integration that characterize it. Such splitting and alienation are revealed in fantasies representing the body as a source of danger, power, or transcendence, but also in fantasies involving a fragmented body image, with the body described in terms of parts rather than a whole, and parts sometimes perceived as ego-alien.

The question of otherness and alienation highlights another important component in the problematic of control - the body as object, the "other" that calls for control and subjugation. There is a fundamental difference between the two theories, one that revolves precisely around the question of body symbolism and the nature of the object

of control. Because the body in Chasseguet-Smirgel represents the body of the mother, all problematics and dynamics around issues of control/passivity involve, are eventually centered on, the maternal object. That is to say, problematics of separation, differentiation, self-sufficiency, and alienation all derive from the body/mother symbolism, and, in the show of force with the body that eating disorders display, always implicate the maternal object, beyond the body.

In contrast, Cross' symbolism being inherent in the female body and functions, and eating disorders rooted in the psychological outcome of biological realities, there is no conspicuous and systematic involvement of the maternal object in the problematics of control as she describes them. Objects are relevant to the extent that they are objects of externalization, not as primary, archaic ones with which struggles over control are fought via the body. In Cross' intrinsic symbolism, feelings of passivity and corresponding urges to control the constraining body are centered on developmental fears of penetration - with penis and fetus ultimately experienced as the "other" within. This brings to the forefront the question of intrusion, which I had temporarily sidelined to explore feminine physical characteristics of interiority in their dualistic/antagonistic dimension as revealed in the problematic of control. Like control, intrusion for Cross does not feature a "generic" or primary object that constitutes a template for later impinging objects. In leaving out the primary object, Cross' problematics of control and

intrusion exclude essential aspects of differentiation, separation and identity, which I think are fundamental to eating pathology.

Irrespective of their attribution of symbolism to the object and/or bodies in eating disorders, Chasseguet-Smirgel and Cross nevertheless both converge on the critical role of dynamics of control in these ailments.

Intrusion and Containment: Lawrence, Williams, and Russell

In opposition with Cross' intrinsic, objectless notion of intrusion, another conceptualization of this phenomenon proceeds from a body symbolism that implicates both introjective/projective processes and objects in pathologies of eating. Lawrence, Williams, and Russell represent this approach[49].

By attributing feminine specificity in eating disorders to a feminine tendency towards introjection, in connection with the female body, and to excessive anxieties of intrusion, Lawrence situates the origin of these disorders more than often in the female subject. As such, the maternal body and object, and, for that matter, the parental couple[50], are the original targets of intrusion (their daughter's intrusiveness), before being experienced in retaliation, and in fantasy, as intrusive objects. This also means that the external object's role in maternal containment, though critical, is nevertheless

[49] For a thorough examination of Lawrence's and Williams' angle on intrusion see Chapter VI.
[50] The concept of a combined parent, which is part of Klein's sexual theory (1932b), is developed in Chapter V. The notion allows expanding the phenomenon of intrusion beyond the object, into the parental couple.

subsidiary - if only because it comes second in the chronological sequence of psychological processes: first, child projects (heavily) and, second, mother fails to contain projections. A more literal anatomic notion of introjective processes in women therefore underlies a greater weight of internal objects. From a psychoanalytic perspective, the subject's intrusiveness is described in terms of faltering symbolization, in connection with failed internal triangulation and related difficulties in differentiation from the maternal object.

An overall similar picture of mental space, although worded differently, characterizes Williams' depiction of failures in internal triangulation, symbolization, and differentiation. Williams proceeds from a similar frame of reference as Lawrence, granting introjective, projective and containing processes a critical place in her theory. However, the fact that she situates intrusions in parental projections - fears and anxieties they trigger, which eating disordered patients attempt to block out or, if allowed in, to expel - implies a very different status for bodies and objects. The absence of a female body in her model also allows broader, more universal connotations to the notions of introjection and projection. This creates a rationale, which, it must be stressed, Williams does not articulate, for a gender free explanation of these pathologies. Accordingly, girls and boys are potentially equally vulnerable to intrusive parental projections, and, therefore, to eating pathology. As for objects, they more than

often are external (projecting anxieties in children) and are likely to be either parent. The cases Williams presents underscore, again without this being articulated, the relevance of external objects, along internal ones, and that of fathers, along mothers, to eating pathologies.

Although feminine anatomy is paramount to Russell's understanding of bulimia as caricatured containment, its influence is nevertheless always mediated by culture. His view of sex-role expectations and stereotypes as shaping the prototype of introjection therefore qualifies the existence of an ultimate and inevitable link between the female body and eating pathology.

Probably because of this background preeminence of sex-role stereotypes and expectations, and even though he describes dynamics of introjections and projections that involve the object, Russell doesn't develop a model of intrusion into or by objects similar to Lawrence's or Williams'. There is no question in his theory of forceful intrusions into mother or child (whatever their origin), no mention either of a dynamic, 'reflective', interplay between anxieties and the defenses they trigger. As a consequence, his view of receptivity and containment is rather on the static end. Beyond consolidating sex-role expectations and stereotypes, introjective and projective processes are relevant to the extent that they allow discriminating between subject and object through the phenomena of attraction and repulsion, which they underlie:

> I propose that *tacit ... or unreflective*[51] ... discriminations of "me" and "not-me" evolve through repeated experiences of taking in and ridding of affective experience which evolves into an affective representation of that which is other than oneself, which holds or contains that which one ejects… [the breast-source-container that] will become the experience of Mother (Russell, 1992, 101).

Although the receptive and containing function of the maternal object is somewhat static, unreflective, mothers nevertheless represent the first symbiotic relationship and object of identification with the feminine position - in both boys and girls. Considering however the weight of gender stereotypes, the latter's captivity in culturally defined containing roles is predetermined. In other words, the bulimic's caricatured struggles and rebellions against containment expectations are ultimately cultural and not directed against the maternal object as a singular entity. In explaining the mechanism that underlies bulimia, the caricature of containment expectations, Russell does not provide clues as to what triggers bulimic defenses beyond the stereotypes that afflict every girl. Neither does he refer to primary objects as the ultimate objects of attraction or rejection. In that sense, despite their psychological function in identification and containment, objects in Russell's model illuminate the role of parents as cultural mediators more than they explain their individual, idiosyncratic, and pathological contribution to eating disorders in offspring.

[51] My italics.

Issues of Identity, Neediness, and Dependence: De Groot And Rodin, and Sands

A self-psychology perspective articulates feminine specificity in eating disorders around issues of identity, neediness and dependence, which involve the interaction of the three components of the so-called biopsychosocial formula: the failure of objects (in their psychological effect), the imprint of culture and the givens of biology.

With the exception of physical similarity between mother and daughter and its critical psychological impact on relatedness and differentiation, biology does not award particular attention to the female anatomy and its symbolism - namely, qualities of interiority, changeability, or introjection. Biological givens are in fact presented in terms of gender differences in neuroendocrine factors and physical activity, differences that do not bear an inexorable dimension. In Sands' own words, "self psychology views the processes of self-formation as fundamentally the same for girls and for boys, and, thus, by factoring out the biological determinism of classical Freudian thinking, it can more clearly elucidate psychological and cultural influences on gender development" (Sands, 1989, 76).

As for objects, they are without any doubt relevant, but their relevance is contextual and instrumental - the facilitation/perpetuation of states of neediness and dependence or their prevention. This is reflected in the dynamics of objects and bodies whose symbolism is consequently different from what it is, for instance, in Chasseguet-

Smirgel. The subduing of the body, part of the eating disordered experience, does not implicate a bad maternal object as such. Instead, the ultimate target of subjugation of the body is the intolerable experience of need of, and dependence on, a constantly unresponsive object (Sands, 2003).

From a self-psychology angle, more emphasis is placed on the symbolism of food than that of the body, with the exception again of the mother/daughter similarity. Similarity with mother is relevant in that it complicates necessary developmental strives towards idealization and differentiation. Disordered eating represents patterns of dealing with an object who has failed in facilitating these critical developmental needs, patterns that are perpetuated with frustrating others throughout life: “longed for, deprived of, greedily gobbled up, restricted, idealized, or rejected - but not able to be taken in, in the calming, incremental way which builds internal structure and capacities” (Sands, 2003, 106).

External and omnipresent, objects in self-psychology critically impact the reality of the female infant - directly in their more or less suitable interactions with her as mothers or fathers and, less directly, in conveying cultural norms pertaining to gender. As such, they either confirm or neutralize the influence of biology. By virtue of this power over biology, objects and culture ultimately mitigate the inevitability of one’s gender.

It is through their ability to acknowledge and attune to their daughters' unique emotional world and subjectivity - with the momentous impact this has on facilitating differentiation and the constitution of identity - that maternal and paternal objects are considered in self-psychology. As such, they virtually hold an equally important status. In reality however, maternal objects remain more significant. This is true at two levels: in the first place, as objects of identification, because of the similarity factor - this has consequences in terms of differentiation, relatedness, identification to the containing function, mirroring and idealization; in the second place, as primary caretakers, given enduring cultural practices of mothering. As for paternal objects, their mirroring and idealizing functions are also paramount, although to a lesser degree due to the reasons just evoked - similarity, or lack of it, and cultural factors and practices. These functions, impacted by the absence or over-presence/seduction of fathers, are seen as particularly critical to the process of differentiation.

A last remark is worth making concerning estrangement from the body in self-psychology, which, although acknowledged in the distancing between body and self, does not imply problematics of otherness as much as it suggests powerful mechanisms of denial and erasure of dependency needs over a failing object. Both control through denial and the substitution of needs for the object - because of the latter's failure to attend to these needs - imply elimination of essential aspects of confrontation and

rebellion that are an integral part of Chasseguet-Smirgel's problematics of control.

The Preeminence of Intrusion over Other Problematics

Chapter III introduced theories on the feminine specificity of eating disorders, which all but one revealed some form of relationship between these pathologies, feminine development, and the female body. With one other exception, all theories showed that the representation of the female body consistently involves maternal dynamics pertaining to control, intrusion, dependence and neediness that find symbolic expression, become incarnated, in the daughter's body. I have suggested that each of the models under consideration privileges one phenomenon or predicament over the others, therefore creating a distinctive hierarchical order whereby one core problematic is complemented by secondary, but nevertheless significant, others.

In the critical examination of the different theories, I argued that specific problematics of neediness/dependence, intrusion/containment, and control derived from particular conceptions of the body, the object, and their interaction. I also pointed out the theoretical significance of excluding or omitting the object or the female body. For instance, the absence of objects in Cross - who stresses instead inherent developmental issues - implicitly and essentially inscribes eating disorders in the female body. In contrast, the omission of the female body in Williams' model allows a

conceptualization of eating pathologies in both men and women, beyond female specificity. The latter omission constitutes a corner stone on which I found my thesis that intrusion is the fundamental problematic in eating disorders and that it transcends gender.

Positing that both objects and body, not necessarily the female body, are central to eating disorders; considering that all theories presented in this chapter illuminate one or another significant aspect of the dynamics, phenomena, or problems at play in these disorders - I suggest that the models do not have to be mutually exclusive. I also propose that, as a metaphor for the most archaic impulse associated with the object (the incorporation of food), intrusion constitutes the primary problematic, which encompasses other problematics and set of difficulties. Intrusion from this perspective aims at controlling objects and states of dependence/neediness as expressed in problems of identity.

I base intrusion's supremacy over other problematics and predicaments on a number of psychoanalytic concepts and hypotheses, which are discussed in Part II of this work. Paramount to the notion of intrusion's preeminence is the concept of projective identification (Klein, 1946) as used in Williams' model (2004a). In a nutshell, in the context of weaning, one way of avoiding unbearable, overwhelming thoughts and emotions concerning total dependence on a lost object, is to force, in fantasy, parts of

the ego inside the object, to control it and to deny differentiation (Chapter VI). Regardless of the question of preeminence, intrusion's relevance to eating disorders is itself grounded in the theoretical merit of introjective and projective processes in explaining unconscious dynamics of taking in and expelling, which underlie restrictive, binging and purging behaviors (Chapter V).

In putting forward the working hypothesis of intrusion's supremacy, Chapter III has added substance to my other working hypothesis - an overlap of control and intrusion derived from the extension of notions of control to intrusion, which itself is founded on an assumption of interconnectedness between anorexia and bulimia, with anorexic control defending against bulimic hunger for the object. The overlap introduced intrusion in the equation of eating disorders (Chapter II). Both hypotheses find substantiation in the psychology literature covered in Chapter VII. The overlap is shown to be inherent in two relevant tests on parenting. Supremacy is documented through the confirmation of a preeminent pattern of intrusive parenting in patients with eating disorders.

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In the first three chapters of Part I, I have gathered essential parameters to articulate my thesis that intrusion, as the overwhelming experience of invasion of receptivity, constitutes the fundamental psychological factor in the etiology of eating disorders, and that this factor transcends gender. Findings from epidemiology/taxonomy, historical accounts, femininity theories and intrusion theories have been critical to the articulation of the thesis. In the next chapter, the last in setting the stage for a dual exploration of femininity and intrusion in their overlapping receptive dimension in eating disorders, I suggest the mother-infant dyad of object relations - the frame of reference on which I base my universal thesis - as an angle to consider the interface at which the psychological, the cultural and the biological meet to elicit the momentous leap of recent years in eating disorders. The integration is in line with current biopsychosocial models of etiology and with the interdisciplinary approach adopted in this work.

CHAPTER IV

A BIOPSYCHOSOCIAL PERSPECTIVE

THE SURGE IN EATING DISORDERS THROUGH THE PRISM OF THE MOTHER-INFANT DYAD

Leaving aside for a moment the gender aspect of eating disorders, this chapter ponders over the reasons behind the remarkable surge in recent times of these diseases, an increase that has been paralleled by a multiplication of disorders of the body in general - explicit pathologies like self-mutilation, or more muted ones that involve compulsive interventions and exaggerated preoccupations with the body (Orbach, 2009). The question pertains in particular to the phenomena, which in recent decades have thrust a group of psychological disorders involving the body from a category of mental illness that concerns a few to a widespread phenomena - if involving milder and more disparate forms.

The recent parallel increase in eating and other bodily-related disorders calls to mind their now commonly invoked and certainly not negligible contextual and cultural dimension. While recognizing this important factor, it is however important to point out

that cultural components can hardly be viewed as operating exclusively - a fact implicitly acknowledged in the equally frequent reference in the recent literature to the composite biopsychosocial etiology of eating disorders.

While there can be no direct and simple answers to a complex question that stretches across a number of disciplines, I try in this chapter to identify broad ways in which the cultural[52] may interact with the psychological and the biological to produce bodily disorders on the large scale witnessed over the past decades. In a more specific way, I try to determine pivots around which various etiological components are articulated to generate such mass phenomena. One pivot or prism is I suggest the object relations paradigm of the mother-infant dyad. The paradigm constitutes the theoretical background for the two models of eating disorders from which I derive my thesis that intrusion, as the overwhelming experience of invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders, and that this factor transcends gender.

Over the past few decades, neuroscience has provided strong support to the mother-infant paradigm of object relations (Schore, 2013a), underscoring in particular the corporeal, bodily dimension of dyadic psychological dynamics. Beyond mere

[52] In other parts of this work I signal ways in which culture is relevant to eating disorders. I posit for instance that the developing child is born into cultural specificities that are implicit in the behaviors of parents, which in turn impact gendered comportments, including in relation to food and bodies. I also describe how cultures and subcultures around gender and sexual identities affect in distinct ways the eating behaviors of heterosexuals and homosexuals in both sexes (Chapter VIII).

confirmation, the notion of embodied minds, which neuroscientific findings imply, allows introducing the outstanding biological component - in specific reference to the body - in the biopsychosocial equation of eating disorders.

In the following two sections, I propose ways in which in eating disorders socio-cultural and biological dynamics may be articulated around primitive psychological processes as depicted in object relations mother-infant dyadic models of interaction. In her book *Bodies* (2009), Susie Orbach provides the seeds for such an articulation.

THE MOTHER-INFANT PARADIGM OF BODILY DISORDERS

In *Bodies*, Orbach traces bodily disorders back to anxieties in the early mother-infant relationship. Speaking of the need for a "more fully psychosomatic theory of human development" that would put existing theories of the mind at par with a theory of body development (14), she integrates case studies from her psychotherapy practice with research in neurospsychology. She also talks about the need to "marry developmental theory - how we understand the passage from infancy to adulthood - with the impact of contemporary social practices" (13).

Orbach argues there are no such things as natural bodies, only cultural ones shaped by one's upbringing and environment. This premise in mind, she suggests that

in today's global cultural-economic environment, a tentacular industry[53], which sells ever changing, illusory and unattainable ideals of beauty[54], has generated, at a collective level, unstable and insecure bodies. Unstable bodies, Orbach goes on arguing, have become a serious source of disturbance for the mind - a fact, which she thinks imposes limitations on orthodox psychoanalytic views that bodily disorders such as self-mutilation, obesity, anorexia and plastic surgery are purely a product of the mind.

Most interesting from my perspective in this chapter is the parallel in Orbach's work between what occurs in the context of problematic mother-infant interactions and what happens as a result of our being bombarded by pervasive and normative societal messages on beauty, size, fitness, nutrition, ageing, and health: in both cases, negative external stimuli lead to feelings of discomfort and inadequacy, which in turn call for adaptations that respectively impinge on our natural psychological development and natural bodies.

Orbach refers in this respect to Winnicott's notion of 'false-self' (1965) in the context of foundering in the early mother-infant dyad, extending the concept to 'false-bodies' in bodily disorders. False-selves develop in situations of consistent maternal failure to attune to a child's idiosyncratic needs and desires, hence pushing him/her to

[53] In Fat Is a Feminist Issue (2006), Orbach dealt with concepts of thinness and fatness as complex social and psychological ideas and feelings, which we find difficulty expressing directly. She calls attention to the way this is being exploited by the diet and cosmetics industries.

[54] One aspect of unattainability is illustrated in the photoshopped imagery of perfection that no reality can ever match. Others are the inherent risk of recidivism in diets and the inbuilt obsolescence of cosmetic surgery.

internalize, act in conformity with, maternal needs and desires as if his/her own. Her concept of false-bodies features identical psychological mechanisms, with parts of the body invested as sites of wrongness that need to be changed and perfected to suit the demands of culture and society. A hopeless and endless pursuit of bodies out of touch with their own needs, like the everlasting and doomed quest of infants seeking in vain maternal mirrors to reflect their unique and true needs and desires.

Today's global cultural-economic environment has created a worldwide atmosphere of obsessive concern with health, nutrition and bodies. An atmosphere, which Orbach sees as having infiltrated the medical field and governmental institutions - dictating for instance unreasonable BMI thresholds, and in some instances ill-conceived recommendations and policies; also normalizing, banalizing, and legitimizing the need for the transformation of bodies, to the extent that countries like Argentina now include plastic surgery in their social security coverage. An atmosphere, which is so powerful that its effect can be remarkably swift - within three years of introducing television in Fiji in 1995, 11.9% of teenage girls had engaged in vomiting to get their body resemble those of Western TV characters; the 2001 Miss Universe election of Nigerian Agbani Darego, more precisely the magazine and billboard campaign that accompanied it,

prompted a previously unseen dieting craze among young Nigerian women who had initially perceived her as undernourished[55].

An essential aspect of the atmosphere in question is visual, the engulfment into, and invasion by, images, what Orbach refers to as a visual Muzak (background music in public places). This visual culture - television, billboards, and magazines - projects the expectations of a gigantic and ever expanding industry of beauty and para/pseudo health onto individuals who, as a result, unconsciously internalize normative standards of beauty and health as their own needs and desires. They become involuntarily attentive and attracted to myriads of practices and procedures that are 'naturally' invoked to make their bodies and body-related behaviors conform.

Two related points come to mind when thinking about the engulfing atmosphere and phenomena around it, which Orbach describes. One concerns passivity - in the involuntary absorption and internalization of norms; or in the deceitful voluntary resort to action, which one genuinely believes reflects free will and agency but ultimately amounts to nothing but compliance to external stimuli. The other point interestingly situates the question of atmosphere in a wider theoretical perspective of domination as put forward by Bourdieu, in particular the paramount significance of the non-verbal aspect of 'symbolic domination' as "something you absorb like air, something you don't

[55] All examples from Orbach (2009).

feel pressured by; it is everywhere and nowhere" (Bourdieu and Eagleton, 1992, 115), and therefore nearly inescapable. Beyond socio-cultural connotations, the non-verbal also links up with what neuroscience reveals concerning the mother-infant dyad as a corporeal entity or unit.

THE EMBODIED INTERACTION OF TWO MINDS - THE CONTRIBUTION OF NEUROSCIENCE

In the previous section I suggested the object relations paradigm of the mother-infant dyad as a pivot around which socio-cultural and biological etiological explanations of eating disorders can be articulated. In this section I present evidence from neuroscience that supports the dyadic paradigm of object relations, thereby outlining the mother-infant biological matrix in which developmental disruptions unfold. This matrix can be viewed as representing the third, corporeal, component in the biopsychosocial etiological mould of eating disorders.

A growing field of research, which examines neurological and brain processes underlying the phenomena described by psychoanalysis, object relations in particular, can be called upon in support of a multidisciplinary perspective on the body mind relationship in eating pathologies. Allan Schore's work (1994, 1997a, 1997b, 2013b) is relevant in this respect. Schore argues for instance that Freud's "Project for a Scientific Psychology" (1895/1950), which sought to establish a model of brain mechanisms that

matched the psychodynamic processes of psychoanalysis, represented a first attempt to bridge the two disciplines. In his article “A Century After Freud's Project: Is A Rapprochement Between Psychoanalysis And Neurobiology At Hand” (1997a), he concludes that the time had indeed arrived[56], citing to that effect Freud’s foreseeing, before their actual discovery, the existence of synapses and the activity of biogenic amines of the reticular core of the brain as well as other findings that broadly correspond to the psychoanalytic concepts of drive, internal representations, consciousness, awareness of emotional states, and dreaming.

Researchers from both disciplines have voiced similar views. Neuropsychoanalyst Mark Solms (2013/2014) describes neuropsychoanalysis as the combination of the subjective psychoanalytic method with the objective neuroscientific approach - an integration of scientific and conceptual frames of reference, which allows the former framework to test hypotheses from the latter and, consequently, a more comprehensive understanding of the mind. Although he warns against seeking in neuroscientific findings a mechanistic validation of various psychoanalytic approaches to the mind, neuroscientist Gallese (2013/2014) suggests that one of the most positive contributions of cognitive neuroscience is its potential to shed light on anthropological

[56] Others have contested the ability of neuroscience to corroborate or invalidate psychoanalytic concepts and claims. Considering the two fields as separate ones and warning against biologistic inferences on the nature of psychoanalysis, Blass and Carmeli (2007) view for instance the latter as a domain concerned with meaning to which neuroscience cannot contribute.

matters by questioning, rephrasing, and even reconstructing the words we use to describe the mental world and make sense of our being in the world. Jaak Panksepp (2013/2014 Parts I & II), founder of the field of Affective Neuroscience, rejects “ruthless reductionism” and warns against the futility of scientific facts when they are not combined with concepts. Emphasizing human adaptive capacities for neuroplasticity as well as the precedence of affective connections over cognitive ones in psychotherapeutic processes of change, he proposes a classification of the complex social brain into seven emotional systems (Seeking, Rage, Fear, Lust, Care, Panic/Grief and Play), which all are amenable to alteration. Referring to Panksepp’s taxonomy along with three other neuroscientific findings - (1) conditioning as a non-cognitive, involuntary and automatic process, and learning as the acquisition of emotional responses rather than a cognitive phenomenon; (2) decision-making as fundamentally emotional; (3) and the left hemisphere as totally unaware of how conditioning happens - , child and adolescent psychoanalyst Lucy Biven (2013/2014) describes ways in which neurobiological perspectives have informed her practice and helped her define the dynamic unconscious in neuroscientific terms, that is, as a disconnect between the cognitive consciousness of the left hemisphere and the affective consciousness of the right hemisphere.

In this regard, Schore proposes that the interface between biology and psychoanalysis "is to be found specifically in the central role of right brain psychobiological processes in the organization and regulation of affect, motivation, and unconscious cognition" (1997a, 813)[57]. In the same vein, Tucker and Moller (2007) write that "(t)he right hemisphere's specialization for emotional communication through nonverbal channels seems to suggest a domain of the mind that is close to the motivationally charged psychoanalytic unconscious" (91). In a more detailed way:

> … developmental neurobiological research reveals that the process of coping with early life stress increases the myelination of the orbitofrontal cortex, a prefrontal region that controls arousal regulation and resilience. For the rest of the life span, the right, not left, lateralized prefrontal regions are responsible for the regulation of affect and stress. The right orbitofrontal cortex, the control system of attachment that encodes an internal working model in implicit-procedural (unconscious) memory, is the highest stress regulatory center in the brain and its connectivity is associated with the emotional regulation that is commonly found in secure children. On the other hand dysfunctions of the orbitofrontal system are seen in insecure attachment and a wide variety of psychiatric disorders (Schore, 2013a, 171, all references in paragraph omitted).

Most significantly however, neuroscience has come in strong support of the mother-infant paradigm of object relations. Dyadic interactions, rather than the discrete behaviors of individual members (Schore, 2013b), are indeed at the center of current neuroscientific findings on motivation and behavior and their relation to emotion and cognition. Concepts such as intersubjectivity, the two-person unconscious, the two-

[57] On the question of bringing together the two fields of psychoanalysis and neuroscience, see also Solms, M. and Saling, M. (1986).

person psychology, the two-person biology, the relational unconscious, the relational brain, and so on are now increasingly invoked, underscoring what Schore (2013b) describes as the blurring of lines between psychology and biology. From the point of view of Gallese (2013/2014), there are at the least three ways in which neuroscience - in particular his theory of embodied simulation[58] as the intercorporeal basis[59] for our understanding of others - is relevant to psychology and psychoanalysis: it permits a unified account of preverbal aspects of interpersonal relations that most likely play a role in shaping the self; it contributes to a new definition of psychopathological processes; finally, it introduces a different perspective to the analysis of the interpersonal preverbal dynamics of the therapeutic setting (Gallese, 2013/2014).

Arguing that the alignment of neurosciences on the dyad has confirmed that the initial contact between mother and infant is between their unconscious systems and internal worlds as well as the corporeal dimension of this unconscious contact, Schore emphasizes the "critical importance of right brain-to-right attachment communications in the progressive social experience-dependent lateralization of the right brain" (2013a, 169)[60]. His statement sums up what I believe are essential characteristics of the two-

[58] "Embodied Simulation theory provides a unitary account of basic social cognition, showing that people reuse their own mental states or processes represented with a bodily format in functionally attributing them to others" (Knox, 2013/2014).

[59] The embodied simulation that Gallese proposes as the intercorporeal basis for our understanding of others are matched in the observation of face-to-face encounters and still-face experiments in infants and mothers, which reveal patterns of turn-taking, rupture and repair (Tronick et al,1978; Beebe, 2000).

[60] Schore (2013a, 169) cites in this regard: neuroscientific research on the dominance of the right brain hemisphere in human infants; the postnatal emergence of a strong and consistent preponderance for the right hemisphere; and the mother's greater involvement of the right over the left hemisphere in emotional processing and mothering.

person construct: 1/ the corporeal support of the interpersonal relationship as indicated in the communication of two brains (*right brain-to-right*); 2/ the relevance of exogenous influences on the developing right brain (*experience-dependent lateralization*), in accordance with the epigenetic principle of continuing dialectics between developing organisms and their fluctuating environment (Chapter VII); 3/ the gradual (*progressive*) nature of brain development; 4/ neuroplasticity, as inferred from the two preceding points; and finally, 5/ the emotional/affective quality (*attachment communications*) of the phenomena involved in dyadic neurological processes.

Particularly interesting from a body-mind angle is the corporeality of mother-infant right-brain to right-brain interactively regulated attachment communications. Indeed, current neuroimaging data highlight the critical impact of visual, auditory, and tactile communications on the right brain in both mother and infant as well as their paramount importance for early and later social development. These bodily-based emotional communications, the implicit, nonconscious processing of nonverbal affective cues, either promote or inhibit the experience-dependent maturation of the infant's developing brain (Schore, 2013a, 2013b).

Starting with the mutual mother-infant gaze, findings show that future aptitudes to process fundamental social information through face-to-face communications -

aptitudes that are also key to building and furthering intimate relationships - are rooted in early caregiver-infant eye contact and visual gazing:

> The emergence of the capacity to efficiently process information from faces requires visual input to the right (and not left) hemisphere during infancy. At two months of age, the onset of a critical period during which synaptic connections in the developing occipital cortex are modified by visual experience, infants show right hemispheric activation when exposed to a woman's face. Using EEG methodology, Grossmann … report that 4-month-old infants presented with images of a female face gazing directly ahead show enhanced gamma electrical activity over right prefrontal areas. Recent near-infrared spectroscopy (NIRS) research (perhaps the most suitable of all neuroscience techniques applicable to human infants) reveals that specifically the 5-month-olds' right hemisphere responds to images of adult female faces. By 6 months infants show a right lateralized, left gaze bias when viewing faces, right temporal activation when looking at angry faces, and significantly greater right frontotemporal activation when viewing their own mother's (as opposed to a stranger's) face (Schore, 2013a, 167-168, all references in paragraph omitted)[61].

Current studies similarly stress the importance of prenatal, perinatal, and postnatal auditory-prosodic (patterns of rhythm and sound) attachment communications on "the development of the right temporal areas, and the burgeoning ability of reading the emotional tone in the voice of others, an essential element of adaptive social relationships" (Schore, 2013a, 169). In particular, it has been shown that, irrespective of cultures, infant-directed speech - shorter, slower, separated by longer pauses, higher in pitch, with wider pitch range and exaggerated pitch contours - is preferred over adult-

[61] See footnote 58 on observations of face-to-face encounters and still face experiments in infants and mothers (Tronick et al, 1978; Beebe, 2000).

directed speech. Finally, research on tactile-gestural attachment communications has established the vital importance of affective touch on the healthy maturation of the right hemisphere of infants. In the prototypic context of breastfeeding, six-month-old babies exhibit an increase in EEG amplitude in the right posterior cortical areas. Interpersonal touch has also been shown to be important for the transmission and regulation of emotional information (Schore, 2013b).

Eventually, around toddlerhood, the interactively regulated right brain visual-facial, auditory-prosodic and tactile-gestural attachment communications of securely attached children become integrated, integration that allows the development of a coherent right brain emotional and corporeal sense of self (Schore, 2013a). Once more it is important to emphasize the interactive, interpersonal nature of integration, an aspect well expressed in Siegel's statement that "integration between us harnesses integration within us" (2013/2014).

In addition to demonstrating the corporeal, pre-verbal, nonconscious basis of communications in the mother-infant dyad - visual, auditory, and tactile - neuroscience has documented the workings of mirroring mechanisms, establishing a relevant correspondence with the object relations version of this phenomenon. Mirror neuron research has indeed revealed that the same cortical sites are activated during first-person experiences and their mere observation, therefore establishing the existence of

channels of access to others. These mirroring mechanisms are not restricted to the sphere of motor action but extend to all possible ranges of experience, including emotional, in interpersonal exchanges (Gellese, 2013/2014). In other words, we know what another person's actions or emotions mean through the activation of our own neuro-mirror system and the same motor and intentional pathways in our own brains that correspond to the intentions and actions of the other. Such resonance with the emotional state of others bears significantly on the notion of intersubjectivity as the embodied relational matrix out of which individuals emerge and in which they remain embedded (Gellese, 2013/2014; Knox, 2013/2014).

The preceding section has allowed some central inferences. To start, it has confirmed areas of similarity between the dyadic paradigms of object relations and neuroscience. Indeed, the neuroscientific findings presented above - those pertaining to visual-facial, auditory-prosodic and tactile-gestural dyadic interactions, and most importantly mirroring mechanisms - invoke Winnicott's central concepts of mother-infant mutual gaze, mirroring, and holding. Many other comparable correspondences have been pointed out in the literature. Schore signals for instance two such parallels. In the first, he links Winnicott's identification of two forms of love, 'quiet love' and 'excited love' (1975) to two specific neurological processes: respectively, "low arousal, mutually decelerating, parasympathetic-dominant energy conserving, calming, soothing comfort",

and “high arousal, mutually accelerating, sympathetic-dominant energy expanding joy and excitement” (Schore, 2013b). In another parallel he remarks that “(t)he older psychoanalytic concept of “containment” is now being replaced by the more complex construct of “regulation” (2013a, 165). Similarly, in an exploration of the neurobiology of empathy, Fishbane (2013/2014) suggests that neuroscience has contributed additional complexity to the concept, characterizing it as a multilayered process that involves: 1/ resonance, a subcortical automatic process whereby one feels in one’s own body what the other feels (through mirror neurons, as described above); 2/ cognitive empathy, a prefrontal cortex process whereby one deliberately puts oneself in another’s shoes, wondering what he/she thinks or feels; 3/ boundaries between self and other whereby, if one is truly going to feel the pain of the other and not confuse oneself with him or her, one needs to know where one begins and the other ends; and finally 4/ self-regulation.

In addition to validating theories of child development founded on a two-person unconscious, neuroscience has shown the relevance and applicability of these models to the treatment of infants, children, adolescents, adults (Schore, 2013a) and couples (Fishbane, 2013/2014). This is true, including from the stance of the therapeutic encounter between patient and psychotherapist, whether in terms of transference, countertransference (Knox, 2013/2014) or flashes, hunches and gut feelings (Marks-

Tarlow, 2013/2014)[62]. Mirroring mechanisms have in particular granted meaning to the unbearable embodied emotional discomfort, which therapists sometimes experience in sessions and from which they may try to escape as opposed to tolerating and integrating them to understand their patient's experience (Knox, 2013/2014). Finally, the process of change, anticipated and noted in the psychotherapeutic endeavor, is echoed in the crucial notion of neuroplasticity as documented by neuroscience. Mostly dominant in the first months and years, but nonetheless enduring over life (Fishbane, 2013/2014), neuroplasticity and its actualization in the process of change within a two-person unconscious framework underscore once again the meeting point of environment and biology with psychology.

By inviting the corporeal dimension into the two-person unconscious, there is no doubt that the overlapping dyadic paradigms of object relations and neuroscience have somehow unsettled the body-mind relationship, something Orbach touched on when challenging orthodox psychoanalytic views that bodily disorders or preoccupations such as self-mutilation, obesity, eating disorders and plastic surgery are solely products of the mind. Considering that psychoanalysis "plumps for biology" (libido steers desire) while obeying at the same time the laws of psychology (the hysteric's body), Dimen has actually suggested paradox as a way to revisit the body-mind relation beyond linear

[62] Marks-Tarlow describes clinical intuition as a moment-to-moment spontaneous dance of leading and following (2013/2014).

causality and contradiction (2000, 14-15). Neuroscience presents another avenue to think about the body-mind conundrum as the embodied interaction of two minds, the matrix out of which the individual develops (Gellese, 2013/2014; Knox, 2013/2014) - two minds whose reciprocal influence involves two bodies or bodily channels/processes of communication; two minds and two bodies, which mirror, resonate with, one another. Finally, although the premise of an embodied interaction of two minds seems particularly relevant to disorders of the body, I it also applies to psychological disorders in general.

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In tracing eating and other bodily disorders back to anxieties in the early mother-infant relationship and linking these dyadic dynamics both with contemporary social practices and findings from neuropsychology, Orbach has sketched the broad lines for an integration of socio-cultural, biological and psychological etiological factors. Taking a cue from the integration, which corresponds to current biopsychosocial perspectives on eating disorders, I have suggested the dyadic object relations paradigm of development as an axis around which socio-cultural and biological (corporeal) are articulated. Significantly, this mother-infant object relations paradigm is the frame of reference for

my thesis that intrusion, as the overwhelming experience of invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders.

The cultural component in this integration/articulation of biological, psychological and social factors - a global and enveloping visual culture obsessively preoccupied with bodies - sheds a light on the contemporary surge in bodily disorders, including eating pathologies. False-selves complying with alien, exogenous maternal emotional demands, at the detriment of a child's own needs; false bodies obeying the extraneous, impinging exigencies of an insatiable culture/industry of beauty and its health affiliates, in disconnection with the real needs of one's body - these two analogous processes are relevant to understand channels of cultural influence on bodily disorders. On the one hand, processes whereby an infant's development does not occur and cannot be conceptualized in abstraction from his/her interactions with the mother, what Winnicott has rendered in his aphorism "there is no such a thing as a baby" (1975, 99). On the other hand, and in correspondence, the impossibility for natural bodies to exist outside the culture in which they develop. Orbach's parallel could translate into 'there is no such thing as a natural body'. The parallel provides a plausible angle of reflection on the recent surge in eating disorders.

In confirming two-body, unconscious and non-verbal channels of communication, in particular visual-facial communications, in the mother-infant couple, neuroscience has

provided the biological (bodily-based) component of an integration/articulation around the dyadic object relations paradigm of development. The new field of social neuroscience (Siegel, 2013/2014) will in the future hopefully help document the intricacies of integrating cultural and biological components of eating pathologies with the object relations perspective.

This chapter is the last in setting the stage for an exploration of the feminine paradigm of eating disorders in its relation to intrusion. Chapter I revealed the homosexual exception as a parameter to examine the female landscape of eating disorders. This came on the basis of the consistent description in the psychological literature of male homosexuality in terms of femininity. Chapter II introduced intrusion as a problematic in these pathologies. This followed the extension of notions of control to intrusion as proceeding from an assumption of interconnectedness between anorexia and bulimia, with anorexic control defending against bulimic appetite for the object. Chapter III further developed the intrusion thesis, proposing its supremacy over other problematics and extending its metaphorical relevance beyond the female body. Leaving aside the gender dimension of eating disorders, the present chapter probed into biopsychosocial dynamics - and what may constitute their quintessential foundation in dyadic mother-infant interactions - as shedding light on the remarkable surge in recent years. I propose that these biopsychosocial dynamics specify the surge in its

particular impact on women and on a subgroup of male homosexuals (Chapter VIII), both categories presenting particular vulnerabilities to intrusion into receptivity.

In Part II of this work (Chapter V and Chapter VI) I examine intrusion from a psychoanalytical theoretical perspective, first generally and then in the context of eating pathology.

PART II

INTRUSION

A PSYCHOANALYTIC PERSPECTIVE

CHAPTER V

INTRUSION

A GENERAL BACKGROUND

> Implicit in this statement is the use of the alimentary system as a model for the processes of thought. There is reason to believe that the emotional experiences associated with alimentation are those from which individuals have abstracted and then integrated elements to form theoretical deductive systems that are used as representations of realizations of thought. There is reason for using the alimentary system as a model for demonstrating and comprehending the processes involved in thought (Bion, 1962a, 62).

Apart from suggesting a theory of the mind, Bion's metaphor allows insight into what constitutes perhaps the most symbolic[63] expression, in alimentary terms, of failures of the mental apparatus. Such failures are revealed in the problematic of intrusion, which, as I argue in this work, underlies all forms of eating pathology, when food, eating, and digestion acquire meanings beyond the nutritional, social, or cultural

[63] My use of 'symbolic' here is in the general sense and does not attempt to capture the various psychoanalytic meanings, which follow immediately and are further described later on in the text.

ones associated with meals. The relevance of intrusion to eating disorders is premised on the notion that restricitive, binging and purging behaviors reflect unconscious dynamics of introjection and projection. Failures in mental processes in these disorders take the shape of what has been described as concreteness of thought when symbols are confused with objects they are meant to symbolize - food and eating functions are confused with primary objects associated with them.

In Part I of this work I laid down the foundations for an examination of eating disorders as based on a problematic of intrusion that transcends gender. In Part II, which consists of two chapters, I look at the psychoanalytic theories on which a concept of intrusion is based - first generally, in Chapter V, and then, in Chapter VI, in their specific application to eating disorders. Part III provides confirmation from the field of psychology to the intrusion hypothesis, including its universal, gender-free dimension.

In this first chapter, I examine the location of intrusion in a bodily context where the fundamental psychological processes of introjection and projection determine, in health and in pathology, the position of individuals vis-à-vis objects and the world. I then present the main theories on symbolization[64] and its failures, which are critical to understand intrusion in terms of concreteness of thought.

[64] 'Symbolization' is meant here as a psychoanalytic process whose various conceptualizations are presented in this chapter.

THE CORPORAL SUPPORT OF INTRUSION

Generally speaking, the notion of intrusion implies the existence of separate spaces and the violent, because uninvited, trespassing of one space by an alien entity belonging to another space. Underlying a psychoanalytic outlook on intrusion is the body, its orifices, its oral, anal, and genital functions, as well as corresponding psychological mechanisms of introjection, projection, and more or less implicitly outlined internal and external spaces. It is through these bodily-rooted psychological mechanisms and spaces that intrusive objects circulate in a dynamic and violent way.

Incorporation, Expulsion, and Corresponding Psychological Mechanisms of Introjection and Projection

Laplanche and Pontalis (1973) define introjection as the process whereby the subject transposes, in fantasy, “objects and their inherent qualities from the ‘outside’ to the ‘inside’ of himself” (229). Internalization, sometimes used as a synonym, refers to the transformation of intersubjective relationships - in contrast with objects and their qualities in introjection - into intrasubjective ones. The nuance is well rendered when saying for instance that, upon the decline of the Oedipus complex, subjects introject the paternal imago, but internalize prohibitions or conflicts of authority (Laplanche and Pontalis, 1973).

It is the corporal facet of introjection with which I am particularly interested in my approach to intrusion. It is best reflected in the analogous[65] concept of incorporation, described by Laplanche and Pontalis as the "process whereby the subject, more or less on the level of phantasy, has an object penetrate his body and keeps it 'inside' his body" (1973, 211), and by Hinshelwood as "a phantasy of the bodily taking in of an object, which is subsequently felt to be physically present inside the body, taking up space and being active there" (1991, 321). In both definitions, intrusion is potentially implied in the penetration of, location into, and activity inside an internal space.

For Freud, incorporation constitutes a first manifestation of the opposition between introjection and projection, which is originally expressed in a concrete oral mode. In this respect, incorporation implicitly delineates the inside from the outside of the body, discriminates between subjects (ego) and objects (external world), and outlines concepts of pleasure and unpleasure that are prototypically bound with the latter (Laplanche and Pontalis, 1973):

> Expressed in the language of the oldest - the oral - instinctual impulses, the judgement is: 'I should like to eat this', or 'I should like to spit it out'; and, put more generally: 'I should like to take this into myself and to keep that out.' That is to say: 'It shall be inside me' or 'it shall be outside me'. As I have shown elsewhere, the original pleasure-ego wants to introject into itself everything that is good and to eject from itself everything that is

[65] Incorporation and introjection refer to a single process, yet two experiences - the subjective experience of the patient, and the "objective description of the observing psychologist". In Kleinian literature, they are often used interchangeably (Hinshelwood, 1991, 333). Edward Glover, mentioned in Hinshelwood, has criticized this "conflation of objective observation with the subjective experience of the patient" (Hinshelwood, 1991, 42).

> bad. What is bad, what is alien to the ego and what is external are, to begin with, identical (Freud, 1925b, 237).

From this perspective, a preliminary glimpse on eating pathology reveals its plausible rooting in the oral mode of incorporation, and consequences thereof in terms of functioning at a primitive concrete level, including the negotiation of relations with the environment through literal introjections and projections. Indeed, if mechanisms of absorption and excretion of food - as prototypes for the fundamental, normal or pathological, psychological processes of introjection and projection - lose their symbolic dimension; that is, if food becomes literally equated with the object it represents; then, the object (or its functions), in the form of food, becomes longed for or intrusive, and is consequently ingurgitated, blocked out or expelled, depending on the dynamics at work between subjects and objects.

Another aspect of oral incorporation, the ambivalence that inevitably accompanies it, is interesting because it highlights the complexities of dealing with the object. Freud's initial thinking on identification as an offshoot of the oral phase of the libido likened it to the concept of incorporation (Hinshelwood, 1991) - in the primal horde, the sons' killing of the father is a cannibalistic endeavor that allows the incorporation of (identification with) his qualities of strength[66]. In this sense, the cannibalistic oral phase represents a prototype of identification, stamping it with the kind

[66] "Cannibal savages as they were, it goes without saying that they devoured their victim as well as killing him. The violent primal father had doubtless been the feared and envied model of each one of the company of brothers: and in the act of devouring him they accomplished their identification with him, and each one of them acquired a portion of his strength" (Freud, 1913, 141).

of ambivalence to be expected from the annihilation of an object at the very moment of its loving absorption:

> Identification, in fact, is ambivalent from the very first; it can turn into an expression of tenderness as easily as into a wish for someone's removal. It behaves like a derivative of the first, oral phase of the organization of the libido, in which the object that we long for and prize is assimilated by eating and is in that way annihilated as such. The cannibal, as we know, has remained at this standpoint; he has a devouring affection for his enemies and only devours people of whom he is fond (Freud, 1921, 105).

With ambivalence coloring oral incorporation, the equation of what is bad with what is alien and external becomes somewhat more complex: 'the wish for someone's removal' no longer concerns bad objects exclusively but also extends to good ones. Here is one instance when the impulse to expel is in some way bound with the impulse to incorporate. The dynamic interaction is implicit in this work's theorization of anorexia as linked to bulimia. It will be brought up below in the context of envy and greed, when aggressive impulses prevail over libidinal ones.

I will mention a final characteristic of oral incorporation, which as I show later[67], bears much significance on the symptomatology of eating pathology: its transmission, displacement to other receptive bodily organs or functions, such as feminine genitals or hearing. In other words, receptivity, in its prototypic association with incorporation,

[67] See Williams in Chapter VI.

metaphorically extends beyond oral impulses and dynamics to difficulties in sexuality or in being reached by the analyst's words, and so on.

As for projection, Laplanche and Pontalis (1973) define it as "the operation whereby qualities, feelings, wishes or even 'objects', which the subject refuses to recognise or rejects in himself, are expelled from the self and located in another person or thing" (349).

I have indicated above the corporal dimension of introjection, best expressed in the analogous concept of incorporation. In projection, it is the experience of expulsion that constitutes the equivalent bodily foundation, and thus the prototype, for the psychological phenomenon. Beyond Freud's notion of an oral impulse to spit out what is bad, Abraham's identification of a first anal stage of the libido, characterized by the aim to destroy through expulsion (Abraham, 1924; Hinshelwood, 1991), grounds the psychological phenomenon of projection in anal excretions. It is however important to point out that, in the same way incorporation, although embedded in oral impulses, nonetheless extends to other bodily functions, expulsions also are not restricted to anal impulses and find expression in a multitude of bodily-rooted functions such as screaming, vomiting, crying, urinating (Hinshelwood, 1991). Ultimately, both incorporation and expulsion, in their various manifestations, tag on to what Freud identified as the oldest oral instinctual impulse to spit out what is bad and keep in what

is good, and are in this respect similarly critical to discrimination between inside and outside, subject and object, pleasure and unpleasure. Seen from this perspective, vomiting, as well as other forms of purging through laxative or diuretic medicine that accompany certain forms of eating disorders, can be envisioned as the concrete expulsion of objects, feelings, wishes, or qualities to which Laplanche and Pontalis (1973) referred in their definition.

In their concrete corporeal expression, introjection and projection illuminate a great deal of phenomena and symptoms in eating pathology. Their combination in the Kleinian notion of projective identification, which I refer to below, is critical to object relational conceptualizations of these disorders, particularly in terms of failures in symbolization.

Intrusiveness of the Object and Intrusion into the Object

I have so far looked into intrusion from the specific angle of the subject, a subject being intruded upon. It is however important to note that the concept of projection also evokes, beyond the mere and concrete evacuative phenomenon of expulsion, the question of an object being itself intruded into. A number of interrelated Kleinian concepts are key to understanding intrusion as targeting the object rather than the subject.

Klein draws attention to the existence in infant boys and girls, in the context of 'epistemophilic' impulses - the child's urge to know about sexuality - incited by early Oedipal struggles, of fantasies of intrusion into the mother's womb (1928). The destructive impulses are expressed in fantasized oral-sadistic attacks to suck dry, bite up, scoop out and rob the mother's body (an extension of the first object, the breast) of its good contents (feces, the father's penis, and children), as well as in anal-sadistic and urethral-sadistic impulses to expel dangerous substances (excrements, but also the bad self) out of the self and into her, to injure her and control her from within (Klein, 1946, 1975). Klein adds, and this is crucial to the question of differentiation, itself critical to eating pathology, that "in so far as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be *the*[68] bad self" (Klein, 1946, 102).

Another manifestation of intrusion into the object is captured in Klein's concept of projective identification. A prototype of aggressive object relationships, projective identification is the forcing, in fantasized anal attacks, of parts or the whole of the self into the object in order to take over its content, harm it, or control it. The fantasy involves the feeling that certain aspects of the self are located elsewhere (Klein, 1946; Laplanche and Pontalis, 1973; Hinshelwood, 1991).

[68] Italic in the text.

Klein identifies envy as ‘one of the motive forces’ (1932b, 188) behind intrusion into the object. A “powerful expression of oral- and anal-sadistic impulses”, envy is for her constitutional (1975, 229) and represents a fantasized destructive attack on the good object, precisely “because of its goodness” (Hinshelwood, 1991, 168): “… when I wrote about the greedy scooping out of the breast and of the mother's body, and the destruction of her babies, as well as putting bad excrements into the mother, this adumbrated what I later came to recognize as the envious spoiling of the object” (Klein, 1975, 183). As such, envy is to be distinguished from rivalry (the rival keeps the good object for itself), and frustration (the frustrating object refuses to give what it has) (Hinshelwood, 1991), although it is reasonable to imagine their dynamic interaction in the context of environmental failures or Oedipal strivings:

> Envy appears to be inherent in oral greed. My analytic work has shown me that envy (alternating with feelings of love and gratification) is first directed towards the feeding breast. To this primary envy jealousy is added when the Oedipus situation arises. The infant's feelings in relation to both parents seem to run like this: when he is frustrated, father or mother enjoys the desired object of which he is deprived—mother's breast, father's penis—and enjoys it constantly. It is characteristic of the young infant's intense emotions and greed that he should attribute to the parents a constant state of mutual gratification of an oral, anal and genital nature (Klein, 1975, 79).

Fantasies of attacking and sadistically entering the mother’s body lead to various anxiety-situations and corresponding future psychological disturbances. For example, attacks of claustrophobia or male impotence are one expression of paranoid fears of

entombment in the mother's womb (Klein, 1946,1975). In other instances, the envious forcing (projection) of the self into the object to control it and destroy it leads to fantasies of a retaliatory entry back into the infant for similar purposes of control and destruction - introjection becomes equated to "a forceful entry from the outside into the inside, in retribution for violent projection"; or, to depletion and a weakened sense of self and identity (Klein, 1946, 103; Laplanche and Pontalis, 1973; Hinshelwood, 1991). The vicious circles of projective attacks and reprisals through "forced introjection", and their attending anxieties (Hinshelwood, 1991, 171), are particularly relevant to the dynamics of expulsion and absorption at play in certain forms of eating disorders. They also constitute the theoretical basis for Lawrence's suggestion that the cycle of intrusion often originates in the subject (Lawrence, 2001, 2002, 2008). Equally important to these dynamics is greed - an extreme form of envy that results from, and at the same time reinforces, aggressive impulses[69] - as it accurately embodies endless states of internal 'unnourishment' and hunger for good objects:

> When envy is strong there may be an equally omnipotent phantasy of an *introjective* aggression - taking in with a damaging violence so that the object is spoiled through a violent form of possession and control. The internal state then remains unnourished with a continually unsatisfied hunger. Greed may result in an accumulation of damaged objects inside,

[69] "We assume that there is always an interaction, although in varying proportions, between libidinal and aggressive impulses, corresponding to the fusion between life and death instincts. It could be conceived that in periods of freedom from hunger and tension there is an optimal balance between libidinal and aggressive impulses. This equilibrium is disturbed whenever, owing to privations from internal or external sources, aggressive impulses are reinforced. I suggest that such an alteration in the balance between libido and aggression gives rise to the emotion called greed, which is first and foremost of an oral nature. Any increase in greed strengthens feelings of frustration and in turn the aggressive impulses… Accordingly, the strength of the destructive impulses in their interaction with libidinal impulses would provide the constitutional basis for the intensity of greed" (Klein, 1975, 62).

> each provoking a greater demand and hunger for a good object to be taken in to alleviate the steadily worsening internal state (Hinshelwood, 1991, 171).

Insatiable hunger is not however the only outcome of violent retaliatory introjective aggressions and, “while in some cases persecutory anxiety may increase greed, in others… it may become the cause of the earliest feeding inhibitions” (Klein, 1975, 62). In newborns with sucking difficulties for instance, “aggressive impulses towards the breast tend to turn it in his mind into a vampire-like or devouring object, and this anxiety could inhibit greed and in consequence the desire to suck” (Klein, 1975, 97). Both greed and defenses against it are therefore critical in defining feeding behaviors of infants, and quite probably, later parallel difficulties in adolescents and adults. Restrictive forms of anorexia could for example reflect situations of greed inhibition whereas bulimia could evoke full-blown expressions of unappeasable greed, with compensatory purging mechanisms in the form of oral, urethral, and anal expulsions embodying conflicting dynamics with the object.

There is a final manifestation of intrusion into the object, or, to be more precise, between objects, in Klein’s theory that is worth mentioning here. In the passage on envy quoted above (Klein, 1975, 79), the greedy infant’s attribution to parents of constant states of mutual gratification evokes her concept of combined parent or combined parent-figure (Klein, 1928, 1932). Inherent in Klein’s view of the Oedipus complex (Klein, 1928), the notion of a combined parent represents “a sexual theory, formed at a

very early stage of development, to the effect that the mother incorporates the father's penis in the act of coitus, so that in the last resort, the woman with a penis signifies the two parents joined together" (Klein, 1932, 102-103). From this perspective, intrusion into the object expands to intrusion into the parental couple. This notion we will see occupies a central position in object relations conceptualizations of eating disorders, in particular with regards to processes of symbolization.

The Feminine Body and Feminine Vulnerability to Introjective Impulses

Klein posits that, although fantasies of intrusion into the mother's body affect both infant boys and girls, anatomical differences between the two sexes nevertheless weigh on their respective developmental course and mental processes (Klein, 1928), including and specifically on anxieties of intrusion in connection with introjective phenomena. Anatomical differences, expressed in aims of penetration versus receptivity, are particularly momentous upon the passage from pre-genital, oral and anal, to genital positions, as they draw divergent paths and love-object choices for boys and girls:

> The boy, when he finds himself impelled to abandon the oral and anal positions for the genital, passes on to the aim of penetration associated with possession of the penis. Thus he changes not only his libido-position, but its aim, and this enables him to retain his original love-object. In the girl, on the other hand, the receptive aim is carried over from the oral to the genital position: she changes her libido-position, but retains its aim, which has already led to disappointment in relation to her mother. In this way receptivity for the penis is induced in the girl, who then turns to the father as her love-object (Klein, 1928, 167).

Receptivity, initially attached in both sexes to the oral zone, is therefore reinforced in girls through displacement onto their similarly receptive genital attributes. The equation of penis and breast, which accompanies this displacement from above downwards “activates the oral, receptive qualities of the female genital at an early age, and prepares the vagina to receive the penis” (Klein, 1932, 271, footnote 2). In this respect, Klein argues in favor of “not only an unconscious awareness of the vagina, but also sensations in that organ and the rest of the genital apparatus… aroused as soon as the Oedipus impulses make their appearance” (Klein, 1928, 174).

Because of the receptive character of the girl’s genitals, her Oedipus tendencies are, under normal conditions, much more “under the influence of oral incorporative impulses than are those of the boy” (Klein, 1932, 274). Furthermore, the girl’s most intense anxiety that some damage has been done to her inside by her internalized objects “impels her ... to be continually testing her fears by means of her relations to real objects. It impels her, that is, to reinforce her introjective tendencies in a secondary way” (Klein, 1932, 317).

It is on the basis of the significance Klein grants to anatomic receptivity and stronger introjective tendencies in girls that Lawrence has conceptualized feminine specificity in eating disorders. It is the transcending of the female body in Williams’ notion of receptivity that allows me to conceptualize intrusion as the overwhelming

experience of invasion of receptivity - a gender-free concept that applies to men and women with these disorders.

SYMBOLIZATION, CONCRETENESS, AND THE QUESTION OF THE THIRD

A problematic of intrusion as considered in this work reveals obstacles in processes of symbolization - dysfunctions that are manifest in the concreteness of thought, when symbols fail to represent objects, standing instead literally in their place. Such hurdles and their consequences in the form of concreteness have been linked theoretically to failures in triangulation and differentiation. Klein (1930) and, following her, Bion (1962a), Segal (1957), Britton (1989, 1992, 2004), and Birksted-Breen (1996) have made major contributions to the development of the concept of mental space - in its interrelated aspects of symbolization, triangulation and differentiation. Although Lawrence and Williams, whose models are developed in Chapter VI, generally set out from the same Kleinian frame of reference, it is through their respective emphases on one or another of these theories, or parts of a theory, that their principal difference on the question of the origin of intrusion, in the subject or the object, is based.

For Klein (1930), symbol formation, the gateway to both sublimation and reality, develops through the displacement of curiosity away from the mother's body onto an expanding world of external objects. Such displacement ultimately depends on the

ability of an infant's embryonic ego to work out and tolerate powerful anxieties, prompted during the phase of oral ambivalence by correspondingly powerful sadistic fantasies over the mother's body. Inability to tolerate such anxieties leads to inhibitions in fantasy life as well as disconnection from external objects and reality. Although Lawrence and Williams generally proceed from the same Kleinian frame of reference, it is Lawrence's model of an original intrusiveness of the subject that mirrors Klein's concept of an infant's fantasized intrusions into the mother's body.

The 'container-contained' relationship, Bion's theory of thinking (1962a), while acknowledging the importance of an infant's ego ability to deal with aggressive fantasies and their attendant anxieties (Klein's model), equally stresses a mother's mental capacity to receive her infant's projected anxieties, stay with them, process them and restore them to the child in a detoxified form - *that is, with meaning*. In that sense, the theory places a greater accent than Klein's on the interactive and interpersonal nature of processes of symbolization. Failures in the 'container-contained' relationship are expressed in terms of Bion's 'K' (knowledge) link - the most fundamental link for the expansion of thought -, more specifically '-K' (not knowing), which is the instatement of an internal object that malignantly strips away meaning from projected experiences. Bion's theory is relevant to both Lawrence's and Williams' models. It is the latter however that specifically exploits the 'container-contained' concept, albeit its reversal in

the ‘receptacle-foreign body’ phenomenon whereby projections originating in parental objects forcefully intrude into the receptivity of the child.

Segal’s symbolic equations (1957) are an elaboration on Klein’s model of symbol formation - the former representing disturbances in the latter. She links such disturbances to issues of differentiation between ego and object, which in turn lead to disturbances in differentiation between the symbol and the object symbolized - symbols are felt by the ego to be the original object itself instead of representing it -, and, ultimately, to concrete instead of symbolic thinking. It is with Segal’s view of symbolism as a three-term relation involving the object, the symbol, and the ego whereby differentiation between the ego and the object governs differentiation between the object and its symbol, that the notion of a tripartite mental space finds its preliminary sketching. Central to both Lawrence’s and Williams’ theories on eating disorders, the concept is a further, tri-dimensional, expansion on Freud’s and Abraham’s delineation of inner and outer spaces through the dynamics of introjection and projection. It is particularly useful in understanding the articulation of the intertwined phenomena of triangulation, differentiation, and symbolization.

In his turn, Britton (1989, 1992, 2004) develops Segal’s notion of mental space with the concept of internal triangulation - the internal version of the Oedipal situation. Symbolization for him takes place within this triangular mental space and is premised on

the child's acknowledgement of a differentiated maternal object whose loss as an exclusive object of possession must be mourned and whose link to the Oedipal father recognized beyond her link to the infant. Only when a third position outside the mother-infant dyad is perceived, does the expansion of the mind and the world occur. For Britton, such perception is ultimately contingent on a mother's ability to contain her infant's primary anxieties. When maternal containment fails, the third position is undermined - transformed into a malignant, impinging interference that vitiates meaning and distorts reality. While preserving a momentous role to maternal containment in facilitating symbolization, Britton's concepts of internal Oedipal triangulation and third position introduce a novel perspective and accent on the paternal dimension of symbolization and differentiation - a perspective that permeates both Lawrence's and Williams' approaches to intrusion.

Finally, Birksted-Breen's concept of penis-as-link (1996), which pertains to "… the tripartite world of the self in relation to the parents as different but linked to each other" (650), invites the crucial question of sexual difference into Britton's model of symbolization. Holding on to the Lacanian (1966) notion of the phallus as the signifier of omnipotence and completion[70], Birksted-Breen merges it with her concept of penis-as-link, their combined internalization representing the structuring and linking function that

[70] Birksted-Breen (1996) dismisses Lacan's other take on the notion of phallus as covering all areas of symbolism, therefore challenging his view that it represents the Oedipal *structuring* function of separation of the mother-infant dyad (Lacan, 1977).

creates mental space through the acknowledgement of a full oedipal situation. She suggests that both the knowledge of sexual difference and the recognition of incompleteness and of the need for the object exist alongside one another in the unconscious. By bringing together these two signifiers, her model allows insight into the complexity of symbolization, because of its duality, in women: "… a duality and opposition in the unconscious of a femininity experienced as lack, and a femininity which is more closely connected to the body" (650) - i.e. in relation to an innate knowledge of the vagina. The former expresses itself in binary constellations organizing meaning around mutually exclusive characteristics on the axis of presence/absence. The latter allows the integration of couples such as powerful/powerless or masculine/feminine. Lawrence's description of phallic fantasies and binary constellations as reflecting failures in symbolization in women with eating disorders proceeds from Birksted-Breen's model.

Britton's and Birksted-Breen's elaborations on the concept of mental space provide a useful background to understand the inner configurations and dynamics, which in both Lawrence and Williams explain the corruption of meaning and concreteness of thought that define eating disorders. They also open new perspectives on the sexual idiosyncrasies and paternal aspects of these pathologies as respectively emphasized by these two authors.

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The psychoanalytic etymological examination of intrusion indicates its rooting in the body, a body that exists within a space delineated through experiences of taking in (receiving) and evacuating (expelling) food - the most archaic impulses and their corresponding psychological offshoots, introjection and projection. Typically, introjection and projection constitute normal aspects of mental and emotional development. However, when extremely disturbed - as a result of constitutional dispositions or by externally originating factors -, they lead to concreteness of thought whereby symbol fail to represent the object, becoming instead the object itself. This is what happens in eating disorders when food and eating functions are literally confused with primary objects of early infancy.

Concreteness, in its corruption of meaning, occurs in relation with breakdowns in symbolization, which in turn refer to failures in the internal Oedipal situation. It is the existence of the Oedipal father alongside the mother-infant dyad that allows the emergence of an internal triangular mental space and a differentiated maternal object. The third element is the guarantor of both differentiation and meaning and, as such, is

critical in averting the concreteness of thinking that is characteristic of intrusion in eating pathology.

In this chapter, I went back to the origin of the concept of intrusion in psychoanalysis, setting the theoretical background for exploring it in the context of eating disorders. I particularly built on the notion that, in their archaic foundation and connotations, eating disorders represent the quintessential form of intrusion as manifest in disturbances in processes of introjection and projection.

In the next chapter, I look at the psychoanalytic concept of intrusion from the perspective of eating disorders - its contribution to understanding their feminine specificity, but also, further on, its application to male populations.

CHAPTER VI

INTRUSION AT THE CORE OF EATING PATHOLOGY

In Chapter V I have theoretically situated intrusion within the context of the body as well as in primeval alimentary experiences and their psychological introjective and projective derivatives. I will now examine two object relations models that view eating disorders as revolving around a problematic of intrusiveness, understood as the overwhelming experience of invasion of receptivity. The two theories offer contrasting perspectives on intrusion as either directed towards the object or aimed at the subject. Lawrence (2001, 2002, 2008) suggests that intrusions into the object, which bounce back into a receptive female subject, underlie most experiences of anorexia. Williams (1997a, 1997b; Williams et al (eds.) 2004a, 2004b) emphasizes instead parental projections of anxieties and fears into the child and the ensuing obstruction of his/her developmental capacity to receive. Receptivity in Lawrence's notion of intrusion is mostly function of female anatomy. In Williams, receptivity is not confined to the woman's body but acquires broader metaphorical meaning through her reversal of Bion's 'container-contained' dynamics into 'receptacle-foreign-body' relationships.

In this chapter I show how, irrespective of whether they see intrusions as originating in the subject or in the object, both perspectives describe a globally similar inner picture of faltering triangulation, symbolization, and differentiation, and of resulting concreteness of thought. I also argue that, rather than implying incompatibility between the two models, the location of intrusion in the subject or the object is more an indication of their complementarity. In mental diseases known for their extreme complexity, each perspective roughly covers one of two etiologies, constitutional predispositions or environmental shortcomings, which never operate in absolute terms or in abstraction from one another, but interact instead in dynamic, relative terms, and exist on a continuum.

MARILYN LAWRENCE: INTRUSION INTO THE OBJECT

Grounded in Kleinian concepts on the vulnerability of women to anxieties of intrusion in connection with their receptive anatomy, inspired by Britton's and Birksted-Breen's articulation of differentiation and symbolization around the quagmires of internal Oedipal triangulation, Lawrence offers a key contribution to a gendered conceptualization of eating disorders in terms of intrusion, understood as the overwhelming experience of invasion of receptivity.

Female Anatomy and Development

Lawrence's model provides a plausible explanation for the feminine specificity of eating pathology as dictated by two, sometimes coinciding, parameters: first, the receptive anatomy of women, which predisposes them to anxieties of intrusion, is compounded in the case of anorexic girls by excessive introjective tendencies; second, the failure of mothers, in a way or another, in containing (receiving) their daughter's anxieties of intrusion. I only examine the first parameter now, leaving the question of maternal containment for later discussion in the broader context of parental influences.

Lawrence argues that female anatomy and development explain anorexia as a phenomenon centered on intrusion. Considering that "dominant anxieties resonate with the reality of sexual difference" (2002, 841), she refers to Klein's theory (Chapter V) that girls have, in comparison to boys, stronger introjective drives, oral impulses, and tendencies to take in and receive. These specific dominant trends, reinforced by an innate knowledge of the receptive nature of feminine genitalia, are associated with equally specific dominant anxieties - anxieties of invasion and intrusion related to the fear that something will get inside and damage them. Mirroring female sexual constitution, the feminine character is therefore open and inclined to introjection, but also closed and terrorized of being projected into (Lawrence, 2002).

In anorexia, Lawrence proposes, anxieties of invasion are overly excessive. A number of factors explain such elevated levels of anxiety. The projection of strong aggression - both the mechanism and the object onto which it is projected - is an important one. Indeed, in line with Klein's concept of retaliation, the intensity of a girl's anxieties of invasion is proportionate to the intensity of her own fantasized attacks on the inside of the mother's body. Furthermore, unlike boys who can also project their sadism on their penis (the penis incidentally constituting a confirmation of their potency), girls chiefly direct their aggression on the interiors of the mother, with an ensuing dread of retaliation against their own inside (Lawrence, 2002). Another related factor pertains more specifically to excessive constitutional envy of the primitive maternal object.

The Inner Oedipal Triangle - its Link to Symbolization and Differentiation

Using Britton's and Birksted-Breen's models (Chapter V), Lawrence describes the internal world of the anorexic in terms of the challenges a tri-dimensional mental space poses. These include, in particular, renouncing and mourning the loss of an exclusive relationship with the mother and acknowledging, instead, a relationship with each parent as well as the relationship of parents with one another. Intrusion from this perspective is understood in terms of a combined and interrelated phenomenon of failed triangulation, differentiation and symbolization. Failure to recognize the full Oedipal

situation and the parental couple relationship implies impairment in the structuring function of penis-as-link - the function of challenging an exclusive relationship with the mother, which in the specific case of the anorexic girl means protecting her from vulnerability to feelings of intrusion. By coming in between mother and daughter, the internal father, representing the other or third position, allows the tri-dimensional mental space of symbolic thinking to develop. When a third position lacks, symbolic thought is compromised and impeded is the ability to discriminate between what is and what is not intrusive in what the girl takes in or receives.

An Intrusive Internal Object versus External Objects

Flaws in the internal Oedipal situation and the subsequent faltering in symbolic thinking, particularly the ability to discriminate, are illustrated in Lawrence's concept of an *intrusive internal object*. Using Bion's concept of the -K link (Bion, 1962a) - an internal object which deliberately and malignantly misconstrues and strips away meaning -, Lawrence (2002) suggests that a parallel phenomenon takes place in anorexia: an internal object is instated whose aim is to intrude, to get inside and hurt. This internal intrusive object has a momentous impact on the link between the internal father and mother. As such, it brings the Oedipal question - from a mental space perspective, i.e. the emotional space featuring dynamics within the triad - to the

forefront of the discussion on anorexia. Lawrence does not discuss the triangle in its exteriority, neither in terms of each of its individual elements, as much as she views it in relation to the various potential inner couples - mother/girl dyad, parental couple, and father/girl - and to symbolization.

In doing so, she emphasizes the distinction between internal and external objects, and situations, in anorexia. Without dismissing altogether external maternal and paternal objects, she relegates them to a secondary position, giving prominence instead to the intrusive internal object and its impact on the internal parental couple and, thereon, on the external one. While considering that both maternal projections (Williams' model) and paternal sexual abuse - which for her broadly define two contemporary psychoanalytic perspectives on anorexia - may be relevant to experiences of intrusion, she does not believe these experiences are of necessity actual ones that implicate external objects:

> …while it is possible that girls and women who go on to develop anorexia may have been sexually abused and/or projected into by their parents, and some of them certainly seem to have been, this cannot be deduced simply from the existence in the patient's mind of an intrusive object (Lawrence, 2002, 840).

What she however views as consistently at the center of either experience, whether actual or fantasized, is an intrusive internal object, which is always colored by the projections of the subject.

The denial of the parental couple relationship, which characterizes anorexia, is perceptible in the anorexic's own intrusiveness towards the mother. This intrusiveness reflects her desire to interfere between the parents with the ultimate objective of controlling the mother from inside and maintaining the fusional relationship with her, away from the father. "The more the parental relationship is denied and rejected by the girl because it intrudes on her exclusive claims to the mother, the more she feels intruded upon" (Lawrence, 2002, 845). In this form of 'psychic homosexuality' (848), the primitive bond between mother and daughter remains unbroken, and the mother, who has failed to function as a container of anxieties of intrusion, ends up being used, in the fantasy of fusion, as a shield (rather than a container) against these anxieties. This is a crucial aspect of Lawrence's theory as it implies a sequence of intrusion originating in the subject rather than the object.

The anorexic's cycle of intrusion resulting from failures in maternal containment and/or excessive anxieties[71] involves, following the original intrusiveness (projection) of the subject, a bouncing back of intrusion by the object. The bouncing back is perceived as impingement from the external world. Lawrence's cycle of intrusion is based on the Kleinian model of vicious circles of projective attacks and reprisals through forced introjections. Such cycles are clinically apparent in the transference, when fantasies of

[71] See below-quoted passage in which Lawrence describes the case of Miss D. (2002, 841).

intrusiveness - in the form of a special relationship with the analyst/mother, in which professional boundaries are breached and boundaries between self and object blurred - are often matched by fantasies of being intruded upon by the analyst.

The Manifestations of Failed Symbolization in Anorexia

The effects of failed symbolization in anorexia are two-fold - phallic identification and concreteness, both gathered up to counter feminine vulnerability to powerful anxieties of intrusion in connection with fantasies of sadistic attacks on the mother's body.

In phallic identification, anorexics substitute the phallus for the penis-as-link - the phallus becoming a manic caricature of the penis, whereby thought is replaced by omnipotence and structure by power. Identification with the phallus defends against feminine anxieties of intrusion into their receptivity and is detectable in the enactment of fantasies of being male - the erasure of curves, the elimination of menstruation, the thin, straight and rigid body - and can be quite literal. Lawrence describes for example a patient with enduring vomiting who represented herself as a "constantly ejaculating phallus, compulsively ridding herself of any thing which had got inside her, while at the same time denying her anxieties of being invaded" (Lawrence, 2002, 842). Beyond its defensive function, phallic identification also offers, Lawrence suggests, an escape from

the terrifying developmental challenges of womanhood. The description of phallic defenses against anxieties of intrusion as omnipotent, manic parodies of structure and thought, expressed in the obsessive elimination of emblems of womanhood, gives perspective to the body symbolism involved in dynamics of starvation. It also illuminates the problematic of incompleteness as reflected in difficulties of dealing with the need for and dependence on the object that underlies eating pathology.

In concreteness, the other manifestation of failed symbolization, things for the anorexic happen as if she remained trapped in a primal and regressive relationship with the internal mother, a relationship that excludes the father. In this primitive form of thinking where symbolic equations (Segal, 1957) prevail, psychic introjection occurs upon eating. Some aspects of the mother function, feeding in particular, are split and equated with food and the father's role seems beyond comprehension or symbolic significance, except in its equation with a "catastrophic wrenching apart of the mother-daughter couple" (Lawrence, 2002, 846). An eloquent example of how splitting mechanisms and symbolic equations operate is presented in the next section.

The External Oedipal Situation

In a model that does not recognize a necessary relation between external impingement and overwhelming feelings of invasion of receptivity, not to mention its

claim that intrusiveness more than often originates in the subject, questions arise about the relevance of environmental influences to the problematic of intrusion. In other words, what is the role, if minimal, played by actual parents, if traumatic external experiences are not primordial components of intrusion in eating pathology?

Lawrence attributes different qualities and weights to maternal and paternal influences. On the maternal side, she views the role of mothers in actual and positive terms - mothers help female infants and pubertal girls negotiate anxieties about their invisible, difficult to locate and uncontrollable internal space. This maternal function, which involves a supportive dimension, in addition to the containing one, is critical for the facilitation of smooth and sound developmental transitions towards feminine maturity:

> Crucial… is the unintrusive but active support of the mother in the process of the female infant's need to master anxieties connected with the body and genitalia. It is the capacity of the mother to act as container for these anxieties which is at issue here. In the case of patients who develop anorexia it might be that the anxieties were either particularly strong or else not sufficiently ameliorated or contained by parental support (Lawrence, 2002, 841).

In contrast, Lawrence describes the role of actual, external fathers in secondary and negative terms - acts of omission that do not involve active participation similar to that of mothers. Still, it is the fantasized father rather than the actual one, which occupies center stage in her theory. Indeed, the father’s absence or insignificance, as revealed in the representation of their family by anorexic girls, mostly reflects the failed

internalization of the parental couple relationship, and, seldom corresponds to reality. It is the internal father, not necessarily the actual one, who is absent, and denying him his place aims at denying any separateness between daughter and mother, between self and object. Such denial is furthermore an attempt to prevent the suffering, isolation and exclusion, which, from an Oedipal perspective, accompany the recognition of the parents' relationship.

To conclude, intrusion in anorexia for Lawrence is linked to the patient's own intrusiveness into the parents' relationship, and, beyond it, into the mother. The following passage, a good description of what she considers a familiar presentation of anorexia, offers the gist of her conceptualization of the dynamics at play between inner and outer worlds - in particular, the vicissitudes of the internal Oedipal triangle and their impact in terms of lack of differentiation (the struggle against separateness from the mother, what she calls psychic homosexuality) and symbolization (the equation of the feeding function of the mother with intrusion). It also indicates the relative weight she grants to external objects, in particular fathers - colored by internal dynamics, they do not necessarily match reality:

> A 17-year-old anorexic girl, Miss D, was referred, by a somewhat circuitous route at the instigation of her mother, herself a doctor… What she [the mother] conveyed was her sense of a daughter terrified of intrusion, and her own anxiety that she was indeed the intrusive mother her daughter dreaded…
>
> … As the patient proceeded to describe her situation, she did not describe her mother as intrusive. Instead, she spoke in glowing

terms of their good, trusting and open relationship; a mother with whom she could and did share everything…— the ideal couple in fact. As long as mother did not try to feed, or threaten future feeding by suggesting that her daughter was ill, she could be the idealised partner. The external mother had understood this, and was trying to obey the rule that she must not try to feed her starving daughter. There seemed to be no trace in the material of the intrusive object I had been expecting. *What seemed to have happened was a kind of splitting off of the feeding function of mother, which was equated with the intrusive internal object*[72]*…*

… it transpired that she was a deeply jealous and possessive little girl, resenting from the very start that she couldn't have total possession of her mother.

Father, although he did sometimes travel abroad, enjoyed a warm and passionate relationship with his wife. This was hated by his daughter. *The creation in the mind of the patient of an intrusively destructive object seems to have been based upon the parental couple, perceived as intrusive and damaging to the fused mother—infant couple upon which the child insisted. Throughout her development, Miss D had had to contend with her wishes to intrude between and destroy the love and intimacy between her parents… Finally, the intrusive aspects of the patient were projected into the mother. In the mind of the patient it is not she but her mother who insists on getting inside and taking over.* She is left in her anorexic state, wanting nothing, feeling nothing and certainly not feeling her hatred and rage against the object of her love whom she feels has betrayed her. This sense of betrayal is not simply that mother has stayed with father, but also that she has allowed her daughter to reach a stage of development whereby separateness seems a certainty. The patient lapses into her comfortable fantasy in which all is well and father and siblings do not exist.

This projection of intrusiveness into the mother is a very familiar aspect of the presentation of anorexia (Lawrence, 2002, 846-847).

[72] All italics are mine.

GIANNA WILLIAMS[73]: INTRUSION (PROJECTION) INTO THE SUBJECT AND AN ENSUING INCAPACITY TO RECEIVE

Two psychoanalytic readings of eating disorders propose paternal sexual abuse and maternal projections[74] as alternative models of intrusion to Lawrence's model. In choosing Williams' interpretation (parental projections of anxieties), I am guided by a number of reasons. To start with, research on the correlation between eating disorders and sexual abuse has proved inconclusive[75]. Although patients with eating disorders share a lot of characteristics with those who have been sexually abused, "it is now widely recognized that sexual abuse in childhood is relatively common and is linked with many forms of mental illness and psychological ill health later in life. It does not seem to be the case that it predisposes towards eating disorders in particular" (Lawrence, 2002, 838). Another reason to favor Williams' model of external parental projections is the fact, also underscored by Lawrence, that, unlike sexual abuse, projections are "couched in psychological terms" (2002, 838) - a view in line with the perspective of this work. In this respect, it is important to point out that a psychological dimension ultimately underlies all forms of physical intrusion - whether sexual (Lawrence, 2002), surgical, or relating to other forms of invasive medical interventions (Cross, 1993[76]).

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[73] As mentioned earlier, my reference to Williams encompasses both her individual writings (Williams, 1997a, 1997b) and those of authors published in her co-edited work (Williams et al, 2004a, 2004b).
[74] Projections do not emanate exclusively from mothers but also originate in fathers, a point which is made below.
[75] Inconclusiveness on the correlation between eating disorders and sexual abuse is discussed in Chapter VII.
[76] Cross (2003) mentions invasive medical interventions but does not envision them from the angle of parental projections that may accompany them (Chapter III).

Although it is founded, like Lawrence's, on a Kleinian frame of reference that emphasizes introjective processes, Williams' conceptualization of eating disorders in terms of intrusion does not derive from Klein's view that women's vulnerability to anxieties of intrusion is connected to female development and receptive anatomy. In fact, her model does not address the question of feminine specificity in eating pathology. Instead, it extends the notion of receptivity beyond the female body, through presenting an alternative, gender-free, and more universal account of eating disorders. The model is based on the conceptual reversal of Bion's alpha structuring function into what she coins an omega disorganizing one - one that leads to the dysfunctional introjection of 'foreign bodies' (Williams, 1997a, 1997b; Williams et al. 2004a, 2004b).

Lawrence had suggested a model of intrusiveness into the object, which bounces back into the subject. In contrast, parental projections of anxieties and fears, as identified by Williams, feature patterns of intrusion by the object - intrusions that set off reactive defenses against various forms of taking in, receiving, including in the form of eating[77]. In other words, Williams' model of parental intrusion showcases sequences of projections and counter-projections that are the obverse of those described by Lawrence: first, parents project anxieties and fears, which are forced onto their receptive children; second, children either block these forced entries of anxieties and

[77] Impairment in the capacity to receive is not restricted to eating - other symptoms of non-receptivity in eating disordered patients are mentioned later in the section - or to eating pathology, as shown in Williams' reports of other mental illnesses associated to parental projections (1997a).

fears (anorexia), or, if they have allowed them in, re-project them in turn onto their parents (bulimia).

Symbolization, Triangulation and the Reversal of the 'Container-Contained' Relationship

In Williams' model, failure in triangulation - reflected in the denial of space within the dyadic couple and an attendant desire/dread of fusion with the object - is one of two crucial components of feeding difficulties in infants and eating disorders in children and adolescents (Williams et al (eds.), 2004a, 2004b). The other component is the reversal of the early mother-infant 'container-contained' relationship (Bion, 1962a) into what she coins the 'receptacle-foreign-body' relationship (1997a). Both developmental breakdowns are manifest in issues in differentiation and symbolization.

Critical to Williams' approach is the fact that parental intrusions and the reactions they provoke occur in the context of dependent relationships. More precisely, being on the receiving end of massive projections results in impairment in 'taking from another', including eating, because of vulnerability to overwhelming dependence on the object. The close association between a reversed 'container-contained' relationship and failed triangulation is articulated around "the relationship between impairment in 'taking from another' within the context of dependent relationships and the concreteness of problems with food intake…" (Williams, 1997a, 9). It is in this situation of dependence that

control, a characteristic feature of anorexia, bears its particular significance - control is of course over food and objects, but it is also directed at avoiding the experience of depending on, or needing the other (Williams et al (eds.), 2004a)[78]. This aspect of Williams conceptualization of eating disorders is essential to my working hypothesis of intrusion's supremacy over other problematics (Chapter III). It refers to the context of intolerable dependence and loss around weaning in which eating disorders difficulties, and defenses against these difficulties, unfold. I come back later on the question of intrusion's preeminence as underscored in Williams' use of projective identification.

Williams' articulation of failed symbolization and differentiation around developmental breakdowns in triangulation and in the 'container-contained' relationship features internal as well as external parental objects. Both internal and external objects, and the dynamics that govern them through an omega function that corrupts meaning, are at the heart of Williams' account of the pervasive presence of intrusion in eating disorders.

[78] The context of dependence, significant in most of the theories examined in this work, is particularly emphasized in Chasseguet-Smirgel, Self-Psychology, and Williams.

The Introjection of a Projecting Object with a Disorganizing Impact (The Omega Function)

In the reversal of the 'container-contained' relationship, not only is the infant not contained, it is bombarded with parental projections, which it experiences as intrusive alien objects, 'inimical foreign bodies':

> When projections enter a child's psychic space, they can be experienced as very inimical foreign bodies. I wish to emphasise that I am not focusing, in this paper, on the predicament of patients who receive back their own projections, which is the predicament described by Bion…. as 'nameless dread'.
>
> A mother who cannot deal with her own psychic states will indeed send back the child's projections, but I wish to focus on the experience of patients whose parents need to divest themselves of their own anxieties, psychic pain and ghosts… It is a failure in the relationship between container and contained that is, in my opinion, even greater than the one described as engendering nameless dread; a failure of containment of a second kind (Williams, 1997b, 928-929).

Williams' conceptualization of the origin of foreign intrusive bodies is in line with her observation of transgenerational transmissions as revealed in the disorganized type of attachment[79] of children whose parents had endured trauma (1997a). These parents either are "*frightened* or *frightening*, or both", which from a psychoanalytic perspective means parents "*who project anxiety instead of containing it*"[80] (Williams, 1997a, 126). In normal circumstances, the fundamental aspects of personality - integration, stability and inner security (Klein, 1975) - develop through the introjection of an alpha function (Bion, 1962a), which basically makes feelings thinkable, comprehensible, and therefore

[79] See section on Attachment theory in Chapter VII.
[80] Italics in the original text.

bearable. When mothers (or fathers) are overflowing with projections, an omega function that disrupts these pillars of personality is instead introjected (Williams, 1997a):

> I have been asking myself whether it would be useful to attempt to formulate a hypothesis about the function performed by an internalised projecting object. Bion says that the introjection of a parent capable of containment or performing alpha-function helps a child to internalise a function that links and organises thoughts and feelings, and makes order in his internal world. Could one say that the introjection of a parent overflowing with projections has an obverse function, namely a disorganising impact, in the internal world? ...
>
> When a patient introjects a projecting object, it might be useful and justifiable to formulate the hypothesis that this projecting object also performs a function. A function which is the obverse of alpha-function, not in the realm of the negative grid but at the opposite end of the alphabet. Namely, a possible 'omega function' (Williams,1997b, 938).

It is this omega function, the opposite of the alpha-function, which, Williams suggests, operates in a disorganizing, distorting manner in eating disorders - a distortion manifest in the transformation of any introjective phenomenon into an invasive one that needs to be held off and checked.

Intrusions are therefore manifest at a dual level: (1) parental projections are in themselves intrusive; (2) in instating an *internal projective object*, they additionally subvert the capacity to receive. From Williams' perspective, failure to develop a receptive capacity is, it is important to specify, by no means restricted to eating behaviors and is detectable at many levels in the clinical context: the therapist's feeling that his/her words are not received and his/her difficulty in reaching patients; the patients' avoidance of any forms of emotional exchange; despite an over investment

and control of the mouth, other less controllable functions or organs with a receptive function - hearing, the belly, the vagina - are either impeded or ignored; body image is one of a pipe suited for the swift passage of uncontained, undigested food; and a transference characterized by “a forcefully denied and opposed search for closeness to and possession of the object, accompanied by greed”, a behavior that parallels “the patient’s obsessive concentration on orality and food, without the consequential taking in and digesting of the food” (Tirelli, 2004, 31-32).

The Mother-Infant Dyad: The Impact of a Mismatch on Differentiation

Although it particularly showcases impingements in their external foundation, Williams’ model does not altogether exclude dysfunctions that originate in the infant. Situating the reversal of the container/contained relationship in the critical context of dependence and defining intrusion in terms of a disruption in the capacity to receive, the model actually stresses the interactive and dynamic nature of the dyadic relationship as well as the location of difficulties around receptivity in both mother and child.

When exploring the landscape of eating disorders, there indeed often seems to be a failure, in one form or another, in early relationships per se - a kind of mother-infant misfit, which reflects a reciprocal inability to give and receive and leads to a child’s rejection of feelings of dependence. Not only does the notion of misfit imply the dual

character, constitutional and environmental, of factors affecting the mother-infant relationship, it also highlights their interactive nature. Williams writes for instance about a good feeder who enabled a mother with a history of problematic breast-feeding to give "the best she was capable of" (1997a, 90) and develop, as a result, a greater confidence in her giving capacity. Because he was constitutionally able to receive, the baby allowed his mother to overcome her difficulty in giving. By extension, a good feeder stands as a metaphor for patients craving for insight, or students thirsty for knowledge. In contrast, a 'poor feeder' from the onset (he was 'virtually born with his thumb in his mouth'), whose mother was also extremely lacking in self-confidence, eventually required tube-feeding, and continued, over years, to suffer from feeding difficulties whilst perpetuating patterns of soothing himself by sucking the inside of his mouth, his tongue, and all his fingers. In this case, the mother's initial lack of self-confidence was reinforced by the poor-feeding baby, which further undermined her containing function. Similarly, an anorexic girl who consistently refused 'food for thought' early on in analysis, had been a very poor feeder in infancy, had remained a tenacious thumb-sucker for a long while, and persisted in sucking the inside of her mouth, her lower lip, making it sore until it bled. She needed to "fall back on her own resources" (Williams, 1997a, 93)[81]. Going back to the earlier metaphor, a poor feeder highlights the

[81] See footnote 81 and the question of self-sufficiency as developed by Chasseguet-Smirgel and in Self-Psychology (Chapter III).

difficulty for mothers, teachers, and therapists to perform well when faced with denigration and rejection (Williams, 1997a).

In addition to revealing the dual and interactive nature/nurture dynamics of receptivity in the early dyadic relationship, the notion of mismatch highlights the significance of the maternal function of mirroring for the development of an infant's capacity of emotional perception and apprehension. Brough's (2004) case of an anorexic patient, Rebecca, is an eloquent illustration of Winnicott's (1971) metaphor of the mother's face as a mirror that reflects to the infant truths about his or her feelings and emotions. Rebecca felt compelled to scan the therapist's face, or the weather, to learn about her own state of mind and emotions. The blankness and unresponsiveness of her mother's face, a depressive mother, had not provided her with the necessary tools to decipher her own feelings.

Of course, difficulty in the perception[82] of one's feelings and emotions also evokes a level of thought disorder in connection with difficulty in symbolization (Brough, 2004). Whether expressed in the most concrete way - babies blocking access to their mouth with thumbs -, or in a more symbolic form - children with learning difficulties or anorexics refusing 'food for thought' -, the inability to receive is always associated with suffering for not controlling when and how often mother provides the breast or makes

[82] The inability or difficulty in reading one's perceptions also extends to bodily sensations as described in symptoms of alexithymia in Chapter VII. Bruch's work (1973) puts particular emphasis on this aspect of eating disorders.

herself available. In a context of painful experiences of loss and dependence, particularly around weaning, fingers in contrast are “always available” (Williams, 1997a, 100).

Loss and dependence are pivotal as it is around them that the notion of differentiation is articulated. One way of avoiding painful experiences of dependence and related loss - inevitable when you take the risk of receiving - is to erase differentiation. In eating disorders, fusion occurs through projective identification (Klein, 1946), the fantasy of forcing parts of the ego inside the object in order to control it. Being inside the object, rather than with it, defends against suffering from neediness and separation, as “being with implies the unbearable experience of being without when the object is absent” (Williams et al (eds.), 2004a, xviii). However, if erasing otherness shields from excruciating experiences of separateness and dependence, the consequence, measured in terms of identity loss, blurring of boundaries, and diminished capacity for tolerating limits and frustrations, is dire (Quagliata, 2004). Such confusion of identity is revealed in the fantasy of Brough’s anorexic patient, Rebecca, who starves herself “using her body in a self-punitive way, in order to punish her mother” with whom she is identified (Brough, 2004, 17). Similar projective identification with the mother’s

body - that is, the attack of the mother's body through the daughter's, or boy's, starvation - are common in anorexia (Williams et al (eds.), 2004b)[83].

Fathers: Attack on the Paternal Function often Mirrors Actual Paternal Deficiencies

Overlapping with the mother-infant misfit, another ubiquitous component of the two developmental breakdowns underlying eating pathology - the failure of triangulation and the reversal of the 'container-contained' relationship - is the attack on the paternal function and on the parental couple. It is the denigration of the actual father (and the parents' couple), which is so often encountered in eating disordered patients. It stands for the wish to obliterate the space fathers symbolically hold in family representations. In situations when such denigration is not openly expressed, it always transpires in the patient's material (Williams et al (eds.), 2004b). When attacked, the paternal function becomes caricatured as a persecuting superego that thwarts possibilities of reparation. In eating disordered patients, a benevolent paternal function that allows and encourages reparation is lacking.

Attacks on the paternal function are expressed in terms of mental space - the space within the dyad as opposed to that within the triad. This failure in triangulation is concomitant with problematic differentiation in the mother infant dyad and their

[83] Cf. Chasseguet-Smirgel in Chapter III.

consequences in terms of symbolization. In general, the model converges with Lawrence's depiction of internal dynamics - that is, difficulties in symbolization as linked to failures in differentiation and in acknowledging the full Oedipal situation and the parental couple relationship. In this regard, Williams makes an interesting point about the third element as representing the space in the dyad:

> In a relationship of two people, a dyadic relationship, there is always a third element - that is, the space between them - and in a state of mind of fusion that space is lacking. A dyadic relationship is therefore in effect always triadic, the third element being constituted of the space between the subject and object. The term "dyadic" might imply twoness in its etymology, but in its application the term actually refers to a triadic relationship (Williams et al (eds.), 2004b, xxi).

It is the third element that creates an internal, three-dimensional mental space for receiving and remaining with thoughts and emotions - a containing space. When the third element is absent, in situations of two-dimensionality, the container is lacking, and one way of defending against unbearable thoughts and feelings about a missing loved object is to obliterate, or evacuate, the memory of its existence - for example, through the transformation of what 'could be thought about' into bodily processes. Williams writes about a thirteen year-old girl who had spent the first six years of her life in a children's home, years she had completely 'forgotten' about. The girl managed to avoid insight by converting her painful emotions into bodily processes in the form of vomiting, crying, bed-wetting, and diarrheas (Williams, 1997a, 27).

The third element constitutes the paternal function, which, it is important to note, is a "*function* and not necessarily a *person*". The function may actually be carried out "by the mother herself or the actual father or is the provision of a boundary between mother and child" (Williams et al (eds.), 2004b, xxi).

There is I think an implicit theoretical recognition in the latter statement of a role for external factors, for a potential role for real, actual fathers in the performance of the paternal function. This seems in contrast with - or at least qualifies - Lawrence's contention that the absence or insignificance of actual fathers as represented by anorexic girls seldom corresponds to reality but reflects in fact the failed internalization of the parental couple relationship. My understanding of this implicit conceptual recognition is that the vicissitudes of the paternal function more than incidentally mirror an actual paternal reality. In situations where this occurs, both the actual father and the paternal function are lacking, their dysfunction interrelated, and attacks on the function - whilst reflecting failures in internal triangulation - also speak for failures in the external Oedipal situation. In other words, an actual absence or irrelevance of fathers is bound to resonate as an attack on the paternal function, unless of course the latter is provided through other channels.

There are many accounts in Williams (1997a; Williams et al (eds.), 2004a, 2004b) of genuine paternal absence/irrelevance, but also projection, in the backgrounds

of eating disordered patients. Testifying to the complexity of the dynamics between internal and external realities, it is however important to bear in mind the fine line that often separates actual from fantasized fathers. To illustrate this complexity, I present two examples with varying degrees of blurring between 'real' and 'fantasized' expressions of paternal absence.

In her account of Rebecca's Oedipal configuration, Brough (2004) describes how exclusion by father (and brother) colluded with mother's lifetime self-absorption in depression to precipitate her anorexia. The father abruptly stopped running with Rebecca when the brother withdrew from the running *threesome*[84] he, his son, and daughter had so far formed - a *threesome* that had defended her against a *collapsed* state, a kind of early emotional deprivation, in connection with an absent internal mother. A physical *collapse* of the father, in the form of excessive gain in weight, accompanied his withdrawal from running and he consequently emerged as "a passive, formless father unable to provide a backbone for her and the family" (5). From then on, she led an upfront and relentless attack on the paternal function and the parental couple. The now obsessive running that accompanied her anorexia was both literal and symbolic - a running away from femininity to continue partaking as "one of the boys" (3) in the *threesome* with her father and brother. Both her wish to be a boy and her

[84] Emphases in this paragraph reproduce Brough's (2004).

identification with the “young and virile father of her childhood” were a search for identification with a strong phallic figure. In this case of anorexia, the initial emotional unavailability of a depressed mother joined together with a later emotional withdrawal of the father to drag the young girl down into a *collapsed* internal state of primitive and terrifying anxieties - a state against which the *threesome* had earlier defended her (Brough, 2004).

Ravenscroft’s (2004) account of what he sees as classic family backgrounds and dynamics in normal-weight bulimia patients illustrates in a more direct way an actual role played by external fathers in this eating disorder:

> Characteristically, the mother is in a hostile, dependent masochistic relationship with her husband, while deeply ambivalent, guilty, and overindulgent with her daughter. Typically, the father is counter-dependent, counter-phobic, and sadistic with his wife, while overstimulating and rejecting with his daughter (Ravenscroft, 2004, 80).

In the specific case of his bulimic patient, Ravenscroft extends his understanding of the parental and marital background to include circumstances and dynamics related to the extended family. In his description, Paula’s mother was overprotective, her father overcritical. The mother’s experience with her own parents had led her to develop a ‘false self’ (Winnicott, 1965), “suppressing her negative thoughts and feelings in favour of pleasing and appeasing, while harbouring deep, dependent cravings and bitter resentment” (Ravenscroft, 2004, 62). As a reaction, she sought to marry an apparently strong, bright and independent man who turned out having counter-dependent and

counter phobic tendencies in response to his own parents' dependency, phobias and overprotection. Resenting his wife's dependency and uncertainty - which he had actually sought in his choice of a spouse who would not challenge his domination and independence - he ended up critical towards her, and distant, exactly as her father.

Ravenscroft describes Paula's early relationship with her mother in terms of the misfit situation described above - an insatiable, sleepless, and strongly irritable baby, and a mother ambivalent about nurturing because of her own maternal experience. He shows the mismatch as compounded by the father's lack of protection and nurturing of his wife - the two eliciting in mother a sense of loss and rejection, and ensuing feelings of disappointment and anger against which she defended by depleting herself through unlimited giving to Paula.

Ravenscroft describes the father's impact as not limited to his failure in protecting and nurturing the mother, something that added to her difficulties and contributed to their "shared difficulty in creating an appropriate centred and contextual holding for Paula" (64). He further aggravated the holding situation by allowing his own mother - the overprotective, smothering, octopus-like mother - to be over involved with her granddaughter. He was in this way deflecting his mother's mothering on his daughter, away from him. His wife's tacit assent reflected her own doubts and ambivalence about mothering (Ravenscroft, 2004).

I see three aspects of relevance to intrusion in Ravenscroft's description of Paula's 'actual' father. There is first his "characteristic sadomasochistic overstimulating intrusions with Paula" - as for instance in his enjoyment of clapping to set off her Moro startle reflex when she was infant (59, 64). This matched a general attitude of intrusive and harsh criticism towards his wife and daughter. There is also the episode of his job loss at the time of Paula's pre-adolescence and what this meant for her in terms of sudden weakness, dependence, and irrelevance. There is finally the Oedipal dimension, which Ravenscroft describes as inconsistent in a context of marital impasse: the father sometimes displaced his desires on his daughter only to withdraw for entire periods (Ravenscroft, 2004).

Ravenscroft's account is interesting in many respects. It illuminates ways in which fathers may structurally contribute to the development of eating problems - a contribution set in triangular terms, relative to that of mothers, either offsetting or aggravating it. The family dynamics he described illustrate the latter course of events, "impasses around both dyadic separation-individuation and triadic oedipal issues" that made it difficult for Paula to move developmentally beyond mid-adolescence (Ravenscroft, 2004, 73-74). His description also casts a transgenerational light on eating disorders, which extends the scope of internal and external interactions beyond the dynamics of the nuclear family.

Two Prototypes of Defenses and Patients in Eating Disorders

Williams identifies two prototypes of defense against massive projections by parents. These in turn define two broad categories of eating disordered patients: 'no-entry' patients and 'porous' ones.

'No-Entry' Patients

In order to defend against colossal parental projections, some anorexic patients deploy what Williams coins a 'no-entry' system, a powerful form of defense against an invasion by projections experienced in early infancy as persecutory foreign bodies. In these patients, the dread of something hostile 'coming inside' is felt very concretely and the no-entry syndrome performs the defensive function of blocking access to any input experienced as potentially intrusive and persecutory (Williams, 1997a, 121).

In extreme cases, 'no-entry' patients who do not let anything in erect a second line of defense in the form of "powerful projections of an intensity that parallels their dread of being invaded". Williams for instance describes feeling "temporarily blinded by the impact" of the projections of an anorexic girl, Sally, when the latter asked her whether she had a panic button near her seat, wondering menacingly "what would you do if I threw acid on your face?" (Williams, 1997b, 928). Sally's history was one of extreme neglect and multi-generational trauma, with an alcoholic, promiscuous, and

anorexic mother who died when she was thirteen. The following is an eloquent snapshot of her overdetermined circumstances:

> When Sally told me about her mother's terror at being tube fed, she also told me that her mother was almost always frightened unless she was very drunk. For instance, she was frightened of drowning in the bathtub, and Sally had to hold her hand when she had a bath. I asked whether she remembered how old she was at the time when she started holding her mother's hand during a bath. Sally wasn't sure, maybe she was three or four. Then she said that she knew why her mother was so frightened; when she (her mother) was very little, she had almost been drowned by her own father (Sally's maternal grandfather), who had kept her head under the water and threatened his wife (Sally's maternal grandmother) that he would drown the little girl. This was during a violent marital row (Williams, 1997a, 116-117).

The anorexic intense terror of intrusions is not only manifest in restrictions in food intake, but also in extreme and phobic intolerance of other forms of invasion, such as the sound of alarm clocks or telephones (Williams, 1997b, 927). The case of a young psychotic girl with anorexic symptoms, Natasha, reveals the "indigestible experience of being invaded by persecutory objects, which could originally have been projections". The mother had suffered severe puerperal depression (she had also experienced trauma earlier in her life) and the father, whose family was annihilated in the Holocaust, was obsessed with hunting war criminals. For Williams, the experience of being invaded "might constitute one … of the nuclei around which (her) delusional system was structured" (Williams, 1997a, 106) - she was terrified that fleas would penetrate the orifices of her body, all orifices including the pores of her skin, her ears, eyes, mouth,

which she desperately sought to keep shut. Sally, had very similar terrors, expressed in recurring nightmares of being paralyzed and invaded by a mass of tadpoles that penetrated all her orifices, including her mouth.

'Porous' Patients

There is another prototype of response to massive parental projections in eating disordered patients. To obstruction to entry by foreign bodies (a typical anorexic defense) is opposed alternation between their absorption and expulsion - a defense, which is characteristic of the more 'porous' bulimic patient. These patients do not develop as impervious a shell as anorexics, and consequently have to deal with parental projections they have let in, only to feel compelled to expel them. A bulimic boy, for example, binged on white bread, which, when vomited functioned like a blotting paper to clean the mess of his internal world - a striking "displacement of the chaos within to food that can be brought up, discharged, projected…"(Williams et al (eds.), 2004b, xv; Williams, 1997b).

Williams describes specific interferences with thinking that characterize porous patients and are expressed in the countertransference in messages that sound like: "'Please help me to tidy up. Please help me to differentiate foreign bodies from what is nourishing and to internalise a filing system, an organising function of my own'"

(Williams, 1997b, 938). In the case of patients who have been heavily projected into, porous ones in particular, the core challenge of therapy is to get them to differentiate the analyst's attempts to put them in touch with their psychic pain from what they perceive as an intrusive forcing in of a foreign body.

THE ENDURING QUESTION OF NATURE/NURTURE

Finding its origin in a Kleinian frame of reference that emphasizes introjective and projective phenomena, the concept of intrusion occupies central stage in the two object relations models on eating disorders presented in this chapter. Each model offers however a different perspective on intrusion, its gender components, its origin and its situation/implications in the broader nature/nurture picture. Lawrence's theory addresses the feminine specificity of eating pathology, explaining these disorders in terms of female anatomical and psychological proneness to receptivity and, therefore, to constitutionally triggered fantasies and fears of invasion. Her contribution in this respect is unique. Neither addressing nor challenging the feminine specificity of eating disorders; emphasizing instead the vicarious 'maternal' processing, digestion, and meaningful restitution of thoughts and anxieties - Williams' model provides an alternative channel of metaphorical receptivity to female anatomy through reversing Bion's 'container-contained' dynamics into 'receptacle-foreign-body' relationships. As

such, and as a counter model to Lawrence's femininity theory, it constitutes the basis on which I establish my intrusion thesis, which transcends gender and helps explain eating disorders in both men and women. In both models, my thesis nevertheless claims, intrusion reflects an overwhelming experience of invasion of receptivity.

The question of the compatibility of the two models comes to mind. Are Lawrence and Williams proposing irreconcilable etiologies or are they describing diverse foundations for disorders known for their complex and multiple geneses, manifestations and ramifications? I support the latter notion, noting however that, in certain ways, Williams' theory, in particular her emphasis on the mother-infant two-way complementarity (the misfit situation), encompasses all forms of the disorders. Conversely, Lawrence's model addresses specific expressions of eating disorders - those characterized by a greater genetic component in the nature/nurture balance, with excessive introjective mechanisms in the lead, mostly in the case of women, because of female anatomic receptivity. Lawrence's category of patients would be epitomized in the voracious, insatiable babies described by Williams - babies who, irrespective of maternal containment, will reject receiving from another.

To sum up, everything in intrusion is in a sense about introjective and projective processes - to be more precise, their disturbance in eating disorders, which grants a quality of invasiveness to all phenomena of incorporation and taking in/receiving. This is

initiated for Lawrence in the infant's own intrusions, because of constitutional dispositions, into the mother and, further on, into the parental couple. This in turn triggers the bouncing back of intrusion through the anticipation of retaliation and the instatement of a -K intrusive object, which attacks the link between the internal parents and compromises triangulation. There ensues the corruption of meaning reflected in obstruction in the capacity to discriminate between what is intrusive, and what is not, in objects and what stands for them. For Williams, the disruption of introjective processes starts with parents projecting their anxieties and fears. At a primary level, these projections are experienced as inimical foreign bodies, through the reversal of the 'container-contained' relationship into a 'receptacle-foreign-body' one. At a secondary level, parental projections result in the introjection of a projecting internal object that affects meaning in a disorganizing manner and leads, in a context of overwhelming dependence on primary objects, to incapacitation in the ability to receive. Underlying such incapacitation is failure in triangulation reflected in attacks on the paternal function and on the parental couple.

Ultimately, the internal world and inner triangular dynamics are quite comparable in the two models, boiling down to a denial, an erasure of differentiation and separateness from the mother, what Lawrence colorfully describes as psychic homosexuality.

For both Williams and Lawrence, failures in differentiation and triangulation represent the two facets of the breakdown in symbolization, embodied in the concreteness objects and their representatives acquire. The expression of these failures in terms of mental space occupies as crucial a place in the two theories. Although they use different terminologies and metaphors to describe the internal map of eating disordered patients, Lawrence and Williams refer to phenomena that involve on the whole rather analogous spatial challenges and protagonists.

Differences in formulation, representation and terminology can be attributed to distinct theoretical emphases, beyond the common Kleinian frame of reference, in the two theories. These emphases underlie in particular their essential divergence - sequences of introjections and projections and the ensuing location of primary intrusion in the subject or the object. In this respect, Lawrence's approach relies more heavily on Klein's model of attack on, and anticipated retaliation by, the mother, whereas Williams' essentially emphasizes the interpersonal aspects of Bion's theory of 'container-contained' - albeit its reversal in the 'receptacle-foreign-body' relationship. This is not a negligible difference, as it bears momentous influence on the nature/nurture equilibrium, with Williams' model allowing, I believe, a more balanced account of the relative importance of internal and external realities, of innate and environmental contributions - external contributions, it is important to remember, always couched in psychological

terms. As a consequence, Williams' model also allocates a fairer and more accurate place to fathers in the share of external parental influences on the development of eating disorders.

The question of paternal influence as highlighted in Williams' perspective is important on a number of planes. To start with, it goes beyond a view of paternal presence/irrelevance as mostly reflecting projections of the inner world in connection with successful/failed triangulations. In other words, it signals that an actual irrelevance of fathers constitutes a significant factor in the shaping of internal triangulation. Another important aspect of (actual) paternal influence on the development of eating disorders pertains to the nature and quality of this influence. Williams' perspective shows that there is no reason why paternal (actual) inadequacies should only be defined in terms of omission. Although the (actual) absence/irrelevance of fathers represents a major form of paternal shortcoming in contexts where mothers constitute the principal parental presence, this does not mean that fathers, when heavily projecting, do not impact their children's capacity to receive in the same way projecting mothers do.

It is therefore reasonable to suggest that external Oedipal dynamics involving actual fathers always matter and are particularly and dramatically relevant in cases when maternal containment and support is at stake. Furthermore, it is not logical to understand a mother's containing capacity outside the context of an external triangular

situation - in particular, in terms of the actual presence or absence of the father, and, even more precisely, in connection with the quality of his relationship with her. Maternal containment does not exist in a vacuum, outside the nexus of a mother's relationships and personal conditions and history. One elemental way of capturing the significance of external triangular dynamics is to consider the role of fathers in offsetting failures of maternal containment, either by alleviating these failures through the holding of mothers, or through their own provision of containment.

Both Lawrence's and Williams' models are compelling. Following Klein, Lawrence's offers insight into those patients whose eating disorder is mainly attributable to constitutional givens pertaining to voracity and insatiability (and the fantasized anticipation of retaliation and related anxieties) - which in the case of women implies overdetermination because of female receptive anatomy, propensity for stronger introjective tendencies, and distinct developmental paths -, amplified and crystallized by failures in maternal containment. This category of patients is represented in Williams' model, which, following Bion, nevertheless convincingly puts greater emphasis on the interactive dimension of the mother-infant dyad and, more importantly, focuses on a category of patients whose ordeal is brought about by parents projecting their anxieties. I believe the recognition of a greater environmental role to both maternal and paternal influences is not only necessary to understand the dynamics at work in eating disorders,

but also to broaden this understanding to the occurrence of these diseases amongst men.

In Part III of this work I search the literature for psychological counterparts to the psychoanalytic concept of intrusion - as revealed in Lawrence's and Williams' models and in line with my thesis that intrusion, understood as the overwhelming experience of invasion of receptivity, explains both the feminine specificity of eating disorders and their occurrence in the male population.

PART III

FINDINGS FROM THE PSYCHOLOGICAL LITERATURE

CHAPTER VII

PARENTAL INTRUSIONS
AND
THE DEVELOPMENT OF EATING PATHOLOGY

In Part I, I articulated the rationale for a conceptualization of eating disorders in terms of intrusion, including aspects pertaining to their feminine specificity. I proposed that intrusion, understood as the overwhelming experience of invasion of receptivity, constitutes the fundamental psychological factor in the etiology of eating disorders, and that this factor transcends gender. Part II examined the psychoanalytic theoretical background of intrusion, in general and in eating disorders. Two object relations models suggesting opposite origins for intrusive phenomena were explored - intrusion into the object (Lawrence), which corresponds to internal, constitutional predisposition to insatiatibility; and intrusion by the object (Williams), which stands for external, parental projections of anxieties. The two models I argued are not mutually exclusive, but constitute the foundation on which I base my gender-free intrusion thesis that applies to

both men and women with eating disorders. The thesis is made possible through the extension of the notion of metaphorical receptivity beyond the female anatomy.

In this last part I revisit avenues outlined earlier in my work, asking in particular the question of whether correspondences can be established between the two object relations models on intrusion and the psychological paradigm on eating pathology. Part III examines the psychological literature in search for such correspondences. This is done first, in this chapter, from the perspective of parental intrusions; then, in Chapter VIII, in examining the relationship between intrusion and femininity in eating disorders against the backdrop of sexes, gender, and sexual orientation. The two chapters confirm my thesis that intrusion, understood as the overwhelming experience of invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders, and that this factor transcends gender.

Seeking correspondences between object relations and psychology raises the question of the extent to which constructs from one paradigm can be compared to those from another. I alluded to this issue in general in my introduction, indicating that a comparative method was inherent in my choice of an interdisciplinary approach. I also signaled the benefit of dialogue between disciplines - it broadens the field of knowledge through the verification of hypotheses and the integration of data and perspectives otherwise unavailable within individual disciplines. Such dialogue, I argued, outweighs

the inherent and inevitable discrepancies between constructs across various disciplines. This is true in the specific case of control and intrusion, the two central constructs in my thesis. In the psychological tests described later in the chapter, the concepts refer to controlling or intrusive behavior by parents as perceived by offspring. In the object relations models under consideration, intrusion and control are more concerned with internal objects and dynamics.

In this chapter I show that there is sufficient overlap between perceptions of intrusion and control as described in psychology studies, which have the advantage of encompassing a large number of subjects, and psychoanalysis, which has the advantage of subtlety and detail, to bring together observations of the internal world of eating-disordered subjects with observations of these subjects' perception of intruding/controlling behavior by their parents.

One needs to go beyond what may appear as a rigid frontier between external and internal worlds. In fact, neither psychology nor object relations theories establish an unyielding barrier between the two worlds. As they are brought together in this work, both paradigms/constructs within paradigms allude ultimately to psychological experience in the context of similar pathologies. The notion of 'perception' of intrusive and controlling parenting in the two major tests under consideration is itself akin to the notion of 'experience' as I refer to it when I define intrusion, as the overwhelming

experience of invasion of receptivity. Also, in their exteriority, parental intrusive and controlling behaviors always involve a psychological component - Williams' model of external parental intrusions (parents projecting anxieties), which includes physical aggressions, is always couched in psychological terms. Furthermore, and this is discussed below[85], there exist ways of discriminating, in the psychological measurement of parental behaviors, between psychological and behavioral components.

Finally, and most importantly, the process of internalization - in its specific signification in Williams' model (Chapter VI) and as described in the section below on attachment and schema theories - provides a conceptual way to connect controlling and intrusive parenting behaviors with intrapsychic and interpsychic dynamics of control and intrusion. Williams conceptualizes intrusion as a two-phased mechanism, first involving parental projections of anxieties by parents, and then the internalization of projection through the creation of an internal projecting object. In attachment theory, internal working models - mental representations about self, other and relations, which derive from patterns of early attachment to primary figures - feature mechanisms of internalization and transmission of psychological phenomena in an individual's life, within families, and across generations. A similar process of internalization and transmission of core beliefs about self, others and relations is described in schema

[85] See the part on the PBI three-factor test in this chapter.

theory. To conclude, mechanisms of internalization - of a projecting object, of working models and related mental representations, or of schemas and related beliefs - provide satisfactory conduits to bring together the paradigms of psychology and object relations on control and intrusion. Again, this does in no way imply a perfect match between the two paradigms and sets of constructs.

In the present chapter, I show that equivalences do exist between Williams' model of parental projections (intrusions) and patterns of intrusive parenting as described in the psychology literature. The latter are expressed in terms of dominant defective affective support and excessive control as measured by instruments that also confirm an overlap between intrusion and control. Together, the substantiation of an overlap of intrusion with control and the identification of a predominant pattern of controlling parenting validate the first part of my thesis that intrusion, as the experience of invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders. Chapter VIII verifies the second part of the thesis, intrusion as transcending gender, through additional sets of psychological instruments - including my use of the homosexual exception in males with eating disorders to probe into the feminine nature of intrusion in the two sexes, on the basis of my discovery that research on sexual orientation and gender traits has consistently described male homosexuality in terms of femininity. I discuss in Chapter VIII my recourse to stereotypes of gender

and sexual orientation as found in the literature. I justify my choice by showing that I use these stereotypes precisely to transcend them by way of a gender-free intrusion theory of eating disorders.

As for Lawrence's model of internally triggered intrusiveness, I suggest it reflects the constitutional, biological, dimension in eating disorders. In that sense, and in line with the notion that complex, multiple, and intertwined pathways lead to eating disorders, Williams' and Lawrence's respective object relations models, and their 'quantified' equivalents in the psychology literature, would represent two among these pathways.

I start with an overview of psychological instruments that assess the relationship between parenting behaviors and psychopathology in offspring in general. After selecting those that cast a light on the phenomenon of intrusion, I examine their relevance to eating disorders, exploring in particular the relative contributions of parental intrusions and biological (constitutional) dispositions to these pathologies. I conclude the chapter with an integration of Lawrence's and Williams' respective object relations perspectives with findings from the psychological literature on biological and environmental/parental pathways to intrusion-related problematics in eating disorders. The findings establish the compatibility of the two psychoanalytic perspectives showing that they exist on a continuum - with Lawrence's model standing for innate tendencies

towards insatiability and Williams' for interferences in a child's development through intrusive parental projections. A greater weight is however granted to parental intrusiveness.

PARENTING AND THE DEVELOPMENT OF PSYCHOPATHOLOGY IN GENERAL

Positing that, within an integrated model of development featuring dynamic interactions between biology, culture, and psychology, parenting and family contexts draw boundaries between mental health and psychopathology, I explore in this section the relationship between parental influences and psychological disturbances in general. Amongst various angles on this relationship, I choose two particular perspectives: a first one, featuring two specific tests - the Parental Bonding Instrument (PBI) (Parker et al, 1979) and the Egna Minnen Betrsffande Uppfostran[86] (EMBU) (Perris et al., 1980) - casts a light on parental intrusion; the other - attachment theory, in particular its focus on working models - reveals mechanisms whereby intrusion is internalized and perpetuated[87].

A great deal of research currently focuses on the relative and dynamic contributions of environment and biology to individual development and there is agreement in general that the expression of heritable characteristics depends strongly

[86] 'My memories of Upbringing' in Swedish.
[87] Schema Theory (Young, 1990; Young et al., 2003), which is mentioned below, provides comparable models of transmission.

on experience, including specific parental behaviors (Collins et al, 2000). Gilbert and Perris (2000) propose in this regard that - through shaping and influencing biological maturation, emotion regulation, interpersonal behavior and vulnerability to psychopathology - parenting styles constitute an important factor in the development of children and adolescents (Gilbert and Perris, 2000). In an extensive integrative work on the neurobiology of emotional development, Schore (1994) shows for instance that, over the first eighteen months of life, an infant's relationship with the primary caregiver influences the evolution of brain structures responsible for lifelong socio-emotional functioning. Beyond early life, the "epigenetic principle… the continuing dialectic between the developing organism and its changing environment" (258) holds a critical place in recent biological, psychological, and psychoanalytic models of development (Schore, 1994).

It is important to point out that correlations between patterns of parental conduct and the development and behaviors of offspring are in no way restricted to psychopathology but are also echoed in the general population. Cubis et al (1989) show in this respect that male and female adolescents report experiencing mothers as generally more caring but also more intrusive than fathers. They nonetheless indicate that adolescents who perceive their fathers as uncaring and their mothers as controlling tend to have a more negative psychosocial profile.

Parenting patterns and family backgrounds can therefore signal the frontiers between normality and psychopathology - patterns and backgrounds that have been examined in various ways in the psychological literature. One perspective emphasizes distinctions between authoritative, permissive and authoritarian parenting styles - the first one setting structuring boundaries, the last two likely leading to problematic behaviors and psychopathology (Collins et al, 2000; Gilbert and Perris, 2000). Considering that interactions with parents provide a critical early environment for proper development through forming templates of self, others and relationships, another perspective (Bowlby, 1969, 1973, 1980) distinguishes between secure and insecure forms of attachment with the maternal object. Again, the former favors healthy behaviors, relations, and concepts about self and others whilst the latter encourages harmful ones. Other approaches examine early-life influences through the prism of memories of adolescent or adult offspring. Gilbert and Perris (2000) mention amongst others: memories of childhood traumatic experiences such as physical, sexual, and emotional abuse[88]; recollections of family environments with a focus on conflict, cohesiveness, and expressiveness; and the recalling of early parenting.

Of particular interest to my perspective are recollections of early parental behaviors and the extent to which they overlap with certain patterns of attachment.

[88] Kent el al's (1999) study on childhood maltreatment actually shows results that are not based on recollections. See more on their findings on childhood maltreatment at the end of this chapter.

Memories of early parenting are relevant in connection with the two widely used tests that measure them, the PBI and the EMBU, in particular their use of dimensions of control and intrusion. Attachment theory is relevant because it provides a frame of reference to describe mechanisms whereby enduring templates of self, others, and relationships are internalized and perpetuated - throughout an individual's life, but also across generations. I will be principally examining attachment styles through the literature that explores their links with specific patterns of parenting.

The PBI and EMBU Tests as Reliable Measures of Overlapping Control and Intrusion in Early Parenting

The examination below of the literature on the design of PBI and EMBU tests establishes the overlapping of measures of control and intrusion - both tests include a protection/control subscale that consistently involves the assessment of intrusions on the part of parents. A stable affiliation of control and intrusion, as implied in the design of PBI and EMBU tests, gives preliminary support to my hypothesis that intrusion is the core psychological factor in the etiology of eating disorders. The hypothesis proceeded initially from the identification of enduring themes of control in eating disorders. Measured against two assumptions - the interrelatedness and historical continuity of anorexia and bulimia - control's ubiquity was extended to intrusion, introducing the latter in the equation of eating disorders (Chapter II).

Interconnectedness was supported by contemporary taxonomy (Chapter I) and expressed psychodynamically as avid hunger for the object - with anorexic control a defense against bulimic urges (Shipton, 2004) (Chapter II).

An overlap of control and intrusion was further implied in the psychodynamic positing of intrusion as aiming to control objects and/or states and emotions, in a context of overwhelming dependency on an overbearing internal object, both desperately needed and dreaded - and consequences thereof on issues of identity (Chapter III). The assumption derived from Williams' model of eating disorders, in particular her use of projective identification to describe dynamics of intrusion and control in a context of dependency and loss around weaning (Chapter VI). The substantiation later on in the chapter of this last assumption, through the identification in PBI and EMBU findings of a dominant pattern of intrusive parenting, brings additional support to the overlap of control and intrusion and, further on, to the thesis that intrusion, as the overwhelming experience of invasion of receptivity, constitutes the fundamental psychological factor in the etiology of eating disorders.

As mentioned earlier and demonstrated below, the constructs of perceived parental intrusion and control in the PBI and EMBU instruments overlap sufficiently with the psychoanalytic concepts of intrusion and control as I define them in my work - intrusion as the experience of an imposed disruption of one's sense of security in

identity or sense of self, whether the origin of that interference is experienced as, or originates in, the external world (in the parents), or in the internal world (a fantasy based on insatiability); one dimension of this experience is a loss of control of oneself to an internal object.

I will now proceed with the description of the tests.

The PBI assesses levels of Protection (control) and Care respectively reflecting dimensions of "dominance-submission" and "affection-hostility", which underlie all interpersonal relations (Parker, 1998, 2). The protection/control component involves parental behaviors defined by control, overprotection, intrusive and excessive contact, infantilizing, and prevention of independent behavior (Arrindell et al, 1998). Technically speaking, the PBI is divided in and measures four broad areas (quadrants) of maternal and paternal parenting styles: 1) 'Affectionate Constraint' [high care/high protection], (2) 'Affectionless Control' [high protection/low care], (3) 'Optimal Parenting' [high care/low protection], and (4) 'Neglectful Parenting' [low care and low protection].

As for the EMBU, it consists of three subscales: (1) Rejection, which stands for parental punitive, shaming[89] and indifferent behaviors, favoring of sibling, and verbal or physical aggression; (2) Emotional Warmth, which covers physical and spoken manifestations of parental love, affection and acceptance; and (3) Protection, which

[89] See section below on shame as a mediator in eating pathology.

indicates over-protective behaviors that reflect parental attempts to control children's behaviors, over-concern about their security, as well as intrusion and overinvolvement (Arrindell et al, 1998; Rojo-Moreno, 2006). High scores on the Rejection and Protection subscales and low scores on the Emotional Warmth measures signal more negative recollections of parental styles (Perris et al., 1980; Castro, 2000 (EMBU); Jones et al, 2006 (EMBU)).

In their study on the convergent validity of the major dimensions underlying the PBI and the EMBU - including in a sample of eating disordered inpatients -, Arrindell et al (1998) show that, overall, the two tests represent parallel assessments of the same constructs. According to the study, the overlap is particularly marked between the Emotional Warmth (EMBU) and Care (PBI) scales, but less so between the more comprehensive EMBU Protection and Rejection measures and the PBI Protection ones. In this respect, Arrindell et al suggest that the EMBU Protection measure represents a better assessment of its underlying constructs than its PBI counterpart.

Studies using the PBI and EMBU scales tend to dismiss the unreliability of retrospective evaluations. There is general agreement that overall and over time, through periods of disease and recovery, perceptions of parenting styles offer an acceptably valid and reliable measure of actual parenting behaviors in the past (Gilbert and Perris, 2000; Panfilis et al, 2003 (PBI)).

It is however important to bear in mind that, even if they did form a subjective defensive prism through which past experiences are processed or evacuated - as for instance in the anorexics' frequent idealizations of parents, or, alternately, their fantasies expressing paternal irrelevance -, recollections and perceptions nevertheless offer invaluable insight into the psychic reality of patients and into the mechanisms and meanders of their pathology. Pedersen (1984) argues that it is the subjectively perceived quality of the parental relationship, as measured by the PBI, which constitutes the ultimate and central question of interest. A conclusion of this chapter is that both objective and subjective/fantasized experiences of intrusion are relevant to the development and perpetuation of eating pathology. This is in agreement with the epigenetic principle mentioned above and with my proposition that Williams' and Lawrence's respective psychoanalytic models of parental projections and patients' intrusiveness are complementary. Not to mention the psychic reality of internal objects and their dynamics, which the two models similarly underscore.

An annotated bibliography (Parker, 1998) on studies using the PBI between 1979 and 1998 documents consistent recollections of perceived harmful parental upbringing by offspring suffering a broad range of psychopathology. A quick glance at this bibliography reveals some phenomena and dynamics that are worth keeping in mind

when examining eating disorders through studies measuring recalled perceptions of parenting behaviors.

In addition to uncovering patterns of perceived parenting along with criteria and levels of care and overlapping protection/control and intrusion - the overlap between control and intrusion, it is important to repeat, is of particular significance in this study -, the PBI studies reviewed in the annotated bibliography reveal two other sets of axes: one examines and contrasts paternal and maternal influences; the other, the gender of offspring. Furthermore, these studies appear in some cases to discriminate between genetically/biologically-based pathologies and those related to parenting deficiencies, as well as between categories and sub-categories of diseases. The latter aspect is relevant to questions of interconnectedness and severity. In other cases, studies highlight dynamics between pathologies of parents and offspring. Finally, in other instances, they signal the additive and compensatory dynamics at play between mothers and fathers as well as those involved in the crisscross gender interactions of parents with offspring[90].

[90] Some examples from Parker (1998) describe such phenomena and dynamics:
The low care/high protection ('Affectionless Control') combination of parenting is for instance over-represented in the reports of patients with anxiety disorders - although sub-classes of these pathologies reveal variations such as greater maternal overprotection in cases of panic disorder, and less maternal care/greater paternal protection in patients with general anxiety disorder. From the perspective of parental symptomatology, patients with obsessive-compulsive disorder (OCD) who report anxiety in either parent also describe mothers as significantly less caring.
Again, with the exception of pain patients, higher depression levels are linked with low parental care and, to a lesser extent, with parental overprotection. Besides, neurotic depressives - to be distinguished from endogenous ones whose pathology is biologically/genetically induced and does not involve detrimental parental influences (as depicted by the PBI) - are unlikely to report experiences of 'Optimal Parenting' and much more prone to assign their mothers and fathers to the 'Affectionless Control' category. Furthermore, vulnerability to depression in offspring assigning either parent to the 'Affectionless Control' quadrant of the PBI is strongly mediated by exposure to parental

Internal Working Models and Schemas

Having established that PBI and EMBU tests assess levels of overlapping controlling/intrusive parental behaviors and their effect on psychopathology, the question arises of how perceptions of being intruded upon are internalized and transmitted. Two somehow comparable conceptualizations - schemas and working models - offer interesting insight in this respect. In this section I briefly describe the two models in their general lines. Later on in the chapter I discuss their relevance to eating disorders.

The theory of schemas (Young, 1990; Young et al, 2003) views the stability of patterns as mediated by schemas, which emerge in childhood and form templates that reflect steady, lifelong enduring themes. These themes relate to absolute beliefs about the self through which later experience is processed. In various pathologies, including eating disorders, enduring maladaptive schemas that result from traumatic experiences in early infancy are in operation (Turner et al, 2005).

As mediators of attachment-related experiences, internal working models are the key component of attachment theory. They are mental representations, which consist of

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depression. Also, when both mother and father are negatively assessed (the 'Affectionless Control' or 'Neglectful Parenting' quadrants), the risk of depression in offspring is considerably increased. In contrast, the positive rating of one parent, particularly 'Optimal Parenting', does compensate somewhat for the poor impact of the other parent. Interestingly, a same-sex patient/parent dynamic seems at work in depressive disorders, with women reporting more abnormal relations with mothers, and men with fathers. A selective offspring/parent gender dynamic however appears to operate in OCD patients - with higher obsessionality scores linked with both maternal and paternal high protection scores in daughters, but only with high paternal ones in sons.

expectations about the self, significant others, and their relationship. They form the mechanisms through which specific forms of attachment to primary figures arise early on in childhood and are transferred to relationships throughout life (Bowlby, 1969, 1973, 1980; Pietromonaco & Feldman Barrett, 2000).

Some elaboration on the question of attachment is useful as the concept encompasses aspects of anxiety and dependency that are central to Williams' and Lawrence's psychoanalytic models of intrusion - in particular Williams', because of her particular emphasis on anxieties in the critical early-life context of dependency. Attachment represents a specific relationship, or aspects of a relationship, characterized by the use of others as a source of security. In situations of anxiety and fear, a person's attachment style or organization induces behaviors aimed at securing closeness to the attachment figure - proximity which functions as a calming factor, both in health and in pathology. Secure attachment develops when the available and emotionally attuned primary caregiver is used as a secure base from which exploration can occur, and to which to return safely in the event of distress. If unable to use the primary caregiver as a secure base for exploration, the child develops a chronic separation anxiety in connection with the experience-based assumption that attachment figures are weak, frustrating, or unpredictable and will therefore fail to respond when solicited for help. Insecure attachment takes three forms. One is anxious/avoidant attachment - a denial

of attachment, and the absence of appropriate distress emotions in both situations of separation and reunion. The second is anxious-ambivalent/resistant attachment - the child seeks proximity in the context of separation; upon separation, he/she is distressed, ambivalent, and angry; upon reunion, he/she is reluctant to be soothed by the caregiver. The last is disorganized attachment - the child is caught in inconsistent attachment strategies, reflected in contradictory and disoriented behaviors. In general, insecure attachment expresses itself in numerous ways - including wary hyper vigilance, angry menaces or compulsive niceness - and may result in phobias, low self-reliance, and proneness to separation depression (Aisnworth, 1967, 1968; Bowlby, 1969, 1973, 1980; Main and Solomon, 1986; O'Kearney, 1996).

PERCEIVED[91] INTRUSIVE PARENTING AND EATING PATHOLOGY

Before examining perceived parenting styles per se and their impact on eating pathology, a remark concerning the actual utilization of PBI and EMBU tests in these disorders is worth making. EMBU studies on eating pathology are fewer than those using the PBI. This is unfortunate if indeed EMBU protection and rejection measures offer, as mentioned earlier, a more sophisticated and comprehensive assessment of parental protective behaviors. In this respect, one could also deplore the limited use in

[91] Apart from the introductory part, and for the sake of clarity and to avoid repetition, I will not systematically specify that parental patterns of behaviors in PBI and EMBU scores are actually perceived ones.

research on eating disorders of another version of the PBI, the three-factor model. This model refines the concepts of control and intrusion through distinguishing between their psychological and behavioral components (Laporte and Guttman, 2007) (PBI-3F). As such, it addresses parental contributions to eating pathology in their complexity, challenging a rigid barrier between implicit and explicit interferences. This is particularly significant considering what was said earlier on the disparity between psychological and psychoanalytic constructs of control and intrusion. Through shedding additional light on distinct psychological and behavioral components in perceptions of controlling/intrusive parenting, a more widespread use of the PBI-3F model in eating pathologies would contribute to narrow, or at least document, the breach between the two constructs in the two paradigms.

Bearing these remarks in mind, I will now present findings deriving mainly from PBI studies on eating disorders[92], interspersed, whenever available, with results from the EMBU and the PBI-3F model scales. I will then draw the main conclusions that follow from them.

As in the case of general psychopathology, PBI studies on eating disorders reveal patterns of perceived parenting styles in offspring suffering from these pathologies. In this section, I present the findings of a large number of studies, which I

[92] PBI studies covered in Parker's (1998) review and later ones up to 2011 identified in my research.

first consider in an aggregate manner (all categories of eating disorders combined), then through specific categories of anorexia, bulimia, and binge eating[93]. These findings confirm correlations between eating disorders and a predominant pattern of parenting - a combination of high control/intrusion and low care, what I designate as a 'Parental Affectionless Control Dynamic'. This predominant parenting pattern across all categories of eating disorders is critical because it ultimately confirms, in combination with the overlap I established between intrusion and control, my hypothesis that intrusion is the fundamental psychological factor in the etiology of eating disorders. It also is critical in underscoring the significant paternal dimension of this pattern, therefore contradicting the exclusive relevance of mothers often associated with these pathologies.

The distribution in Table I indicates that, when eating disorders are considered aggregately, both maternal and paternal parenting styles - in particular clusters of low care and high control - appear equally relevant to their development. Indeed, four out of six studies attribute parenting styles to the 'Affectionless Control' category: one study emphasizes the influence of the two parents, two other that of fathers, and a last one that of mothers. It is important to note that patterns of care and/or control are manifest in a number of combinations and are by no means restricted to strict PBI quadrant

[93] Findings are tabulated at the end of this section.

formulations and/or exclusive maternal or paternal clusters of influence. In one instance for example, eating disorders are associated with lower levels of maternal care and higher levels of paternal protection (Katena et al, 2004) (PBI), whereas in another they are only linked to high paternal control (in combination with the frequency of recent adverse life events) (McEwen and Flouri, 2009) (PBI). Also, distinct maternal and paternal clusters of 'Affectionless Control' appear to be respectively compounded by low paternal (Turner et al, 2005) (PBI) or low maternal (Calam et al, 1990) (PBI) levels of care. This seems in line with the additive parental dynamics mentioned above.

Associations are sometimes examined in terms of symptoms that are typical or common in eating pathology. For instance, Panfilis et (2003) (PBI) identify the link between alexithymia (the inability to identify, distinguish and describe bodily and emotional states) and body image disturbance in terms of failures in parent-child interactions - in particular, low parental care predicts body image disturbance and low maternal care alexithymia. Furthermore, they associate avoidance, depersonalization, and compulsive self-monitoring with parental intrusiveness (Panfilis et al, 2003) (PBI).

Various EMBU findings on eating disorders considered aggregately corroborate PBI results of overall deficient parenting in areas of care and control, also without a categorical attribution to either parent or issue. For instance, Ihle et al (2005) (EMBU) describe control/overprotection by the mother as a significant variable of eating

disorders in both sexes. Esparon and Yellowlees (1992) (EMBU) show that clinical patients with eating problems rate both parents as being less consistent, less emotionally warm, and more rejecting than controls. Rojo-Moreno (2006) (EMBU) indicate a significant propensity in patients with eating disorders to consider their two parents as less affective, more overprotective and more rejecting than healthy individuals - with more rejection and negative ratings for emotional warmth in bulimics than in anorexics.

PBI results for the anorexia subgroup (Table II) also show an equal distribution of high control and low care behaviors amongst the two parents, whether in distinct maternal or paternal clusters of 'Affectionless Control', or in variable independent and/or additional parental combinations. Interestingly, a maternal 'Affectionate Constraint' pattern (high care, high control) also appears in this subcategory of disorders (Laporte and Guttman, 2007) (PBI-3F). The high care dimension, along with results that indicate similarities between anorexics and normal controls (Russell et al, 1992) (PBI) may reflect a tendency for this group of patients to idealize family atmospheres and parents (Fichter and Quadflieg, 1996) (PBI). I discuss below this divergence from the otherwise predominant "Affectionless Control" pattern of parental behavior in anorexic patients.

Other findings are worth mentioning. Canetti et al (2008) (PBI) identify two psychological dimensions as more consistently related to specific forms of parenting in

anorexia: asceticism - an inclination towards self-discipline, self-denial and the control of bodily urges -, which is associated with mother care and mother control; and social insecurity - the belief that social relationships are unsafe, unsatisfactory, and unfulfilling -, which is associated with mother control and father care[94]. Using the three-factor PBI model, Laporte and Guttman (2007) (PBI-3F) mention similar levels of maternal care in anorexia and in controls, but detect more maternal psychological protection (intrusion) and denial of behavioral freedom in anorexics than in the general population. Finally, Canetti et al (2008) (PBI) highlight the transgenerational transmission of patterns of low care through both maternal and paternal grandmothers of anorexics (Canetti et al, 2008) (PBI).

One EMBU study (Castro et al, 2000) on anorexia as a subgroup[95], which shows that dysfunctional parenting may influence the short-term outcome of the disorder, does not support the existence of abnormal rearing practices in this population of patients - at least in young patients with a short evolution of the disease. As in the case of the 'Affectionate Constraint' quadrant revealed in Russell et al's (1992) (PBI) study, this contradiction of the otherwise predominant "Affectionless Control" parental pattern of behavior will be discussed below.

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[94] Two remarks are worth making here in connection with the two dimensions of asceticism and social insecurity. Except for the spiritual connotation, asceticism is akin to enduring expressions of self-starvation throughout history as described in Chapter II and Chapter III. As for social insecurity, its association with mothers and fathers in Canetti et al's study hints at the still common paternal function of socialization and separation from the mother.

[95] Other EMBU studies such as Rojo-Moreno et al's (2006) and Esparon and Yelowless' (1992) consider eating disorders in an aggregate way.

PBI studies on bulimia (Table III) are not unlike those on anorexia, with a globally equal distribution of patterns of ‘Affectionless Control’ between the two parents. For Sordelli et al (1996) (PBI), the compounding of ‘Affectionate Constraint’ in both mothers and fathers with overwhelming parental protection reflects the fact that, unlike anorexics, bulimics do not tend to idealize parents. While idealization has been shown to be a common defense in anorexics, the finding that perceptions of controlling and intrusive patterns of parental behaviors are quite extreme in bulimics shows that idealization is not in the defense repertory of this group of eating-disordered subjects.

Finally, two PBI studies on binge eating (Table IV) confirm an overall equal distribution of patterns of ‘Affectionless Constraint’.

TABLE I - EATING DISORDERS AS A GROUP (PBI)				
Study	**Affectionless Control**			**Other control/care combinations***
	Parental	**Maternal**	**Paternal**	
Steiger et al, 1989			X	
Calam et al, 1990			X	Low maternal care
Panfilis et al, 2003	X			
Katena et al, 2004				Low maternal care & high paternal protection
Turner et al, 2005		X		Low paternal care
McEwen & Flouri, 2009				High paternal protection
* In addition to, or independently from, PBI quadrant combinations				

TABLE II - ANOREXIA (PBI)							
Study	**'Affectionate Constraint'**			**'Affectionless Control'**			**Other control/care combinations***
	Parental	**Maternal**	**Paternal**	**Parental**	**Maternal**	**Paternal**	
Gomez, 1984					X		
Calam et al, 1990						X	Low maternal care and protection
Russell et al, 1992							More similarity with controls than with other adolescent patients
Sordelli et al, 1996							High parental care
Fichter and Quadflieg, 1996							Same as normal adolescents
Laporte and Guttman, 2007 (3F)		X					High parental care High maternal behavioral & psychological protection
Canetti et al, 2008				X			Also low maternal & paternal grandmother care + Association of asceticism with maternal care & control and social insecurity with mother control and father care
* In addition to, or independently from, PBI quadrant combinations.							

TABLE III - BULIMIA (PBI)							
Study	**'Affectionate Constraint'**			**'Affectionless Control'**			**Other control/care combinations***
	Parental	**Maternal**	**Paternal**	**Parental**	**Maternal**	**Paternal**	
Gomez, 1984							Low paternal care
Pole et al, 1988						X	Low maternal care
Palmer et al, 1990							Low maternal & paternal care
Fichter and Noegel, 1990				X			
Sordelli et al, 1996	X						Overwhelming parental protection
Fichter and Quadflieg, 1996				X			Particularly significant for fathers
Murray and Waller, 2000							High paternal protection
Meyer and Gillings, 2004							High paternal protection
Katena et al, 2004							Low maternal care and high paternal protection
* In addition to, or independently from, PBI quadrant combinations.							

TABLE IV - BINGE EATING (PBI)							
Study	**'Affectionate Constraint'**			**'Affectionless Control'**			**Other control/care combinations***
	Parental	**Maternal**	**Paternal**	**Parental**	**Maternal**	**Paternal**	
Fichter et al, 1993				X			
Fowler and Bulik, 1997					X		High paternal overprotection
* In addition to, or independently from, PBI quadrant combinations.							

I will now critique the main findings from the above overview and propose conclusions that follow from my critique.

Conclusions from PBI and EMBU Findings

A Definite Link

Some PBI and EMBU studies appear to contradict, or at least qualify, what most findings nevertheless confirm as the existence of a definite link between certain forms of perceived parenting, namely a predominant parental 'Affectionless Control' pattern and eating pathology. Before referring to these inconsistencies and suggesting some interpretations as to their possible meaning, a reminder of the importance of the 'Affectionless Control' pattern to my thesis (intrusion as the fundamental psychological factor in the etiology of eating disorders) is necessary. Considering the extension of notions of control to intrusion and the ensuing introduction of the latter in the equation of eating disorders - an extension, which I confirmed in the overlap of control and intrusion as inherent in the design of PBI and EMBU tests -, the identification in PBI and EMBU

studies of predominant patterns of controlling parenting can accordingly be extended to, and conceptualized in terms of, predominant intrusive parenting. This verifies this work's hypothesis of intrusion as the core problematic of eating disorders. I elaborate on this essential confirmation later on in the chapter by showing how intrusion prevails over other important problematics in these disorders.

Back to studies contradicting a link between parenting and eating disorders, Palmer et al (1988) (PBI), although warning against excluding family dynamics altogether from an understanding of eating pathology, argued for instance that their results do not support the idea of particular or stereotyped patterns of familial interaction. Castro et al (2000) (EMBU) reported a similar absence of link between particular rearing behaviors and eating pathology in young anorexic patients. Finally, Kent and Clopton (1988,1992) (PBI) found similarities in the parental care of bulimics and controls; so did Fichter and Quadflieg (1996) (PBI) in the parenting of anorexic and normal adolescents.

The absence of link suggested in the above examples can nevertheless be explained by two sets of reasons, operating at two different levels: structurally, in the studies themselves - for example, methodological flaws in selected instruments or samples of population -, and at the level of individuals and psychological defenses that

characterize them. Explanations involving both sets of causes are inherent in these examples.

Starting with structural causes, a short evolution of the disease could explain Castro et al's (2000) (EMBU) results in young anorexic patients. The use of less sensitive instruments and the failure to detect/include partial forms of disease could account for similarities in parenting as reported by bulimics and controls in Kent and Clopton's findings (1988, 1992) (PBI). In this respect, it is interesting to mention Rojo-Moreno's study (2006) (EMBU). The research, which uses instruments that allow the detection of subclinical forms of pathology, shows that there are no differences in paternal rejection and lack of emotional scores between community (partial and subclinical forms in majority) and hospitalized (full syndromes) cases, but that significant ones exist between the latter two groups and normal controls. As a result, and in support of a conceptualization of eating pathology in terms of dimensionality, Rojo-Moreno (2006) (EMBU) go as far as recommending the generalization of results from clinical studies on abnormal rearing to community groups.

Finally, at the individual level this time, defense mechanisms such as idealization in anorexics could account for the blurring, and hence non-reporting, of atypical rearing attitudes. Steiger et al (1989) (PBI) have shown that perceived or actual empathic failures of parents encourage the dependence of anorexics and bulimics on primitive

defenses such as projection and acting out, and that parental overprotection restricts the development of mature ones such as sublimation. In a similar way, the idealization of parents in the above-mentioned cases of anorexia can be seen as reflecting another primitive defense (Fichter and Quadflieg, 1996) (PBI).

My critique above of studies that seem to contradict the existence of a consistent link between certain forms of perceived parenting and eating disorders leads to my conclusion that such a link does ultimately exist in the form of a predominant parental 'Affectionless Control' pattern - which allows me in turn to establish intrusion as the core problematic in these disorders. I take up this predominant parenting pattern separately under the section "'A Complex 'Parental Affectionless Control Dynamic'" that follows the next one on the relevance of fathers to eating pathology.

The Irruption of the Father and the Challenge of the Maternal Paradigm

PBI and EMBU studies contradict psychoanalytic and other theories of eating disorders that view these disorders as belonging to the exclusive realm of the mother. Not only are both parental influences integral components of the general problematic of eating disorders, paternal ones do emerge as weighing significantly in these pathologies. Paternal patterns of 'Affectionless Control' (overprotection in particular) are for instance described in Calam et al (1990) (PBI), who observe that trends towards

perceived paternal overprotection in American women with eating disorders are also found in women in the United Kingdom. Remarking that a common theme in eating disorders involves object representations of fathers, Steiger et al (1989) (PBI) emphasize instead the care dimension, showing that eating disordered patients uniformly recall less paternal empathy than controls. Jones et al (2006) (EMBU) underscore the importance of father-daughter relationships in the etiology of disordered eating. Rojo-Moreno (2006) (EMBU) find it striking that all studies, including their own, confirm abnormal paternal rearing behaviors (both rejection and lack of emotional warmth) as an important player in the development of eating disorders. They identify such dysfunctional attitudes as the most prominent correlate in eating pathology: “Far from being a passive and neutral factor, maladaptive paternal behavior appears to play an even greater role than maternal behavior in female offspring developing an eating pathology” (40). Contrasting paternal influences with maternal ones, Laporte and Guttman (2007) (PBI-3F) point out the compensatory dynamics at play in the families of women with anorexia, which are characterized by imbalances in parental control - and the related need to “loosen the bonds between mother and daughter and foster father’s self-assertiveness” (137). Finally and as mentioned above, McEwen and Flouri (2009) (PBI) specifically identify the psychological dimension of paternal control (in conjunction with the frequency of recent adverse life events) as an important component of eating

disorders.

PBI and EMBU findings on the individual or combined contributions of mothers and fathers are in line with results from research that uses other approaches and instruments of investigation. Walters and Kendler (1995) indicate for instance that women with eating disorders generally report negative interactions and relations with their parents. More specifically, fathers and mothers are depicted in the literature as commonly presenting distinctive interpersonal styles. Sights and Richards (1984) and Strober and Humphrey (1987) report that mothers of eating disordered women are overprotective, controlling and intrusive, whilst fathers are distant, withdrawn, and passive. Although pointing to a growing conceptual understanding in the 1990's of bulimia and anorexia in terms of degrees of maternal involvement in childcare - over-involved mothers of anorexics, and, intentionally or unintentionally neglectful mothers of bulimics -, Zerbe (1992) invokes the dynamic interlocking of paternal and maternal influences: maternal influence is inscribed in the developmental struggle of separation and differentiation that underlies eating disorders; conversely and complementarily, paternal influence is inscribed in the consequences uncaring or overprotective fathers have on self-esteem, and the cascading effect this has in turn on fostering or discouraging differentiation and autonomy (Zerbe, 1993). Fosse and Holen (2006) signal an important paternal component, more coldness and overprotection, in the case

of bulimic outpatients. Similarly, in identifying rejection as a predictor of the drive for thinness, bulimia, and body dissatisfaction, Stuart et al (1990) and Dominy et al (2000) suggest that paternal rejection is particularly relevant to the etiology of disordered eating.

Having confirmed the equivalent importance of maternal and paternal influences on the etiology of eating disorders as well as their compounding versus compensatory effect, I specify the controlling/intrusive nature of these dynamic influences in the following section.

A Complex 'Parental Affectionless Control Dynamic'

Acknowledging equally important paternal and maternal contributions only partially illuminates the complex relationship between parenting and eating pathology. Such complexity is reflected in the disconcertingly varied permutations of maternal/paternal and control/care components as revealed in the reviewed literature.

In order to make sense of some of the stable connections that do nevertheless emerge, it may be useful to stress the distinction between two sets of data in the PBI tables above. As already pointed out, one set establishes in a predominant way the 'Affectionless Control' quadrant, with an overall equal contribution of both maternal and paternal influences - in other words, the contribution of the two parents to both

perceptions of low care and high protection. I will call the latter dominant dynamic the 'Parental Affectionless Control Dynamic' and suggest that it represents a stable pattern that underlies all categories of eating disorders. The other set of data compounds this predominant dynamic with additional maternal or paternal clusters of care and/or protection playing out in infinite combinations.

It is not clear whether the ubiquity of the so-called 'Parental Affectionless Control Dynamic' only signals the failure of PBI studies to discriminate between subgroups of pathology, as suggested by Calam et al (1990) (PBI), or whether it bears, as I believe is the case, larger taxonomic implications. When finding no major differences between eating disorder subtypes in their study, Steiger et al (1989) (PBI) have concluded that these pathologies share significant psychodynamic characteristics - "a homogeneity consistent with beliefs that anorexia and bulimia nervosa fall on a continuum with common psychological factors acting etiologically" (p. 137)[96]. Their conclusion supports Shipton's hypothesis that anorexic control defends against bulimic hunger for the object.

[96] Homogeneity in findings may indeed be explained in terms of a continuum along which subcategories of eating disorders fall. It may however alternatively result from the inability of instruments to detect further distinctions, whether they relate to maternal and paternal objects or to the quality of care and control parents are perceived to provide. A number of studies have attempted to enhance instruments of research to the effect of refining results. Laporte and Guttman (2007) (PBI-3F) made for instance one such attempt in a study that used the three-factor PBI model. Through splitting control into two psychological and behavioral dimensions, their aim was to underscore differences in the quality of maternal and paternal bonding. Their study however is the first one introducing the PBI three-factor model in eating disorder research. Many more similar studies would be needed before confirming the superiority of this instrument in terms of discrimination, namely with regard to specific subcategories of eating pathology. Such ability to discriminate is however never guaranteed since conflicting results are always bound to limit any categorical distinction. For instance, Laporte and Guttman (2007) (PBI-3F) mention two such studies (on adolescents in general) that reveal contrasting findings: in the first, children view mothers as generally exercising more denial of psychological autonomy than fathers, but do not perceive any difference between the two parents in terms of denial of behavioral freedom; in the second, adolescents attribute higher degrees of denial of psychological autonomy to mothers and higher degrees of denial of behavioral freedom to fathers.

The most important implication of the 'Parental Affectionless Control Dynamic' finding is however the preliminary evidence it grants - when combined with an extension of notions of control to intrusion (as inherent in PBI and EMBU tests) - to the thesis that intrusion is the fundamental psychological factor in the etiology of eating disorders. An ultimate confirmation of the thesis comes with the substantiation later on in the chapter of intrusion's supremacy over other psychological factors in these disorders.

COMPLEMENTARY PATHWAYS TO BIOLOGICAL ETIOLOGY AND TRANSMISSION OF INTRUSION-RELATED PHENOMENA IN EATING DISORDERS

PBI and EMBU tests underscore the relevance of parental control/intrusion, in its interface with care, to eating disorders. Implicit in the identification of these parental patterns of behavior is the recognition of environmental influences - beyond those of biology, which are invoked in explaining the larger lifetime occurrence of eating problems among relatives of individuals with an eating disorder (Strober et al, 2000). The two sets of influence need not however be mutually exclusive.

Seeking to verify the thesis of a multifactorial etiology in eating pathologies (Kent and Waller, 1999), and, assuming, for the time being and for the purpose of clarity, that cultural influences[97] are generally speaking internalized by parents, inherent in their behaviors, and transmitted through them, I examine in this section the interactions of

[97] On the question of cultural aspects, see Chapter IV and Chapter VIII.

biology with environment in these disorders. In doing so, I identify attachment theory and schema theory as psychological frames of reference that provide plausible complementary channels of transmission that challenge an exclusive biological interpretation. The constructs are relevant in explaining how intrusion-related phenomena in eating disorders may be perpetuated - throughout the life of individuals (both theories), but also within families and across generations (attachment theory). Such forms of perpetuation, it is important to say again, are compatible with and do not exclude the contribution of biological factors.

The Challenge of Biology

Eating disorders are transmitted in families (Strober et al, 2000) and evidence from twin studies suggests that genetic factors play an important role in the development of these disorders (Canetti et al, 2008) (PBI). It is therefore quite conceivable that biological factors, genetic in this case, may overrule, or at least qualify, specific parental influences on eating pathology.

The etiological contribution of genetics is however a complex and complicated one. This is well expressed by Fichter and Noegel (1990) (PBI), who, whilst recognizing that high concordance rates for monozygotic twins with bulimia and anorexia certainly indicate a genetic vulnerability to these disorders, nevertheless argue that such

similarities could also be explained by the fact that, over time, monozygotic twins assimilate from one another more than dizygotic twins. Indeed, in the former, developmental difficulties in achieving individuation and separation are seriously complicated by physical similarity, similarities in parental expectations and in parental upbringing, as well as by lack of rivalry and competition. Problems of individuation resulting from having a “living double” may therefore contribute to higher dependence on the co-twin and to difficulties in social learning and in relating with other peers. The fact that the latter all constitute serious risk factors for developing bulimic or other eating disorder symptoms shows the difficulty of disentangling genetic from developmental and environmental factors. Besides, Fichter’s and Noegel’s PBI results not only do not reveal differences between monozygotic and dizygotic bulimic twins, but also match other PBI findings in terms of low levels of care and high levels of control in both mothers and fathers - another argument in support of at least partial environmental, parental contributions.

In line with the integrative approach evoked above (Schore, 1994; Collins et al, 2000; Gilbert and Perris, 2000), it is possible to posit that a genetic foundation of eating pathology is most likely inscribed within an interactive etiological model that also involves parental influences. Quantifiable answers regarding the precise input of genetics in familial transmission, but also in discriminating between subcategories of

eating disorders, are however as difficult to single out, in relation to other factors, as those pertaining to parenting.

Insecure Attachment and Shame

Working models in attachment theory and schemas in schema theory suggest plausible alternative or complementary frames of reference to explain the transmission of intrusion-related phenomena in eating disorders. As enduring mental representations consisting of expectations about the self, significant others, and the relationship between the two, working models describe mechanisms through which specific forms of attachment to primary figures arise early on in infancy and are transferred to relationships throughout the life of an individual. On the other hand, as beliefs about the self that emerge in childhood, schemas form stable, enduring templates through which later experience is processed. These templates act as mediators in the relationship between external events and their perception, in health and in pathology. Although the two constructs of working models and schemas are comparable in terms of the mechanisms they involve, they vary with regard to the content they convey. Attachment patterns and attendant anxieties constitute consistent characteristics in working models whereas content in schema theory changes according to contexts or disorders - in eating pathology for instance, shame emerges as a significant mediator in the

relationship between perceptions of parental behavior and the development of the disorder.

A number of studies, which associate eating disorders with insecure forms of attachment, cast a light on how attachment-related phenomena and anxieties are a critical component of these pathologies. Armstrong and Roth (1989) show that anorexic and bulimic patients display significantly more severe separation and attachment difficulties than is normal in adolescents and adults going through development-based relationship crises - 96% manifest anxious attachment and 85% extreme separation depression. In a review of the literature on the subject, O'Kearney (1996) finds solid evidence for attachment disturbances in eating-disordered populations - anxious attachments, fears of abandonment, and difficulties with autonomy differentiate young women with eating disorders from controls - and for an association of these disturbances with key aspects of eating psychopathology. Ward and Ramsay (2000) confirm significant differences in reciprocal adult attachment levels between eating disordered patients and controls. Particularly characteristic of the former are contradictory attachment styles involving compulsive care seeking (anxious) and compulsive self-reliance (avoiding) dimensions - a paradox often encountered in the clinical setting when eating disordered patients simultaneously send two sets of contradictory messages, "the overt verbal 'leave me alone' and the covert somatic 'you

can't leave me, I'm dying'" (5). Finding that attachment patterns fail to discriminate between subcategories of eating disorders, Ward and Ramsay conclude that similar attachment difficulties must lie behind anorexia and bulimia. They suggest a model whereby early attachment insecurities provide the template against which all eating disorders develop whilst later events ultimately determine specific forms of anorexia or bulimia. In addition to reflecting transactional struggles of distance and closeness with the internal object, this again supports the notion of psychodynamic interconnectedness between the two poles of eating pathology as adopted in this work.

The literature on attachment styles in eating pathology calls attention to enduring themes around issues of separation, abandonment, dependency, autonomy - and, their attending anxieties. It also reveals an interesting overlapping between these attachment-related themes and problems pertaining to control/intrusion as shown in PBI and EMBU studies. I will get back later on the question of hierarchy between anxieties of intrusion and attachment-related ones - the question is of extreme relevance to my thesis of intrusion's supremacy over other problematics. At this point, I will concentrate on how insecure forms of attachment, in their two aspects of anxious clinging and avoidance, emerge in the context of experiences with primary care givers, endure over time, and become manifest in eating disorders; and also, on how they explain higher prevalence rates in eating disorders in families of patients suffering from these

pathologies. Both aspects shed a light on alternative or complementary channels of perpetuation and transmission of intrusion-related phenomena in eating disorders.

The PBI study by Canetti et al (2008) (PBI) finds that insecure attachment going back to early object relations is characteristic of individuals with these disorders. Reviewing studies since 2000, Tereno et al (2008) (EMBU) also confirm the association between insecure attachment and eating disorders - with bulimics showing higher proportions of preoccupied, anxious attachment patterns and anorexics higher proportions of avoidant ones. The latter study specifically establishes a bridge between the two frames of reference of parenting perceptions and attachment styles: (1) anorexics and bulimics display higher anxiety and/or avoidance than control groups in their present parental relations and perceive higher overprotection and/or rejection in their past maternal and paternal relationships; (2) in both anorexics and bulimics, anxious and/or avoidant attachment styles are related to negative memories of parental rearing - more specifically, there are significant relations in anorexics between avoidance and maternal/paternal overprotection, whereas higher anxiety in bulimics is associated with lower emotional support and higher avoidance in mothers as well as with lower emotional support in fathers; (3) as for their own attachment styles, parents of both anorexics and bulimics perceive them as more anxious and/or avoidant than do parents from the control group.

The last point touches on the question of the transgenerational transmission of eating disorders through the perpetuation of attachment and parenting styles. The study by Canetti et al (2008) (PBI) shows indeed that the transmission from generation to generation[98] of parent-child relationships acts both directly and indirectly on the etiology, maintenance, and level of intensity of anorexia. In particular, they underline the central role of the care dimension of parental bonding: (1) anorexic granddaughters report both their parents as less caring and their fathers as more controlling; (2) paternal and maternal grandmothers' low care is associated with the severity of anorexic symptoms of anorexia in granddaughters; (3) the controlling behavior of paternal grandfathers is associated with more controlling behavior and less caring in their sons - it is nevertheless the father-daughter relationship that has a direct impact on eating disorders. The study, the first on the transgenerational transmission of parenting influences in eating disorders, specifically proposes attachment theory as a frame of reference[99] for these pathologies. Experiencing one's parents as lacking care or exerting excessive control induces internal representations of such relationships, which, in turn, influence one's caring and controlling attitudes towards one's own children, and,

[98] Irrespective of eating disorders, a daughter's report of 'Affectionless Control' in her mother after a ten-year follow up period is significantly associated with the mother reporting 'Affectionless Control' in her own mother (Parker, 1998).

[99] Another frame of reference is learning theory, which conceptualizes parental influences on future generations in terms of processes of modeling and reinforcement. Lack of care and/or controlling attitudes are accordingly conceived in terms of the imitation, by parents, of the parenting styles of their own parents (Canetti et al, 2008) (PBI). My preference for attachment theory and parenting styles as described in PBI and EMBU studies is determined by the focus these two frames of reference place respectively on anxiety and intrusion.

further on, the development of eating disorders.

I will now turn to schemas, leaving aside their relevance as mechanisms of transmission within the individual, which I believe are akin to those of working models in attachment theory. The concept of schema is particularly interesting in that it highlights shame as a significant mediator in the relationship between perceptions of parenting and eating pathology.

A ubiquitous technique of socialization - even the gentlest form of parenting involves a minimum of mild shaming to influence behavior in children -, shame marks the “rapid transition from a preexisting high arousal positive hedonic state to a low arousal negative hedonic state” corresponding respectively and sequentially to maternal amplifications and deflations of the narcissistic affect (Schore, 1994, 203). This powerful emotional experience arises around the beginning of the second year of life when the role of mothers significantly changes from care giving to socializing through the inhibition of a toddler’s enjoyable activities. As such, shame is seen as constituting an ontogenetic adaptation (Schore, 1994). Morrison (2011) describes a developmental sequence of shame, which, although not necessarily linear, involves experiences from: (1) inefficacy to obtain an anticipated soothing response from the early caregiver (equated with rejection, abandonment); to (2) a more distinct sense of self separate (both separateness and isolation) from the other, with ensuing comparison and

competition; and, further, to (3) a more particular sense of failure regarding certain ideals one shapes for oneself (the internalization of shame as one's gaze turned inward).

Whereas the first experience described by Morrison (2011) highlights the origin of shame in the failed attunement of the primary care giver, the latter two distinguish between external and internal forms of emotional experience as amply described in the literature on shame (Goss and Allen, 2009). External shame involves the belief that 'the other' despises the self, sees it as flawed, inadequate, insignificant and unappealing, and its primary anxiety is fear of exposure with ensuing social diminishment, devaluation or rejection. In this form of shame, where attention is focused outwards with particular efforts to process information about what others think about the self, a typical impetus is to hide from the other unattractive aspects of the self. Internal shame in contrast is about inner experiences of a flawed, inadequate, inferior and unattractive self - filtered and processed through self-criticism and self-hatred (Goss and Allen, 2009).

Research on shame and eating disorders as reviewed by Goss and Allen (2009)[100] describes shame as a major factor in the onset and maintenance of these disorders and experiences of feeling ashamed and being shamed by others as painful

[100] Unless otherwise specified, the following section on shame is based on Goss and Allen's (2009) review.

and associated with social rejection and humiliation. Goss and Allen's review highlights shame-related defensive behaviors that are critical to the maintenance of eating disorders. These include coping strategies per se, which provide clues about underlying feelings of shame: *attentional bias*, e.g. increased attention to external social cues from others regarding one's size, shape and weight; *aggression*, active or passive [sulking, non-compliance with therapy programs], towards those who criticize one's size, shape, or eating behaviors; or, instead, *excessive submission to authority*, such as high compliance to therapeutic programs leading however to later difficulties and relapses; *concealment* [hiding of body, bingeing, vomiting, laxative use, hoarding, and of desire and need to eat]; *avoidance and withdrawal* [avoidance of triggers for eating, of size- and shape-related information, of public bodily exposure or intimate relationships, and withdrawal from social (eating) situations]; *destruction of the object of shame* such as fat through extreme food restriction, recourse to potentially dangerous surgical procedures, self-mutilation, or suicide; *compensation* (for belief of being a bad person or lacking attractiveness) by providing excessive care and consideration for others or over-performing in other areas of life.

A counterpart of shame, pride (in eating behavior and in resistance to authority) may be particularly significant in the maintenance of pathological eating. At once a powerful social and psychological defense, it interacts with external and internal forms

of shame in cycles that may suggest, as will be shown below, specific paths towards the development of various forms or sub-categories of eating disorders. High levels of both external and internal shame, sometimes concealed in pride, are indeed revealed across all categories of eating disorders. The following specific associations have been suggested.

Subjects with restrictive forms of disorder experience higher levels of external shame than those reporting bulimic symptoms - a phenomenon also positively associated with underweight severity. A model based on a vicious circle of shame-pride-shame has been suggested for these pathologies. In a few words, background factors (genetic predispositions, personality, early attachment failures, histories of rejection or abuse, and cultural dynamics) induce various forms of external shame. In a first phase, vulnerability to negative social outcomes generates pride in the capability of changing body weight and shape to fit actual or perceived cultural standards. In a second phase, however, when the ability to manage weight or shape collapses, direct and amplified forms of shame inevitably resurface.

In the same way external shame is more often associated with anorexic symptoms, internal shame is more frequently related to bulimia. Bulimics are first and foremost preoccupied with controlling and managing unstable and negative affects in interpersonal contexts, and with preventing others from uncovering their secret

bingeing/purging/exercising[101] coping behaviors. Managing weight/shape and/or affect in ways that are not as socially obvious and objectionable as is the case in restrictive behaviors, which leads to emaciation, explains the lower forms of external shame and higher forms of internal shame experienced by bulimics. A model entailing a shame-shame cycle has therefore been suggested for bulimic pathology.

Binge eating is also strongly correlated with internal shame and involves similar shame-shame cycles. Incidentally, this form of pathology reveals significant gender differences in etiological and maintenance pathways - in men, shame is related to body dissatisfaction; in women, to weight concerns.

I will now look into some studies that have examined shame in its specific mediating function between perceived parental behaviors, which underscore patterns of intrusive parenting, and eating disorders.

Turner et al (2005) (PBI) describe Defectiveness/Shame and Dependence/Incompetence as perfect mediators in the relationship between parental care and maternal overprotection, on the one hand, and eating pathologies, on the other. Murray and Waller (2000) (PBI) suggest that experiencing shame is critical to the relationship between perceived family dysfunction and bulimic psychopathology. More specifically, they propose that proneness to shame is a character trait that acts as a

[101] Waller and Ohanian (2000) suggest further differentiation (in intensity) between emotional inhibition (the urge to control, and fear of losing control over, emotions), which predicts the severity of bingeing, and defectiveness/shame beliefs, which predict the frequency of vomiting in bulimics.

moderator[102], whilst internalized shame operates as a perfect mediator[103], between paternal control/intrusion and bulimic attitudes. They accordingly identify direct and indirect dynamics of shame induction in bulimia as per a model whereby “perception of one’s father as underprotective seems to have a direct influence on internalized shame, whereas seeing one’s father as overprotective only leads to higher levels of internalized shame if one is already predisposed to be relatively shame-prone” (p.88). The latter dynamics provide an eloquent illustration of the complex and multilayered intertwinement of biological/constitutional factors (proneness to shame) with parental influences in the form of control/intrusion. Finally, the study by Jones et al (2006) (EMBU) suggests that the combination of defectiveness/shame and abandonment beliefs mediates the relationship between paternal rejection and eating symptomatology more significantly than any belief on its own, as “perceived paternal rejection can lead to the development of a combination of fear that significant others will not be able to continue providing emotional support and to underlying feelings of shame and inferiority” (327).

Other studies have identified additional mediators in the relationship between

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[102] "In general terms, a moderator is a qualitative (e.g., sex, race, class) or quantitative (e.g., level of reward) variable that affects the direction and/or strength of the relation between an independent or predictor variable and a dependent or criterion variable. Specifically within a correlational analysis framework, a moderator is a third variable that affects the zero-order correlation between two other variables. ... In the more familiar analysis of variance (ANOVA) terms, a basic moderator effect can be represented as an interaction between a focal independent variable and a factor that specifies the appropriate conditions for its operation" (Baron and Kenny, 1986, 1174).

[103] "In general, a given variable may be said to function as a mediator to the extent that it accounts for the relation between the predictor and the criterion. Mediators explain how external physical events take on internal psychological significance. Whereas moderator variables specify when certain effects will hold, mediators speak to how or why such effects occur" (Baron and Kenny, 1986, 1176).

perceived parental behaviors and eating pathology. Rojo-Moreno (2006) (EMBU) finds for example that paternal and maternal rejection is the correlate that is most strongly associated with eating disorders in teenage women - paternal rejection through the mediation of psychiatric comorbidity, and maternal rejection in a direct way. Meyer and Gillings (2004) (PBI) introduce mistrust/abuse as mediators in the relationship between perceived parental behavior and bulimic symptoms. In a few words, their results indicate that paternal overprotection triggers bulimia through the development of mistrust/abuse beliefs involving the assertion that the child will be taken advantage of. As a result, the child becomes over suspicious, which in turn hinders the development of adequate interpersonal coping skills and the forming of relationships. In this context, the functional role of bulimic attitudes is to help block out the pain of experiencing mistrust/abuse beliefs and ensuing feelings of isolation.

AN INTEGRATED PERSPECTIVE THAT MATCHES AND ENCOMPASSES WILLIAMS' AND LAWRENCE'S PSYCHOANALYTIC VIEWS ON INTRUSION

An important contribution of this chapter is the identification of parental and biological (constitutional) influences that match Williams' and Lawrence's respective psychoanalytic categories on intrusion. In Chapter VI I had contrasted the two models, suggesting that they represented two etiologies along the nature/nurture divide - Williams's model attending more particularly to pathologies of eating that result from

parental projections into the child; Lawrence's emphasizing innate dispositions towards intrusion into the mother. Given the assumption of a multifactorial etiology for eating disorders, the two models were not viewed as mutually exclusive. In this chapter, PBI and EMBU findings did confirm environmental impingements and I suggested attachment theory and schema theory as complementary or alternative channels to genetic pathways for the transmission of intrusion-related phenomena. This is in line with the suggestion that intrusion exists on a continuum - fantasized, on the one end, as in Lawrence's model, and actual, on the other, as in Williams'. In the former case, genetic and temperamental dispositions are decisive, creating the prism through which parental behaviors are filtered. In the latter case, they are negligible. The two sets of genetic and environmental influences are, it is essential to emphasize, difficult to differentiate without falling in the trap of simplification and polarization. They nevertheless broadly correspond to the models put forward respectively by Lawrence and Williams.

Whilst supporting the dual biological and environmental/parental etiology of intrusion, this chapter's exploration of parental intrusions has particularly underscored correspondences between the latter and what in Williams' psychoanalytic model is depicted as projections of anxiety by parents. Further support to the view of projecting parents can be found in the literature on childhood maltreatment. Describing the role of

childhood maltreatment in the development of eating disorders as extremely complex because of the multifactorial etiology of eating disorders and the multidimensional nature of abuse, Kent and Waller (1998, 1999) suggest that the influence of childhood maltreatment on psychological processes is indirect, with sufferers developing eating disorders only when other etiological factors are also involved. Taking into consideration the full range of experiences of childhood maltreatment - physical abuse, sexual abuse, emotional abuse, and neglect - Kent and Waller's (1999) study establishes the following: (1) when considered individually, all forms of maltreatment, except sexual abuse, are independently related to eating pathology; (2) emotional abuse nevertheless appears to be the most reliable predictor of disordered eating behaviors and attitudes; (3) finally, the effects of emotional abuse on eating pathology are entirely mediated through anxiety and dissociation, with anxiety representing the stronger mediator. Kent and Waller (1999) conclude that, within a multifactorial model of eating problems, emotional abuse, primarily mediated by anxiety, seems to be the form of childhood trauma that most clearly affects eating psychology. Although physical abuse and neglect also emerge as predictors of eating behaviors, their influence appears to operate through their interaction with emotional abuse. As such, emotional abuse seems to bring together, and underlie, all forms of childhood maltreatment. The preeminence of emotional abuse, and its mediation through anxiety, bears particular

significance when considered in the context of William's theoretical model of parents who project anxieties and fears - those parents who are "*frightened* or *frightening*, or both", in other words "*who project anxiety instead of containing it*" [104] (Williams, 1997a, 126).

When tipping decisively in the direction of external influences on eating disorders, one important aspect of real versus fantasized intrusion is that it brings to the fore the critical, previously less/un- acknowledged - at least from an object-relations perspective, in particular Lawrence's - actual influence of fathers. This confirmation of a significant paternal component beyond the fantasies of patients is in accord with Williams' model, which presents the absence/irrelevance of fathers that some patients describe as more than just a reflection or projection of their inner world. Furthermore, the chapter's confirmation of intrusiveness on the part of fathers backs up another key aspect of actual paternal deficiencies as revealed through Williams' perspective. Paternal flaws, again actual as opposed to fantasized, are not solely deficiencies pertaining to absence/irrelevance, but also encompass heavy intrusive projections into the child. Both the absence and over presence of fathers, the former defined in terms of omission and the latter in terms of intrusiveness, are therefore relevant to eating disorders. Exactly as is the case with mothers.

[104] Italics in the original text.

The dual implication of mothers and fathers in patterns of control/intrusion and care confirms other underlying aspects of Williams' perspective to which I called attention in Chapter VI. These came under the heading of external Oedipal dynamics and their contribution to dynamics of containment inherent in the concept of intrusion in eating disorders. I had suggested in particular that a mother's containing capacity cannot be understood in a vacuum, in abstraction from her actual relation with the father - especially his absence/presence and the quality of his holding -, neither can it exist outside the nexus of her relationships and history with her own parents. To capture the significance of external triangular dynamics, I suggested looking at the role of fathers in terms of their ability to offset failures in maternal containment - either by alleviating these failures through the holding of mothers, or through their own provision of containment. Consistent with recent research on the important role family dynamics play in eating disorders, this chapter's findings have confirmed the shift away from individual maternal (or paternal) dynamics onto interlocked parental ones, which act in additive or mitigating combinations. These dynamics and the various cumulative/offsetting combinations they involve do support the view of containment as a phenomenon that also involves the external, actual father and mother. As for the suggestion that a mother's capability for containment is further inscribed within relationships with her parents, it finds support in the chapter's findings on the intergenerational transmission of

intrusion-related phenomena in families of eating disordered patients. Given the interactive implication of both mothers and fathers in the development of eating disorders, the latter point should also apply, if in forms yet to be researched, to the containment capacity of fathers.

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In its exploration of the psychological literature, this chapter has shed light on intrusion in its utmost significance across all categories of eating disorders. It also has suggested that, as a psychological phenomenon, intrusion is located between innate (biological) and environmental (parental) influences, at the center of the relation between self and other.

The findings of Chapter VII confirm a number of propositions from Parts I and II, bringing together, as a result, the paradigms of psychology and object relations on intrusion in eating disorders. They confirm for example that in eating disorders: anorexia and bulimia are interconnected through specific psychodynamics between control and intrusion - this supports the view that anorexic control defends against bulimic appetite for the object; intrusive patterns of parenting are predominant - this validates the notion that actual parents who project their anxieties play a chief role in etiology;

intrusive/controlling fathers actively contribute to etiology - in addition to challenging an exclusive maternal paradigm, this shows that fathers are not mere projections of the internal world; intrusive/controlling patterns in one parent complicate or offset those in the other - this confirms that mothers and fathers contribute jointly and dynamically to etiology; intrusion-related phenomena and anxieties are transmitted from one generation to others, a finding that provides alternative or parallel channels of transmission to biological predetermination.

Most importantly, and to be absolutely clear, psychological tests and findings under consideration in Chapter VII have established that eating disordered offspring characterize their perceptions of overprotective interferences by their parents in terms of overlapping control, over-concern about their security, intrusion, and over-involvement in their lives. This psychological depiction of overlapping control and intrusion, in particular its focus on perception, is close enough to the psychoanalytic meaning to confirm the thesis that intrusion, as the overwhelming experience of invasion of receptivity, is the fundamental psychological factor in the etiology of both anorexia and bulimia. The thesis was developed on the basis of findings and assumptions brought to light in Chapter II and Chapter III.

Chapter II had suggested an overlap between the two constructs of control and intrusion. The hypothesis was founded on the identification of some form of historical

continuity in anorexia around control-related themes of assertion, protest, and superiority. When viewed against a psychodynamic assumption of interrelatedness between the two poles of eating disorders - with anorexic control defending against a bulimic appetite for the object (Shipton, 2004) -, the notion of control was extended to intrusion. In documenting an overlap of intrusion and control, inherent in the design of the two principal tests measuring parenting patterns as perceived by offsprings, Chapter VII has validated the inclusion of intrusion in the equation of eating disorders.

Pushing further the intrusion hypothesis, Chapter III had put forward the proposition that, as a metaphor for the most archaic impulse associated with the object - eating - intrusion held a leading position among other problematics that also characterize eating disorders. This supreme position derived from the conceptual worth of introjective and projective processes in reflecting dynamics of taking in/receiving and expelling as manifest in restrictive, binging, and purging behaviors. I articulated the preeminence within a psychodynamic formula whereby intrusion aims to control objects and/or states and emotions, in a context of overwhelming dependency on an overpowering internal object both desperately needed and dreaded - and consequences thereof on issues of identity. In this formulation, I specifically designate and emphasize dependency and neediness as constituting and reflecting the context of weaning and loss whereby intrusion is enforced to control objects and/or states of emotions -

projective identification in this context illuminates the dynamics of *intrusion to control* as well as issues of identity, in particular differentiation, that result from intrusion into the object.

My formulation derived from Williams' use of projective identification in her conceptualization of eating disorders in the prototypic context of weaning. In a nutshell, in order to avoid painful experiences of dependence on, and loss of the object, parts of the ego are forced in fantasy inside the object, to control it and to obliterate separateness. Merging with the object, being inside it rather than being with it, defends against experiencing the pain of loss, neediness and separation (2004a). Such dynamics of *intrusion to control* carry serious consequences in the form of identity loss, muddling of boundaries, and intolerance to frustrations (Quagliata, 2004).

Chapter VII has brought support to the thesis of a nuclear standing of intrusion among other problematics in eating disorders. This came first with the significant discovery, through PBI and EMBU findings, of a predominant pattern of intrusive parenting. Predominant patterns of intrusive parenting express, it is important to repeat, perceptions by offspring of overlapping control and intrusion by their parents.

The integration of these PBI and EMBU results with findings on attachment and shame added an ultimate level of confirmation to intrusion's supremacy through associating intrusion and control with problematics of dependency and neediness. In

connecting perceptions of intrusive/controlling parenting with insecure attachment styles in eating disorders; in showing that shame mediates the relationship between these disorders and perceived parental control/intrusion dynamics - I have documented the dyadic context of early life in which patterns of perceived intrusive parenting have been shown to unfold and prevail.

Indeed, the overlap between intrusion, control, insecure attachment and shame featured tensions between experiencing low care, abandonment, rejection, and underprotection, on the one hand, and control, overprotection, and intrusiveness, on the other. These perceptions, experiences, of low care, abandonment, rejection, and underprotection refer explicitly to the pain of loss and to overwhelming affects (shame) over unworthiness or defectiveness, which beliefs or working models about the self and its relation to others entail. It is in this matrix of unbearable and unsettling dependence and loss, in the context of weaning, that intrusion to control objects and/or states and emotions - via projective identification - finds its place. Intrusion to control finds its quintessential, concrete, expression in eating disorders dynamics of restricting, binging, and purging.

In examining relative parental and constitutional contributions to the development of intrusion-related phenomena in eating disorders, Chapter VII has left out an essential biological consideration - the sex of patients. This aspect, which is particularly important

considering the femininity question underlying this work, is the object of the next chapter. Chapter VIII explores intrusion and its relation to aspects of femininity against the backdrop of sexes, gender, and sexual orientation.

CHAPTER VIII

THE GENDER SPECIFICITY OF EATING DISORDERS IN THE LIGHT OF SEXUAL ORIENTATION

BEYOND SEXES, THE FEMININE DIMENSION OF INTRUSION

In Chapter I, sexual orientation has emerged as a conceptual tool to explore femininity in its relevance to eating disorders. More specifically, the homosexual exception in males - homosexuality and bisexuality as specific risk factors for eating disorders in men - has signaled what might illuminate the lopsided gender landscape of eating pathology. This is in connection with what I show below as a gender-related research paradigm of sexual orientation and its consistent depiction of male homosexuality in terms of femininity.

In this final chapter, I make use of the homosexual exception to probe into the nature of its relationship with femininity in eating pathology. In my exploration, I bear in mind the question of whether this exception encapsulates the feminine dimension of intrusion, as argued for in my thesis - intrusion as feminine in essence, because of its

association with receptivity (intrusion into receptivity), but transcending biological sexes. The thesis emphasizes a notion of receptivity beyond the metaphor of the receptive female body - as implicit in Williams' exclusion of the gender dimension in her model of eating disorders (Chapter VI). It explains both the significantly higher prevalence of eating pathology in women and its occurrence in male populations.

The psychological literature reviewed in the previous chapter has substantiated the hypothesis of an overlap between control and intrusion and revealed the preeminence of a pattern of intrusive parenting in eating pathology, therefore validating the thesis that intrusion, understood as the overwhelming invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders. Chapter VIII, the last in Part III and in this work, establishes the gender-free dimension of intrusion in the eating disorders equation. This is done through the examination of the psychological literature on the conceptualization and measurement of sex roles, sexual orientation, and their relationship to each other and to intrusive parenting in eating disorders.

Setting the homosexual exception as an avenue for the examination of femininity and masculinity immediately calls to mind the questions and dangers stereotypes of gender and sexual orientation commonly pose. An obvious one is the danger of considering males and females, on the one hand, and homosexuals of either sex, on the other, as homogeneous groups. I have also mentioned in the introduction the

difficulty of avoiding terminology that may carry - at one or another time, in one or the other group, and in different contexts or disciplines - offensive connotations. The challenge is particularly significant when questions of gender and sexual orientation are discussed in the context of pathology, which is the case in this work. I nevertheless argued that the benefit for research of referring to stereotypes, in order precisely to transcend them, outweighed the risk of using controversial terminology. This is hopefully demonstrated in this chapter where my use of stereotypes of femininity and sexual orientation does not matter beyond tying my work to existing work. In the last instance, gender and sexual orientation stereotypes do allow me to extract invariants - intrusion and receptivity -, which demonstrate that, whether in male or female, the occurrence of eating disorders is ultimately function of these invariants. Another, less obvious risk is worth mentioning. As much as stereotypes of gender and sexual orientation may constitute a challenge, attempts at avoiding them sometimes result in equivalent difficulties and in unintended consequences. I will mention later on in the chapter how for instance a spirit of political correctness may have impacted the direction of research on the relationship between sexual orientation and parenting. Finally, the cultural weight of stereotypes of gender and sexual orientation raises the critical question of the relation they have with culture's counterpart, biology. From this work's perspective on the paradoxical feminine quality of intrusion (quintessentially feminine, on the grounds of

receptivity, but transcending biological sexes, through extending channels of metaphorical receptivity beyond the female body), the question begs, and I will try to answer it, as to where gender aspects of intrusion stand in the dialectic between culture and nature.

In order to examine these issues and their complex interface with intrusion, I will be looking at the psychological literature on the relationship between femininity/masculinity and sexual orientation, in general and in the context of eating pathology.

THE GENDER-RELATED RESEARCH PARADIGM OF SEXUAL ORIENTATION

In Chapter I, I asked whether it is the association of homosexuality with factors such as increased femininity that specifically increases risks for eating disorders (Russell and Keel's, 2002)[105]. The question signaled the stereotypic themes of masculinity and femininity that sexual orientation usually invites. A crucial aspect to bear in mind when addressing this question is the extent to which an overlap between male homosexuality and femininity traits goes beyond the conventional nature/culture dichotomy to encompass meanings of intrusion as implied in this work: intrusion as feminine in essence, because of the receptivity element, but transcending sexes

[105] It should be mentioned in this respect that, in contrast with other studies, Russell and Keel's (2002) work actually does not establish increased femininity as a risk factor for eating disorders in homosexuals.

through the extension of channels of metaphorical receptivity beyond the female body. The matter is of importance because, should intrusion emerge as a psychological component in the femininity of homosexual men, it would somehow represent a dent in antinomic cultural or biological interpretations of gender traits.

In this section, a bird's eye view on studies on sexual orientation and gender over a period of three quarters of a century shows that it has not been possible to depict homosexuality beyond popular stereotypes on the femininity of homosexual men or masculinity of lesbians. Indeed, since the 1930's, the literature on the subject establishes one form of connection or another between sexual orientation and attributes of masculinity and femininity.

Until the 1970's, this connection was conceptualized and measured in terms of bipolar masculinity-femininity (M-F) scales, which assumed that M-F is an either/or, unidimensional trait, with masculinity at one end and femininity at the other (Sandfort, 2005; Lippa, 2005; Lippa, 2008). Studies during that period show that, on average, the scores of homosexual men are more feminine than those of heterosexual men, whereas the scores of lesbians are more masculine than those of heterosexual women (Lippa, 2005).

In the 1970's, the notion of a bipolar unidimensional M-F scale was rejected as reductionist and not allowing for androgyny in people. A new generation of two-

dimensional concepts and scales was introduced, which assessed masculinity and femininity as separate and independent entities[106]. Masculinity became defined in terms of instrumental (I) personality traits (dominance, independence, assertiveness) and femininity in terms of expressive (E) personality traits (nurturance, compassion, interpersonal sensitivity), applying to both men and women (Sandfort, 2005; Lippa, 2005; Lippa, 2008). Instrumentality was alternatively referred to as agency, and expressiveness as communality. Although increasing the dimensionality of gender-related traits, the new scales nevertheless explicitly defined masculinity and femininity in terms of gender stereotypes - in this case, stereotypes of personality (Lippa and Connelly, 1990). Comparisons of heterosexuals and homosexuals show that homosexual men score as high on instrumentality as heterosexual men, but higher on expressiveness, and that lesbians score as high on expressiveness as heterosexual women, but higher on instrumentality (Lippa, 2005).

Arguing that gender-related individual differences can only be defined in terms of behaviors that differentiate men and women in a particular culture, during a particular historical era, and, considering that gender-related interests (occupational and hobby preferences, participation in everyday activities) constitute an important dimension of masculinity and femininity, Lippa and Connelly introduced in the 1990's gender

[106] The Bem Sex Role Inventory, (BSRI) (Bem, 1974), The Personal Attributes Questionnaire (PAQ), and the Extended Personal Attributes Questionnaire (EPAQ) (Spence et al, 1979).

diagnosticity (GD) measures to account for the latter dimension. GD assessed how male- or female-typical an individual's interests are, compared to the interests of normative groups of men and women (Lippa and Connelly, 1990; Lippa, 2005). Although still situated in the "either-or" tradition of bipolar M-F scales, GD measures differed from the latter in their focus on a homogeneous item domain (interests) and to the extent that they calibrated masculinity and femininity against local and contemporary standards of gender-typicality (Lippa, 2005). Used in conjunction with instrumentality and expressiveness, gender-related interests presented a homogeneous, largely independent personality dimension to measure masculinity and femininity (Lippa, 2005).

Lippa examined the relation between sexual orientation and personality in a meta-analysis in 2005, and again in a large international data set in 2008. His results show that, overall, heterosexual-homosexual differences mirror sex differences in personality, with homosexual men shifted in female-typical and lesbians in male-typical directions; that bisexual men score intermediate between heterosexual men and homosexual men on masculine versus feminine occupational preferences, but are slightly more feminine than homosexual men on self-ascribed masculinity-femininity; that bisexual women score intermediate between heterosexual women and lesbians on both masculine versus feminine occupational preferences and self-ascribed femininity;

and that these results are consistent across five nations/world regions, thereby suggesting a biological component to these differences (Lippa, 2005; Lippa, 2008).

Irrespective of their dimensionality, the three reviewed sets of concepts and scales illustrate to a lesser or greater degree homosexuality in terms of masculinity or femininity, hence establishing some form of relationship between sexual orientation and gender-related attributes. It would therefore seem reasonable to posit that, whether a social construct or not - and, bearing in mind the critical point that “gender is not the whole sum of personality” (Woodhill and Samuels, 2003, 555) -, the relationship between sexual orientation and questions of femininity (or masculinity) is nonetheless “real” (Sandfort, 2005, 599). What would this ‘real’ relationship mean then with regard to Lippa’s reference to a biological foundation of homosexuality, including in its femininity (or masculinity) undertones? As emphasized earlier, the question is of particular significance if examined against the intrusion framework of this work - I pointed out that the identification of a psychological component of intrusion in the femininity of homosexual men would constitute a dent in antithetic, cultural or biological, interpretations of gender traits.

In the next sections I discuss the respective contributions of biology and culture to sexual orientation, and further on, to gender related traits, in general and in the

context of eating disorders. This allows me to proceed and examine aspects pertaining to intrusion in homosexual men suffering from these pathologies.

THE INCONCLUSIVENESS OF BIOLOGICAL RESEARCH ON SEXUAL ORIENTATION

Over the past years, theories suggesting a biological foundation of sexual orientation have abounded. In the following examination of the relevance of biology to homosexuality, I refer to Mustanski et al's (2002) comprehensive and critical review of research on the subject over the previous decade. My reading of the review, which covers four main areas of investigation and assesses their individual outcomes, is that it does not present unequivocal evidence that biology, alone, explains sexual orientation. After summing up the four areas covered in the study I conclude this section by presenting Byne and Parsons' (1993) interactional model on the multifarious development of homosexuality, suggesting to extrapolate and apply the model to gender personality traits, in particular in relation to intrusion.

The Neurohormonal Approach

It involves investigations in psychoneuroendocrinology, prenatal stress, cerebral asymmetry, neuroanatomy, otoacoustic emissions, and anthropometrics. Neurohormonal influences have been somewhat substantiated, mostly in men.

However, inconsistencies across studies make it difficult to draw any definite conclusions concerning this hypothesis.

The Genetic Approach

In the absence of chromosomal differences among homosexual subjects, genetic effects have been explored: in family studies (testing the frequency and patterns of occurrence of homosexuality in families); in twin and adoption studies (separating population differences in sexual orientation into genetic and environmental components); and in molecular genetics studies (identifying specific genes that influence an individual's sexual orientation). Both family and twin methodologies have produced consistent evidence that genes do influence sexual orientation - without however identifying how, how much, and when such influence occurs. As for molecular research, it has not produced compelling evidence on the relevance of specific genes to homosexuality.

Fraternal Birth-Order Effects

Beyond the recognized fact that older brothers increase the odds of homosexuality in men - the most replicated finding in the research on sexual orientation -, nothing is known about the process that leads to this phenomenon.

Developmental Instability

This represents an organism's inability to form an "ideal" (e.g., bilaterally symmetrical) phenotype under developmental perturbations during gestation. Perturbations may result from maternal illness, infection, chemical use or exposure, or any other factor. An underlying assumption is that if homosexuality does result from a fetus' inability to protect itself against developmental and/or environmental agents, then homosexual people should show other markers of developmental instability, such as left-handedness or fluctuating asymmetry. Support for the developmental instability hypothesis has remained limited.

Mustanski et al (2002) end their long review concluding that, whereas sexual orientation is influenced to some degree by biological factors, the question of how and when these biological factors act and the degree to which they affect sexual orientation remains unanswered. They nevertheless propose some tentative and partial answers:

1. Biological factors seem to exert a portion of their influence before birth

2. Genetic factors appear to explain the familial variance in sexual orientation - although this does not necessarily prove that sexual orientation is canalized prenatally, as genes influence a host of traits that are not expressed until after birth

3. Brain anatomy and neuropsychological measures point to structural and functional brain differences related to sexual orientation in women and in men - although the corroboration of findings is yet to come

4. And, finally, that sexual orientation in women and men appears to involve very different phenomena.

What do Mustanski et al's conclusions tell us about the contribution biological research makes to the question of sexual orientation? What is striking is the tentativeness and inconclusiveness often encountered across the different areas surveyed in this review. Inconclusiveness certainly reflects the conceptual difficulty underlying an exclusive biological explanation of sexual orientation. However, it also is explained by a number of other factors: sampling sizes; hypotheses suggested, or verified, in animal studies but not necessarily applicable to humans; outcomes that need corroboration, but are not replicated, or are later disproved; and impossibilities to test some hypotheses for ethical or practical reasons.

A couple of examples illustrate some of the factors accounting for the inconclusiveness of biological research on sexual orientation. A famous brain study by LeVay (1991) found the volume of one cell group in the anterior hypothalamus of the brain to be half the size in both women and homosexual men as it was in heterosexual men, and suggested this could constitute a biological basis to sexual orientation.

Results were contested for a number of technical reasons, including sample size and the fact that most of the homosexual men in his study had died of AIDS, which in itself could have affected outcomes. Most importantly however, findings on hypothalamic structures were not replicated (Byne, 1994). Another example is Hamer et al's (1993) molecular genetic study. The study, which aimed at testing the existence of chromosome X-linked genetic factors favoring male homosexuality, was suggested by high rates of homosexuality in the maternal line of homosexuals. Although DNA linkage analysis did identify a particular gene Xq28 on the X chromosome, which explains some cases of male homosexuality, here again findings failed to be replicated ((Camperio-Ciani et al, 2004).

The conceptual and technical complexities behind inconclusiveness are well described in an article by neuroanatomist William Byne (1997), entitled 'Why we cannot conclude that sexual orientation is primarily a biological phenomenon'. Acknowledging the influence of biology on sexual orientation, Byne nevertheless challenges the notion of a biological supremacy on three grounds. To start with, sexual orientation is not a monolithic phenomenon that can be accounted for with a single explanation, but a rather complex one reached through a multitude of pathways. Second, to the extent that they only exist within the biological activity of a living brain, all human phenomena are

ultimately biological[107]. This does not mean however that biological factors prevail over psychosocial or experiential ones. Instead, processes such as perception, internalization, association, and assimilation, which are integral to experience, are inextricably entangled with biology, and biological and experiential factors can neither be separated nor individually measured. Finally, evidence favoring a biological theory of sexual orientation has been lacking (the inconclusiveness mentioned above). Unless they are adequately corroborated, but also integrated with psychological and cultural models, Byne (1997) concludes, findings suggesting biological preeminence are bound to remain tentative. This accords with biopsychosocial approaches as favored in contemporary social sciences.

Suggesting an alternative interactional model, Byne and Parsons (1993) propose that genes or hormones do not define sexual orientation per se, but impact particular personality traits in a way that influences how individuals and their social and family environment interact - more specifically and from the perspective under consideration, as sexual orientation unfolds developmentally. Such a model allows for multiple developmental pathways to homosexuality, against exclusive biological or psychosocial etiological explanations, to explain for instance high concordance rates for homosexuality among identical twins reared together.

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[107] Greenberg and Bailey (1993) also hold similar views concerning biological influences, considering that, to the extent that all behavior can ultimately be seen as neurophysiologically caused, biological causation in male homosexuality does not have implications beyond those applying to any other behavior.

In conclusion, against the view that conjoint theories, which synthesize biological essentialist and social constructionist influences, are not sustainable (DeLamater and Hyde, 1998), I suggest Byne and Parsons' model as credibly illustrating the complex interaction of biology, culture and psychology at play in sexual orientation. Moreover, in opposition to a critique of the all-encompassing character of the model, I emphasize instead its anti-reductionist dimension - the tapestry over which individual perspectives are woven and must be examined. Later on in the chapter, I extend Byne and Parson's construct of sexual orientation whereby some personality traits embody the intricate interactions of biology, culture and psychology and I apply it to the specific question of gender personality traits. This allows me to explore the extent to which an element of intrusion overlaps, at the psychological level, with some feminine traits of personality.

GENDER AND SEXUAL ORIENTATION IN EATING DISORDERS: CULTURES AND SUBCULTURES

Earlier in the chapter, I looked into questions of femininity/masculinity through the lens of homosexuality, showing that, whether constructed or not, a relationship had been consistently established in the literature between gender traits and sexual orientation - more precisely between male homosexuality and femininity. In this part, I expand the sexual orientation perspective on gender traits through their combined examination in eating disorders. I argue eventually in favor of a femininity theory of

these disorders - criteria and levels of femininity as factors in eating pathology in both women and men, as highlighted against a background of sexual orientation. The perspective here is cultural - the counterpart of the biological dimension discussed in the previous section. It reveals dialectical dynamics between homosexual subcultures and the broader culture of society.

Before proceeding, I will once again stress that as I make use of stereotypes of femininity and sexual orientation, these stereotypes do not matter beyond linking my work to existing work. By ‘homosexual exception’, I mean no more than men who have sexual relations with other men. In the first instance, I refer to a statistical fact - the particular vulnerability of male homosexuals to disorders of eating that by and large affect the female population. In the last instance, and contrary to stereotypes, I discover and refer to a subgroup of homosexual males whose attributes compare with women with respect to receptivity - more specifically, to vulnerability to intrusion into receptivity. It is this subgroup of men whose receptivity matches that of women with eating pathologies that shows higher occurrences of these disorders. Similarly, my work does not attempt to define femininity. In my recourse to gender stereotypes on the female receptive anatomy, I ultimately transcend these femininity stereotypes through a gender-free theory of intrusion, which goes beyond

a notion of receptivity as exclusively tied to the feminine body. It therefore applies to both men and women.

Mirroring the above research on the relationship between sexual orientation and gender-related traits are studies on the link between femininity/masculinity and disordered eating, which globally confirm connections of one or another kind in the two sets of variables. One meta-analysis on femininity, masculinity and their relationship to disordered eating in women (Murnen and Smolak, 1997) indicates for instance that eating pathology has a positive relationship with femininity and a negative one with masculinity. Similarly, a majority of studies show that disordered eating is associated, in both heterosexual women and men, with high identification with feminine attributes (Hawkins II et al, 1983; Paxton & Sculthorpe, 1991; Wichstrom, 1995: Lakkis et al, 1999).

The question of course is whether the two sets of associations - sexual orientation/gender traits and gender traits/eating pathology - are connected. A study by Lakkis et al (1999) offers a perspective in this respect. In an effort to further examine the complexity underlying the relationship between femininity/masculinity, sexual orientation, and eating disorders, the study investigates the three parameters together. If, the study assumes, gender traits reflect cultural stereotypes about feminine and masculine behaviors, and, if sexual orientation expresses the ideals of the male

homosexual and lesbian subcultures, then, identifying their independent and relative contributions to eating pathology would help illuminate the fabric of socio-cultural influences on these disorders. In particular, it would help answer the question of whether in these disorders gender trumps sexual orientation or if things happen instead the other way round.

Lakkis et al (1999) refer to earlier studies that had indicated some differences in findings between the male and female populations of both sexual orientations. Amongst males, homosexuals were overall consistently more concerned with body weight and shape, and reported higher levels of body dissatisfaction and dieting as well as greater bulimic symptoms than heterosexuals. This had been attributed to the male homosexual subculture, with its emphasis on looks, style and the lean and muscular body ideal. Things, in contrast, were not as consistent in the case of women: some studies had suggested that lesbians were less concerned with body weight and shape, dieting and bingeing less frequently than heterosexual women – an effect of the lesbian subculture; other studies had shown instead that gender did trump sexual orientation on a number of disordered eating attitudes and behaviors. In the latter case, the lesbian subculture had not been sufficient to reverse enduring messages from society and the media concerning thinness and attractiveness.

Lakkis et al's (1999) results came overall consistent with prior research, showing

that lesbians score significantly lower in comparison to heterosexual women on all disordered eating measures under consideration - body dissatisfaction, drive for thinness, dietary restraint (chronic and unsuccessful dieting), and bulimia - and that homosexual men score significantly higher than heterosexual men on body dissatisfaction and dietary restraint. In terms of their relative contribution to eating disorders, the study finds both gender traits and sexual orientation to be important. It reveals however some differences between men and women. In men, sexual orientation (the homosexual subculture factor) was the single predictor of body dissatisfaction, both sexual orientation and gender traits significant predictors of dietary restraint, and gender traits the single predictor of the drive for thinness and bulimia - concerning the latter, the authors suggest that, because they were primarily developed to be used in women, measurements of the drive for thinness and bulimia probably did not detect dominant disordered eating attitudes and behaviors among homosexual men. In women, although sexual orientation accounted for a larger amount of difference than gender traits, the impact of sexual orientation seemed to be slightly mediated by the latter traits. The more similar lesbians were to heterosexual women on gender traits, the more comparable their eating patterns. Finally, higher negative femininity scores (stereotypic feminine behavior associated with passivity, dependence, unassertiveness and low-esteem) predicted, in both men and women, higher scores on disordered eating. I show

below that negative femininity in its symptomatic expression is critical to a femininity hypothesis of eating pathology based on intrusion.

Like Lakkis et al (1999), Meyer et al (2001) draw attention to the need, when studying eating disorders, to examine sexual orientation in conjunction with masculinity and femininity. They particularly emphasize that it is the distinction, or lack thereof, between relatively feminine lesbians (when gender trumps sexual orientation) and relatively masculine ones (when sexual orientation trumps gender) that explains disparities in the literature on sexual orientation and eating pathology in women. Their study, which involves lesbians, homosexual men, and heterosexual men and women in a non-clinical setting, shows that, as a whole, the group reveals significant negative correlations between masculinity and most eating behavior scores under consideration (dieting, bulimia, and oral control)[108], and, conversely, positive associations between these scores and femininity.

Similarly, when considering things from a sexual orientation divide, femininity emerges as a specific risk factor and masculinity as a protective one for both

[108] The Eating Attitudes Test (EAT-26) comprises three subscales, Dieting, Bulimia and Food Preoccupation, and Oral control (Garner et al, 1983).
The *Dieting* scale items are: am terrified about being over weight; aware of the calorie content of foods that I eat; particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.); feel extremely guilty after eating; am preoccupied with a desire to be thinner; think about burning up calories when I exercise; am preoccupied with the thought of having fat on my body; avoid foods with sugar in them; eat diet foods; feel uncomfortable after eating sweets; engage in dieting behavior; like my stomach to be empty; and have the impulse to vomit after meals.
The *Bulimia and Food Preoccupation* scale items are: find myself preoccupied with food; have gone on eating binges where I feel that I may not be able to stop; vomit after I have eaten; feel that food controls my life; give too much time and thought to food; and enjoy trying new rich foods.
The *Oral Control* subscale items are: avoid eating when I am hungry; cut my food into small pieces; feel that others would prefer if I ate more; other people think that I am too thin; take longer than others to eat my meals; display self-control around food; and feel that others pressure me to eat.

homosexual men and women: in homosexual men, a negative correlation between masculinity and bulimia scores and a positive one between femininity and oral control scores; in lesbians, similar patterns of positive association between femininity, dieting, and oral control scores.

Based on the generally consistent associations revealed in the preceding findings, it is possible to argue in favor[109] of a femininity theory of eating disorders - femininity as a factor in the etiology of these disorders - that applies to both men and women. Interestingly, the femininity hypothesis appears particularly highlighted when viewed against a background of sexual orientation: in general, lesbians are less, and homosexual men more, prone to eating disorders, and individual levels of femininity in each group appear to exacerbate such propensities.

Emerging as a component in both eating disorders and homosexuality, femininity has so far revealed its cultural and biological dimensions - directly, in the discussion of cultures and subcultures; and indirectly, in extrapolations from biological influences on sexual orientation, considered in conjunction with homosexuality's consistent association with gender personality traits. Invoking once more Byne and Parsons' (1993) interactional model - in particular, their proposition that personality traits embody the complex interactions of biology, culture and psychology at play in sexual orientation

[109] However, as already mentioned, there are studies (Russell and Keel, 2002; Hospers and Jansen, 2005; Green et al, 2008) that challenge or qualify the femininity hypothesis, reflecting the complexity of the relationship between these disorders, sexual orientation, and gender traits.

-, and applying it specifically to gender personality traits, I explore in the next and final section of this chapter what I suggest constitutes femininity's ultimate component in eating disorders: the psychological phenomenon of intrusion, understood in its complementary relation to receptivity.

GENDER TRAITS AT THE INTERSECTION BETWEEN CULTURE AND BIOLOGY

In my thesis I argue that intrusion constitutes the fundamental psychological factor in the etiology of eating disorders - intrusion is meant as the overwhelming experience of invasion of receptivity. In extending the notion of receptivity beyond female anatomy I grant intrusion a universal gender-free quality that allows its application to both men and women.

In the previous chapter, I demonstrated that intrusion does occupy a supreme position among other problematics. In order to probe into what could constitute a feminine aspect of intrusion, I proceed in this section to a further exploration of the psychological literature. I try first to detect a relationship between intrusion and femininity in men and women with eating disorders. I then check whether an intrusive dimension is found in the femininity of homosexual men suffering from these pathologies. Once again my reference to gender and sexual conceptualizations of eating disorders relays stereotypes as found in the literature with the express purpose

of transcending these stereotypes. In establishing intrusion and receptivity as invariants in eating disorders, I am able to ultimately confirm my thesis of intrusion in eating disorders as feminine in essence (in connection with receptivity), yet transcending biological sexes (through the extension of the receptivity metaphor beyond the female body).

Three aspects are to be considered jointly in order to understand the relationship between intrusion, femininity, and sexes in eating disorders on which I base my thesis. To start with, there is the conclusion reached in Chapter VII concerning an overlap of intrusion and control in parenting measures. There is also the significant weight that negative control carries in negative measurements of femininity. Finally, there is the coincidence of these negative criteria of femininity and control with symptoms that are characteristic of eating disorders in both men and women. I will now examine the last two aspects as presented in the psychological literature.

The introduction in psychological studies of an opposition between negative and positive measures of femininity and masculinity (Spence et al, 1979; Woodhill and Samuels, 2003) represents an additional effort towards addressing the difficulty of defining and assessing gender personality traits. As mentioned earlier in the chapter, bi-dimensional measures had established the compatibility, within an individual personality (male or female), of both clusters of masculine (instrumental or agentic) and feminine

(expressive or communal) traits. This had allowed a better portrayal of the complexity of human identities, phenomena and behaviors. An implicit assumption of the bi-dimensional model was that androgynous states that encompass high levels of both femininity and masculinity were bound to reflect a certain degree of mental and existential wellbeing. However, although androgyny did present a wider and less rigid array of conceptualization and measurement, it still failed to account for all the complexities at play. Besides, the implicit assumption of androgyny as a measure of wellbeing proved inaccurate. In fact, people scoring balanced levels of femininity and masculinity were not found to be necessarily exempt from psychological and emotional instability. These limitations of the bi-dimensional theories and scales of femininity and masculinity have in fact been attributed to their sole consideration of socially desirable (positive) gender traits to the exclusion of socially undesirable (negative) ones, whether feminine or masculine.

It is to counter these limitations and oversimplifications that distinctions were introduced between positive and negative scales of feminine and masculine features (Spence et al, 1979; Woodhill and Samuels, 2003). In brief, distinctions go as follows: *negative masculinity*, which reflects traits that are judged in general to be instrumental in content, more typical of males, and undesirable in both sexes, broadly covers areas of arrogance, active aggressiveness, and self-centeredness. As for *negative femininity*,

traits that are considered overall expressive, more typical of females, and undesirable in both sexes, it covers two clusters of characteristics: a first one roughly standing for the subordination of self to others, and a second representing various forms of verbal passive-aggressiveness (Spence et al, 1979).

In a study using these positive and negative criteria, Spence et al (1979) show that, in general, stereotypic negative gender traits are, in women and men, related to symptomatic and problematic behaviors. Indeed, their results indicate that self-esteem is related to positive gender traits [(+) femininity and (+) masculinity]. As for neuroticism, measured in terms of depression and anxiety, it is negatively associated with desirable gender characteristics [(+) femininity and (+) masculinity] and positively associated with undesirable ones [(-) femininity and (-) masculinity], particularly verbal passive-aggressiveness [(-) femininity]. Finally, acting out behaviors, including alcohol and drug abuse, have high positive correlations with negative masculinity. Again, these findings apply to both sexes.

Quite significantly, considering control's overlap with intrusion, which was established in Chapter VII, correlations have also been established between sets of positive and negative gender traits and sets of positive and negative modes of control. These correspondences are revealed in four gender-defined styles of control: negative femininity, associated with a negative yielding style of control - i.e. having too little

control (being indecisive, timid, and dependent); positive masculinity, which corresponds to a positive assertive style of control - i.e. taking action to change a condition (being assertive, confident, responsible, etc…); negative masculinity, which is equated with a negative assertive style of control - i.e. over-control (being aggressive, bossy, etc…); and positive femininity, which is associated with a positive yielding style of control - i.e. being accepting of the giving over of control (being gentle, patient, accepting, etc…) (Lakkis et al, 1999).

Critically from this work's perspective, symptoms of eating disorders in both men and women have been described in terms of negative femininity - specially, the subordination of self to others, which "reflect(s) a need of approval from others and low self-esteem" (Lakkis et al, 1999, 3). Furthermore, Lakkis et al's study has substantiated these pathologies' link to negative yielding, the negative feminine style of control signaled by having too little control, in other words being indecisive, timid, passive, dependent and unassertive.

Williams and Ricciardelli (2001, 2003) confirmed and expanded on Lakkis et al's (1999) findings, both in terms of negative gender traits and negative styles of control. In a study (2001) in which they examine symptoms of disordered eating and problem drinking in relation to positive and negative gender traits, they establish that higher degrees of eating symptoms in women are related to lower levels of desirable

masculinity as well as to higher levels of both desirable and undesirable femininity – in particular the latter. Drinking problems are in turn associated with negative masculinity and low identification with positive femininity. Finally, women with joint eating and drinking problems show high identification with both negative masculinity and negative femininity - a comorbidity that results in more extreme forms of pathology. In their study on adolescents, Williams and Ricciardelli (2003) also show that, typically and regardless of gender, problem drinking is related to negative masculinity, binge eating to negative femininity, whereas conjoint binge eating and drinking problems are linked to a combination of high levels of negative femininity and negative masculinity as well as to a low positive and high negative sense of control.

The double negative gender identification revealed in the comorbidity of eating disorders and problem drinking is I think interesting in that it juxtaposes two extreme, problematic, and contradictory, at least on the surface, styles of control, as well as their related aspects of dependency: the negative masculine traits of assertiveness, which aim at controlling others, and negative feminine yielding, which basically means surrender to others. This dual identification and the contradiction that apparently underlies it nevertheless reproduce common clinical presentations, not necessarily restricted to comorbidity with drinking, when eating disordered patients send other conflicting signals of both badly needing and forcefully rejecting help. The paradox

reflects tensions and oscillations between issues of dependency and autonomy as much as it outlines the workings of false selves in eating disorders - what I see as desperate and unconscious pretenses of independence and self-sufficiency to cover up, compensate for dramatically opposed states of mind. I suggest that, rather than reflecting incoherencies, contradictions of the sort affecting forms of control actually and ultimately echo struggles and conflicts over dealing with the object - alternately seeking or rejecting it. Such struggles would support, once again, the interconnectedness of anorexia and bulimia, anorexic impulses as defenses against bulimic desires, as suggested in Chapter II and further considered in the previous chapter.

To sum up, I see the juxtaposition of negative femininity with negative control in eating disorders as interesting at two levels. On the one hand, it establishes some form of relationship between issues of control and difficulties over dependency, neediness and autonomy - a relationship of significance given the strong emphasis this work has placed on both sets of difficulties in eating disorders. On the other hand, the substantial weight of negative control in negative femininity invites the critical theme of intrusion into the gender discussion of eating disorders - in relation with the overlap of intrusion and control, as confirmed in the examination in Chapter VII of parental influences on the development of these pathologies.

Consequently, if in eating disorders issues of control overlap with issues of intrusion (as demonstrated in the previous chapter); also, if in these disorders the weight of negative control in negative femininity is important; finally, if stereotypic negative feminine traits and control styles match up symptoms of anxiety that characterize these pathologies in both females and males - then it becomes possible to support a 'gender-free' femininity theory of eating disorders that centers on anxieties of control/intrusion and explains the higher prevalence of these disorders in women, but also their occurrence in men.

The Parents of Male Homosexuals with Eating Disorders

A final question remains: is an intrusive component to be found in the femininity of homosexual men, which would explain, beyond socio-cultural aspects discussed in this chapter, the proneness of male homosexuals to disorders that otherwise are characteristic of women? In other words, can the femininity of homosexual men with eating disorders, *and by extension all men suffering from these pathologies*, be defined in terms of a particular vulnerability to feelings and anxieties of intrusion into receptivity that puts this group theoretically at par with female populations? I bring a positive answer to this question in my discovery of a subgroup of homosexual males with higher occurrences of these disorders and whose receptivity matches that of

women with eating pathologies.

Addressing the question of an intrusive element in the femininity of male homosexuals requires an approach similar to that used in Chapter VII. In other words, to explore whether and how parental influences - expressed in PBI, EMBU, or other measures of intrusive parenting - encapsulate, in the homosexual exception, the feminine dimension of intrusion.

Probing parental influences on sexual orientation in offspring is a direct leap into the paradigmatic shift, which has altered the status of homosexuality over the past few decades. Beyond changes affecting its cultural, legal, ideological and psychiatric position within societies in general, the shift extends to the field of research on sexual orientation - its directions, findings, and, underlying them, the significant fact that a de-pathologization of homosexuals has meant a parallel rehabilitation of their parents.

I will start with changes that have affected the broad direction of research on homosexuality. The gradual turning away since the mid eighties from studies scrutinizing parental behaviors to explain same-sex orientations in offspring mirrors the gradual dissociation of homosexuality from pathology as reflected in taxonomic changes introduced in successive DSM entries: in 1973[110], the elimination of homosexuality as a mental disorder and its substitution with the new category of Sexual orientation

[110] American Psychiatric Association. (1973). *Diagnostic and statistical manual of mental disorders* (2nd ed., 7th printing) (DSM-II). Washington, DC: Author.

disturbance; in 1980[111], the creation of a new diagnosis of Ego-dystonic homosexuality; and, ultimately, in 1987[112], the elimination of the latter category and its subsuming under that of Sexual disorder not otherwise specified.

Irrespective of whether parental influences are relevant to sexual orientation, it is reasonable to assume that an imperative of political correctness may have, consciously or unconsciously, discouraged further studies in the field. A disinclination to pursue research in a direction that ostentatiously pathologizes homosexuals and their parents is of course difficult to verify categorically. It is indeed impossible to determine retrospectively whether more research would have been undertaken had the paradigm shift not occurred. Although it does not deal with patterns of parenting leading to homosexuality in offspring but with the effect of same-sex parenting on children, a study by Schumm (2010) lends some indirect support to this line of reasoning. Of three refereed journal articles on lesbian family life - the articles shared the same authors, academic institution of origin, samples, dates of publication, and even the same journals -, one article reported evidence less, and the two others more, supportive of lesbian parenting. Comparing citation rates for the articles, the study shows that supportive reports had been cited 28 to 37 times since their publication compared to only two citations for the less supportive report, despite the latter's probably superior

[111] American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.) (DSM-III). Washington, DC: Author.
[112] American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders, revised* (3rd ed.) (DSM-III-R). Washington, DC: Author.

methodological quality. Back to the question of interest to us, an examination of the literature since the late fifties does signal a decline after 1986 in the number of studies on the relationship between parenting patterns and sexual orientation in offspring - 18 studies between 1959 and 1986 and only four since 1986. It is therefore possible to say that opportunities to research the relevance of parental intrusiveness to male homosexuality are less available in the literature today than they were in the middle of the 20th century.

Looking at the existing literature, another aspect of the changing perspectives on parenting systems and sexual orientation in the past fifty years concerns a first level of discrepancy - a split that confronts similitude in findings with contradictions in their interpretation. Bieber et al's 1962 articulation of what had emerged since the late fifties (West, 1959) as a classical pattern of parenting associated with male homosexuality in offspring became a point of reference indeed for both advocates and opponents of such an association. Bieber et al's typical parental constellation implicates a close-binding, dominant, intimate mother, what is more derogatory towards her husband, and a particularly hostile and detached father. A number of studies confirmed, though not necessarily from similar perspectives and with similar measures, the relevance of this characteristic constellation (West, 1959; Thompson et al, 1973; Stephan, 1973; Koenig, 1979; Sipova and Brzek, 1983; van den Aardweg, 1984). Another study (Nash and

Hayes, 1965) presented a more limited confirmation of such parental constellations through revealing differences in the relational dynamics between parents of ‘passive’ homosexuals and those of ‘actives’ - an interesting underscoring of hierarchies and patterns of control in sexual orientation (Nash and Hayes, 1965).

Although acknowledging the existence of distinctive parental constellations, another group of studies has offered divergent interpretations of the association between parenting patterns and male homosexuality. The studies actually recommend reversing the causality relationship: parents of homosexual men may be behaving in a characteristic way, but such behavior is in reality a reaction to their son’s early manifestations of homosexuality rather than the foundation of their sexual orientation (Evans, 1969; Freund, 1974; Zuger, 1980; Mallen, 1983).

Discrepancies however are not limited to the interpretation of findings but also apply to results themselves. Challenges to the typical constellation as articulated by Bieber et al (1962) came in three different sets of findings.

A first one pertains to the contradiction of one or another component (or their derivatives) in the constellation. For instance, some studies found that neither the absence/loss of the father (Freund and Pinkava, 1959; Moran and Abe, 1969) nor a too powerful maternal relation (Roberston, 1972) was relevant to or of primary importance in the development of male homosexuality. There were also partial confirmations

involving paternal deficiencies but clearing mothers from any stereotypic behavior (Bene, 1965; Apperson and Mcadoo, 1968; Buhrich and McConaghy, 1978; Mallen, 1983).

A second form of contradiction came in studies that did not find significant differences in the behaviors (or their derivatives) of parents of homosexual versus heterosexual offspring: Newcomb (1985), in the relative distribution of five personality traits in parents, including dependence and aggressive-dominance[113]; Ridge and Feeney (1998), in attachment and working models; and Kiatkowski (2010), in perceptions of both maternal and paternal attitudes.

Finally, some studies contradicted the notion of a typical constellation through the identification of maternal and paternal behaviors that are strikingly similar in their positive (Skeen and Robinson (1984), but most significantly, in their negative manifestations: mothers and fathers as both scoring higher on childhood emotional and physical maltreatment (Corliss et al, 2002); as both showing a statistically higher level of detachment (Wilson et al, 2011); and as both being more rejecting and less loving (Siegelman 1974; Milic and Crowne, 1986) or lower in affectionate care and higher in controlling overprotection (Friedman, 1996). Negative findings above show remarkable correspondences with aspects that were deemed critical in the context of eating

[113] The other traits are intellectuality, affiliation, and endurance (Newcomb, 1985).

pathology - in particular, a direct match between Friedman's patterns of low affectionate care and high controlling overprotection and the so-called 'Parental Affectionless Control Dynamic', which was identified in Chapter VII as typical of offspring with eating disorders. Quite significantly also, the above negative results emphasize the compounding effect of additive parental behaviors, in alignment again with phenomena encouraging the development of eating pathology.

Underscoring the de-pathologization/rehabilitation dual phenomenon that characterizes recent changes in lay, legal, political and medical perspectives on parenting styles and their relation to homosexuality, findings from the past fifty years call for some tentative conclusions. To start with, parenting styles do not emerge as a consistent and necessary factor in the development of male homosexuality. When patterns of parenting do emerge, they are not restricted to one universal parental constellation, namely the classically invoked combination of a close-binding/dominant mother and an irrelevant/rejecting father. A number of other patterns are indeed revealed, of which one - low care and high protection in both parents - is of particular relevance to eating disorders.

Back to the central question of how to explain the vulnerability of male homosexuals to disorders of eating that otherwise mainly affect female populations, and consequences thereof on the nature of femininity, such proneness would concern a

subgroup of homosexual men whose upbringing is characterized by intrusive control and low care by both mother and father - the prototype of intrusive parenting identified in the previous chapter in individuals with disorders of eating.

Combining this inference with the femininity hypothesis in male homosexuality (the amplified femininity of homosexual men as a measured, if stereotypical, risk factor) and in eating disorders (femininity as a risk factor in these disorders) allows integrating the psychological and cultural dimensions of femininity, along with their biological support, to explain higher prevalence rates of these disorders in women as well as their occurrence in men.

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In this chapter, I followed a thread that led, in a rather non-linear way, from the postulation of a feminine aspect in male homosexuality to the confirmation of a feminine quality of intrusion - on the grounds of their shared quality of receptivity -, which nevertheless transcends gender in eating disorders. The notion of feminine quality, and its connection with male homosexuality and intrusion, reflects its stereotypical usage in the psychological literature. Inside what has become a concept of femininity, I have been able to extract an invariant that is more likely found in females, is moreover found

in a subgroup of homosexual men, and is closely associated in these two groups with the occurrence of eating disorders. That element is intrusion, paired with an exaggerated receptivity, so these two elements combine to create a susceptibility to eating disorders.

A feminine aspect of male homosexuality is premised on the consistent association of attributes of femininity with male homosexuality, as revealed in the gender-related paradigm of research on sexual orientation and gender. The notion of receptivity as linked to intrusion reflects my conceptualization of intrusion as the overwhelming experience of invasion of receptivity. This notion of intrusion as the invasion of receptivity is itself theoretically founded in processes of introjection and projection, which underlie dynamics of taking in/expelling as expressed in restrictive, binging, and purging behaviors. The transcending of gender derives from the extension of the receptivity metaphor beyond the receptive female anatomy.

In an examination of the gender-related paradigm of sexual orientation, I first showed that, even if a social construct, the relationship between sexual orientation and questions of femininity (or masculinity) is nevertheless a tangible and verifiable one. I then presented findings suggesting that biology cannot on its own explain sexual orientation, let alone its femininity (or masculinity) ramifications. Next, bearing in mind the homosexual exception, I extended my scope of investigation to eating pathology

and argued in favor of a femininity theory of these disorders - femininity, as conceptualized in the literature, as a factor of etiology. I pointed out the cultural underpinning of this femininity theory as manifest in the dialectical dynamic between the broader culture of society, which reproduces stereotypes about feminine/masculine behaviors and related messages about thinness and attractiveness, and the homosexual subculture, which contradicts these normative behaviors and messages. At that point in the chapter I identified what I suggested is an aspect of femininity, situated within, yet distinctly from the two poles of nature and nurture. This facet of femininity pertains to receptivity - beyond the metaphor of the receptive female anatomy - and supports a gender-free intrusion theory of eating disorders that applies to the two sexes. Going back to the homosexual exception in eating disorders as a conceptual tool of investigation, I established that intrusion explains, beyond cultural and biological explanations, the vulnerability of homosexual men to disorders that otherwise are typical of women.

The critical steps establishing intrusion as the psychological component of femininity in eating disorders in the two sexes involved the articulation of a number of findings from this chapter with Chapter VII's confirmation of an overlap between control and intrusion and its identification of a predominant maternal/paternal intrusive pattern of parenting in these pathologies.

A first set of findings established correspondences between negative femininity (subordination of self to others and verbal passive aggression as expressed in symptoms of low self-esteem, depression and anxiety) and negative styles of control (having too little control, being indecisive, timid and dependent).

A second set showed the coincidence of negative femininity and its yielding style of control with symptoms, which are typical of eating disorders in both males and females.

The combination of the above two sets of findings with those from Chapter VII (an overlap between control and intrusion and a predominant parental intrusive pattern of parenting) supports a gender-free femininity thesis of eating disorders that centers on anxieties of intrusion and explains the higher prevalence of these disorders in women as well as their occurrence in men. This establishes the relationship between intrusion and femininity in both males and females with eating disorders on the basis of a shared dimension of receptivity.

A last set of studies on the relationship between parenting patterns and male homosexuality cast some light on the relevance of intrusive parenting to men homosexuals. The findings dispelled the notion of a single pattern of parenting that has commonly been associated with male homosexuality. A typical and exclusive parental constellation involving a close-binding dominant mother and an irrelevant/rejecting

father is not sustained by the literature. Findings revealed instead the existence of a subgroup of homosexual men whose parenting is characteristic of that of women and men who suffer from eating disorders. I infer, on the basis of these similarities, that the relationship between male homosexuality and eating disorders is mediated by intrusive parenting. The inference is to be further verified by research on the parenting styles of male homosexuals suffering from eating disorders.

Chapter VIII concludes the last part of this work, which, in addition to verifying propositions on intrusion in its relation to femininity in eating disorders, has established bridges between the paradigms of psychology and psychoanalysis on the question.

Chapter VII addressed the external dimension of intrusion, with particular support to William's psychoanalytical model of intrusions as parental projections, without dismissing however the relevance of innate dispositions towards intrusiveness in eating disordered persons (Lawrence's model). The chapter actually confirmed the interlocking of the two etiologies in various combinations in the nurture/nature dynamics - permutations, which mirror Williams' notion of mismatch in the mother-infant dyad. In line again with Williams, it allocated an equal share to paternal and maternal intrusions,

therefore qualifying object relations views that restrict eating disorders to the exclusive realm of the mother, with paternal figures mostly relinquished to the world of fantasy (Lawrence).

While Chapter VII looked at the psychological literature from the perspective of parental intrusions, Chapter VIII has considered these intrusions in their relation to femininity and against the backdrop of sexes, gender, and sexual orientation. The homosexual exception in males has emerged in this respect as a valuable conceptual tool to understand some biological and socio-cultural parameters of femininity and their relation to intrusion in eating pathologies. This has underscored the merit of conceptualizing intrusion in terms of receptivity - beyond exclusive connotations with the female anatomy, yet beyond purely cultural explanations. Abstracted from a strict and exclusive association with women, but also from absolute constructionism, the notion of intrusion, understood as the overwhelming experience of invasion of receptivity, can be thought of as the psychological component of femininity in eating disorders, located within, yet distinctly from, culture and biology.

Chapter VII and VIII support an object relations understanding of eating disorders based on a conceptualization of intrusion in terms of invasion of receptivity. In transcending a receptivity metaphor exclusively linked to female anatomy, the notion of intrusion explains the disorders in the two sexes.

Without falling in the narrow confines of constitutional essentialism, and while allowing for cultural and environmental influences, it has been possible to invoke gender traits, in this case femininity in its receptive dimension, to think about the gender bias of eating pathology. In its intermediary stance between the two poles of culture and nature, the psychological component of intrusion, understood as the overwhelming invasion of receptivity, can be thought of as the tipping point where femininity blurs the boundaries of sexes.

CONCLUSION

> Primally and profoundly, classical psychoanalytic metaphor plumps for biology: as hunger rules the world (Freud, 1905b), so libido steers desire. At the same time, psychoanalysis renders the body the mind's creature: the hysteric's body… obeys the laws of psychology, not biology. Instead of a contradiction to be resolved then, perhaps the mind-body problem is a paradox to be explored (Dimen, 2000, 14-15).

Prompted by an intriguing phenomenon - eating disorders remain to a large extent a disease of the female -, my work has looked into the intricacies of this feminine island in the mental health landscape of the 20th century. There, in this uniquely lopsided epidemiological gender profile, lay I thought avenues to explore aspects of femininity in their most extreme and negative connotation, that is in their outright association with pathology.

Using the very notion, intrusion, on which an object relations understanding of the feminine link in eating pathology has been based, the major contribution of this work is the extension of its conceptual relevance beyond sexes, to also include men. Through linking extensive data from historical accounts, femininity theories, social and clinical psychology, and neuroscience with the intrusion paradigm of object relations, I have

shown that women and men are susceptible to eating pathology in proportion to their susceptibility to fears of intrusion into receptivity. This has confirmed my thesis that, while intrusion, understood as the overwhelming experience of invasion of receptivity, is the core problematic in disorders of eating, these pathologies are not of necessity a strictly female disease. Theoretical emphasis on the interpersonal dimension of intrusion and receptivity, in particular its parental pole, has been critical in expanding the scope of metaphorical receptivity to include women and men with eating disorders, but also mothers and fathers of persons with these disorders. From a broader interpersonal perspective, the notion of intrusion into receptivity underscores failures in the capacity to receive on either or both ends of the parent-child relationship. It emphasizes in particular Bion's 'container-contained' dynamics and their reversal in Williams' 'receptacle-foreign-body' relationships.

Adhering to the intrusion paradigm of object relations as one that captures the most elemental psychological phenomenon in the multifarious and complex dynamics leading to eating pathology, I have severed the model from an exclusive conceptual linkage to female receptive anatomy or dispositions. In doing so I have separated the theory of eating disorders from a definition of femininity based on its confusion with an attribute, susceptibility to dynamics of intrusion into receptivity, which may be more evident, for biological reasons in the broad sense, in females. A significant

consequence has been the outlining of aspects of femininity in ways that transcend sex, beyond conventional gender equations and their equally stereotypical contradictions.

A crucial moment and decisive finding in my research has come with what I have called the homosexual exception in disorders that otherwise mainly affect women. Evidence that a greater and increasing number of men are suffering from eating pathology presented from the onset a challenge to a femininity hypothesis exclusively linked to the female body and development. That homosexual men represented a relatively larger proportion of the affected male population brought a more specific challenge to the notion of an almost exclusive female disease. The challenge was underscored by the inability of research on sexual orientation and gender to describe male homosexuality beyond clichés and characterizations of femininity. There arose the rare opportunity to use the homosexual exception in men with eating disorders as a crucial test of both the femininity and intrusion hypotheses in these pathologies.

A constant reference in the thesis to the biopsychosocial etiological model of eating pathology - a widely recognized model in social sciences - has helped refine and strengthen an object relations intrusion perspective on eating disorders. The biopsychosocial model justifies my decision to go outside psychoanalysis to address the complexity of eating disorders. While I have argued that intrusion into receptivity is the most elemental psychological factor that explains eating disorders in both men and

women, my interdisciplinary approach - and its underlying biopsychosocial framework - has underscored the relevance and value of integrating intrusion, as a psychological component, with biological and social factors in these disorders.

Biology refers, amongst other things, to corporeal aspects, which carry unconscious metaphorical meanings of receptivity. From a purely anatomic perspective, the receptivity connotation is compelling and has explained, following Lawrence (and Klein), why women may be more prone to eating disorders.

However, a conceptual emphasis on interpersonal dynamics - the dyadic intertwinement in the 'receptacle-foreign-body' function as the reverse of the 'container-contained' one - has extended, following Williams (and Bion), the receptivity metaphor beyond the female body, in particular, and beyond innate/biological predispositions, in general.

In turn, this extension has invited the external - parental and social - dimension of eating disorders in the biopsychosocial relationship. It is this extension that sketches an explanation, beyond anatomy and constitutional predispositions, of why a subgroup of male homosexuals with a receptivity profile similar to that of women with eating disorders may be more prone than other males to these disorders.

I have specified external influences as social/cultural interferences (mainly visual messages and injunctions of slenderness) as well as perceived forms of intrusive

parenting. I have furthermore suggested that the remarkable contemporary surge in eating disorders, which I explain through biopsychosocial dynamics, is reflected in higher prevalence rates of eating disorders in female and male homosexual groups with a heightened susceptibility to intrusion into receptivity.

The mother-infant dyad of object relations - the mould in which the notion of intrusion into receptivity is conceptualized - provides the prototypic bridge between innate and acquired characteristics. In an intricately interdependent matrix, interferences from without (including gender-related norms and stereotypes) can be seen as interfacing with innate (sometimes corporeal) predispositions - the interface occurring around and through the psychological phenomenon of intrusion, understood as invasion of receptivity. Neuroscience has brought support to the mother-infant dyad model of early life.

A final remark concerning the biopsychosocial question is necessary. When I say in my thesis that intrusion is the core psychological factor of etiology in eating disorders, this elemental standing applies to intrusion at two levels: 1/ intrusion's supremacy over other psychological problematics; but also, 2/ intrusion's ultimate significance, as a psychological factor, among cultural and biological factors - the invariant in these disorders. However, and this is critical, in the same way intrusion does not exclude other psychological problematics, but interacts with them, its ultimate significance does

in no way exclude the influence of biology and culture.

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I would like to revisit essential markers on my winding path across the landscape of eating disorders - concepts and aspects that have emerged in the consideration of these diseases from the dual angles of intrusion - in its structural association with metaphorical receptivity, itself implicit in containment, - and epidemiological gender unbalance.

An underlying premise of my work has been that intrusion (into receptivity) and containment are two sides of the same coin. Their interconnected conceptual worth in what I have often referred to as the most archaic impulse associated with the object, the taking in of food, is essential to my general understanding of pathology and sanity from an object relations perspective. In a nutshell, I see the fundamental equation of pathology as involving the following dynamics: when the containment function is compromised - consistently, and in a context of total dependence on the object -, difficulties centering on fears and anxieties of intrusion arise. This is not only manifest in eating disorders, although the food metaphor, which originates in the primary dyad, is I think particularly powerful, not to say epitomic, in these pathologies. Indeed, what could

better illustrate the potent imprint on an infant of transactions and anxieties surrounding this earliest context of vital nurturance, in its emotional, physical, and metaphorical meanings? Then again, intrusion and containment models are also relevant, beyond pathologies of eating, to all sorts of disorders or intractable dysfunctional mental organizations that are associated with difficulties in the dyad in the early stages of life. Williams' work has offered abundant clinical illustrations, which are not restricted to the realm of food, of disruptions in containment leading to pathological defenses against intrusion.

Does intrusiveness into the object precede anxieties of intrusion into the self (Lawrence) - a projected innate insatiable hunger, which bounces back as the other's intrusion into the self because of fear of retaliation? Or does it happen the other way round (Williams) - parents projecting anxieties, which intrude into the self, and are projected back onto them? The question of the origin of intrusion and its vicissitudes, in connection with containment, is necessary and challenging, both at the theoretical and clinical levels. It does mirror the ever-present interrogation in this work around the relative contributions of nature and culture - beyond the recognition that neither can be considered at the exclusion of the other. It also is important from a practical perspective as it weighs heavily on a therapist's optimal ability to understand patients, females and males, and the context of their core predicament.

Permutations in the sequence and its dynamics with containment are multiple: (1) innate dispositions towards anxieties of intrusion, which are too powerful to be contained, even by parents who do not appear to be particularly deficient in their containing abilities; (2) ordinary projections of anxiety into parents who fail systematically in containing them; (3) parents who consistently project their fears and anxieties, not only failing in containing the child's own projections, but aggressively, if unwillingly, intruding with their issues on his/her normal development - triggering what Winnicott has described as the interruption of going-on-being (1965). There is no doubt that Lawrence's frequent encounter and work with patients whose predisposition to project trumps their parents' capacity to contain, the first instance above, does reflect an actual reality. I nevertheless think these cases are a minority and instances of parents who either fail to contain (the second instance), or, more often, project fears in their children (the third instance) are probably the majority. Chapter VII has presented ample evidence confirming the relevance of external interferences, in accordance with the ever-increasing consideration over the past century of the significance of trauma, both individual and collective, in the development of psychopathology.

This in no way implies a lesser status for internal triangular dynamics, which are bound to external Oedipal ones in what object relations theory establishes as an incessant interplay. Similar internal Oedipal dynamics are actually at the center of both

Lawrence's and Williams' intrusion-based models, which, despite their differing take on the origin of intrusion, equally invoke concreteness of thought to illustrate particular inner object constellations and dynamics in eating disordered patients. Whether innate dispositions towards anxieties (excessively powerful and/or inadequately contained) or massive parental projections are at stake, patients with eating disorders do not distinguish between the symbol (food/eating) and the object (mother) it is meant to represent. Overeating, not eating, eating then purging, all this relation to food is ultimately a relation to the internal object: longing for it, rejecting it, being torn apart between powerful and conflicting impulses of longing and rejecting. Such undifferentiation between symbol and object mirrors undifferentiation between self and object, the collapse of mental space upon the faltering of internal Oedipal triangulation. It reflects the baby's inability to mourn the loss of the mother as an exclusive object of possession who entertains an independent link with the Oedipal father, beyond her link to the infant - in other words, the infant's incapacity to recognize the parents' relationship with one another as well as his/her own separate relation with each one of them. Differentiation between object and symbol, and object and self, on which the capacity for symbolic thinking depends is accordingly contingent on the intervention of a third in the dyad. In eating disorders, the third element is lacking and capacity for

symbolic thinking compromised, which in turn is reflected in the concreteness of thought whereby food and eating are confused with the object and her functions.

An important aspect of the reflection on the intrusion/containment paradigmatic couple of eating disorders is the challenge it has posed to the concept of pathology in its application to sexual orientation and parenting. I will come back below on what I believe is a critical achievement of this work, which has allowed the extension of the intrusion into receptivity metaphor to the male population: the separation of the intrusion theory of eating disorders from a definition of femininity founded on its confusion with intrusion. At this point I will mention that another comparable achievement has been to separate male homosexuality from its circumstantial association with pathologically intrusive parenting in the context of eating disorders. Such differentiation restricts a commonly held view that male homosexuality occurs within a prototypic Oedipal constellation - a domineering, overwhelming, intrusive mother and an absent, irrelevant father - to instances among those typical of perceived intrusive parenting in eating pathology. It becomes then possible to assume that homosexual males with eating disorders belong to a subgroup of homosexual men who suffer from a problematic of intrusion in relation with certain forms of intrusive parenting. The relationship therefore is only between intrusive parenting and eating disorders, irrespective of sexual orientation. In this way, not only is the parenting of homosexual men freed from systematic association with

pathology, so is any implicit extrapolation to homosexuality per se. By refuting the prototypic Oedipal constellation of a dominant/intrusive mother and an absent/irrelevant father in male homosexuals I have enhanced the standing of my theory that intrusive parenting characterizes a specific subgroup of homosexual men whose eating disorder I link to vulnerability to fears of intrusion into receptivity.

A related aspect of parenting, which probing into the intrusion/containment model of eating disorders has also illuminated, is the equal relevance of fathers and mothers to problematics of intrusion in offspring suffering from eating disorders: fathers, like mothers, intrude, and contribute therefore to the etiology of eating disorders. I am referring here to the external father and mother, not to internal representations of parents, which, as emphasized in Lawrence's and Williams' distinct models, and reflected in my work, always depict lopsided dynamics between an overwhelming, because undifferentiated, maternal object and an inconsequential paternal one - the failed triangulation and differentiation that lead to concreteness of thought in these pathologies. The maternal paradigm of eating disorders is I believe valid to the extent that mothers are the primary caretakers and, as such, the objects to which issues of differentiation pertain. In this regard, the intrusion/containment paradigm has revealed a last essential characteristic of parenting: the combined additive intrusiveness of parents - fathers and mothers who, jointly and consistently, project their fears and anxieties - as

a non-negligible factor in the development of eating disorders. By refuting the exclusive maternal paradigm of eating disorders I have enhanced the standing of my theory that father do intrude and, as such, are critical to the development of these disorders.

Finally and most importantly from the perspective of this work, it is through freeing the metaphor of intrusion/containment from a strict and exclusive linkage to the female receptive body - the body Klein suggested was more likely to channel anxieties of intrusion - and extending it to the body in general that it is possible to apply the conceptual relevance of the twin metaphor of intrusion/containment to the two sexes. While receptivity can be specifically invoked in the case of the female body, this does in no way exclude its metaphorical relevance to processes of incorporation and expulsion that have been associated, from the onset of psychoanalysis, with anatomy in its 'non-gendered' aspects. This is even truer when thinking about receptivity from an object relations two-person, two-body perspective on introjective and projective processes. Therefore, even if feminine specificity does fit in particular in the intrusion into receptivity model of eating disorders, the model is nonetheless applicable in theory to all, males and females.

Broader Frontiers

Additional thoughts come to mind in connection with the feminine/receptive component of the intrusion/containment metaphor. There is indeed benefit to further define, from a conceptual perspective, the interface between intrusion/containment, in their confusion with femininity, and the broader societal context in which eating diseases unfold. I am not speaking here about cultural specificities, which encourage the propagation of these disorders, in different ways, at different degrees, in different parts of the world, at different times in history. I am instead interested in revisiting, from a comprehensive perspective this time, the challenge posed by what appears as a historical, stubborn connection of femininity with intrusion - in its specific containment facet, which I will be emphasizing thereafter -, and, beyond it, with eating pathologies.

In disentangling femininity from its confusion with containment in what I nevertheless confirmed as the intrusion/containment paradigm of eating disorders, my interdisciplinary work has both unraveled discrete categories in the so-called biopsychosocial construction of these pathologies and revealed some aspects of their perennial entwinement. A pertinent question arises in this regard of whether it is possible to identify an overarching principle that would explain lasting and universal assumptions about a containing ‘eternal feminine’ - beyond all interpretations put

forward in this work, and in a way that integrates biology (anatomy), culture and psychology.

Bourdieu provides an interesting perspective in this respect with his concept of symbolic domination[114], which, in accordance with the *paradox of doxa* - "the fact that the order of the world as we find it, with its one-way streets and its no-entry signs, whether literal or figurative, its obligations and its penalties, is broadly respected…" - comes across as being in the accepted order of things, even though it actually reflects the "transformation of history into nature, of cultural arbitrariness into the natural" (2001, 2):

> The social world constructs the body as a sexually defined reality and as the depository of sexually defining principles of vision and division. This embodied social programme of perception is applied to all the things of the world and firstly to the *body* itself, in its biological reality. It is this programme which constructs the difference between the biological sexes in conformity with the principles of a mythic vision of the world rooted in the arbitrary relationship of domination of men over women, itself inscribed, with the division of labour, in the reality of the social order. The biological difference between the *sexes*, i.e. between the male and female bodies, and, in particular, the *anatomical* difference between the sex organs, can thus appear as the natural justification of the socially constructed difference between the *genders*, and in particular of the social division of labour (Bourdieu, 2001, 11).

[114] "… what I call symbolic violence, a gentle violence, imperceptible even to its victims, exerted for the most part through the purely symbolic channels of communication and cognition (more precisely, misrecognition), recognition, or even feeling. This extraordinarily ordinary social relation thus offers a privileged opportunity to grasp the logic of the domination exerted in the name of a symbolic principle known and recognized both by the dominant and by the dominated - a language (or a pronunciation), a lifestyle (or a way of thinking, speaking and acting) - and, more generally, a distinctive property, whether emblem or stigma, the symbolically most powerful of which is that perfectly arbitrary and non-predictive bodily property, skin colour" (Bourdieu, 2001, 2).

Accordingly, the containing function, which, in its enduring association with women and feminine traits may seem natural and biologically inherent in the female anatomy, is actually inscribed in history and, as such, arbitrary. As *habitus* however, and in line with the principle of symbolic domination as recognized both by the dominant and the dominated, containment qualities are *embodied* in the form of unconscious schemes of perception, thought and action, which strike us, men and women, as fitting in the order of the world as it exists.

Feminine attribution to the concept of containment as encountered in this work would fit into Bourdieu's description of what may appear as "normal, natural, to the point of being inevitable…" in the division between the sexes (2001, 8). Such deceptive inevitability would be reflected from both positions of intrusion and containment, and at more than one level.

First, in the percentage of female victims of eating disorders who objectively remain the majority thus reinforcing the connection (and confusion) between being a woman and proneness to suffer from anxieties of intrusion - what Bourdieu refers to as "a relationship of circular causality which confines thought within the self-evidence of relations of domination inscribed both in objectivity, in the form of objective divisions, and in subjectivity, in the form of cognitive schemes which, being organized in accordance with these divisions, organize the perception of these objective divisions"

(2001, 11-12). The illusory, arbitrary dimension of inevitability in the relationship between femininity and vulnerability to anxieties of intrusion would of course be demonstrated in the recent surge of eating disorders in the male population.

Deceptive inevitability would also be reflected in the attribution of containing roles to mothers and wives. The view of mothers as containers of their children's anxieties has been a constant theme in this work. Then again, the containing role of fathers has equally been underscored - conceptually, once the transcending of sexes and sexual bodies in the dynamics of projection and introjection is posited; but also in the cases presented by Williams as well as in findings in the psychological literature. As for the other perennial bastion of feminine containment, wifehood, it is illustrated in Bourdieu's reading of Virginia Woolf's *The Lighthouse.* In her display of emblematic qualities of intuition, protection, tender affection, and confident comprehension of her husband - all fitting well under the banner of containment - Mrs. Ramsay holds "the whole of the other sex under her protection; for reasons she could not explain" (Woolf, 2004, 12). What Mrs. Ramsay could not explain, Bourdieu interprets in terms of symbolic domination.

How does Bourdieu's reading fit with my extension of the feminine metaphor of intrusion in eating disorders to the male population? The question is subsumed, once again, under the two poles of interpretation of human behavior that have underlied this

research - nature and culture, and their theoretical essentialist and constructivist underpinnings. I would like to return one last time to this pervasive polarity.

From the start, the dichotomy of clear-cut oppositions has represented a serious and constant challenge in my exploration and condensation of correspondences between clinical and social psychology, epidemiology, neuroscience, femininity theories and object relations. In my effort to overcome this difficulty I have tried to avoid the converse danger of intermediary imprecision and elusiveness, which all-embracing approaches naturally entail. Both concerns may have been imperfectly addressed. My attempts to categorize, for the sake of clarity and precision, may have sounded at times like sheer dichotomizing. The opposition between intrusion into or by the object is one, if prototypal in this work, among many examples. The deliberate location of my psychoanalytic perspective within a multidisciplinary context may have seemed at other times like a dilution of what I nonetheless posit as its ultimate significance.

Back to Bourdieu's "transformation of history into nature, of cultural arbitrariness into the natural", I do not see his constructionist proposition as representing a strict alternative to my psychoanalytic perspective. Instead, I view it as providing invaluable perspective to think about recent indentations in the feminine paradigm of eating disorders in conjunction with my thesis of a feminine dimension to intrusion that extends to the two sexes. Intrusion indeed has emerged as the psychological component, which

in these complex disorders bridges the distance between innate and acquired. As such, it is fundamental to any reflection on causality - in the relation of self to other - between constitutional dispositions, parenting, or culture, on the one hand, and pathology, sexual orientation, or sex role identifications, on the other.

Maintaining a meaningful tension between the two generic poles of etiology by avoiding inconsequential all-inclusiveness is certainly a difficult and delicate undertaking. The present research has shown however that such an undertaking is possible and that invaluable meaning lies in the interface of psychoanalysis with other disciplines, but also within object relations theories in their specific emphases on either external reality (couched in psychological terms) or innate unconscious fantasy as two nonetheless intimately related phenomena. In this regard, my take on interdisciplinary dialogue does not emerge in a void but links with a growing interest in psychosocial approaches - both at the theoretical level as depicted in Lisa Baraitser's "case" of psychosocial studies (2015), and as an arena for government and non-government programs of intervention among vulnerable groups of population, including refugees.

The intrusion into receptivity metaphor of eating disorders in the two sexes has signaled many avenues for additional research in the fields of clinical and social psychology, not to mention related areas in epidemiology and biology. I will give a few indicative examples. Further research around the fundamental question of time trends

incidences among men is needed, not only to answer the question of actual increases, but also to monitor and assess the meaning of increasing trends, if indeed they are confirmed. A related area of exploration that calls for development is the effect on prevalence rates among men of amenorrhea's exclusion as a diagnostic criterion in the DSM-V. A critical area that needs validation is the assumption of intrusive parenting in male homosexuals with eating disorders as discussed above. Additional attachment studies and statistics on trauma, including its transgenerational perpetuation, will help better apprehend alternatives to exclusive biological explanations of pathological transmissions within families. Such explorations could extend to the specific and comparative impact of paternal containment (relative to mothers') in families where fathers are the primary caretakers. Similarly, this time however from the perspective of its repercussions on parents, the parenting/containing relationship suggests many novel areas of investigation. Indeed, the recent and expanding field of maternal studies (Baraitser, 2003, 2006, 2008, 2012), which the mother-infant paradigm of object relations has sensibly invited, could inspire, considering the earlier and more consistent involvement of fathers in the care of infants, the development of corresponding studies in the paternal. The focus on maternal subjectivities would in this way broaden to address the increasing relevance of paternal subjectivities. Finally, an interesting expansion of the 'intrusion, as the overwhelming invasion of receptivity' metaphor would

consist in probing into what appears as its masculine expression and specificity, the compulsive pursuit of muscularity, as opposed to the feminine specificity of eating disorders.

To conclude, I believe my interdisciplinary approach has offered strong support to my thesis that intrusion, understood as the overwhelming invasion of receptivity, is the fundamental psychological factor in the etiology of eating disorders, and that it transcends gender. I am aware of the incomplete standing of any theory, but also of the intriguing array of questions and directions for new research that I have suggested.

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