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Recurrent Abortions in a Bulimic
Implications Regarding Pathogensis

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Despite agreement in psychodynamic formulations that bulimia nervosa results from relatively early developmental difficulties, the role of transitional objects in the syndrome has been debated. We describe the case of a severe bulimic in which repeated pregnancies and abortions fulfilled the same calming function as repeated binging and vomiting. We suggest that the cycle of incorporation and expulsion is central to affect regulation and is most compatible with the view that bulimics use their own bodies as transitional objects. We suggest further that such symptoms represent overdetermination, and reflect not only primitive deficits in regulation of internal states but also consequent unresolved conflicts. Thus therapy must be flexible enough to deal with both primary and secondary issues.

Although bulimic behavior is ancient (Boswell, 1987), it gained official recognition only recently by being formally listed in the third edition of the *Diagnostic and Statistics Manual of Mental Disorders* (American Psychiatric Association, 1980). Biological, behavioral, and psychopharmacologic theories and treatments have been advanced, but analytic formulations have yet to explore the subject adequately.

The first detailed analytic case presentation conceptualized bulimic behavior according to the traditional psychosexual model, as representing the wish to be impregnated and the rejection of that wish (Lindner, 1955). More generally, the bulimic was described as having regressed to the oral phase of development, with binge eating and vomiting representing incorporation and oral sadism, respectively (Lowenkopf & Wallach, 1985).

Viewed from the framework of object relations theory, binge eating symbolizes a fusion with the omnipotent maternal object, which is rejected or

destroyed then by vomiting (Wilson, 1983). Sugarman and Kurash (1982) carried the theory further and suggested that bulimics use their own bodies as transitional objects. They proposed that the *acts* of eating and vomiting are of greater significance than the food itself. In contrast, Goodsitt (1983) disputed the view that the patients body can serve as a transitional object. Instead, he argued that one's inability to control states of overstimulation or impending fragmentation leads to desperate attempts to calm these feelings. He suggested that the food itself may serve as a transitional object.

Similarly, Lerner (1983) and Swift and Letven (1984), following Bruch's (1982) model, identified a defect in the bulimic's sense of self. Swift and Letven (1984) referred to this defect as a "basic fault" that stems from a mismatch of infant needs and parental provisions – a concept very similar to that underlying incorporation of the omnipotent maternal object – and results in an over-burdened self incapable of regulating inner tensions and anxieties.

Within the framework of the object-relations theory, then, bulimia nervosa has been held to be an attempt to fuse with and then destroy the omnipotent maternal object. Disagreements have centered on the question of what constitutes the transitional object in bulimia nervosa? Is it the food (Gaddini & Gaddini, 1978; Goodsitt, 1983) or the patient's body (Sugarman & Kurash, 1982)?

We recently encountered a severe bulimic for whom repeated pregnancies and voluntary abortions produced the same internal calming function for the patient as did the bulimic behavior. To highlight the parallel, we will refer to her pregnancies and abortions as a "sexual bulimia" and binge/vomiting cycles as "food bulimia".

CASE PRESENTATION

U is a single 33-year-old white woman with a 15-year history of an eating disorder: 8 years of anorexia nervosa followed by 7 years of bulimia nervosa. U has been in outpatient psychiatric treatment for approximately 7 years. She has had a 6-year-long therapeutic relationship with one therapist (A.T.), meeting 2 or 3 times weekly. Over the course of therapy, it became clear that she used the binging/vomiting as a means of calming herself during unpleasant states of intense affect, either pleasurable or unpleasurable. She was admitted for her fourth inpatient hospitalization with increasing suicidal ideation.

Symptoms of anorexia nervosa began at age 16, soon after her sister's departure to college upset U's sense of family stability. U was 130 pounds (lbs) before the onset of her anorectic symptoms and has re-achieved that weight once briefly since that time. Her lowest weight was 89 lb and her current weight

remained stable near 100 lb. The bulimic behavior began after she completed her bachelor's degree, when her father insisted that she return home and work in the family's business. Binge-purge cycles rapidly developed into an average of a thrice daily ritual lasting several hours, this situation caused her to seek psychiatric help.

On initial hospital presentation, U was neatly dressed, well-groomed, and cachectic. Initially, she was poorly interactive, with downcast eyes and psychomotor retardation. She noted subjective depression and hopelessness. Cognitive examination was normal. She fulfilled the DSM-III-R diagnostic criteria for bulimia nervosa, major depressive episode, and borderline personality disorder (American Psychiatric Association, 1987).

Her medical history was significant for multiple complications of bulimia nervosa with esophagitis, dental carries, and chronic fungal pharyngitis. Of particular note was the fact that she had had five pregnancies, all of which were terminated by voluntary abortion.

The meaning and purpose of eating, vomiting, and death were central themes of her therapy. Death was described as a "soothing companion" that made life tolerable. At times, she resented psychotherapy because she felt it removed death as an option. She clearly identified suicide as a necessary part of her fantasy life. Suicide was also a vengeful, rageful act to her, and she described a recurrent fantasy of shooting herself in front of her father. Another aspect of this fantasy, however, was the wish that her father would save her from dying at the last moment. Her relationship wither her father appeared to be a central part of her psychic turmoil. She described her father as clearly "inside" her and it was therefore impossible to separate from him, which accounted for part of her rage towards him. She believed she would destroy her father if she were no longer ill. She experienced her mother as alternatively "smothering" or distant and hostile.

Her feelings regarding her food bulimia paralleled her feelings surrounding her "sexual bulimia" very closely. She described eating as "revolting" and always associated it with her father's eating habits. Likewise, she always associated intercourse with her father, stating that she invariably saw her father's face during intercourse and found the experience "disgusting". She consciously equated eating with intercourse and rape. Pregnancy was always as uncomfortable as the bloating sensation following a binge, even before the pregnancy resulted in noticeable anatomical changes. Vomiting or abortion removed this discomfort and resulted in a sense of relief. Particularly important is the abdominal pain that followed both the bouts of purging or the abortions. The abdominal pain was central to the "peaceful feeling" that this behavior produced, and she equated it with "eliminating" the father inside her. A cycle of pregnancy

and abortion was greatly superior to a cycle of binge/vomiting in terms of producing inner calm. Following her abortions she would not need to binge and vomit for several days.

DISCUSSION

Authors have used both self-psychology and object-relations theories to conclude that the inability to relate adequately to an early mother figure is central to the syndrome of bulimia nervosa (Lerner, 1983; Sugarman & Kurash, 1982; Swift and Letven, 1984). These unsatisfactory early experiences lead to a life-long attempt to recapture a sense of inner tranquility by whatever means possible. Clinically significant bulimic behavior can produce an ephemeral sense of peace.

Sugarman and Kursh (1982) noted their surprise that little attention is paid to the meaning of the patient's own distorted or abused body in proposed formulations of the eating disorders. They argued that the patient who develops bulimia nervosa has experienced difficulty in the transition from the differentiation to the practicing subphase. They noted that the first transitional object is a child's own body, which may, as with autoerotic behavior (Winnicott, 1953) or bodypart transitional object precursors (Gaddini & Gaddini, 1978), function to comfort the infant during times of distress. Consequently, from this view, the physical act of eating revives the comforting mother object for bulimics; however, incorporative behavior leads to a fear of fusion and stimulates vomiting (Sugarman & Kurash, 1982).

Goodsitt (1983) rejected the idea that the child's body could serve as a transitional object because it is a central requirement that a transitional object be perceived as "not me". He argued, instead, that, like anoretics, bulimics are driven to autoerotic behavior to calm states of intense internal overstimulation and/or fragmentation (Goodsitt, 1983). He went further, however, and stated that food may serve the role of the transitional object as it might in anoretics.

Our case, in which sexual bulimia has an effect on the patient's inner turmoil very similar to that of her food bulimia, suggests that U uses her own body as a transitional object – it is the very actions of *incorporation* and *expulsion* that provide the calming effect. Food, consumed and expelled (by vomiting, diuretics, or cathartics), is a very immediate and available vehicle to achieve this. But other methods of bodily incorporation and expulsion (e.g., pregnancy and abortion) may be equally or more effective in recalling a mother object and calming the inner tension but are not as immediate or available. Once the cycle of incorporation and expulsion has been completed, the bulimic momentarily feels the same sense of soothing inner peace that a normally developing child might be able to gain from his or her chosen transitional object.

Nonetheless, understanding U's symptoms exclusively in these terms fails to address the entire body of evidence. U entered the oedipal phase with a handicapped sense of self, that is, she lacked the internal capacity to regulate her own affective states. This deficit would not allow her to resolve the highly charged oedipal conflicts with any degree of success. According to Kohut (1977), early problems in the development of the self will be reflected in incomplete resolution of subsequent psychological maturation conflicts. Specifically, U struggled with her conflicted identification with her father: she experienced him as very aggressive, and this highlighted her own all too familiar intolerably high levels of aggression. She wished to be like her father (Freud, 1925/1955), yet the intensity of the wish made it intolerable. Consequently, she repeatedly incorporated him (both by eating and during heterosexual intercourse) and rejected him (purging and abortion). The rejection of denial of the highly intense drive to identify with her father calms the rage that the drive generates and re-establishes a transient sense of peace.

This discussion is consistent with the concept of overdetermination of symptoms, that is, U's behavioral symptoms addressed both her inability to regulate internal affective states and her unresolved oedipal conflicts, reflecting both primitive and more advanced developmental difficulties. Her presentation supports the idea that eating and vomiting are not essential for self-regulation; rather, the generic acts of incorporation and expulsion are more important. In other words, because the symptoms address several different psychological issues, they can express themselves in varying configurations.

This view has important therapeutic implications. Psychotherapy with severely disturbed patients often focuses primarily on early developmental deficits relating to self-regulation. U illustrates that the psychotherapist must address not only early developmental problems but also the manifestations of later developmental conflicts that may be superimposed. Although such a view is consistent with Kohut's formulations on the nature of the primary psychopathology in oedipal symptomology, one need not enter into the debate about this issue to be aware that both oedipal and preoedipal issues must be attended to during the course of psychotherapy.

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