

**A Far Cry From A No Thing**

**Psychoanalytic Perspectives on Women and  
Secondary Amenorrhea**

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## Declaration of Authorship

I, Danielle Redland, declare that this thesis is my own and that it has been generated by me as the result of my own research. Where information has been derived from other sources, I confirm that this has been referenced. Historical clinical case studies have been sourced from published material and new cases have been presented in this thesis with the consent and support of those involved.

*For Sarah, Evie, Jonathan and Benjamin*

*“Wait without thought, for you are not ready for thought:  
So the darkness shall be the light, and the stillness the dancing” (Eliot, Four  
Quartets: East Coker).*

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## **ABSTRACT**

Secondary amenorrhea is predominantly viewed outside of the social norms, somehow beyond the natural order of things. It might appear to reside in the shadows of its menstruating counterpart, viewed as that which is lacking, but this thesis will prove otherwise.

Secondary amenorrhea is a very powerful and present symbol that makes its mark in medical, cultural, social, anthropological, political and religious life. Narratives of womanhood and statehood dominate. Examples will be drawn from women in war and the Holocaust, hysterics of the late nineteenth century, prominence of patriarchy, gynecology, psychogenic trauma and eating disorders.

What though for the individual? What does it mean when a woman of menstruating age stops bleeding and what does it matter to her or to us? This thesis considers how the mind weighs heavily on the body. Through the application of psychoanalytic thinking, this thesis will link the cessation of menses to the unconscious registers suggesting that there is a communication of the psyche that looks to the body to find expression. Issues of symbiosis, interdependency, individuation, alienation, separation and loss are themes that recur in cultural and historical narratives worldwide and in the clinical work. These are discussed using examples from the consulting room. Psychic conflict and the search for resolution will be demonstrated in a psychoanalytic review of Ovid's *Pygmalion* and Shaw's retelling of the story. We shall also consider the role of the analyst by studying Freud's failed treatment of Emma Eckstein.

The purpose of this thesis is to show just how much presence there is in this supposed absence.

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## INTRODUCTION

The purpose of this PhD is to elucidate and validate the exploration, thinking, understanding and treatment of secondary amenorrhea as seen through a psychoanalytic lens. The study of secondary amenorrhea from a psychoanalytic perspective is designed to reveal just how much presence there is in this supposed absence. It is a rich terrain, as yet unexplored.

Amenorrhea, by definition, describes a woman's absence of menstrual bleeds. Primary Amenorrhea is the failure to start having periods by the age of sixteen. Secondary amenorrhea describes a cessation of periods in women of menstruating age and it is with secondary amenorrhea that this thesis concerns itself.

On a physiological level, the reasons for secondary amenorrhea can be linked to genetic patterns, endocrine systems and hormonal imbalances. A woman's menstrual physiology can also be influenced by race and / or ethnicity with differences in cultural attitudes and beliefs mirroring differences in menstrual cycles. All this will be examined to illustrate the ways in which we as individuals and as a collective engage with secondary amenorrhea. We shall explore its symbolism and demonstrate its usage and its value in the realms of both conscious and unconscious thought and motivation. Whilst there are some written works on the menstrual cycle, one might question to what extent the subject of amenorrhea is taboo. Often, the word amenorrhea does not feature in the indices of some of these books on menstruation and it's lucky to get a mention at all. When it features in medicine, obstetrics and gynaecology it is frequently dismissed as an error, solved by overriding the body's system with medication or intervention. In the consulting room, psychotherapists often "forget" about their patient's menses. The opportunity to think about that which has been "lost," is lost to both analyst and patient. As eminent psychoanalyst and writer Christopher Bollas reflects

“it is curious (odd, unconsciously significant?) that the menses is rarely discussed not only in the literature, but actually in the “course” of an analysis” (C. Bollas, pers. comm, 13<sup>th</sup> Sept 2016).

My thesis intends to identify and locate the many different places in which secondary amenorrhea does feature, both alongside its menstruating counterpart and in its own right. As far as I am aware, this thesis is the first of its kind to bring together all the different strands and to present them in one body of work.

On a biological level, the female menstrual cycle and the female reproductive system depend on a coordinated interplay between a quartet of organs – the hypothalamus, the pituitary, the ovaries and the hormonal priming of the endometrium. This interplay either results in a successful embryo implantation or it results in the onset of menses and the start of a new reproductive cycle. Failure of one of these components to play their role in this organisational set-up causes disruption and can result in amenorrhea. More specifically, it is the hypothalamic – pituitary ovarian axis that receives and integrates external incoming information such as light, pain, temperature and smell alongside internal information such as blood flow that brings about a menstrual bleed: And if this information is not successfully processed, the function of the axis becomes disrupted and amenorrhea will result (Santoro & Neal-Perry, 2010).

Let us suppose now that this bodily disruption is mirroring and being mirrored by a similar organisational state of mind in the psyche of the amenorrheic patient. In other words, there is disharmony in her internal world and the way in which information is communicated, distributed and processed is sent off kilter. A dislodging might perhaps be the result of a trauma, a fear or a neurosis. It might reside in the place of fantasy (known) or phantasy (unconscious). Whether it be real, imagined or what we term “as real,” a disturbance comes into its own. As a result, her psychic axis is no longer in a state of equilibrium and unconscious, conscious, external and internal communications are interfered with. Thus, both her mental and menstrual flow are shored up and halted. Over time, perhaps this state of secondary amenorrhea becomes a friend to the patient rather than a foe, as it defends against the complexity and mess that is normally associated with

the bodily menstrual process and the mental maturational process. One of the difficulties in the treatment of these patients comes about when the body supposedly betrays the mind and the patient's menses returns. Of the case studies I have included, the reader shall see how some patients who have come to psychotherapy with amenorrhea "miraculously" start to menstruate and continue to have regularly monthly menstrual bleeds. Some become pregnant: This, without any medical interference. The shift in the bodily mechanism is often mirrored by an internal shift in the psyche but all this comes with its own health warning. Carefully managing the patient's metamorphosis, safeguarding a fragile ego and maintaining her psychic equilibrium are no mean tasks but they are imperative in ensuring the successful outcome of these analytic encounters. If the patient experiences a rebirth, "shedding a skin" as one patient described it, what must be foregone?

It was in the unearthing of these case studies that my own seeds of curiosity took root and it is hoped that this PhD will arouse the curiosity and interest of clinicians and patients in all fields of therapeutic work. Importantly though, I hope to engage all those who are interested to learn more about secondary amenorrhea.

The starting point for writing this thesis was the time when I started to menstruate after a prolonged cessation of menses. I was in my late thirties. The red came out of the blue so to speak. At the time I was training to be a psychotherapist and my analysis was an integral part of that training. One day, about three years into my analysis, I got my period and from then on I had monthly bleeds. I am a woman whose body has perfected the art of the twenty-eight day cycle. There is no one more regular than me, much to my total annoyance! How dare my body be so compliant to the whims of society that dictates that to be a woman one must menstruate? Where is my non-conforming, autonomous, rebellion of a body, the body that more aptly reflected my concept of my own identity? I wanted it back. I missed my amenorrheic days.

Growing up I had a handful of menstrual bleeds and at the age of twenty, just before I got married, I went to the doctor who put me on "the pill." Monthly bleeding was novel and at first I welcomed this newfound sense of "normality." I

liked the idea of sharing stories of menstrual experiences with my female friends. But I couldn't quite understand why I was in a system where my artificial periods would actually be the cause of my non-conceiving, "The Pill" after all is an oral contraceptive. To be honest, the whole thing got boring rather quickly and I wanted to go back to my own world; the anomalous, non menstruating terrain, free from signposts, markers or indicators that could allow anyone to claim knowledge of my body. My amenorrheic state was very clearly defined in that it was an absence of the menstrual bleed but at the same time it represented so much more than that. I prided myself on a sense of androgyny, a tomboy attitude to my environment and as an adult I enjoyed my career as a television broadcaster in a male-centric world, never feeling that my gender got in the way. If there was any masquerade, I was in possession of it. I believed that I did not need to rewire my body. I understood my body and I had a non-complicated relationship with it. My amenorrhea linked me back to my childhood as the youngest of three, playing cricket with my two older brothers, happy to be one of the lads. I would field while my brothers played bat and ball. If the corky went over the neighbour's fence, I retrieved it. I didn't fight against the hierarchy, I didn't envy them having a penis and I didn't want them envying me having a womb. In some representational way my amenorrhea meant that I had both male and female attributes and I was not significantly lacking in either. I just wanted to keep the status quo in that we were all equal and gender did not divide us.

In adulthood, with my newly acquired menstruating body I was managing to reconfigure a new found sense of self with a new body boundary, even though it could never be to my preferred choice. I don't recall this being discussed in my analysis. I do remember it was celebrated as an achievement, testimony to the power of the analytic process. All the meanwhile, my analysis was losing shape. The boundaries were felt to be blurry and eventually the analytic walls came tumbling down. Some sort of psychic trauma was being relived. The analysis was felt to be spinning off its axis into a dense fog of confusion. So as to bring about a fresh start, by means of an end (just as in the menstrual cycle), a creation that can only emerge from destruction, I aborted the analysis and left, abruptly. I wandered the psychoanalytic land, in self-imposed exile, and I felt enough peace to try and reflect and process my experience. Exile is a form of

silencing but paradoxically it is the space that provides the freedom and safety to speak out. “Cursed” perhaps, (like so many young girls feel at menarche and so many women declare in their struggles with menstruation) but nevertheless the job had been done. The analytic chord had been cut. Oh, and I survived!

From my trying to work out psychoanalytically what had happened I discovered very important patterns that made a lot of sense when thinking about patients for whom issues of symbiosis and individuation, separation and loss are tantamount; no more so than with acute cases such as anorexia, hysteria, narcissism, trauma, abuse, neglect and deprivation, all of which have important links to secondary amenorrhea.

I had not intended to refer to my own analytic experience, nor indeed my border crossing from amenorrhea to menses but having consulted with several colleagues it made sense to “testify.” This of course comes with its own set of challenges – does this confuse the issue more than it clarifies it? What amount of disclosure is the right amount? What is the purpose and the relevance of my declaring and am I able to discern my own motivation and my own subjective view within a wider objective stance that can help the study along? To not have mentioned it would have allowed for my continued anonymity but the further I advanced into my research work, the more I thought it would be more truthful and helpful to state my own position as researcher. My aim would be to document my process as if with a third eye (that which was lacking in my own analysis). I have been cautious to remain in the analytic stance.

#### A NOTE ON METHODOLOGY

From the outset, I have been well aware of my own resistance against formulating and adhering to a carefully crafted research methodology. Despite them being a requisite in almost all academic theses and despite my thinking and applying them in my other projects, on this particular occasion I have been curiously contrary. More than once, eminent scholars in the field of social sciences would ask me to describe my research method. Responding with “I read a lot of books searching for secondary amenorrhea” was, as the reader will

appreciate, an insufficient and troubling answer for them. Whilst a formal written methodology can function as a holding container for a myriad of the researcher's thoughts and ideas it can also, in some instances, impede the work of a researcher, acting as a defence mechanism that then creates distance between them and the work that they are engaged in. Whilst the researcher does not want to become engulfed, submerged or taken over by the work, equally she does not want to be pushing square pegs into round holes. Unencumbered by a methodological container, too loose or too tight, I sought to go to wild places in my analysis of the subject, whilst trusting in myself not to make wild assumptions, particularly psychoanalytic in nature. I intended to systematically and objectively review and interpret all the evidence and I was open and receptive to all the information I gleaned en route. I trusted myself and I trusted my supervisor. So too was I open to both continuity and change. As Robert Romanyshyn writes of the method of alchemical hermeneutics in his book *The Wounded Researcher* (2013)

"The spirit of enquiry is, therefore, open ended, giving the structure of one's research a degree of freedom to arise out of the ongoing relation between the researcher and the topic. A creative method is not rigidly wedded to an inflexible structure or to immutable procedures for the work. It is a method that is supple and subject to change as the research progresses. It is a method that encourages a way of inquiry that is first and foremost in tune with the spirit of the work as it unfolds. It is a method that remains open to the playful possibilities in the work, and one that invites, and even encourages, a researcher to get lost from time to time in his or her dreams, reveries, and fantasies of the work" (Romanyshyn, 2013: 264).

Earlier on in his book Romanyshyn explains that

"In reverie, the work takes on a symbolic character and is freed of its literal and factual density. The work becomes many-layered and is laden with numerous meanings, which require interpretation. It is laden with possibilities, which require understanding" (Romanyshyn, 2013: 87).

The more I thought about secondary amenorrhea and the more I spoke about it with my interviewees, colleagues and my supervisor, the more it revealed itself to me. A narrative, rather than a methodology started to take shape. Our lives are led as stories; those that we are told and those that we tell ourselves all shape who we are. At the end of a conference where I had presented an overview of my thesis, a fellow presenter came up to me to tell me that he was planning to go home that evening and try to speak to his teenage daughter about periods because he's been resistant to do so up until hearing me talk. Another participant told me that her friend's menstruation had abruptly grinded to a halt when her mother had died: Two testimonies shared, following what was a very simple presentation on the subject.

Secondary amenorrhea, which is often thought of as an illness, an irregularity, an inconvenience or an anomaly, interrupts a narrative. There is a before and an after like migration stories or conversion stories or trauma stories and secondary amenorrhea is at that point of intersection. Similarly, the subject of amenorrhea is found in so many different places and it is a subject that deserves an interdisciplinary approach when it comes to furthering our knowledge and understanding of it. That is why the reader will find paragraphs in this thesis on law, science, medicine, art, film, myth, politics, history and so on. I experienced my researching into the subject as a multifaceted affair. It was as if the research mirrored that of secondary amenorrhea, medically described as emerging out of the interplay between many components. My role as researcher also reminded me of the therapist's role in the way that we approach and seek to make connections and reach our patients, many of whom are seeking relief from mental and physical pain. Whilst they are open to receiving treatment all the meanwhile, a prism of new receptors materialise, new psychic defences form that change the dynamics of the treatment. My friend spoke of a new drug he is taking to stave off not his cancer but the receptors that have recently mutated and that appear as ferocious if not more so than the original cancer. Things are forever on the march and we soldier on. With this in mind I have tried very hard to approach (sometimes attack) this thesis on secondary amenorrhea from all sides, leaving no stone unturned.

Secondary amenorrhea is a condition that although in itself represents for many non movement and non flow of menses, does itself move in between personal, cultural, social and historical genres. I think people have too often unconsciously colluded with the idea that secondary amenorrhea is elusive, enigmatic, mysterious and hard to get hold of. This partly explains why I have formally referred to it in the title of this thesis. It had been suggested to me that I use “missed periods” or “non menstruating” in the title so as to make the thesis more accessible to the reader. I can see the logic in this but I have wanted secondary amenorrhea to be a familiar term used in our everyday language just like “the menopause” or “cancer” or those increasingly more known and understood states such as Alzheimer’s or PTSD. We do not need to be afraid of engaging with it.

With so much material gathering, how did I organise my research? I located the places in which secondary amenorrhea figured. I looked in all sorts of texts, narratives, stories and portraits. My method meant me looking for the continuity and the discontinuity in individual, family, group and collective narratives to locate the point at which secondary amenorrhea came into being and took up residency. I searched for patterns and links and themes and I searched for opposites, transformations, changes, inclusions and exclusions to try and discern and interpret all that the amenorrheic form could represent and communicate. What was it revealing and what was it hiding? In true psychoanalytic style, it was when my understanding was disrupted and when my interpretations caused disruptions that I could start to sift through the information I had gathered. The sediments, the residue and the gaps in our knowledge and understanding often led to discussions and conversations and explorations about secondary amenorrhea that only the third ear of psychoanalysis could grasp and make sense of.

“Psychoanalysis takes this remainder, these symptoms, into account . . . It is based on an experience inaugurated by Freud, and takes care to ensure that Knowledge will not be an obstacle to the emergence of Truth. It is an *ethic of the Subject*. . .” (Clavreul, 1987 trans. Gallagher, 2002: 21).

In *Time Present and Time Past* (2005), British psychoanalyst Pearl King skillfully explains a key component of an analysis, which is called the transference phenomena. Within, the patient

“repeats and re-lives in the present of the psychoanalytic relationship unconscious conflicts, traumas, and pathological phantasies from his past and re-experiences them – together with affects, expectations, and wishes appropriate to those past situations and relationships – in relation to his analyst, who is then felt to be the person responsible for whatever distress he is re-experiencing. In this way, the symptoms of the patient’s illness are given a new transference meaning...”(King, 2005 [1980]: 138).

If we apply this in the context of working with a patient who is amenorrheic, the analytic couple can reconsider and re-examine the aetiology of amenorrhea and can locate the points at which it appears in the patient’s narrative. In obtaining past traumas, events, relationships and so on, the pathology behind the phenomena can be thought about, its purpose and relevance for the patient having meaning. Psychoanalytic thinking about the circumstances in which amenorrhea presents itself can also be applied in our understanding of the life cycles of communities, countries, groups and so on. When do they turn to the symbol of amenorrhea, why and what does the symbol signify and is it used to good affect? In its endeavour to elucidate a narrative far beyond the conscious realm, the practice of psychoanalysis seeks out a second structure through the encounter and interpretation of the patient’s unconscious; a dynamic system, a second text, a reality that is characterised by a series of processes operating under different rules to consciousness. As French psychoanalyst Serge Leclaire, beautifully describes in *La réalité du désir*

“The unconscious is not the ground which has been prepared to give more sparkle and depth to the painted composition: it is the earlier sketch which has been covered over before the canvas is used for another picture. If we use a comparison of a musical order, the unconscious is not the counterpoint of a fugue or the harmonics of a melodic line: it is the jazz one hears despite oneself behind the Haydn quartet when the radio is badly tuned or not sufficiently selective. The unconscious is not the message, not even the strange or coded message one

strives to read on an old parchment: it is another text written underneath and which must be read by illuminating it from behind or with the help of a developer” (Leclaire cited in Lemaire, 1977: 137-138).

When starkly truthful answers begin to emerge, and the reality of the unconscious weaves new lines of narrative of its own, the patient is “held” and “contained” in the psychoanalytic frame in a way that for many patients allows them to start to make sense of their lives and to bring understanding to what was once unintelligible. I have perhaps engaged with this thesis like an analyst engages with her patient, as companions learning from one another. I think the outcome is a positive one particularly because the thesis was borne out of difficult circumstances. But as I said earlier both in my approach to all of the clinical work and in my own experience of researching, organising and writing up this piece of work, I have always remained in the analytic stance, thinking on multiple levels, pulled towards that which is inciting whilst maintaining an air of neutrality and level headedness. I have wanted to discover what all this means to me and based on who I am in relation to others, what then does all this mean to others and to all of us. In what way does the experience of secondary amenorrhea connect us to history which affects us and in turn all those around us? In what way does our understanding of secondary amenorrhea enable us to view ourselves in relation to who we are and to who we were? Also what is the meaning of our suffering? What stuff are we made of that makes us select the position of victim or survivor? Where is our angst, our anger, our needs, fears, desires, loving and hating qualities and from where do they originate and in what ways do they translate themselves into forms that create faulty narratives; tics, neuroses, phobias, somatisations, stutters, disorders, menstrual irregularities and so on. It is my belief that only the science and the art of psychoanalysis can offer us a portal through which we can start to truthfully ask those questions of ourselves.

Through a psychoanalytic lens I have come to identify myself as an auto-ethnographer which places the researcher as an “insider” or “native” observer of her own cultural milieu (Reed-Danahay, 1997). As Karra & Phillips (2008) describe it, autoethnography

“does not mean that the researcher studies only himself or herself, but that the researcher is an insider who can draw on personal experience, cultural competence, and linguistic resources to frame and shape research in a way that an outsider cannot” (Karra & Phillips, 2008: 547).

Similarly,

“the portraitist’s reference to her own life story does not reduce the reader’s trust – it enhances it. It does not distort the responsibility of the researcher and the authenticity of the work; it gives them clarity” (Lawrence-Lightfoot & Hoffmann Davis, 1997: 96).

It is at this juncture that a distinction needs to be made between the researcher that is a vulnerable observer (Behar, 1997) and the researcher that is a wounded one. Both are personally attached to the project they are researching, open to feeling and engaging with what’s going on around them but the wounded researcher, as she witnesses and records it, so too somehow relives it. Romanyshyn expands on this

“the vulnerable observer merely seeks to bridge the gap between subject and object. The wounded researcher, on the other hand, is meant to go down into the terrain beneath the bridge, into the abyss that the vulnerable observer attempts to bridge. The difference is that while the vulnerable observer includes only those subjective factors that he or she is conscious of, the wounded researcher delves into his or her unconscious complexes, which he or she then strives to make conscious” (Romanyshyn, 2013: 109).

The auto-ethnographer, similar to the psychoanalyst must check in with herself to locate where she is in the narrative, why she is there and what she is doing in those moments, notably when she is sharing the same space with those she is observing, interviewing, treating, speaking with. I am a native secondary amenorrhoeic, locating myself in the text (Behar, 1996). I also know the plains of the menstruating woman and the borders which all women share but I have been carefully aware of the limitations of all of this knowing, particularly

“The voice of the insider is assumed to be more true than that of the outsider in much current debate. However, this issue is more complicated, partly because of the multiple shifting identities, which characterise our lives. Double identity and insider/outsider are constructs too simplistic for an adequate understanding of the processes of representation and power” (Ellis, 2004: 310).

I think it is my experience in the field of psychoanalysis, as a practitioner, patient and academic that has prevented me from acting in to such a web of conflict and confusion. The blurring of lines can be difficult to avoid, as Carolyn Ellis notes in *The Ethnographic I: A Methodological Novel about Autoethnography* (2004)

“Back and forth the autoethnographers gaze: First they look through an ethnographic wide angle lens, focusing outward on social and cultural aspects of their own personal experience; then, they look inward, exposing a vulnerable self that is moved by and may move through, refract, and resist cultural interpretations. As they zoom backward and forward, inward and outward, distinctions between the personal and cultural become blurred, sometimes beyond distinct recognition” (Ellis, 2004: 37-38).

The practice of psychoanalysis grounds me, as does my research in to what makes a good psychoanalyst. My secondary amenorrhea, my menses and this thesis bear testimony to my own early struggles as an analysand. They are in part the products and creations of an analytic intercourse, the experience of which is an increasingly distant memory, the scars from which still sometimes sting. Experiences are often both a blessing and a curse and I think this ambivalence is analogous to the way in which menstruation and amenorrhea are often thought of and felt. I hope this thesis, in its exploration of such powerful symbols, will reveal the depth of such thought and feeling.

## CHAPTER SUMMARIES

The first chapter of this thesis will demonstrate the ways in which secondary amenorrhea can be studied not just in terms of concrete, biological, genetic and endocrinological facts, but by reading and interpreting it as that which can transcend beyond the parameters of medicine and the conscious thoughts applied to it. The psyche and the unconscious phantasy life of patients who present with secondary amenorrhea can traverse space and time even though the physical being and the body, as science would have us understand it, appear to be telling a different story. The hypothesis that will thread through this chapter is that secondary amenorrhea is often connected with psychological conflict. It can be interpreted as a condition deployed by the unconscious to keep the subject in an illusionary state of balance and order. This safeguards her from the dread of psychic fragmentation. For many women, secondary amenorrhea is a price worth paying for a sense of control and continuity. But what is at stake? What past experience or trauma and what future perceived threats are hidden in the narrative, as yet undisturbed and unexplored? This chapter will present the literature on this.

The second chapter will give an overview of how secondary amenorrhea and menstruation are used as symbols in the realms of medicine, religion, history, anthropology, politics and literature. We shall look at the ways in which they are represented and understood by mankind. In societies and cultures they are often polarised at either end of a spectrum and they are tools employed in the wars for and against gender, economic and social division. Menses and non-menses can each symbolise omnipotence or impotence, inclusion or exclusion and the ying to one another's yang. We shall come to see how secondary amenorrhea is a powerful symbol both in its own right and by way of its associations with menstruation. It is undeniably suggestive of a presence of something rich in symbolism with a multiplicity of narratives and identities.

Chapter three will look at the symbolism of menstrual blood during Nazism, with the blood of Jewish women being politicised as the biggest threat and pollutant to the Arian dream and a return to a Golden Age. In this chapter we shall also

describe War Amenorrhea and reflect on the impact that a cessation of menses had on female camp inmates and the legacy it left with those that survived.

Chapter four considers the role of secondary amenorrhea associated with eating disorders and it explores the degree to which non-menses is a useful indicator of a patient's mental health. Does the absence of menses reflect the psyche's wish to clear the decks of a troubled, fragmented and messy mind and put in its place a system of order? Is this wish realised through the use of a stark eating regime and embodied by an amenorrheic state?

Chapter five will illustrate how difficult it is to relinquish certain psychological states and will show the means with which the unconscious preserves them. It will do so by looking at the myth Pygmalion, taken from Ovid's *Metamorphosis* and from George Bernard Shaw's retelling in his play *Pygmalion*. Interestingly, when you ask people who Pygmalion is, they often say it's the statue from Ovid's tale or the Eliza Doolittle character from Shaw's version. In fact it is the artistic creator; the sculptor, the Higgins character and such a mix up highlights the symbiosis within the unconscious and internal psychic process. Transformation, identification, separation, alienation and loss, both consciously and unconsciously experienced and communicated, are prevalent themes shared in these tales. They are themes that are tantamount in our interpretive approach to secondary amenorrhea. Ovid and Shaw were revolutionists who disrupted the reader's assumptions about certain beliefs asking that we as individuals rethink our views on things and the ways in which we engage with them. In a parallel way, I ask that we question and review our assumptions of secondary amenorrhea.

Chapter six concentrates on one of the earliest hysterical cases treated by psychoanalyst Sigmund Freud. The patient Emma Eckstein presented with hysterical symptoms and irregular menstrual bleeds and she was one of Freud's first psychoanalytic patients. With a careful review of the key commentaries on this case we can then proceed into uncharted waters in an attempt to work out what happened between Freud and Eckstein that resulted in her nearly bleeding to death. What was truly going on between the two of them and indeed what was it that Freud was not picking up and interpreting from their conversations? What

were the impasses in both the patient and her analyst that caused a torrent of emotional and physical damage and what part did Fliess, the surgeon, play in all of this? Having analysed the case material I will endeavour to present my own ideas on the matter. By doing so I challenge some of the accepted views and in furthering the line of enquiry and in perhaps speaking the unspeakable I am in a way paying homage to Eckstein and other hysterical patients who dared contest the might of the institutions.

To conclude, analysis for the patient with secondary amenorrhea can be experienced as something transitional. Either the actual analyst or the sessions are the transitional objects and the more attached the patient becomes the harder it is for her to give them up. In the conclusion we shall briefly consider the importance of the third position and the forces that “impel” the patient “to do work and to make changes” (Freud, 1915: 164-165).

## CHAPTER ONE

### A FAR CRY FROM A NO THING: COMMENTARIES ON SECONDARY AMENORRHEA

It is hoped that this chapter, designed to explain the what, how, where and why of secondary amenorrhea will redirect the reader out of the shadows of derelict pathways and onto the sidewalks of menstrual crosstown traffic, rich in movement and flow. In other words, the cessation of menses is much more than a static, one-dimensional No Thing. This chapter will present and review literature that supports the view that secondary amenorrhea is both a concrete and symbolic representation of a woman's physical and mental health. In fact, the stopping of the menstrual blood flow can be *the* giveaway clue of an underlying organic disorder and it can also indicate that the psychic apparatus, designed to safeguard and contain, is flooded. Trauma, loss, deprivation, helplessness, hopelessness, fear and shock are all possible "truths" behind the supposed blank canvas of the body that has stopped bleeding. So too, omnipotence and impotence, symbiosis and individuation, desire and a repulsion of that desire are possible routes to be explored. Secondary Amenorrhea is multifaceted, as should be our approach to understanding it.

On the surface it would appear that the work of psychoanalysis deals with a selection of shared themes. Patients bring to the consulting room feelings associated with depression, anxiety, loss, frustration, fixation and so on. When they speak of illness, pain, symptoms and bodily function so too the content, broadly speaking, might sound familiar from one patient to the next. But importantly, the analyst will focus on the experience of each individual because each individual is unique. From an existential point of view, the reality of each person can only be understood if it is viewed from each individual's unique perspective. And in psychoanalysis, the analyst is often required to put him / herself in the patient's shoes in an attempt to experience what it's like to be them. Analysis can then go deeper to ascertain what lies beneath the surface, in the thinking (direct thinking) and in the imagining (fantasy thinking) of the experience. As Jung writes in *Symbols of Transformation* (1911 /1912)

“We have ... two kinds of thinking: directed thinking, and dream or fantasy thinking. The former operates with speech elements for the purpose of communication, and is difficult and exhausting; the latter is effortless, working as if it were spontaneously, with the contents ready to hand, and guided by unconscious motives. The one produces innovations and adaptation, copies reality, and tries to act upon it; the other turns away from reality, sets free subjective tendencies, and, as regards adaptation, is unproductive” (CW5, para.20).

The skilful analyst will be capable of reading between the lines, interpreting what is amidst the interplay between phantasy and reality and between realities of self and other. Nothing is taken for granted and nothing is presumed. There is a whole other narrative, that of the unconscious, that is there to be explored.

However, when it comes to amenorrhea, as with many other biological conditions, we must not overlook the essential structure of the very thing that presents itself. We can't just rush on to explore what we perceive amenorrhea to be or what we hypothesise the psychological components in its formation are. We must study the experience (Husserl, 1915), in our consideration of it - its essential structure from a phenomenological point of view (Giorgi, 2009). What's more, we need to describe it if we are going to go on to interpret it and evoke further meaning (Heidegger, 1927; Merleau-Ponty, 1948; Gadamer, [1960] 2004a,).

Let us think about all of this in the context of women who have PCOS (polycystic ovary syndrome), which is often accompanied by amenorrhea. In fact, amenorrhea is often the first diagnostic symptom or sign of PCOS. It affects one in five women of reproductive age and as a heterogeneous condition it has diverse and significant clinical implications on women; reproductive, metabolic and psychological (Teede et al. 2010). It is crucial, that the aetiology of PCOS is fully understood so that the medical team can provide the best treatment in each patient's case. From a psychological, psychoanalytic point of view, we must look at it through the phenomenological view finder, if we are to fully apprehend the actual “lived experience” including the experience of “embodiment and emotion”

(Kruks cited in Jagger & Young, 1998: 66). What is PCOS? What is it like having it? In what way does it play on a woman's mind? What feelings are stirred up by the amenorrheic symptom? In other words, the biological and the physiological along with the psychological must be brought together in our thinking about PCOS.

“Most research has focused on the biological and physiological aspects of the syndrome. The challenges to feminine identity and body image due to obesity, acne and excess hair, as well infertility and long-term health related concerns compromise quality of life and adversely impact on mood and psychological well-being. Limited studies to date have reported that women who have PCOS are more prone to depression, anxiety, low self-esteem, negative body image, and psychosexual dysfunction. The other critical aspect of psychosocial impact in PCOS is the negative impact of mood disturbance, poor self-esteem and reduced psychological well-being on motivation and on ability to implement and sustain successful lifestyle changes that are critical in this condition. These issues all need to be explored and addressed as part of PCOS assessment and management” (Teede et al. 2010)

The treatment of amenorrhea in PCOS might involve lifestyle changes (weight loss, structured exercise, modified diet) or taking the oral contraceptive pill, cyclic progestins or specialists drugs such as Metformin. For women wanting to have children, infertility therapies are usually discussed. The reality of all of this weighs heavily on a patient's mind. Furthermore this reality of body and mind dualism then impacts on the unconscious reality that exists in the patient's internal world. We must remember that the traffic can be more than one way and the control tower, the body, is active, not passive. The body is a synthesis of the psychogenic and the hormonal, the biological and the cultural. French existential phenomenologist Maurice Merleau-Ponty brilliantly refers to the way in which they “gear into each other” (Merleau-Ponty, 1945). In *The Body as Object and Mechanistic Physiology*, in his enquiry into what accounts for the phenomena of phantom limbs, he writes

“no psychological explanation can overlook the fact that the severance of the

nerves abolished the phantom limb. What has to be understood, then, is how the psychic determining factors and the physiological conditions gear into each other” (Merleau-Ponty, 1945 cited in Mooney & Moran 2004: 428).

Siri Hustvedt uses Merleau-Ponty’s thinking to further her own understanding of hysteria. She writes in her paper “I Wept for Four Years and When I Stopped I was Blind” (2014)

“Merleau-Ponty argues against the physicalist notion of the body as a passive extended machine with a dis-embodied Cartesian ego, a model that stubbornly persists in representationalist cognitive science with its computational metaphors, albeit often implicitly, not explicitly. If, as Merleau-Ponty argued so passionately we are active “body-subjects” in a world with others, equipped with pre-reflective intentionality and developed capacities that form over time, rather than isolated subjects inhabiting corporeal machines, then the “no-man’s land” between the psychological plane and the physiological plane begins to close. If thought, ideas, and speech are embodied, psychobiological, intersubjective realities, not floating abstract representations but embedded in a bodily sensorimotor dynamic, then “conversion disorders” may cease to look quite so supernatural. Rather than charting correspondences between two distinct realms, psyche and soma, we can look for meanings in a live body that is socio-psycho-biological, with each hyphenated segment mingled into the other, rather than neatly stratified” (Hustvedt, 2014: 309).

We know that the psychosomatic interrelationship is stronger in some regions more than in the Euro-American cultures, and amenorrhea falls into this camp. For example, amongst the Yoruba in Nigeria, for whom reproduction is a task that *must* be experienced, anxiety is rife. In his study “Physical Health and Psychiatric Disorder in Nigeria” (1966), Robert Collis refers to Lambo’s work “Neuropsychiatric Observations in Nigeria” (1956) to emphasise the significance of reproduction:

“Failure to accomplish this function seems to be the key to the understanding of some of the neurotic conflicts that would otherwise be puzzling to a European observer (Lambo, 1956 cited in Collis, 1966: 14).

Collis writes about impotence and infertility as barriers to reproduction and to the desired social status that accompanies the production of children. These barriers lead to psychiatric disorders:

“A continual state of fertility for women and an extraordinary sexual prowess for men must always be present if they are to have peace of mind. The most minor deficiency of these functions can lead to morbid degrees of anxiety and depression, often with the worsening of the defect” (Collis, 1966: 42).

The Yoruba responded better to physical treatment as a curative method, rather than to psychological treatment. A settled mind comes about when all the parts of the body work harmoniously with one another. Physical illnesses are precipitants of psychiatric disorders. For example, many post-menopausal Yoruba women, in their hope to become pregnant, develop pseudocyesis and

“Even amenorrhea of three years duration may fail to convince them that they are not pregnant.” (Collis, 1966: 15).

Pseudocyesis, as we shall discuss further on in this chapter, is an example of the way in which the body enables the unconscious to avoid facing up to a new reality. Body memory is a powerful tool in this process. In “Body Memory and the Unconscious” (2012), Thomas Fuchs writes

“In body memory, the situations and actions experienced in the past are, as it were, all fused together without any of them standing out individually. Through the repetition and superimposition of experiences, a habit structure has been formed; well-practiced motion sequences, repeatedly perceived gestalten forms of actions and interactions have become an implicit bodily knowledge and skill. Body memory does not take one back to the past, but conveys an implicit effectiveness of the past in the present. This approach converges with the results of recent memory research on the central significance of *implicit* memory which is just as much at the basis of our customary behaviour as of our unconscious avoidance of actions (Schacter, 1999, Fuchs, 2000c)” (Fuchs, 2012: 91).

The unconscious is absence in the presence, the unperceived in the perceived (Merleau-Ponty, 1986,308f.) and as Wittgenstein asks

“If someone says “I have a body,” he can be asked, “Who is speaking here with this mouth?””(Wittgenstein, On Certainty, 244).

## THE CLASSIFICATION OF SECONDARY AMENORRHEA – WHAT EXACTLY IS IT?

Amenorrhea signifies an absence of menstrual flow, transient or permanent. Primary Amenorrhea describes

“a lack of menses by age fifteen years in a patient with appropriate development of secondary sexual characteristics, or absent menses by age thirteen years and no other pubertal maturation” (British Medical Journal, 2016).

The prevalence of primary amenorrhea in Britain is 0.3% and in the US it is <0.1%.

Secondary amenorrhea in females during reproductive years is defined as

“lack of menses in a non-pregnant female for at least three cycles of her previous interval, or lack of menses for six months in a patient who was previously menstruating” (British Medical Journal, 2016).<sup>i</sup>

Central to an understanding of secondary amenorrhea is its classification of four organ systems and the way in which they interrelate with one another. They are, the central nervous system, the anterior lobe of the pituitary, the ovaries and the uterus.

“Amenorrhea may be caused by an organic or functional defect in any one of these four interdependent links, the dysfunction of one being reflected in the structural or functional disturbances in one or more of the others. Sturgis’

classification into hypothalamic, pituitary, ovarian, adrenal, and thyroidal amenorrhea is often used” (Björo, 1966: 70).<sup>ii</sup>

Discounting physiological amenorrhea such as before menarche, in pregnancy, after the menopause, lactational (breastfeeding) or postoperative (e.g. a hysterectomy), and ruling out the use of oral contraceptives, amenorrhea can be categorised as either an organic or a non-organic disease. If we take the organic one first, this would include anatomic defects in the genital tract, hypothalamic and pituitary causes, ovary insufficiency, endocrinopathies and chronic oligo-ovulation or anovulation (American Society for Reproductive Medicine, 2008). A cessation of menses is often a significant precursory symptom of a serious medical illness which left undiagnosed could lead to osteoporosis, endometrial hyperplasia or endometrial cancer (Pritts, 2004). It may also be a symptom of endometrial tuberculosis or AIDS wasting, notably in developing countries (Harlow & Campbell, 2004).

As with cases of anorexia as well as extreme obesity, secondary amenorrhea is linked to metabolic and psychogenic (of psychological origin) disorders. Here too, the cessation of menses is sometimes the first early sign of a serious illness. A psycho-endocrinological process triggers the amenorrhea and the malnutrition perpetuates it. We shall be looking at the significance of this in detail in chapter three.

In terms of the non-organic diseases there is a record in Buchan’s 1797 *Treatise on the Prevention and Cure of Diseases* of what is now commonly referred to as stress or emotional amenorrhea, formally classified as psychogenic, functional or hypothalamic amenorrhea. Buchan wrote

“Barrenness is often the consequence of grief, sudden fear, anxiety or any of the passions which tend to obstruct the menstrual flux” (Buchan, 1797: 368).

Put simply, this is a matter of cause and effect. Psychological and socio-environmental factors are usually present covering a broad range of situations with likely triggers being shock, stress, trauma, abuse, separation and loss. In

many of these cases, the psychic factors influence the endocrine functioning, which disrupts the reproductive system and periods stop, often abruptly. Psychogenic amenorrhea is also linked to nervous disorders and major psychiatric disorders “frequently interwoven in the aetiology of neuroses or some psychotic states.” (Bjoro, 1966: 78).

There are so many different ways in which the variables on the axes interact with one another and form interdependent links. That’s what makes secondary amenorrhea so unique.

The prevalence of secondary amenorrhea in women who have previously menstruated regularly is approximately 5-7% in the US and 3-4% in Britain (NICE CKS, 2014). In a developing countries study, the frequency ranged from 5-9%, similar to the figures from population-based surveys in Europe (Harlow & Campbell, 2004). The numbers are particularly over-represented in competitive endurance athletes (5-60%), ballet dancers (19-44%), enlistment (73% of women entering the U.S Military Academy), army recruits (25%) and women entering a religious order (16%) (Thompson, 1988). The higher prevalence in war and famine is unmistakable. In a ground breaking publication, “The epidemiology of Secondary Amenorrhea” (1961), Frances L. Drew collected together previously sourced data. She found the percentages of women with secondary amenorrhea ranged from 1.9% in a control group of gynaecological patients to 16-51% following the bombings of Nagasaki and Hiroshima, highest amongst those closer to ground zero. The figure was 100% in young prisoners condemned to death. Bear in mind, the standard rate at the time of Drew’s publication was 4-6%.

“The frequency rates of secondary amenorrhea when examined epidemiologically appear to be quantitatively related to separation from home and family and to the extent of the threat associated with such separation. In peacetime circumstances the rates are low but increase to 100 per cent in those about to be executed” (Drew, 1961: 396).

For Drew, the root cause of secondary amenorrhea in these cases was “separation and / or hopelessness” (Drew, 1961 and Drew & Stifel, 1967: 47), war

and disaster being unequivocal. Whilst many cases of stress amenorrhea are easily reversible with periods resuming from between six to eighteen weeks (Jones & Jones, 1981 cited in Thompson, 1988: 60) some are much more prolonged and persistent. This is because the amenorrheic body has become entrenched in a more complex system of “intrapsychic vulnerability, external stress and neuroendocrine disturbances” (Khuri & Gehi, 1981: 883).

We shall now look into what’s going on in those trenches and the circumstances in which amenorrhea emerges and is then deployed as a defence to secure the survival of the individual.

#### EMOTIONAL AND TRAUMA INDUCED AMENORRHEA

There are several striking examples of trauma-induced amenorrhea. For example, in *The Psychobiology of Emotions* (1988), Thompson refers to a woman who was menstruating regularly but became amenorrheic after she was severely beaten and abused by her husband on their wedding night. For the whole of the six-year marriage and for two years following their divorce, she did not have one menstrual bleed. When she got engaged to a man whom she then went on to marry, her periods came back (Coldsmith, 1979 cited in Thompson, 1988: 60). In “The etiology of some menstrual disorders: a gynaecological and psychiatric issue” (2007), authors Sheinfeld et al. give an example of an orthodox Jewish woman forced to have intercourse with her husband when menstruating. Jewish law states that husband and wife should not have contact with one another whilst the woman is menstruating. Sheinfeld writes that the woman stops bleeding as a “defence” against her feelings associated to her suffering in sin. In her thirteenth year of amenorrhea she feels relieved rather than annoyed. Is it not also that her condition somatises and anaesthetises the rage that exists cornered by the impotent stance she must adopt, framed by Jewish law that states a bride is the property of her husband. He owns her. His lawlessness in terms of domestic abuse is within the law of patriarchy.<sup>iii</sup>

In *Psychosomatic Aspects of Gynaecological Disorders* (1969), Alfred O Ludwig focuses on integrating psychoanalysis with medicine. One of the cases he

presents is of a thirty two year old woman who had her first period at 14 and her periods stopped aged around 18, soon after her father was involved in a car accident. The driver of the car was killed and the patient's father's face was "smashed." He lost sight in one eye, he lost his sense of smell and the depression that took hold of him had a long lasting impact emotionally and financially. Ludwig writes

"During the course of this patient's psychoanalysis, one theme recurred: death wishes to herself and more particularly to others...Women seemed to be outstanding targets for her aggression" (Ludwig, 1969: 27).

This patient often envisaged herself as a heroine. As Joan of Arc, her amenorrhea was a sign of her strength. Recurring fantasies were of having a penis and urinating standing up. At the time of the accident, with the onset of her amenorrhea "she died as a girl" (Ludwig, 1969: 32).

In Helke Sander's "Remembering / Forgetting" which is an essay taken from *Liberators Take Liberties: War, rapes, children* (Sander & Johr, 1992), the reader is shown examples of women and the soldier "liberators" who raped them during and after the war in Germany, notably in Berlin 1945. One witness reports:

"The women's hysteria set in once the rumor started about the black troops who would be the first to march in if the Russians were not faster. I also witnessed the ways in which mothers who tormented us with warnings about washing made themselves unattractive and dirty to repel the conquerors" (Sander, 1995: 16).

Venereal disease, contracted through rape, was widespread with many women being subjected to forced examinations and medication. Of these women, many became amenorrheic, often for some years. Most remained silent, developing

"a distance from socially proclaimed truths and a sense of absurdity associated with withdrawal, mistrust and the reflexes of those who play dead" (Sander, 1995: 25).

Perhaps the amenorrhea developed as an organic symptom following the invasive and unhygienic examinations. Perhaps too it was a result of the shock and trauma that caused a schism in the previously well regulated hypothalamic-pituitary-adrenal (HPA) axis or might we think of it in symbolic terms as the emergence of a most powerful and evocative symbol of playing dead. The body is dead, shut off to life and to all men who wish their sperm to impregnate her. Is not her amenorrhea an act that diffuses the acute pain and creates a watertight defensive system that is defiant, even scornful, aspiringly transcending of nature? At the same time, we have Sander's point that many women "forgave" their rapists and perhaps in these instances the amenorrhea was a state that subscribed to being outside the natural order of things yet at the same time inside a societal system governed by law but where that law did not clearly and definitively oppose transgression. She is compromised by a perverse version of Freud's notion of "turning towards the father" (Freud, SE. 21: 221-46). Whilst many women who had been raped had to decide whether to abort an unborn child or to give birth to it, amenorrhea could signify at the very least a barrier to entry and the prevention of unwanted pregnancies.

It is often difficult to cut through the culture of silence that inhibits many women from talking about their experiences and menstruation itself is "commonly invested with a variety of sociocultural, ethnic, and other highly personal beliefs" (Youngs & Reame, 1985 cited in Rosenthal & Smith, 1985: 25).

Religion plays a big part in this too (Paige, 1973; Good & Smith, 1980). By taking a multi-disciplined approach, where the patient feels her case is much more to the clinician than just cause, effect and treatment, she might feel enabled to resolve that which inflicts on both body and mind.

The next part of the thesis will be a compilation of research and clinical work to illustrate and examine cases of secondary amenorrhea. I have put together case studies from psychiatry, psychoanalysis, psychosomatic medicine, other sciences, books and journals. The theories and the clinical examples in many ways interlink and formulate a dynamic of interplay. We shall begin with hysteria

as it is one of the most richly documented conditions in which amenorrhea features.

## HISTORICAL TREATISES ON AMENORRHEA AND HYSTERIA LINKED TO TRAUMA

Whilst looking through the books on hysteria at Senate House Library in London, in and amongst the more familiar ones was a treasure of a find that had not as yet been signed out; *Hysteria Complicated by Ecstasy – The Case of Nanette Leroux* (2010). It's author Jan Goldstein, whilst rummaging around a Paris archive, came across a manuscript from the 1820s, which she suspected was terra incognita. Goldstein discovered over two hundred pages of notes recording and narrating the case of Nanette Leroux. Nanette's hysterical catalepsy was, according to her French physician Antoine Despine, caused by fright. The first entry in the medical diary reads

“The patient attributed the onset of her malady not without reason to the repeated frights caused her by an evil person, a rural policeman (*garde champêtre*), who on several occasions had attempted to offend her modesty. The first time he pursued her, she was having her period, and the flow stopped immediately. She was at that time, seventeen years old” (Goldstein, 2010:138).

The blocked and suppressed fluids caused the catalepsy and hysteria, which led to a loss of speech and “*transport des sens*” (sensory transportation). Despine had called his case study “History of the Catalepsy of Nanette Leroux” but his co-author, Alexandre Bertrand, renamed it “Hysteria Complicated by Ecstasy” even though both of them avoided any interpretation of a sexual nature for fear of being incriminated. They sought to dispense of Nanette's symptoms and went about it with a series of shock therapies, cold showers and magnetism. It was as if the body was an intricate system of currents, some of which had short wired, that could be fixed and re-circuited by such therapies. This was common in its day (Shorter, 1991).

Not all though colluded with the belief that cold showers could kick start menses into action. As French midwife Marie-Anne Victoire Gillain Boivin wrote with French Obstetrician Antoine Louis Dugès

“The imprudence of some persons however, in checking the catamenia by immersing the hands in cold water, is sometimes followed by severe symptoms of hysteria” - (Boivin & Dugès, 1834: 422).<sup>iv</sup>

If Nanette’s care team were to consider that her hysteria was perhaps the articulation of a friction between psyche and soma, they would draw a line around the experience of that which is “being outside oneself” like the religious hysterical fantasies of Joan of Arc and other saints. They would have known that there were other practitioners such as Louyer-Villermay who were exploring an “erotic dimension” linked to hysteria with “insufficient sexual satisfaction and an overactive imagination” (Goldstein, 2010: 54) at the root of the etiology. The unmet eroticism with the nervous spasms caused hysteria. This type of theorising was overlooked by Despina, so too was Nanette’s behaviour and exhibitionism in front of her carer Maillard, upon whom she relied. Goldstein has observed in this coupling what Despina would not:

“By the force of his folksy eloquence, he succeeded in getting through to the patient and reassuring her.” But he becomes her “misplaced accomplice” (Goldstein, 2010: 180).

Years later Nanette married and became pregnant, fulfilling the role of what society deemed fit for a woman, but once her body was a procreating body, her old symptoms returned. In fact she was a contradiction to the idea that the best remedy for menstrual maladies in woman like Nanette was marriage and motherhood.<sup>v</sup> Goldstein offers her interpretation that all along Nanette had been seeking autonomy, testing out her capacity to self regulate. The longer she could remain ill, in the care of her doctors, the longer she could reside in the place described by Erik Erikson (1959) as a “moratorium”. Goldstein writes that the cataleptic symptoms were apt in dramatising this. I would add, so too did Nanette traverse time and create for herself a middle space, a suspended transitional space, by means of the non menstruating, amenorrheic state.

In general during the 19th century, medics were obsessed with a woman's menstrual cycles and Michel Foucault describes it as a time of "hysterization" of the female body (Foucault, 1978: 104). Contrary to Foucault's assertion that this was going on amongst the bourgeoisie, lots of documents prove that the poor, just as much as the rich, were concerned with their bodies and sexual function. In "Hysteria At The Edinburgh Infirmary: The Construction and Treatment Of A Disease, 1770-1800" (1988), Professor Risse uncovers the ambiguous constructions of disease formulae and proves that working class women (like Nanette) sought treatment for hysteria. Nearly 80% of women at admission were amenorrhic. Obviously, nutritional and environmental factors were taken into consideration but nevertheless, they usually received a daily dose of electrical shocks to the lower abdomen; a method termed "drawing sparks." But physicians noted that whilst the hysteria might subside, "most menstrual irregularities, especially the amenorrheas, remained unchanged" (Risse, 1988: 13).

Désiré Bourneville observed this in 1873 when working on the theory of a uterine etiology of hysteria. He wrote of one patient:

"Her periods are sometimes accompanied by attacks, but not in any absolute way. Often the attacks occur in the interval between periods. Delays in menstruation do not appear to have any action. Finally, a very long amenorrhea (19 months) did not prevent the attacks from returning for ten months" (Bourneville, 1877: 164 cited in Bogousslavsky, 2014: 72).

Bourneville is often thought of as a "pioneer in neuropsychology" (Walusinski, 2014) and is credited for his capacity to listen and empathise with his patients, developing a social analysis of the condition of hysteria rather than just making it accountable to clinical diagnostics. Bourneville introduced the older physician Jean-Martin Charcot to the Salpêtrière Hospital in Paris (Goetz, Bonduelle & Gelfand, 1995). It is Charcot's work with hysterical patients, one that gradually evolved over a twenty year period, that propels us to view hysterics as specimens, theatrically posing their hysterical wares in front of their physicians and their audiences.<sup>vi</sup> Despite all of the theatrics, both in terms of what went on

then and the way in which it is endlessly commented on and analysed, French scholar Asti Hustvedt, in *Medical Muses: Hysteria in Nineteenth-Century Paris* (2011) crucially points out that Charcot was linking neurology with somatics and the psyche. Hustvedt tells us that many of Charcot's patients refused food, many were diagnosed with depression, multiple personality disorders and some self harmed. They were assimilated into his thinking about patient work and they complied with his treatment of conditions, many of which are common today. As Hustvedt says in an interview for *The Guardian* newspaper's review of her book,

"There's been a lot of talk about how hysteria has disappeared...In some ways that's accurate – it's no longer considered a medical entity or diagnosis. And at the same time, of course, it hasn't disappeared. People continue to write about it, people continue to talk about it; it's been broken up and reclassified into other, separate disorders. It's just that the names have shifted" (Adams, 2011).

The theory of hysteria as "*maladie mentale*," was advanced by Janet and Freud. Some groundwork had been done by doctors such as William Cullen and fellow professor James Gregory responsible for classifying hysteria under a new category of illnesses termed neuroses (1769).<sup>vii</sup> They explored psychological factors such as fear, anger and disappointment as triggers. Menstrual disturbances flagged up psychic discord.<sup>viii</sup> In 1781, Dublin Obstetrician Edward Forrester linked amenorrhea with

"a vehement desire of venery, attended with melancholy or mania." (Forster 1781 cited in Shorter, 1992: 17).

According to S.W.D. Williams writing in the *Journal of Medical Science* (1863-1864) amenorrhea was "a cause of insanity." In 1873, Thomas Clouston, a lecturer on mental diseases at the University of Edinburgh, identified thirty five different types of insanity, a quarter specific to women, including "amenorrheal insanity", "puerperal insanity", "insanity of pregnancy", "lactational insanity" and "hysterical insanity" (Skae & Clouston, 1873: 348).

Many medics incorporated psychoanalytic theories of sexual desire and sexual function into their treatment of “the female maladies” (Showalter, 1986, 1997). As they understood it, during important stages in a woman’s life cycle, notably puberty, a failure of the impulse or libido to direct mental energy resulted in mental illness such as hysterical or puerperal insanity (Mott, 1922: 465). This theory was put to use at the Maudsley Hospital between 1923 and 1938. Patients were given glandular extracts taken from animal sources as one form of treatment. The practice of administering hormonal secretions in to the body was commonplace in the early twentieth century. Alongside this, a psychological enquiry took place to discover what might have caused an illness of the mind; what were the patients lacking and what were they in need of from their environment. One case study was of a twenty one year old woman, admitted in April 1923, under the care of Doctor Isabel Emslie Hutton. She was diagnosed with “compulsion neurosis” caused by the “condition of [her] sex organs.” Hutton stated that a stay at the Maudsley would allow this patient the space she needed, away from her mother.

“Her mother's fussing at puberty about her amenorrhea and warnings about men appeared to have made her regress towards childishness and she says she “wanted to remain a child”, cared for by and dependent upon her mother. Her fear of going out of her mind is associated with her amenorrhea and with masturbation, which she feared had injured her. The compulsion to touch things, and her own body, are also connected with this (CFM 003.1125)” (Evans & Jones, 2012).

After eight months of discourse and treatment with glandular and hormonal extracts, the patient was reported as being in better physical health, menstruating regularly although “the obsessive doubt and slowness persist more than ever.”

It seems that throughout history, many medical doctors have wanted to reaffirm womanhood in their patients, patching up the physical and stabilising the emotional components in the women who seek treatment from them. Stabilising the menstrual cycle is classified as a stabiliser of the mind, reducing hysterical insanity or other such female maladies. Psychoanalysis has always been

concerned with delving much deeper into the root causes of an illness and Freud, Breuer, Janet and their contemporaries had been exploring hysteria seeking to reveal the layers of psychological pain and conflict that had gone into creating the hysterical masterpieces they witnessed in their patients. Pierre Janet focussed on trauma.

That menarche was in itself experienced as a traumatic act that could cause insanity was a position commonly held at the time of Janet publishing his first insights into psychological trauma in *Revue Philosophique* (1887). Janet worked on the principle that a person could not move on and develop their personality if they had not successfully integrated traumatic memories from the past. In one of his treatment methods he substituted the content of the original picture of the trauma with replacement images. In other words, he changed his patients' traumatic memories. One of his early patients at the Salpêtrière was Marie who had been deeply shocked by her first menstrual bleed (Janet, 1889 cited in Leys 2000: 106). To stop the bleeding she had jumped into a tub of cold water and she did not bleed again for another five years. When her menses returned, each cycle was a reminder of the original trauma for which she had total amnesia after the event. Under hypnosis, Marie regressed to the age before menarche and Janet informed her that having periods was normal. However, her anxiety persisted and later on in the treatment they uncovered another trauma. Aged sixteen, Marie had seen an old woman fall down the stairs and die. Whenever Marie heard the word "blood" her somatic sensations relating to this event returned. Janet suggested the old woman had not died but had only tripped and as a result of this directive hypnotic substitution technique, Marie did not have any more anxiety attacks. Many praised Janet's 1889 paper and his treatment of Marie but criticism was and continues to be never far away.

"The question whether such approaches lead to further dissociation of traumatic memories, as Janet thought, or to their implicit assimilation remains unanswered. Contemporary authors (Kluft, personal communication) have warned that in patients with a history of incest where the child was denied validation of the trauma because of threats by the perpetrator, the substitution technique could

easily be misunderstood by the patient as an extension of the process of negation of the trauma” (Van der Hart, Brown & Van der Kolk, 1989: 9).

There was also the need to reflect on the fact that Janet’s patients would start remembering the original trauma and become disturbed again. He would give top ups of hypnosis but his faithfulness to the process waned and in 1919 he wrote: “Hypnosis is quite dead until the day of its resurrection” (Janet 1919 / 1976: 203).<sup>ix</sup>

What was increasingly evident was the quality and intensity of the rapport between patient and clinician impacting the treatment. Janet recognised the dependency of the patient to his / her therapist referring to it as an “act of adoption” (Janet, 1919: 1154). The rapport was tantamount to the cure and when we read Janet we cannot miss the links to Freud’s understanding of transference love. Janet writes of the therapeutic relationship

“In all these cases, what is involved is a kind of love, but it must be emphasized that it is a very special kind which is involved” (Janet, 1898 / 1925: 465f).<sup>x</sup>

In terms of a talking cure, whilst Janet convinced his patients to take false memories as truth, in contrast, Freud insisted his patients face the truth, as he understood it. In *Rewriting The Soul: Multiple Personality and the Science of Memory* (1998) Ian Hacking suggests that Freud himself was deluded, so resolutely attached to his theories. Many patients ended up believing things that were false,

“things that were often so bizarre that only the most devout theorizer could propose them in the first place” (Hacking 1998 cited in Bronfen, 1998: 282).

And what Freud himself knew to be lies, many of his patients would not accept that as truth. As Hacking puts it “Janet fooled his patients; Freud fooled himself” (Hacking, 1998: 196).

Whilst Janet favoured a theory of dissociation, Freud believed that conversion arose out of the repressed conflicts and phantasies expressed through somatic and behavioural symptoms. The motivation behind the symptoms was the libido. “These symptoms like dreams are the fulfilment, a wish” (Appignanesi & Forrester, 2005: 121).

Freud distinguished between two main types of somatisation: actual neurosis (neurasthenia and anxiety neurosis) and conversion hysteria.<sup>xi</sup> As described by Joyce McDougall in “The Psychosoma and the Psychoanalytic Process”

“In a sense one was the antithesis to the other. Whereas in hysterical conversion we witness the 'mysterious leap' from mind to body, in the concept of the actual neuroses there is a leap in the opposite direction from the somatic to the psychic sphere. In either case an invisible barrier is crossed. The problems raised by this transition have, to this day, lost little of their mystery” (McDougall, 1974: 440).

In writing about the Paris school of psychosomatics, Marilia Aisenstein explains: “Hysterical conversion makes the body into a language, the symptoms telling an unconscious story” (Aisenstein, 2006: 668).<sup>xii</sup>

Furthermore, Aisenstein states that Freud does not focus on the conflict between the desires of the body on one hand set against the wishes of the psyche on the other but rather a single somatic site locates the conflict of contradictory forces. In every case “the symptom tells a story” (McDougall 1974: 441).

We shall look now at those narratives in which deprivation, loss and abuse feature in the analysis of the symptom of amenorrhea, reminded of Drew’s description of many case of secondary amenorrhea being born out of “separation and / or hopelessness” (Drew, 1961 and Drew & Stifel, 1968: 47).

## CONTEMPORARY STUDIES OF AMENORRHEA ASSOCIATED TO LOSS AND DEPRIVATION

A study in 2015 that looked at the associations between adverse experiences during childhood and fertility difficulties in adulthood claimed to be the first of its kind. Jacobs, M.B. et al. (2015) published in *The Journal of Psychosomatic Obstetrics and Gynecology* "Adverse childhood event experiences, fertility difficulties and menstrual cycle characteristics". One of the conclusions was

"The effect of childhood stress on fertility may be mediated through altered functioning of the HPA axis, acting to suppress fertility in response to less than optimal reproductive circumstances" (Jacobs, Boynton-Jarrett & Harville, 2015: 46).

The stress triggers were aligned to traumatic family events such as parents separating, death or abuse. The interactions of children with those around them were said to be critical psychosocial stressors. Such life events elevated the cortisol levels and also impacted on menstruation causing disruption to the cycles and to fertility in general (Mangold et al. 2010). Furthermore, for each additional adverse event experienced, the risk of fertility difficulties increased as well.

"The child abuse subscale, sexual abuse and physical abuse more specifically, and experiencing parental substance use or neglect during childhood, showed stronger associations with fertility issues than the full ACE (adverse childhood experiences) scale" (Jacobs et al. 2015: 50).

Women in the high and low adversity groups were more likely to report fertility difficulties and a history of amenorrhea than those who reported no childhood adversity. Cumulative exposure to four or more childhood adversities was strongly associated with fertility difficulties and amenorrhea. Ten years or so earlier, a study was undertaken of twenty girls with functional hypothalamic amenorrhea (Bomba et al. 2007). The question posed by the team at the Department of Gynaecological Endocrinology of the University of Brescia was whether early life experiences had anything to do with present non-menses. The

Children's Depression Inventory and the Eating Disorder Inventory were the two tests that were given to the girls who were also interviewed by a specialist in Child and Adolescent Neuropsychiatry, as were their parents. The study found that "early traumatic experiences" were evident in many of the interviews. Eighteen couples (90%) of parents reported incidences of psychopathology such as anxiety or depression in at least one close relative to their daughter. Eleven reported familial conflict, five of which were domestic violence. High too on the list with eleven couples (55%), was the reference to a house change during the first year of their daughter's life. The study concluded that psychic conflicts were transformed into somatic symptoms and the change in the endocrine levels was proportional to the degrees of the psychosomatic disturbances. Notably, 80% of girls when interviewed reported having an "excessively demanding, controlling and intrusive mother", and 50% reported conflict in the family. The data also showed that all the teenagers were concerned about body image with a desire to be thin and there was a general theme of disordered eating of a "restrictive type."

We could say that for some, amenorrhea is the successful exertion of control. It offsets the feelings of disempowerment instigated by the control of others to which they must be subjected. The amenorrhea also refutes any conflict associated with separation and loss that is otherwise represented by the menstrual cycle. Unlike menses and its associated fantasies to other fluids such as urine and sweat that rekindle orality and anality (extensively commented on in eating disorders), amenorrhea again overrides any feelings of "helplessness and passivity." We know that this surmounting is undertaken with such precision in eating disorders. As Joyce Kraus Aronson writes in her introduction to *Insights in the Dynamic Psychotherapy of Anorexia and Bulimia* (1993)

"Some anorexics and bulimics who have complied with dominating and controlling parents all of their lives silently, unconsciously exercise their own need to control at a neuroendocrine level through amenorrhea. Menstrual bleeding can represent loss and separation from the patient's childhood attachment to the maternal object. Amenorrhea can serve to deny maturation and allow the patient to hold to a childlike self image" (Kraus Aronson, 1993: xxv).

In “Hyperprolactinemic Amenorrhea – Insights From A Case Cured During Psychoanalysis” (2005), the reader is offered an insight into hyperprolactinemia and weight gain that is commonly present after a significant life event and predominantly affects women brought up in conditions of paternal deprivation. A loss usually triggers the symptoms. The authors present a case of a twenty seven year old woman with “idiopathic hyperprolactinemia, amenorrhea, binge eating and rapid weight gain following the death of her father” (Cardoso & Sobrinho 2005: 44).

The woman, referred to as “Helen” undergoes psychoanalysis. She describes how her grandparents had looked after her and her younger sister until the age of twelve at which point the two girls went back to live with their parents. The grandmother was described as a strong woman, “reassuring but not affectionate, obsessed with stuffing her grand-daughters with food” (Cardoso & Sobrinho, 2005: 45). Helen described her mother as “insecure, beautiful, distant” frequently intruding on Helen’s life, even trying to make an appointment with the psychoanalyst. The father was impatient and sometimes violent. He warned his daughter away from boys and Helen believed that she was a surrogate for his stillborn son who had died before she was born. Her father suddenly died, (Helen having only “discovered” him in her adolescent years) and her boyfriend who had promised to care for her during this time of mourning broke off their relationship. Amenorrhea and binge eating started immediately. The importance of the absence of a “true” Oedipal phase was noted. During the analysis Helen’s ambiguous and unsatisfactory relationships were explored and when she felt sad or upset she would get up from the couch needing to see the analyst with her own eyes whilst expressing her doubts about the analyst’s competence. As the work progressed she one day confronted her boyfriend with whom she was having a “sticky, asexual relation” (Cardoso & Sobrinho, 2005: 49) and he confirmed that he no longer wanted to be with her and whilst she was sad about this she was “willing to face the situation.” The following day the first of a series of menstrual bleeds came. This signified the restoring of a normal neuroendocrine state based on the patient’s new capacity to mourn an unsatisfactory relationship. In the concluding commentary, the authors

emphasise how important it was for this patient to have met first with the endocrinologist who then referred her on for psychoanalysis. They write:

“The endocrinologist reassured the patient about the innocence of her bodily symptoms and offered a solid, but peripheral, support. By so doing, this doctor became a strong reference to the patient while, in the same process, she was freed to establish a massive transference relationship with the psychoanalyst. This situation, however unplanned, turned out to be the patient’s first opportunity for a healthy triangulation” (Cardoso & Sobrinho, 2005: 50).

In 2011, Sobrinho and colleagues presented a research paper that they described as robust in its evidence that linked an absent or violent father with coping strategies formulated by the child that favoured specific neuroendocrine responses used later on in life. In “Paternal Deprivation Prior to Adolescence and Vulnerability to Pituitary Adenomas” Sobrinho writes up the data on an observational control multicentre study of 830 patients, male and female, with pituitary adenomas, of which 395 patients tested for prolactinoma and one hundred and thirty with acromegaly.<sup>xiii</sup> It was found that compared to control populations these patients with higher scoring pituitary adenomas had a history of paternal deprivation. In addition:

“We found that absence of the fathers is primarily associated with prolactinomas while violence is primarily associated with acromegaly, a finding which is of itself new and unexpected. Absence of father early in life is not necessarily deleterious. Foster families, stepfathers or other persons may fulfil a satisfactory parental role in some cases. Violence may have a more damaging potential” (Sobrinho, 2011: 55).

Sobrinho cites McGowan et al. (2009) who reported abnormal regulation of hippocampal glucocorticoid receptor expression in suicides of those who had been abused as children compared to non-abused suicide controls. The point being that neuroendocrine responses later on in life might be conditioned by early life experiences. Fascinatingly, the secretion of prolactin, perhaps stimulated by

adverse environmental and psychological factors rooted in childhood is itself a hormone that optimises the survival of the young.

“Whether adaptive, as in the case of surrogate maternity, or pathological, as in the case of pseudo-pregnancy, prolactin responds to a perceived need to take care of a child” (Sobrinho, 1998: 133).

Conditions for the nursing mother would include amenorrhea.

## SECONDARY AMENORRHEA, PREGNANCY AND PSUEDOCYESIS

Missed periods are symptomatic of pregnancy, breast-feeding or menopause. The amenorrhea in these instances are of a physiological nature (i.e. in the normal course of life). Most women who present with secondary amenorrhea are given a pregnancy test by their GP, as pregnancy is the most common “cause.” Some of these women are shocked when the test result comes back negative because they are convinced that they are pregnant. When we consider this through a psychoanalytic lens, many of these cases of amenorrhea reveal “fantasies of pregnancy as their unconscious content (Eisler, 1923: 41).

In “Emotional Settings of Functional Amenorrhea” (1964), Engels presents the theory that amenorrhea is linked with the fantasies of young women who wish to mobilise organisational patterns from a pre-genital age, so that they might return to that Golden Era, before things got messy. One amenorrheic patient in the study reports a conscious fear of pregnancy and Engels interprets her non-menses not as being bought on by stress but as an unconscious wish colliding with an unconscious fear of being impregnated by her father.

In *The ego Ideal, Being-In-Love, And Genitality* (1985) Janine Chasseguet-Smirgel refers to the work of gynaecologist Hélène Michel-Wolfrom who had found that many women who had come to see her thought their periods had stopped because they were pregnant. This denial of reality, for they were indeed menopausal, Chasseguet-Smirgel explains is experienced as “a mutilation and

the wish for a child that replaces it can be directly linked to the oedipal situation” (Chasseguet-Smirgel, 1985: 51).

Chasseguet-Smirgel goes on to write about a patient, a woman doctor and mother, who came back to see her eight years after the end of her first treatment. The patient’s periods had stopped a few months previously and she was experiencing “hypochondriacal anxieties and fears due to the beginning of the menopause” (Chasseguet-Smirgel, 1985: 51). They worked together for four sessions and discovered mainly through analysing dreams that the menopause was a symbol of her desire to have a child by her father. It was also a symbol of a punishment inflicted upon her by her mother for having such guilty wishes.

“She had come to ask me – in the maternal transference – not to punish her by depriving her of her procreative powers. Needless to say this wish and these fears had been elaborated at length during her analysis. Her periods recommenced during the week of this brief treatment, and I have every reason to suppose that she accepted their subsequent disappearance better, since she had no further recourse to my help” (Chasseguet-Smirgel, 1985: 51).

In some cases of women who think they are pregnant, alongside the amenorrhea they have other pregnancy symptoms. This condition is termed Pseudocyesis, (from the Greek word *pseudes* (false) and *kyesis* (pregnancy)). The body is in a false, phantom pregnancy. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) categorises it as “Other Specified Somatic Symptom and Related Disorder” and defines it as,

“a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy, which may include abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensations of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery” (DSM-5 American Psychiatric Association, 2013).

Here we have the ultimate marrying of psychological and somatic causes that bring about a condition of false pregnancy difficult to prove otherwise. In fact as Aldrich writes in “A Case of Recurrent Pseudocyesis”,

“Symptoms are often related with such complete conviction by the patient that the physician or obstetrician is led to omit examinations or tests he might otherwise perform” (Aldrich, 1972: 11).

Sixty years earlier, in 1912, Walsh had observed in one patient: “Her mental attitude had produced the series of symptoms that proved so deceptive.” (Walsh, 1912: 438).

Pseudocyesis is not an imagined pregnancy (officially termed “delusions of pregnancy”), which is no more than a belief or a thought. In Pseudocyesis, an intense desire to be pregnant triggers the pituitary gland to secrete elevated hormones that mimic those of a pregnant body. In 50-70% of cases of pseudocyesis, amenorrhea is tied to hyperprolactinemia and so a medical “disease” or hormonal disorder goes a long way to explain the symptom. But in terms of psychopathology, it’s the trigger, the desire, the stress, the “regressed impulse” (Marty & de M’Uzan 1963) that finds an outlet when no other option (psychically or behaviourally) is available to them.

We have a 2013 case report of a forty- year old woman from India who had three female children and was under pressure to produce a male heir to secure the generational line and social status and to provide economic security in old age (Makhal et al. 2013). In explaining this extraordinary version of mind over body, the psycho-socio-cultural context of pseudocyesis is important to note so too the depth of the desire and the need to bear a male heir. It is no surprise that the incidence of pseudocyesis is higher in rural and undeveloped countries where access to medical care is limited. In cultures such as the Igbo of southeast Nigeria, where pregnancy and childbirth confirm womanhood and a married woman’s place in her husband’s family,

“societal pressure may precipitate pseudocyesis as a psychological defence to intense stress if the woman proves to be infertile” (Tarin et al. 2013: 39).

The rates of incidence are higher in most African black cultures compared to others, given the significance that is placed on fertility and the lower levels of education and sterility problems (Tarin et al. 2013). Interestingly, the lower number of incidences reported amongst women from developed countries who can access diagnostic procedures at an early stage was also put down to the fact that they, being more cultured,

“their emotional conflicts will seek a more “refined mode of expression than that of spurious pregnancy” (Pawloski & Pawlowski, 1958: 440 cited in Kelly et al. 2007: 152).

The rate of incidence has declined from one in two hundred pregnancies in the late eighteenth century to about one in ten thousand today (Ramachandran & Blakeslee, 1998: 218 cited in Kelly et al. 2007: 152). It’s as if it has fallen out of fashion, like hysteria. Aldrich (1972) explains:

“Earlier psychodynamic formulations considered pseudocyesis to be a manifestation of a hysterical conversion. Later formulations viewed the condition as an organ neurosis. A more recent view implicates depression as a major determinant. Childhood deprivation, the need to avoid the abandonment or loss of love object, and the fear of losing the capacity to bear a child (most cases occur in childless women of an average age of thirty-three) have been implicated as potential contributors to causation” (Aldrich, 1972: 11).<sup>xiv</sup>

Pseudocyesis has been called “a paradigm of psychosomatic research” (Murray & Abraham, 1978: 629,631). In terms of the physical mimicking the psychological what is being expressed or denied still remains much of a mystery. Perhaps the psychoanalytic hypothesis that suggests it reveals the unconscious wish or dread for a child is out dated. More in fashion is the idea that it is linked to depression and it is amenorrhea that provides substance to this explanation.

“The neuroendocrinological picture in pseudocyesis differs markedly from that in other forms of secondary amenorrhea and has been attributed to a reduction in dopamine, possibly as part of a clinical depression, with consequently higher levels of prolactin and luteinizing hormone (Yen, 1986)” (Brown & Harris, 1989: 288).

This might be the case but I think it would be premature to write off psychoanalytic theories, no matter how out dated they might appear to some. In terms of extricating the meaning and message of secondary amenorrhea it signifies a strong bond in the relationship between the psychological and the physiological. In fact, I think that secondary amenorrhea is one of the most creative acts to come out of the union between mind and body. So too the body of work that surrounds it.

#### HIDE AND SEEK IT

In James Walsh’s 832 page book, lengthily titled: *Psychotherapy Including The History of The Use of Mental Influence, Directly And Indirectly, In Healing And The Principles For The Application of Energies Derived From The Mind To The Treatment Of Disease* (1912). Walsh writes,

“No feature of menstrual difficulty shows so clearly the influence of the mind over bodily function, and especially over those genital functions that are supposed to be involuntary and spontaneous, as amenorrhea. Almost any kind of mental trouble may produce a cessation of the menstrual functions. Profound grief or a severe fright nearly always does....Among my notes is a case of a woman frightened by a revolver which a maniac had flourished for hours at her while she dared not make a move nor a sign. Her menstruation stopped completely for a time and then came back irregularly and usually from the ear. The bleeding was from the pierce in the lobule which had been made for earrings, and before it started a large swelling of this would come on in the course of an hour, often not subsiding for days. In another case a woman who was frightened during menstruation by an insane person flourishing a knife near her had for several years after an extremely irregular menstruation, and usually only the molimina in

the genital tract, while the bleeding was from the nose. Deep emotion can very seriously affect menstruation” (Walsh, 1912: 436).<sup>xv</sup>

In an earlier account, “Amenorrhoea in Adults” by Dr James Blundell, included in *Observations on Some of the More Important Diseases of Women* (1840), an accident, fright or cold are cited as the main triggers in women in “the full vigour of life.” Blundell writes,

“At first, perhaps, no inconvenience is experienced beyond the alarm, but afterwards the general health seems to give way, and the habit becomes sallow and emaciated, and there is darkness around the eyes, and the cheek bones rise into notice...at the same time the stomach and bowels get into an unhealthy condition, and perhaps there are irregular determinations of blood to different parts of the system: the chest, bowels, and stomach...but where the determination takes place to other parts where the vessels seem to be less secure, effusion is by no means infrequent, therefore bleeding from the nose, bowels and lungs, are by no means uncommon” (Blundell, 1840: 183).

Dr Blundell (one of the first physicians to perform blood transfusions on humans) suggests one method for treating the amenorrhoea would be to make another part of the body bleed, such as the arm. “Excitement of the uterus” is also recommended, so too a remedy of ammonia and if all else fails “warm hip baths, or general immersion of the body, and horse exercise” (Blundell, 1840: 184-185).

Termed “vicarious menstruation” the phenomena of menstruation as an organism bleeding from organs other than the uterus has its roots in Hippocratic texts stating that a nosebleed was a good thing as it released menses that were hitherto suppressed. Haemorrhages of these kinds relieved the pressure. In Kisch’s gynaecology textbook, *The Sexual Life of Woman in its Physiological, Pathological and Hygienic Aspects* (1910), the work of Fliess (whose treatment of the haemorrhaging Emma Eckstein we shall review in depth in chapter five) is applauded:

“Regarding vicarious epistaxis, especially exact observations have been published, showing the mutual relationship between the genital and the nasal mucous membrane” (Kisch, 1910: 106).

Kisch goes on to list other exit routes such as the mouth, anus, gums, ears, lungs, brain and eyes that “restore the disturbed equilibrium of blood distribution” (Kisch, 1910: 165).

In terms of studying the transactional relationship of bodily functions, the findings in historic sources are similarly found in contemporary studies. Many link menstrual disturbances, notably amenorrhea, with constipation and irregular bowel movements. Psychoanalytic enquiry can consider such links in ascertaining the significance of the psyche on the body that “bleeds” or does not “bleed” fluids and matter. In “Varieties of Somatization – Psychological Components in Psychosomatic Bleeding” which is a chapter in *Psychosomatic Symptoms: Psychodynamic Treatment of the Underlying Personality Disorder*, (1989) Ira L. Mintz outlines the case of a twenty two year old nurse with severe ulcerative colitis, suffering from cramps, mucus, and diarrhoea and bleeding. Blood was usually in her stools in small amounts.

“One day she reported that she was five weeks overdue with her period. Before this she had been regular. I encouraged her to associate to the overdue period. This resulted in a series of childhood memories about bleeding, bodily injury, and loss of control...She remembered wondering where her menstrual blood came from and whether it would even stop. Initially, she wondered whether she was bleeding or whether the blood came from a bowel movement. It all seemed to come from the same hole. I suggested that, unconsciously, she might still have the same fantasy – that it all came from the same hole. In her strong attempt to stop the rectal bleeding, thinking in the back of her mind that it all came from the same hole, she stopped her menstrual bleeding. She thought about the possibility of that fantasy for a few moments and allowed that it might be so. Shortly thereafter, the session ended and she left” (Mintz cited in Wilson & Mintz 1989: 172).

Fifteen minutes later, whilst on the bus, the patient's period came. Mintz concludes that the amenorrhea was not primary related to drives, anxieties or indeed "transference phenomena" but was an attempt to stop the rectal bleeding with the patient wanting to "work constructively in treatment" (Wilson & Mintz, 1989: 173). Previous to this treatment, the patient had been working with a physician who had proctoscoped her every week, at which point she was experiencing up to thirty-five stools per day.

Conflict and its resulting outcomes are a given but we can turn to Fenichel's *The Psychoanalytic Theory of Neurosis* (1946) to clear up some confusion associated with the role of the unconscious finding expression through various organ systems. Fenichel warns that sometimes hormonal functions are influenced by unconscious instinctual conflicts "and thus produce secondary somatic symptoms not intended as such" (Fenichel, 1946: 240). With regards to menstrual or premenstrual mental disorders in women, Fenichel writes,

"somatic factor always plays a part, namely, the physical alterations at the source of the instinctual drives. But on the other hand the unconscious significance of the idea of menstruation and the mental reaction to this significance may likewise alter the hormonal events. In cases of disturbances, the premenstrual body feeling represents tension, retention (sometimes pregnancy), dirt, pregenitality, hatred; the menstrual flow may bring relaxation, and is felt as evacuation (sometimes birth), cleanliness, genitality, love; but it may also represent loss of anal and urethral control, Oedipal guilt, castration, the frustration of wishes for a child, and humiliation" (Fenichel, 1946: 240).

#### CASTRATION, CONFLICT AND THE CLOAK OF AMENORRHEA

In classical psychoanalysis, menstruation was thought to represent a woman's castration. It was symbolic of "no child and no penis" (Deutsch, 1925: 39).

In *A Short Study of the Development of the Libido* (1924) Karl Abraham wrote of one patient,

“during menstruation which used to excite her castration complex in a typical way...she scarcely ever stopped crying” (Abraham 1927 [1924] cited in Grigg et al. 2015: 78).

This patient’s tears in part mourned the loss of her masculinity. In a footnote Abraham added that the tears of patient “X” were “her unconscious wish to urinate like a man” (Abraham, 1927: 501).<sup>xvi</sup>

One of Abraham’s first patients was Karen Horney who later became a psychoanalyst and an active member of the Berlin Psychoanalytic Society. Horney was irked by Abraham’s assumption that women felt inferior because of their genitalia. Horney criticised Abraham for viewing things through a male narcissistic gaze. She developed her own theory in which the menstrual bleed represented the castration of the woman that masked her phantasies to bear her father’s child (1926). Melanie Klein suggested that the girl envied her mother’s possession of the penis and her hatred of her was disguised as anxiety. Only this time though, as a menstruating woman, she really could bear her father’s child. Adolescent turmoil was indeed a replica of earlier oedipal strivings and puberty might realise those incestuous wishes.

In a 2016 paper for the *Psychoanalytic Review*, “Penis Envy and the Female Oedipus Complex: A Plea to Reawaken an Ineffectual Debate” authors Zepf & Siegfried propose that the oedipal conflict is the result of the parents’ complexes projected into the children. In containing this projective identification, the rivalry with penis envy is both the girl’s wish for father and for her own maternal power and it is a wish to have the penis so as to satisfy mother.

In terms of linking menarche to unconscious fantasy and castration fears, Mary Chadwick highlighted the importance of mothers preparing their daughters for their first menstrual bleed. She also warned that all too often these mothers’ “own complexes concerning menstruation hinder them from speaking freely about it.” Furthermore, the result is that of “sadistic manifestations of the woman in her treatment of the girl at her first menstrual period” (Chadwick, 1932: 34).

Often, the first rip in a young women's sense of self comes with the first tear from the first menstrual bleed. In its most rudimentary form, menarche can represent the bogeyman. As Elaine Showalter writes of a time when people shuffled around in the shadows of knowledge:

“Many of these young innocent women, notably in Victorian times, were left in “what they could only construe as vaginal haemorrhaging” (Showalter, 1987: 56).

Menarche was said to be a trigger for “adolescent insanity” by thinking men such as Kant as well as many medics. More scientifically speaking, it has been proven to be a hotbed for mental breakdown and depression (Young et al. 2000: 1157).<sup>xvii</sup>

The newly acquired menstruation might pose a threat to the adolescent's greatest task, which according to Erikson is to develop an identity as

“a conscious sense of individual uniqueness....an unconscious striving for a continuity of experience, and...as a solidarity with the group's ideals” (Erikson, 1968: 208).<sup>xviii</sup>

In many cases of amenorrhea, the constitution of the non-menstruating body might be a way to realise the wish for an uninterrupted, cohesive state. So too it might symbolise a regression to a desired pre-pubertal state. All the meanwhile, under this cloak what is often hidden is a more complex state of being. In “Emotional Settings of Functional Amenorrhea” (1964) Engels et al. present a patient whose menses stopped when she had to start caring for her dying father. For this patient adult sexuality was associated with sin and damnation because of a real or imagined incestuous experience as a child. Menstruation associated to womanhood was a source of conflict. Menses had been irregular for a long time but she stopped bleeding altogether when her father became gravely ill. Engels writes:

“Menses returned within forty eight hours of the interview, in which for the first time she disclosed her secret probably because the doctor's condoning attitude

served temporarily to lessen her guilt. Reasoning that there had been no real resolution of the conflict, we rightly predicted a return of amenorrhea” (Engels, 1964: 687).

Another example given is of a thirty one year old postgraduate nursing student who presented with amenorrhea of four years and with anorexia. She was the youngest of four children born into a “very close and loyal family.” She was her father’s favourite and she looked like the mother “whom he deeply loves. ” He was intolerant of any references of sexual relationships. At twelve she was very anxious at the thought of separation from her mother. The patient liked the idea of being normal by menstruating but also viewed this as “weakening” which she would have to offset with controlled eating. The idea of relaxing this control, and the control she had over feelings for others panicked her with the idea that it would lead to complete sexual abandon. The thought of medication to bring on a period caused great anxiety and anger “for forcing this onto her.” (Engels, 1964: 692). Engels commented that this patient was very anxious at any awareness of

“instinctual impulses and gravely limited her life in order to avoid such feelings. Her family relationships bespoke of unresolved Oedipal complex, and her defences, particularly reaction formation, were characteristic of her pregenital adjustment. Amenorrhea and compulsive dieting began as she sacrificed more and more of the conflict-producing aspects of normal life in her ascetic role as a hardworking student nurse” (Engels, 1964: 692).

One leading psychoanalytic theory on amenorrhea, developing in the 1930s, was that as a sign of neurosis, amenorrhea was a simple statement of an “unconscious repudiation of women.” Linked with sterility, frigidity, dysmenorrhea and vomiting, Menninger (1939) wrote in “Somatic Correlations With The Unconscious Repudiation of Femininity in Women:”

“All of them, I think, may be visualized, as representations in different spheres of a profoundly influential drive, the subjective aspect of which is a wish to repudiate, or destroy one’s own femininity, one’s femaleness, expressing at the same time self-directed aggression and self punishment” (Menninger, 1939: 526).

Menninger also wondered why it was that many women volunteered for the invasive treatments on offer from male doctors. Using the theme of penis envy, Menninger outlined the strivings of a little girl who must give up her wishes to emulate the men in her household whilst at the same time managing the envy she might feel for them. Thus, with a hostility towards men “some women wish to destroy or to have destroyed the femaleness within them” (Menninger, 1939: 524).

The alignment to the male is picked up by Christopher Bollas in *Hysteria* (2000). Bollas writes about the paradox of the hysteric’s “demi-erotic transference” to her doctor and suggests that the illness is a matter of the mother’s rejection of her daughter’s sexuality. A man’s love is sought after:

“When he or she is pleased to have an ailment confirmed as real, possibly even to have some small surgery, the hysteric feels that he or she will be the recipient of the doctor’s intelligent love. Casting aside the paradox of a love that would remove a part of the body – in the unconscious always the genital – the hysteric finds in the surgeon’s attentions a hand that seems so much more alive to the body’s needs than that of the mother” (Bollas, 2000: 59).<sup>xix</sup>

In chapter two we shall look in detail at how and why medics and menstruation featured so prominently in research, practice, culture and society. Prominence of penis envy and the castration complex penetrating psychoanalytic discourse was at the time of Menninger, de rigour.<sup>xx</sup>

If we suppose that amenorrhea is a rebellion against societal dictates of what a woman should be then it can also be seen as an assertion of what a woman wants. Amenorrhea provides a legitimate space separate from the one assigned to her by a societal system which curbs her rights and limits her possibilities. Indeed the space that is on offer to women can be experienced as castrating to them as much as it is virile to man. And with menstruation being the quintessential symbol, who needs it?

Victoria, a patient of Italian psychoanalyst and psychiatrist Riccardo Lombardi, had come for analysis because she and her husband wanted to have a child. As the analysis progressed, a deeper meaning behind the difficulty to conceive was starting to unravel. In one session Victoria said to Lombardi:

“My husband says that my uterus bleeds because I mortify my femininity by not having a baby. I told him, “It’s really clever, this thought of yours, what a pity that it doesn’t correspond in the least with reality! If you really want to know, I don’t have the least intention of having a baby. Despite what you think, it’s possible to be a woman even if you don’t have babies” (Lombardi, 2011: 11)

I emailed Dr Lombardi to ask for his thoughts on why too often discussions of menses and amenorrhea are left out of the consulting room and how we can incorporate these bodily states into our thinking and practice. Thoughtfully Lombardi replied,

“I see the cessation of menses of what I call the Body Mind Dissociation. When the body and most primitive bodily emotions are integrated into the mind’s horizons, the menses come back...In my view it is not only, as you say, that it seems that psychoanalysis unconsciously props up the menstrual taboo by leaving all discussions of menses and non menses out of the consulting room, BUT that psychoanalysis leaves out the real body out of the consulting room, stimulating self-referential working through based on metaphoric and symbolic linking. This is specifically counterproductive especially now, since most analytic patients need to integrate the body into their personality and to work through the most concrete and elementary level of functioning” (R. Lombardi, pers. comm., 17th March 2017).

Perhaps a shift in thinking from the analyst might enable one in the patient, if she feels they are in some way attuned to one another. I am thinking about cases of extreme eating disorders where the patient believes that the analyst cannot possibly know what it feels like to be in her shoes. Analysts are often experienced as talking the talk but can they really walk the walk? When a patient is prepared to express herself through a bodily state, and in some circumstances

when only death will do, where in the patient's frame of mind is the analyst? Are you with me, or without me? How much can you truly bear?

## AMENORRHEA AND ANOREXIA

This thesis will look into anorexia and eating disorders linked to amenorrhea in a detailed chapter later on. Here though, we can consider the mechanism of starvation employed to avoid psychobiological maturity and keep the person in an uninterrupted childlike state (Hsu, 1984; Crisp, 1970, 1980). With this in mind, psychoanalysis in the 40s and 50s linked psychological motives behind the disorder with themes based on orality. Anorexia, like a form of conversion hysteria, repudiated oral sadistic fantasies. But some argued that many of these young girls did not display a conflict or even an interest in such issues. Alan Goodsitt (1997) proposed that the condition was more concerned with a deficient ego and a lack of cohesion to the overall structure of the psyche. The eating disorders are

“attempts to drown out the anguished feelings by frantic self-stimulatory activities...The symptoms are misguided attempts to organise affects and internal states meaningfully.” (Goodsitt, 1997: 59).

If this is a condition that is about self-regulation and autonomy (Bruch 1973), then surely it is amenorrhea that best acts this out, divorced from the uncertainty and unpredictability of menstrual bleeding? In *Insights in the Dynamic Psychotherapy of Anorexia and Bulimia* (1993), editor Joyce Kraus Aronson refers in her introduction to Mintz's paper “The Relationship Between Self Starvation and Amenorrhea” (1983e). Aronson helpfully summarises Mintz noting that

“the experience of menstrual flow, in contrast to urine and feces, cannot be controlled voluntarily by sphincters and therefore elicits feelings of helplessness and passivity. This in turn operates to reawaken early oral and anal conflicts over inability to control urine, faeces, and people. Some anorexics and bulimics who have complied with dominating and controlling parents all of their lives

silently, unconsciously exercise their own need to control at a neuroendocrine level through amenorrhea” (Aronson, 1993: xxv).

If amenorrhea is an embodied state devoid of erraticism and is a reliable marker of a permanent state of totality then it can be thought of as symbolising the early childhood characteristics of obedience and conformity that many of these patients displayed, deficient in their sense of separateness. The anorexia and the amenorrhea offset all such deficiencies enabling the unconscious to exert control.

In the paper “What It Means To Bleed: An Exploration of Young Womens’ Experiences of Menarche and Menstruation” (2013) one of the arguments put forward by Kate Donmall is that menstruation is not an organising experience as many would have us believe (Kestenberg, 1967) but that in fact some women want no part in it. She gives us the example of Laura who “longs to make it stop” and longs for a “totally empty womb.” Donmall helpfully writes about Laura’s wish to be castrated:

“Linking this to classical theories of female masochism, a psychic refusal to accept menstruation, or to long for it to cease, may be a refusal to accept the kind of femininity that, in the theories of Deutsch and Horney (and one might argue extant in today’s society) is linked to passivity and pain. The discomfort and pain, and the guilt induced by repressed and potentially incestuous desires, cause the woman to draw back from the feminine erotic function or to hide her sexuality and the menstruation that may symbolize it. We might consider how the “mess” of menstruation might awaken unconsciously the sadistic conception of coitus (Bonaparte, 1935: Klein, 1932) and thus a fear of sexuality, or reawaken feelings of confusion and shame in relation to the mess of infantile incontinence. Alternatively, if menstruation may indeed be unconsciously interpreted as a punishment for masturbation (Deutsch, 1925) this offers another explanation for the intimate connections between menstruation, mess and shame as seen across the sample” (Donmall, 2013: 213).<sup>xxi</sup>

For many specialist psychotherapists, eating disorders and issues of femininity cannot be separated out. Amenorrhea can be thought of as a symptomatic

rejection (Plaut & Hutchinson, 1986) of a particular type of femininity stained with menstruation. As Malson and Ussher explain, it is

“alien, out of control, highly emotional, sexual, vulnerable and dangerous. It is argued that amenorrhea in anorexia may signify a rejection of this particular negative construction of “femininity” rather than of adulthood or femininity per se” (Malson & Ussher, 1996a: 505).

Malson and Ussher’s research showed that amenorrhea as a symptom of anorexia cannot be viewed as simply biological but instead represents a psychological communication. They interviewed 23 women with anorexia aged seventeen and over, many in their early twenties. Most were white British and of “middle class” background. The participants were asked to discuss their ideas and experiences on anorexia, the body and gender identity. The interviews were analysed using a discourse-analytic methodology. Amenorrhea was viewed by the participants positively as “not being a woman anymore” (Malson & Ussher, 1996a: 512). The menstruating body was

“the locus of all that threatens our attempts at control. It overtakes, it overwhelms, it erupts and disrupts” (Bordo, 1992: 94 cited in Malson, 1998: 118).

And so amenorrhea might be read as “a physical and discursive consolidation of this dissociation” (Malson, 1998: 118).

Over fifty years earlier, in the *Bulletin of the Menninger Clinic*, Gill wrote up “Functional disturbances of menstruation” (1943). He had observed that amenorrheic patients consciously or unconsciously regarded their menses as a degrading visible sign of a feminine inferiority. Many more studies that came later on showed that this was compounded with difficulties associated with body image. In Osofsky and Fisher’s “Psychological Correlates of the Development of Amenorrhea in a Stress Situation” (1967) the authors sought to “crystallize physiological and psychological variables which might play an etiological role” (Osofsky & Fisher, 1967: 15).

They carried out a longitudinal study of “normal” menstruating women beginning their freshman year at nursing school focussing on the question of whether the move from home to college would bring about an amenorrheic condition. They looked at those who did not have a history of menstrual disturbance, as they would be a group vulnerable from the outset. The outcome of the study showed that it was the psychological parameters specifically linked to the women’s body image or body concept that impacted their menstrual flow. The more “distorted” their view of themselves was, the greater chance of there being a distortion in their menstrual cycle. So too, women with low body awareness and conflicts about their feminine identity and role in society were more likely to develop menstrual disturbances in stressful situations.

#### AMENORRHEA AND PSYCHIATRIC DISTURBANCES

“In Emotional Settings of Functional Amenorrhea”, (1964) Engels et al. set out to show how amenorrhea was more than just a sign of emotional upset but was a reliable indicator of a psychiatric disorder. Furthermore,

“There is a fundamental difference in the personality structure and in the psychodynamics between these patients and patients with amenorrhea resulting from an acute emotional distress” (Engels et al. 1964: 683).

Engel et al. cite studies in which amenorrheics referred for observation on psychiatric grounds showed histories and incidents of neurosis, psychosis, oral and psychosexual conflict and schizophrenic thinking. Often the prognosis of recovery was poor. They refer to Decourt and Michard’s paper “Les aménorrhées de cause psychique” (1953) and summarise that

“while some patients are severely disturbed emotionally, most do not display overtly neurotic traits. They add, however, that a neurotic “terrain” must pre-exist when such unremarkable events as a change of environment or an examination failure can precipitate amenorrhea” (Engels et al. 1964: 683).

It has been for a while widely accepted that psychiatric morbidity and amenorrhea share a commonality but it is not so clear if an amenorrheic landscape feeds the development of psychiatric disturbances or if on the flip side psychiatric morbidity is fertile fodder for the growth of amenorrhea and other menstrual disorders. The fact that there was uncertainty surrounding this issue was overlooked during the late nineteenth century when many women were subjected to ovariectomies to save them from amenorrheic insanity. Bergemann et al. summarise at the beginning of their paper “Acute Psychiatric Admission and Menstrual Cycle Phase in Women with Schizophrenia” (2002)

“Various menstrual cycle disturbances, anomalies of the genital organs, and masculinisation were seen in conjunction with psychotic disorders, so genital abnormalities and menstrual cycle disturbances were considered possible causes of psychosis...the terms uterine or amenorrheal insanity illustrate the hypothesis that “insanity in some few cases actually results de novo from this [amenorrhea] as an exciting or predisposing cause” (Clouston, 1906)” (Bergemann et al. 2002: 119).

Psychotic disorders were put down to a dysfunction of the gonads before endocrinological processes were found to be responsible for menstrual cycling. Medicine has advanced to the stage where we know that neuroendocrine pathways impair the hpg axis, which then leads to secondary amenorrhea. Schizophrenia and depression display similar hypothalamic-pituitary-axis abnormalities. Anorexia, depression, stress amenorrhea and exercise-induced amenorrhea all show similar alternations to the hpa axis patterning.<sup>xxii</sup> So too, bipolar disorder, in which many women report menstrual irregularities, and depression share similar disruptions of function in the hpa (Rasgon et al. 2000).

Among women with bipolar disorder one third report to having menstrual disturbances during adolescence before they are diagnosed and treated for bipolar (Joffe et al. 2006). Once again, amenorrhea could be a vital sign and gynaecological investigations might be an opportune moment to detect a psychiatric complaint that deserves attending to early. Brockington (2011) lists the illustrative monographs of the clinical features of menstrual psychosis,

generally those of manic-depressive (bipolar) disorder. His argument is that investigations of menstrual psychosis can better inform us about bipolar disorder.

## AMENORRHEA AND MEDICATION

Medication used for neurologic and psychiatric disorders such as epilepsy, migraines and bipolar disorder often disrupt the hpa axis which can then go on to disrupt the menstrual cycle and cause amenorrhea. These drugs are highly effective but for adolescents, the worry is that prolonged amenorrhea with hyperprolactinemia can risk healthy bone development. (Joffe & Hayes, 2008: .225-226). Not everyone thinks this is a side effect worth risking. Mary Seeman, Professor Emerita at the Department of Psychiatry at the University of Toronto, outlines her reasons why attempts should be made to avoid the antipsychotic side effect of amenorrhea. In her paper "Antipsychotic-Induced amenorrhea" written for the *Journal of Mental health* (2011) Seeman refers to her earlier study of women with schizophrenia. Most of the women viewed amenorrhea as not being "normal" (Zhang-Wong & Seeman 2002) associating it negatively with sterility. Also, amenorrhea induced by antipsychotics increases the risk of the delusion of pregnancy (Dubravko, 2010) and

"gender identity, a classical issue in schizophrenia, is affected by amenorrhea. Twenty per cent of all patients with schizophrenia are said to experience sexual delusions, among them the conviction of having changed sex. The literature reports many cases of delusional-pseudotranssexualism, reinforced by antipsychotic-induced side effects such as hirutism and amenorrhea" (Seeman, 2011: 487).

As a result, Seeman actions for the meaning of amenorrhea to be respectfully explored in the therapeutic relationship.

## TO BLEED OR TO NOT?

The dominant Hippocratic Tradition was that amenorrhea threatened a woman's "matrix." Onwards into the Middle Ages,

“no menses, no conception” was a tenet widely held without reference to the specific reproductive role attributed to menstrual fluid” (Cadden, 1995: 173).

It was menses as a “visible red badge of femininity.” (Dewhurst, 1972: 70) that was central to the invention of hormonal contraceptives. The “Pill” halts ovarian cycling and makes changes to the endometrial and cervical site required for fertility. Many critics have described it as a man made imposition of recurrent “unnatural” bleeding prescribed by medics and pushed by pharmaceutical companies. It is marketed as giving women a “choice” but in fact it propagates menstrual related stigma. In her book *Issues of Blood: The Politics of Menstruation*, Sophie Laws quotes Dewhurst to make the point that too often, women are “cheaply and conveniently” put on the pill. (Dewhurst cited in Laws, 1990: 137). Laura Fingerson (2006), in *Girls in Power: Gender, Body and Menstruation in Adolescence* explains how the inventors of the contraceptive pill devised the three week off and one week on menstrual cycle not based on medical science but on the fact that women would feel reassured by a pill that replicated nature. The goal was to invent a successful and lucrative commodity (Fingerson, 2006: 70). Thus, the contraceptive pill was designed to “mimic the monthly menstrual cycle in the belief that this was more normal than amenorrhea” (Anderson, 1983: 31).

But as Anderson found in his study “The Reproductive Role of The Human Breast” (1983), which looked at the effects of lactation on fertility, whilst monthly menstruation was seen scientifically as normal and amenorrhea as abnormal there was substantial evidence that menstrual periods were disadvantageous to a woman’s health and that

“many women would now welcome a form of contraception that mimicked the natural effects of breast feeding and produced amenorrhea.” (Anderson, 1983: 31 cited in Buckley and Gottlieb, 1988: 44)

Buckley and Gottlieb go on to explain,

“the scientists who developed the contraceptive pill assumed both the normalcy and desirability of regular periods. Yet there is strong evidence that “normal” monthly periods are probably not that at all, historically and cross-culturally, but rather are most likely biologically anomalous products of particular cultural systems at specific historical conjunctions” (Buckley & Gottlieb, 1988: 44).

Louise Lander writes in her book *Images of Bleeding: Menstruation as Ideology* (1989) that it is more common to have amenorrhea than menses in tribal, religious and / or non-industrialised communities where women are often pregnant or breastfeeding. Elsimar Coutinho, a Brazilian gynaecologist argues that amenorrhea is more natural a state than menstruation. In *Is Menstruation Obsolete?* (1999), Coutinho, along with endocrinologist Sheldon Segal, writes that for preindustrial women “continuous menstrual cycling is not a natural attribute of human females” (Coutinho & Segal, 1999: 2).

They cite the Mali tribe where women menstruate about one hundred times in their lives compared to western women who menstruate around three hundred and fifty to four hundred times in their lives. Coutinho and Segal suggest that regular repeated menstruation might be harmful to the health and wellbeing of a woman and for those who suffer from PMS, endometriosis or anaemia suppressing menstruation is just what the doctor ordered. According to Alyssa Dweck, at the time of interview, assistant clinical professor of obstetrics and gynecology at Mount Sinai School of Medicine in New York,

“There is no medical reason why a woman has to menstruate every month.... And there is nothing wrong with tweaking the system if bleeding is difficult for women” (Massey, 2015).

A study of 1224 healthy women of reproductive age from Brazil, Germany and the United States found that a high percentage of these women would prefer amenorrhea above all other bleeding patterns. “Association Between Characteristics of Current Menses and Preference for Induced Amenorrhea” (2009) recorded that

“Women and physicians who declare their preference for induced amenorrhea over monthly bleeding argue that menses are associated with discomfort, messiness, bad mood, cramps, inconvenience, premenstrual syndrome, loss of time from work/school, interference with sex, economic cost and potential anaemia” (Hardy et al. 2009: 266).

Induced amenorrhea was favoured more by those who experienced more difficult menstrual disturbances than fellow participants who described their menstruation as normal. The report concluded that those with menstrual alterations were “more willing to accept pharmacological amenorrhea as a practical option to resolve their problem” (Hardy et al. 2009: 268)

These women were incentivised by the fact that amenorrhea would alleviate stress, anxiety and pain associated with the waiting for and the experience of menstruation. Many research papers of this nature come to the similar conclusion:

“Patients and their families can be reassured that menstrual suppression has not been associated with any long-term negative health consequences, and may improve contraceptive effectiveness. The use of extended cycles offers adolescent patients more control over their menstrual cycle and improved relief from the symptoms that may accompany it” (Kantartziz & Sucato, 2013: 136).

This study into menstrual suppression in the adolescent reported that nearly one third of adolescents who used combined oral contraceptive pills were not taking the pill for the contraceptive purpose but were most commonly taking it to treat symptoms associated with menstruation. The study cited a survey of over 300 adolescents in the Netherlands aged between fifteen and nineteen of whom seventy one per cent said they would prefer to menstruate less frequently than monthly or never. Similar trends were spotted in the United States and Europe. It should be stated that these studies were done in relation to oral contraceptive and reproductive investigation.

Data from other studies shows that suppression of menstruation is regarded with ambiguity. Thematic content analysis from a study of sixty-four women aged between twenty-one and fifty one years old who all menstruated regularly revealed that “although regarded as a nuisance, menstruation was associated with femaleness, youth, fertility and health.” (Amaral et al. 2005: 157).

Although most of the women would have liked to be free from menstruation many feared negative consequences of induced amenorrhea and were put off by the idea that it would more than likely be instigated by a male physician intruding into what they considered to be a natural female condition. I wonder if, based on their cultural and religious history, these Brazilian women want to fulfil the role of woman as defined by man but only up to a point. In other words - look but don't touch! And as reported

“The statements of the women in this study revealed their differing attitudes toward their own menstruation, reflected in the way they reacted to the possibility of its artificial suppression. Both menstruation and amenorrhea were regarded with an intrinsic ambivalence” (Amaral et al. 2005: 158).

Some would say that this ambivalence is a red rag to the bullish scientist who still views women through an androcentric lens, her body available and ready to be opened up to inspection and regulation. It's always a Q and A of the feminine problem.

## **CHAPTER TWO**

### **CURRENCIES OF BLOOD AND LAWS OF THE LAND**

#### **INTRODUCTION**

This chapter will outline the main ways in which the amenorrheic woman and the menstruating woman are viewed and used by societies and groups. We shall see them in political, cultural, medicinal, anthropological, religious, literary and historical contexts. The chapter will set about to fill in the gaps in our understanding of amenorrhea and menstruation and will question how and why amenorrhea is experienced as being outside the “natural” order of things. If we look at amenorrhea and menstruation as signifiers in the wider sociocultural context, both the amenorrheic and the menstruating woman can be construed as possessing both positive and negative forces. They appear in composite guises depending on what is needed of them in any given moment. For example, the menstruating woman is aligned with the very existence and continuation of the whole of the human race. Her monthly menstrual cycles provide the arena in which a procreative act can ensue. She is a force of nature and the survival of the species depends on her. Meanwhile, this very same menstruating woman has been cast aside as inferior and polluting. She has been vilified as insane and a danger to the healthy organisation and progression of the collective. As for the woman with amenorrhea she can be seen as a saviour, a survivor and a martyr in times of economic hardship, political strife and religious awakenings. Anomalous to the natural order, she represents other worldly qualities on this earth either in light or shade: During medieval times she was a sorcerer and a witch. In stark contrast, in biblical times she was revered as being close to the Divine. Our exploration into the way in which menses and non-menses are used as powerful symbols will highlight the need and dependency that “man’s” attachment with them ensues.

## BLOOD LINES

For centuries people have studied, drawn and gazed upon the naked female body. There has been much discussion on the clean lines and unblemished skin of the late twentieth and early twenty-first century that go towards representing an idealised version of beauty. There are no marks, no flaws and often no pubic hair on these images that are “lean, taut, smooth and hairless, something like a mobile, androgynous statue” (Sceats, 2004: 66).

This aptly describes Pygmalion’s statue Galatea from Ovid’s *Metamorphosis*. The verse describes the way in which a man relates to his “model” and offers us a particular model of the mind whose organisation is composed of clean lines and clearly identifiable separate parts. For many feminists this commodification of the body is abhorrent as it suggests that mess, (notably, menstrual mess) is done away with and assigned to the artist’s waste paper bin.

In response, artists have created works such as “Menstruation Bathroom” (Judy Chicago, 1972); a bin filled with used tampons. In 1975, spectators of the performance piece “Interior Scroll” saw feminist Carolee Schneemann read from a long piece of paper as she slowly pulled it out of her vagina. Forty-six years later, “Dr Carnesky’s Incredible Bleeding Woman” came to the stage. Associations and taboos on menstruation were raised from Jesus’ blood on the cross being the menstrual magic ritual appropriated by patriarchy to the disregard for our bodily cycles reflecting our ambivalence to the cycles of our planet. The procreating qualities of women were expressed in Romanian artist Timea Páll’s work “The Diary of My Period.” Páll collected her menstrual blood and used it to paint nine squares of one whole canvas to make a picture of a baby in the womb. In 2017, her work made the headlines from Nigeria “Unbelievable! Just imagine what a lady did with her menstrual blood (Disturbing Photos)”, to India “The woman used period blood of nine months to paint an unborn child.”<sup>xxiii</sup> Páll said of her work:

“The periodic elimination of my ovum with my menstrual flow inspired me to give birth to something which has a biological end, and to create the start of the end” (Páll, 2017).

In 2013 Chilean artist Carina Úbeda exhibited what was a collection of five years worth of her used sanitary rags embroidered with words such as “destroyed” and “production.” Her work was exhibited at the Centre of Culture and Health in Quilotta, Chile. In *Passions, Persons, Psychotherapy, Politics* (2015), Jungian analyst Andrew Samuels refers to the 1979 work of artist Cate Elwes. Elwes had organised a three day performance that took place while she was menstruating. Called “Menstruation II” Elwes was enclosed in a white box, which had a glass panel on one of its sides, through which she could be watched. Viewers could pass questions to her and she would write her answers on the walls inside the box. Dressed in white and with her menstrual blood visible in its flow, Elwes’ commented that her menstruation work “confronted forcible eradication of women’s biology from culture” (Elwes, 1985: 182 cited in Kent & Moreau 1985).<sup>xxiv</sup>

Samuels quotes feminist art critics Parker and Pollock for their analysis on the importance of acknowledging important events of the body. The event

“is not reducible to biological essentialism, a facet of patriarchal ideology which supposed a primordial difference between the sexes determined by anatomical and specifically genital structures. How the body is lived and experienced is implicated at all levels in social or societally determined psychic processes” (Parker and Pollock, 1987: 29 cited in Samuels, 2015: 106).

Elwes’ performance demonstrated how the “menstruation huts” implemented by women in early societies to protect them during menstruation and childbirth were reconstructed by patriarchy as places to isolate women and separate them out from men. Under the patriarchal system menstruating women now were polluting and dangerous and needed to be kept apart.

To find a time before portraiture of women had been hijacked and held hostage by the might of man's patriarchal (phallic) pen, we can go all the way back to the Old Stone Age where it is believed that women, using basic stone tools, drew pictures of one another into the rock face. "The Woman of Le Gabillou" is a perfect example of this. Discovered in 1940, it dates back to 15 000 BCE and is a drawing of the simple outline of a woman's body, Matisse like. It shows the curve of the belly, breast, one leg bent and a bend in the line to locate the vulva. Like so many Paleolithic vulva images of its time, be it in drawings or objects, it tells a story about womanhood,

"sometimes associated with the mother goddess or presented as a symbol and aspect of her story, sometimes in graves, sometimes associated with other symbols. These uses and variations increase our understanding of the complex, interrelated nature of the story and take it out of the realm of mere sexuality. It is not the anatomic "sexual" organ that is being symbolized, but the stories, characters, and processes with which the symbol had become associated" (Marshack, 1972: 279 cited in Lubell, 1994: 63).

Lubell's book *The Metamorphosis of Baubo* (1994) explains how the Paleolithic symbols of female power including the vulva and the menstrual fluid signified the way in which female sexual energy was aligned with the earth's sacred energy. Earlier images dating back to 30 000 BCE, show rituals in which chosen women would squat over fields and their "moon blood" would fall onto the newly ploughed fields. The "magical" regenerative qualities of the menstruating vulva were just as much about religion and cosmology as they were about biology. The fact that many of these artworks show the simple outline of a woman's body is interesting as they might in some way have been an unconscious representation of a boundary devised and used to contain the engulfing qualities of women.<sup>xxv</sup> The boundary also separates women out from men. This would fit with Lubell's explanation of art that develops in a way to mirror the evolution of a consciously driven patriarchal system, where castration fears are surmounted:

"The concept of menstrual blood as part of earth's sacred energy no longer fits the ideology of the emerging aggressive civilizations that had seized

power...“wise blood” or “magic blood,” became something to be feared and was rejected as an obscenity” (Lubell, 1994: 5).

In *Great Mother: An Analysis of the Archetype* (1955), Erich Neumann refers to the work of social anthropologist Robert Briffault who wrote in *The Mothers* (1927) that all taboos originated in the menstruation taboo which was imposed by women on themselves and on men. Neumann writes

“We even have traditions - among the primitive aborigines of Tierra del Fuego, for example – to the effect that the earliest mysteries were mysteries of the moon goddess, against which the men rebelled under the leadership of the sun, slaying all the grown women and only permitting ignorant and uninitiated little girls to survive” (Neumann, 1955: 290).

It was the menstrual blood, habitually associated with staining, that became a main divider of women from men. And it also split the pre-menarche age of girls away from the lustful and sinful lewd images of post menarchy. Jane Ussher explains in her book *Managing the Monstrous Feminine: Regulating the Reproductive Body* (2006),

“The margins of the body, in particular, the markers of fecundity – menstruation, pregnancy, the menopause – stand as signifiers of the difference between within and without the male and female, necessitating containment through taboo and ritual, in order to keep the abject body at a safe, non polluting distance from the symbolic order” (Ussher, 2006: 5).

Menstruation and puberty with a newly acquired sexuality was split off and spun into narratives, mainly reworked by men, as a threat to patriarchy. The prepubescent girl

“carries no menace, she is under no taboo and has no sacred character...But on the day she can reproduce, woman becomes impure” (Simone de Beauvoir, 1988 [1949]: 180).

Feminists are always contesting this iconoclasm which indicates how deep rooted a mantra it is; almost like a religious edict. I wonder though, does this flagellating of the old worn image precipitate it even further into our psyche? Lorraine Berry asks in her article “The horror of female adolescence – and how to write about it”

“Why does literature so often depict the onset of sexuality – or indeed any aspect of girls’ growing up – as a strange, feverish thing?” (Berry, 2016)

Berry cites among several, Stephen King’s *Carrie* (1974) and Jeffrey Eugenides’ *The Virgin Suicides* (1993), which she says portray female puberty as “something preternatural.” Examples of man’s inability to be “natural” with menstrual symbols are numerous. Bruno Bettelheim, in his analysis of the fairy tale *Sleeping Beauty*, a tale of menstruation initiation, observes this:

“It is very much to the point that the king, the male, does not understand the necessity of menstruation and tries to prevent his daughter from experiencing the fatal bleeding. The queen, in all versions of the story, seems unconcerned with the prediction of the angry fairy. In any case she knows better than to try to prevent it” (Bettelheim, 1975: 232).

Sleeping beauty in her non-menstruating, sleeping state is non-threatening. But issues of menstruation bring with them a curse to the whole kingdom. Bettelheim underscores a clear demarcation between those who are a threat and those who are not. This innate need for a division between is reminiscent of the biblical story in *Genesis* chapter one.

“And G-d created man in His image, in the image of G-d He created him; male and female He created them” (Genesis 1:27 cited in JPS, 2000: 2).

Many people interpret this as Adam being created as one being, originally designed to be on his own. Of course this being one of the most famous “stories” of all time it is open to countless interpretations. One widely accepted view is that Adam was at first “coupled” with Lilith. According to Ragnheidarottir in her

book *Quest for the Mead of Poetry – Menstrual Symbolism In Icelandic Folk and Fairy Tales* (2016):

“Adam is said to have favoured the missionary position in sex, but Lilith pointed out that she was his equal and refused to lie beneath him” (Ragnheidardottir, 2016: 127).<sup>xxvi</sup>

Ragnheidardottir goes on to quote Pamela Norris’ *Eve: A Biography* (1999),

“when Adam threatened to overpower Lilith by force, she uttered the magic name of G-d and flew away to the Red Sea [...] where she lived with a horde of lascivious demons and became renowned for her promiscuity” (Norris, 1999: 278 cited in Ragnheidardottir, 2016: 127).

The Red Sea can be interpreted as menses and whilst Lilith was replaced by Eve we have from the very start the picture of Adam vulnerable and at risk from the cursed, menstruating, scheming woman. Eve is a great example of how a repeated image creates an identity, a theme explained by Judith Butler in her book *Gender Trouble: Feminism and the Subversion of Identity* (1990). Butler explains how if we start at the beginning and take gender itself, it is not something that is and that causes things to happen but rather, it is a

“performance discursively constituted, something one does rather than what one is: Gender is the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory framework that congeal over time to produce the appearance of a substance, of a natural sort of being” (Butler, 1990: 33).

The menstrual substance is arguably the first blot on the gender landscape that separates woman out from man. It will not wash away. Many will play on mankind’s fear of the powerful menstrual bleed as a method by which they can bring unquestionable order to the social system (which we shall see time and again throughout this thesis). But, in times of desperate need, when a decaying social and political landscape appears beyond redemption, man turns to a different symbol – Amenorrhea.

## AMENORRHEA – A NARRATIVE OF EPIC PROPORTIONS

The amenorrheic woman is beyond the simple tale of man's management of the feminine problem. Her narrative is one of epic proportions. This is a woman who is immune to and beyond the waxing and waning of earthly existence, represented by menstrual cycles and procreation. She is beyond representation of the body "associated with notions of corporeality" (Buckley and Gottlieb, 1988: 76-77).

In fact, she is much more a symbol of order itself. She is closely aligned to the Goddesses, Saints and Amazonians, than she is to womankind, with a more superior narrative of redemption, salvation and survival. If she is to represent immortality then it won't be through childbirth like her menstruating sisters. Immortality of the amenorrheic is that of the saviour not of the procreator. However, when her symbolism as a saviour, warrior or leader turns sour it is her very nature and her constitution that recalls her superior status to that of mere fantasy. She is alas, just a woman, nothing more. We shall see now how the regard for the amenorrheic woman rests on a pendulum so big that it can swing from one end, from the place of majesty, awe and the sublime to the other, where disgust, loathing and the inhumane reside.

Let's start with the famous case of Joan of Arc (1412 – 1431) whose amenorrhea elevated her to Sainthood. Non-menses of the amenorrheic and a young virgin's pure mind, pre sexual knowledge, were gold dust to medieval man. The amenorrhea of Joan of Arc symbolised a power and a purity that could somehow conquer the enemy and rid the world of evil. She represented the coming together of a disembodied state. She would save France. Living in the early 1400s, she was a figure of chastity and of angelic cleanliness, which was mirrored by her absence of menses. Amenorrhea, although thought of as a failure, was in medieval times linked with outstanding strength. As this extract from a medieval medical text states,

"Such a failing of the menses happens on account of the power and quality of strength, which digests well and converts the nourishment from the limbs until no

superfluities remain, as it so happens amongst strong, mannish women who are called viragoes” (cited in Warner, 1981: 11).

Unencumbered by menstrual mess, Joan of Arc became the ultimate warrior. However, despite her presenting like a man, including the way in which she dressed, the blood she shed in warfare was not considered as important as that of a man who bled masculine blood (McCracken, 2003). Given a bespoke suit of armour, a banner and sword by The Dauphin, she marched with her army to Orleans and in four days took back the town from the English. The Dauphin was crowned King Charles VII and all was at last well. But on her way to liberate Paris, the young “maid” was captured. It was a simple script from the outset. If she wins she truly is G-d’s messenger, if she loses, she is the maid who has been tempted by the devil. In 1431 she was burned at the stake for heresy. Jean Toutmouille is said to have heard her cry in her prison on the morning of her execution:

“Alas! That my body, clean and whole, never been corrupted, today must be consumed and burnt to the ashes!” (Douglas Murray, 1902)

It is now her corporeal body that defines her purity. To underplay her spiritual, transcending status as G-d’s interlocutor, her amenorrhea was described not as a holy signifier but as a biological consequence of fasting (albeit religious) and athleticism. Perhaps it was her being in a state of anorexia that delayed the onset of menarche. So too, stress might have taken its toll.

The wasting away of the body, later termed “consumption” was a condition discussed as early as the time of Hippocrates.<sup>xxvii</sup> If the cure for this wasting away and its associated amenorrhea was not to be found in a covenant with G-d, then according to the medical literature the best thing for it was marriage and motherhood.

“My prescription is that when virgins experience this trouble, they should cohabit with a man as quickly as possible. If they become pregnant, they will be cured. If they don’t do this, either they will succumb at the onset of puberty or a little later,

unless they catch another disease. Among married women, those who are sterile are more likely to suffer what I have described” (Hippocrates, ca. fourth century BCE cited in Eghigian, 2010: 36).

In *Case Reports in Psychiatry: “A Case Study of Anorexia Nervosa Driven by Religious Sacrifice”* (2014), we are presented with a sixty six year old patient who first started restricting her food intake aged thirteen years old, studying to be a nun at a Catholic convent. She had her first period at about age twelve and when she was thirteen she had amenorrhea. She says she was not trying to be thin or attractive but her hope was that she would be closer to G-d and would one day become a saint through asceticism. Although certain features of the disorder appear to be culturally bound with an idealisation of thinness, the point is that

“a review of the literature suggest a long standing relation between self-starvation and religious asceticism.” (Davis & Nguyen, 2014: 1)

The paper describes how in the Christian context many girls fasted, some to the point of death. Along with flagellations and life-long virginity, these girls were termed anorexia mirabilis, which was not a disease nor was it associated with the modern day anorexia nervosa related to body image. We are told about a girl (St. Wilgefortis) who was made a saint between 700 and 900A.D. Her father, the King of Portugal, had found her a suitor but she had already vowed to serve G-d. She starved herself and the suitor withdrew. By way of punishment, her father had her crucified. Representing freedom from physical and social burdens of womanhood she was eventually sainted. Many of the cases of holy fasting show women’s abstinence to the point of death. Whilst they aim was to reach G-d, the transformation that these women were pursuing took them further away (perhaps unconsciously driven) from marriage, childbirth and motherhood; that which was expected of the ordinary girl.

So, Joan of Arc whilst displaying a strength and defiance in the face of the enemy (England) was also displaying non-conformity against an enemy closer to home – the triad of men, marriage and motherhood. And whilst she has become a symbol of victory against foreign invasion on the political stage (she is used by Le

Front National as an emblem of national sovereignty and independence), she is also a poster girl for the outsider, the protestor who votes against mainstream ideologies.<sup>xxviii</sup>

Whilst we can see amenorrhea in the Christian texts associated with that which is holy and virginal to the point of death, we are offered a different symbolic usage in many of the stories from The Old Testament. Here we find matriarchal figures whose stories are entwined with infertility and yet they are powerful, influential women of purpose and of valour: And they defy nature with their incredible conceptions.

Sarah, the first matriarch, bore Abraham a son, Isaac, when G-d willed it to be so. Upon first discovering that she would become pregnant at the age of ninety she laughed (Genesis 18: 9-16 in JPS, 2000: 31). What this laugh means is something that continues to perplex and intrigue us. Was it the laugh of disbelief, of madness, of anger? I believe she laughed in the face of G-d's audacity. He had enforced change, introduced a new dynamic and a new system for inter-relating and I think Sarah's laugh was one of anxiety in defence and in defiance against He who has the might to will it so. The rhythm of inter-relating and the defences put in place to secure the psyche from a break in uninterrupted states and symbiosis are important themes for the amenorrheic, vital to hold in mind as we explore in more depth later on her unconscious modus operandi. As for Sarah, perhaps her laugh symbolised her ambivalence towards menstruation and her return to the earthly purpose of womanhood. The Midrash suggests that Sarah asks if now withered and old she is to represent renewal with menstrual periods. So, amenorrhea although it signifies barrenness and infertility actually correlates to something much more spiritual and meaningful in comparison to menstruation and childbirth that can be viewed as consigning women to the earthly realms and purposes of mankind on this earth.

Another useful example from the Old Testament is Hannah from the Book of Samuel I, who, in her barren and presumably amenorrheic state, ("for the Lord had closed her womb") prays to her G-d and is blessed with a child (1 Samuel 1:1 – 2:22 in JPS, 2000: 571-575). Like Sarah, Rebecca and Rachel and indeed the

Virgin Mary of the New Testament, she is immortalised as a woman who is closely connected to her G-d. Indeed it is her communications with G-d that she values more than anything. That is why she is prepared to give up her longed wish for son Samuel, after all those years of prayer. One way to look at this is to see how she designs a sterile, barren fate that ensures non - interruption and ceaseless attachment to the Holy One through her ceaseless prayer and communication with Him. When pregnant her womb, which carries and bears the child, is of this life and of this time. Previously she was in the realm of The Divine, a state Hannah wishes to return to.

The power and strength of women like Hannah transcends the sexual powers of their menstruating counterparts - the Delilahs of these texts. The Virgin Mary from the *New Testament*, symbolises a more expansive depth in that her conception is an immaculate one. She really is incandescence personified. Not a drop of menstrual blood or semen in sight! In her not experiencing sex or death The Virgin Mary is construed by the Catholic Church as beyond human. She is “the handmaiden of the Lord” (Luke 1:38) and she is to be the mother of God (Luke 1:34) but despite her motherhood, the cult of The Virgin Mary makes her not a woman at all.

We are now in the realm of the transcendental, the inexplicable, that which man is in awe of, afraid of, wary of. The essential basic image is reworked and represented so that it can be used at any given period in time. What we have here is “a storied way of thinking” (Marshack, 1972: 305).

One of the most extraordinary examples of the way in which one woman created a story for herself using the image of The Virgin Mary was Queen Elizabeth I. She propelled herself out of the patriarchal imprint of a transparent, passive woman who belongs to man, into an active self-agent powerful in political and public life. This queen, the creator and commander of a Golden Reign presented herself as someone of dual sex. She modelled herself on the philosophy of the King’s Two Bodies from The Middle Ages.<sup>xxix</sup> Whilst her outward corporeal body of a woman might be associated with weakness her metaphysical body was that of a man, a Prince, a King. Internally was the place where the secrets of state

were kept. Her royal consciousness and her power were that of a male ruler, privy to no one. Hence, she was not the transparent woman in man's image. And even biologically speaking, she was not a woman in a man's world for it was widely believed that she was amenorrheic. Christopher Hibbert writes in *The Virgin Queen* (1990)

“when she reached the age of menstruation, her periods were highly irregular or, as some reported, non-existent, as in cases of amenorrhea” (Hibbert, 1990: 31).

Sometimes Elizabeth was referred to as Your Majesty or Your Highness, which are gender-neutral terms and sometimes she used language and symbolism to equate her womanhood to that of the Virgin Mary. In this sense she is not akin to the menstruating women whose very menses defines all things corporeal for both women and men; waste, decay, death. She didn't possess bodily blood, she was of Royal Blood but not just monarchical; Elizabeth was now in the most elitist of categories. She was aligned with the Virgin Mary and she was to show her subjects that she could walk amongst men as one of them yet also as one above them. How then did she negotiate the fact that she was in flesh and blood, a woman? She declared to her troops in her famous 1588 Tilbury Speech, just as the Spanish were about to invade,

“I may have the body of a weak and feeble woman, but I have the heart and stomach of a king, and a king of England too!”

According to actress Fiona Shaw who deconstructs this with Dr Amanda Foreman for the television programme *The Assent of Woman* (2015), the shift takes place on the word feeble. Shaw says,

“You want the intellect to win so when she says I have the body of a weak and feeble woman. Feeble had feebleness in it. And it is quite an emotional thing to say. If you stop there she would have been voted out very quickly, but these small words have a huge power” (The Assent of Woman, 2015)

Shaw continues:

“I may have the body of a feeble woman but I have the heart and stomach of a king”. Woman is a softer word than King, which is just there. I think feeble is the word which sticks out in the Tilbury speech, it’s the axis on which she turns the whole thing round. She uses the weakest word, then a ‘but’ and then the word ‘King’. So if you reduce that speech you would go “feeble, but King” (The Assent of Woman, 2015)

Let us put this pure and powerful holy Protestant Spirit that is Elizabeth against her nemesis, her half sister, Mary Queen of Scots. Elizabeth the Virgin Queen versus Mary, the blood haemorrhaging crazed and paranoid Queen. Mary was known as Bloody Mary for her persecution of Protestants in her attempt to restore the Catholic faith. As Queen, she would believe herself to be pregnant even though she had not had intercourse. Her stomach became swollen and her menses stopped but although her amenorrhagic state replicated that of pregnancy, she was indeed without child. If we consider this further, perhaps her pathology was an unconscious defence and repression against feelings of rage in the face of a narcissistic father, who had denied her legitimacy, and an unavailable or even absent mother. The blood that was shed in the name of religion and restoration might have been an attempt to restore her own psychic equilibrium by killing off what the unconscious perceived as the psychic enemy. Some say that Queen Mary got her nickname Bloody Mary from her violent reactions upon hearing the news that she was not after all pregnant.

Interestingly, it was Elizabeth’s execution of Mary that led to an attack on the image of the Golden Reign as being beyond the realms of contamination; an image that Elizabeth had up till this point so brilliantly executed herself. In “From Hillary Clinton to Lady Macbeth: Or, Historicizing Gender, Law, and Power Through Shakespeare’s Scottish Play” (2008) lawyer Carla Spivack quotes Robert Naunton, secretary of state to James I, as describing this act as the “one staine or taint” (Spivack, 2008: 67). Now Elizabeth had blood on her hands and on her soul. Her morality was questionable and she was no longer immune to the judgements made in God’s court, the “court of conscience.” Those that question this blight on her reign argue that not once did Elizabeth reveal her inner

most thoughts. “Thus, the royal conscience remained undefiled because its workings remained hidden” (Spivack, 2008: 71).

Spivack compares this hidden conscience with the conscience of Lady Macbeth. The more Lady Macbeth exposes her conscience, the greater the collateral damage. Shakespeare’s play *Macbeth* shows us a female monarch losing her crown (and her sanity). Spivack suggests that female rule, atypical in history until Elizabeth’s reign, suffered a torrent of post-rule resistance and protest, wielded in literary works. *Macbeth* was written fifteen years after the queen’s speech at Tilbury and was probably performed in front of King James I who was preoccupied with hunting down witches and crazed amenorrhic women (characterised by many of the female characters in *Macbeth*). Whereas Elizabeth revealed nothing to her subjects to the extent that many saw her as a Medusa like figure although were too afraid to gaze upon her (this might also reflect the lengths to which she had to go, later on in her reign, to secure her throne), Lady Macbeth was available for all to look at. Her body and mind were open to investigation and interpretation. Lady Macbeth was a warning of what can happen when you put a woman on the throne.

“In Lady Macbeth, then, the female body is no longer imaginable as a locus for the secrets of state; it is now transparent, accessible to the moral judgements of all, and deprived of the opacity necessary for the exercise of political power. This rewriting was achieved through the reworking of Queen Elizabeth’s iconography; in *Macbeth* the symbols that helped legitimize a female sovereign were given new meanings that undermined the idea of female rule” (Spivack, 2008: 78).

It is interesting that whilst we might regard Lady Macbeth as having a conscience, in many interpretations of Verdi’s 1847 Italian opera *Macbeth*, she is cast as an omnipotent narcissist and all the feelings historically associated with women such as guilt, remorse and sensitivity are lacking. A review in the *Chicago State Standard* (2010) describes

“Nadja Michael’s sultry slim Lady Macbeth seems a triumph of anorexia – malevolence, a wielding siren with a superb soprano.”

In a 2016 broadcast on BBC Radio 3, baritone Scott Hendricks, who plays Macbeth in Verdi's opera, highlights the terror his character feels. "I don't think Macbeth is weak, I think he has a conscience" (Halle – Verdi, Beethoven, 2016).

So who is it then that has the conscience that brings about their undoing? Freud has an answer in that Macbeth and Lady Macbeth are two aspects of the same person. In *Some Character-Types Met Within Psychoanalytic Work* (1916) Freud interprets their first murder, the killing of King Duncan, as parricide: the mother (Lady Macbeth) incites the son (Macbeth) to kill father and once he is murdered, chaos of a destructive mother is unleashed. For a different interpretation, Janet Aderman in "Born of Woman: Fantasies of Maternal Power in Macbeth" (1985) suggests that Duncan is murdered for his female vulnerability and for his lacking effective power. This endows Macbeth and Lady Macbeth with a new power, in the maternal image. Whilst many think of Lady Macbeth as anti feminine with her plea to be unsexed – she is attractive to her husband and magnetically intriguing to us – the two of them are symbiotically tied. It appears that the more their actions and their thinking become out of kilter, the more hysterical she becomes. The loss of attunement affects her. Maybe the deaths, the killings, symbolise the Macbeth children; their creative acts together. This I offer in contrast to the more widely accepted view that the murders reflect her murdered procreative, fertile potential. This was installed in a 2015 film *Macbeth* directed by Justin Kurzel, in which the opening scene showed the burial of their young infant. This certainly makes what follows easier to digest and is reminiscent of earlier interpretations. The idea was that Lady Macbeth's ambition be interpreted as

"a sublimation of a repressed sexual impulse, the desire for a child based upon the memory of a child long since dead" (Coriat, 1912: 28-29).

I wonder what Coriat meant by "memory" in his book *Hysteria of Lady Macbeth* (1912). In my reading of it the memory is not of an actual child but is of the wish and fantasy and imaginations of a state with child that eventually overwhelms Lady Macbeth and all that energy and commitment regenerates itself into an impulse and a drive to kill. To underscore the complex mind of Lady Macbeth,

Coriat makes a useful distinction between her and Aeschylus' Clytemnestra; both women often thought of as resembling one another. Coriat corrects this.

“Clytemnestra is essentially and fundamentally criminal, deceitful, voluptuous, coldly calculating in her motives and shows none of the symptoms which make Lady Macbeth the irresponsible victim of a definite psychoneurosis. Lady Macbeth reacts only as her unconscious complexes make her react, Clytemnestra is the willing slave of her conscious will; one is a flawless and consistent type of hysterical dissociation, the other, the incarnation of criminal tendencies” (Coriat, 1912: 34).

That hysteria dissociation is “the result of unconscious conflicts of complexes” allows for the hypothesis that amenorrhea is a result of an internal displacement of something intra-psychically persecutory onto the body and with the removal of the menstrual flow there is a removal of that which is persecutory. Externally, Lady Macbeth can identify and locate the enemy by aligning herself with the Weird Sisters. They can call on the spirits to change the course of events. The Witches use their powers to influence the way The State operates and Lady Macbeth urges that the operatives, the working of her female bodily state, be altered. All these women are described as defeminised.

If Lady Macbeth is to bring about a change in her personality, a psychological remodelling requires also a physiological one. An unsexing of both her biological and mental make-up is the only way to ensure she has a spirit capable of murder. But she is not up to the task. Her manic need to clean the blood spots off her hands reveals the non-rationale and acts as a stalemate that expresses her inability to make a choice to push on through or to hold out. This compulsive act needs to be interpreted as being more than an attempt to alleviate guilt. As psychoanalyst Ronald Fairbairn interprets, obsessional behaviour is a conflict between separateness and identification with an internal dilemma of whether to hold on to the exciting aspects or to evacuate the rejecting ones in the internal world of object relating.<sup>xxx</sup> An inability to resolve this question is expressed in the rituals of the person who is obsessive compulsive. Consciously, Lady Macbeth wants to remove the stains but unconsciously she wants to hold onto the feelings

that are familiar to her which is why, despite her continual hand washing, her hands remain blood stained. The ritual of hand washing does not offer relief as you cannot wash away feelings that you do not actually want to let go of. Lady Macbeth's unconscious does not want to let go of the internal conflict for fear of where that might lead. Lady Macbeth's unconscious is aligned to the status quo.

In its simplest form what we have here on a conscious level is Elizabethan physiological psychology in that a woman believes that unsexing her biology will bring about a mental defeminisation. It is suppressed menstruation that will be the most effective way of shoring up qualities associated with women. But as Jenijoy La Belle writes in "'A Strange Infirmity' Lady Macbeth's Amenorrhea" (1980),

"She abjured her womanhood in order to be impregnated with cruelty, but the amenorrhea has further results which she has not considered. Indeed, Shakespeare attributes to her those very symptoms that contemporary and near-contemporary medical books claim will occur when a woman's natural visitings cease" (La Belle, 1980: 383).

In other words, the amenorrhea replaces the old set of troubles with new ones. The symptoms of amenorrhea written in the manuals such as John Sadler's *The Sicke Womans Private Looking-Glasse Wherein Methodically are handled all uterine affects, or diseases arising from the wombe* (1636) are "faintings" "swoonings" "melancholy passions" and "fearfulness" (Sadler: 1683: 20-21 cited in La Belle, 1980: 383).

La Belle also cites *The Anatomy of Melancholy* (Burton, 1652), a compilation of seventeenth century books. Burton presents indicators of an amenorrheic melancholy being accompanied by "troublesome sleep" with "terrible dreams in the night, dejection of the mind, much discontent" (Burton, 1652: 478 cited in La Belle, 1980: 383).<sup>xxxi</sup>

These are the things that haunt Lady Macbeth. In "Macbeth: The Prisoner of Gender" (1983), Robert Kinbrough explains how the play can be interpreted as

one that is about gender and not about sex or unsexing. Rather, it is an “essay towards androgyny.” Kinbrough quotes philosopher and poet Samuel Taylor Coleridge (1832): “The truth is, a great mind must be androgynous.”<sup>xxxii</sup>

This is in turn referenced alongside Virginia Woolf’s analysis of Coleridge in *A Room of One’s Own* (1929), which is followed by Woolf’s ideas about androgyny in Shakespeare as being

“the type of the androgynous, of the man-womanly mind...one of the tokens of the fully developed mind that it does not think specially or separately of sex...” (Woolf, 1929)<sup>xxxiii</sup>

Kinbrough concludes:

“Androgyny then, may be defined as fully realized humanity. Because this state of mind is rarely attained and, when achieved, nearly impossible to maintain, androgyny is an ideal goal – a vision of unity and harmony beyond the confines of gender, within the confines of the human” (Kinbrough, 1983: 189).

So what of gender ambiguity, represented by the three witches who appear immune to change and beyond the confines of humans being human? The silent amenorrhea speaks volumes of their capacity to be outside of society. The visible features, like their beards (I.iii.46), refer more specifically to a defeminisation of their sex. It was viewed as early on in the time of Aristotle and Hippocrates that when a woman’s menses stopped, she might resemble a man with facial hair. The physician John Bannister in his publication *The Historie of Man* (1578) wrote about women with beards and referred to a story in Hippocrates’ *Epidemics* (VI. 8. 32). In the story, Phaetousa, the wife of Pytheas and a mother to their children stopped menstruating and grew a beard when her husband was exiled from their home; “her body was masculinized and grew hairy all over.” The doctors treating her agreed that the “one hope of feminizing her” was “if normal menstruation occurred” (Hippocrates cited in Hirsch, 2008: 66-67).

In *Werewolves and Women with Whiskers: Figures of Estrangement in Early Modern English Drama and Culture* (2008) doctoral candidate Hirsch explains in this thesis that the body was often described like an oven:

“In male bodies, hairiness is evidence of the “superior” male capacity to refine and purge superfluities through pores as sweat or as hair. Female bodies, on the other hand, apparently lack these mechanisms for expelling waste, and rely instead on menstruation to do the job. Thus cases of bearded women, such as those reported by Hippocrates or captured on canvas by Ribera, were interpreted as being the result of the female body lacking the ability to properly purge itself by menstruation” (Hirsch, 2008: 69).

Hirsch quotes from a 1605 translation of Le Loyer’s *A Treatise of Specters or Straunge Sights, Visions and Apparitions* in which amenorrhea is described as that which “troubleth the braine” with “idle fancies and fond conceits”, “diverse imaginations of horrible spectres” and “fearfull sights.” Amenorrhea was said to have caused some sufferers to “destroy themselves by hanging, or some such miserable end” (Le Loyer cited in Hirsch, 2008: 99).

In an exhibition at the British Museum in London called “Witches and Wicked Bodies” (Sept 2014-Jan 2015) curator Deanna Petherbridge presented an array of femme fatales from Lilith, Circe and the Nordic Valkyries to the witches and witchcraft portrayed in classical Greek vases, renaissance and nineteenth century art. On display were the seductresses and bewitchers such Giovanni Battista Castiglione’s etching of Circe, the infamous beauty who turned Homer’s Odysseus’ men into beasts. It was striking to see the way in which the hideous hags “hung” alongside the sexualised exotic temptresses in the museum.

Petherbridge presented the work of Francisco de Goya who used the imagery of witches to attack the divisive social, religious and political ills of his day. Their symbolism was powerful and threatening. It was in 1484 that Pope Innocent VIII drew up a text on how to root out and kill witches for they were consorting with the devil, lustful and carnal. *Malleus Maleficarum* written by Dominican Friars Heinrich Kramer and Jakob Sprenger existed for at least three centuries and

many writers describe the witch-hunt as genocide as anyone who did not fit with the image of the pious Christian was killed in accordance with the papal bull. So we are back with the lustful and the carnal and now all of woman is snookered from all sides; man has got her by the balls so to speak. The amenorrhoeic of the misogynist who not only doesn't bleed menses but upon being pricked "the absence of blood was an infallible sign" of her guilt is as obscene and dangerous as the bloody Medusa, the embodiment of the Devil, whose (menstruating) blood dripping from her snake hair is as fatal as is her stony lack of fluidity. No longer women, they are monsters and must be hunted down.

It was James I who came up with the most ingenious plan to get rid of the danger of gender ambiguity portrayed by the witches. He declared that by determining the gender of a witch you do away with the threat and more specifically, by revealing her as the woman she is, her perceived power is taken away from her. The King would literally lift up the skirts of women who claimed to be demonised, to reveal their female genitals. This gender "performance" was dismantled and now that the witch was seen as a woman, the truth of the matter was that her witchcraft had been a sham. And then her narrative, having dropped a stitch, was knitted back into that of the lustful, vane, transparent woman who is to be managed by man. She does not possess power. Her energy is unhinged madness. Her body proves it so and her menses makes it all the more.

A good example in the literature of such a woman is Bertha Mason in Charlotte Brontë's 1847 novel *Jane Eyre*. Diagnosed as insane, she was locked up in the attic, hidden from view by her husband Lord Rochester. The doctors had diagnosed Bertha as possessing a hysterical madness and they linked her mental illness with her menstrual irregularities. Brontë will have referred to the medical encyclopaedias of that time to formulate Bertha's character, whose worst attacks came when the moon was blood red. Her madness, morality and sex drive were all linked to the periodicity of the menstrual cycle. She went by the moon. Bertha is described as a "clothed hyena" and scholars have noted how this portrays her as subordinate and denigrated. Interestingly though the female spotted hyena is in fact far superior to her submissive male counterpart. She has no external vagina; instead her clitoris is larger than the male's penis, and she

urinates and mates through it. During pregnancy she pumps her babies with extra amounts of androgen, the hormone associated with masculine aggression, so that she might bear her male offspring capable of matching and mating with the formidable female. In the Arabic poem *The Hamāsa* of Abū Tammām (804-845), the Arabic verb *dahikat / tadhaku* used in the text in reference to laughing hyenas, can controversially be taken to mean both to laugh and also to menstruate (Pinckney Stetkevych, 1993: 66). Bertha Mason, of “dark” hair and “black” face, is heard to laugh from the attic of Thornfield Hall. She is the mystical “Other” to her polar opposite, the white, pure Jane Eyre. Elaine Showalter usefully writes

“To contemporary feminist critics, Bertha Mason has become a paradigmatic figure...the dark double who stands for the heroine’s anger and desire, as well as for all the repressed creative anxiety of the nineteenth-century woman writer. They point out that Bertha not only acts for Jane in expressing her rage towards Rochester’s mastery but also acts like her, paralleling Jane’s childhood outburst of violent rebellion against injustice and confinement. What is most notable about Brontë’s first representation of female insanity, however, is that Jane, unlike contemporary feminist critics who have interpreted the novel, never sees her kinship with the confined and monstrous double, and that Brontë has no sympathy for her mad creature. Before Jane Eyre can reach her happy ending, the madwoman must be purged from the plot, and passion must be purged from Jane herself” (Showalter, 1987: 68-69).

Jane and Brontë accept and adopt the patriarchal order of things, much more so than Woolf for example. Madness, hysteria etc. must be split off and denied in oneself. It must be projected elsewhere. Furthermore, there’s a crowd and Bertha shall be confined to the “patriarchal desert” (Pollock, 2007: 26) like all other madwomen and hysterics. Paradoxically, the further she roamed, the more fascinated man became in her, which we shall witness in the next section.

It didn’t have to take a diagnosis of insanity or hysteria to attract the attention of the investigative researcher. All that was needed was a woman, her body and the time old question of her femininity. The starting point for research and

analysis was menarche and from then on a woman's menstrual bleeds provided the matter through which man could monitor and track her state of health and wellbeing and by proxy his too and that of the world at large. The symbolic power of the menstrual bleed and the issue of its containment we shall now open up.

## POLICING, PATROLLING AND POLITICISING MENSTRUATION

Our journey here starts in Freud's time in the political arena of nineteenth century industrial capitalism of Northern Europe, during a time of social division in labour. Men were seen as autonomous, rational contributors who were in control of their own fate. At the same time they were tiny parts in bigger economic production lines. Not taking to this lightly, they found relief from this contradiction through the act of displacement onto the body. The consensus was that men could cure themselves of illness, disease and perversion if they willed it so, rational gatekeepers of good health and reliable common sense (thus mirroring their economic prowess). By comparison, a woman lacked any such sophistication and her body was offered as an alternative, stark "economic" theory. As described by Moscucci in *The Science of Women* (1990) a woman's body was seen and treated as

"a closed system in which organs and mental faculties competed for a finite supply of physical or mental energy; thus depletion in one organ resulted in exhaustion or excitation in another part of the body" (Moscucci, 1990: 104).

Women were viewed as a liability and, prone to erraticism, they needed to be carefully monitored by medical men. As Sally Shuttleworth explains in her paper "Female Circulation: Medical Discourse and Popular Advertising in the Mid-Victorian Era" (1990),

"Manhood was articulated against and defined by its opposite: while the attributes of self control and self-help were aligned with masculinity, woman was increasingly viewed as an automaton at the mercy of her body. Like the external economy, however, she also represented a threatening instability of physical forces that needed to be regulated and controlled" (Shuttleworth, 1990: 64).

Menstruation: is there a more reliable, readily available, limitless out-pouring of matter up for inspection that can be regulated and controlled? And if it had been widely believed in the previous century that men and women were similar in physicality except for differences of degree, then menstruation and the study of menstrual cycles in the nineteenth century could be a displacement to represent a letting go, a blood letting of what was once taken as homogenous with a degree of variation. This of course would allow men to split off from women and evolve unencumbered and superior whilst a woman's menstrual cycle rendered her inferior. Just as menstruation was central to ancient medical discourse to reflect this gender division, so too was it in the nineteenth century. As Shuttleworth explains,

“Although the physiology of pregnancy, childbirth, and lactation drew unprecedented medical attention in the early nineteenth century, it was the functioning of menstruation, whose processes remained threateningly mysterious well into the latter part of the century, that seemed to haunt the male imagination” (Shuttleworth, 1990: 47).

So, man's mastery was not to be questioned whilst the concept of woman would hold and contain all notions of disequilibrium and flux, again represented in the irregularities of her menstrual cycle. Man would be the exemplary standard and woman the lesser duplicate. Physician George Man Burrows in his *Commentaries on Insanity* (1828) clearly stated the view of the time; the state of the menstrual flow reflecting the state of the mind:

“In truth, it is the moral and physical barometer of the female constitution” (Burrows, 1828: 146).

In most cases relating to menstrual dysfunction, doctors and psychoanalysts believed that at the root of the problem lay sexual stimuli, either repressed or excessive. It was notably an excess of masturbatory activity that needed attending to. A man not only had the power to control himself but he was the man for the job when it came to curing wanton women. Not only did this reflect

the wider social division of power but so too was social control once again mapped onto a woman's body. As feminist psychologists continue to argue today, "conceptions of knowledge and truth that are accepted and articulated today have been shaped throughout history by the male-dominated majority culture" (Belenky et al. 1986: 5).

In which case, psychological theory

"has established men's experience and competence as a baseline against which both men's and women's development is then judged, often to the detriment or misreading of women" (Belenky et al., 1986: 7).

Women could not speak for themselves and it was often their bodies that formed a language, as with Hysteria, notably accompanied by menstrual disruption. Even with Freud's "talking cure" his female hysterical patients' communications were often mis-heard, mis-read or overlaid with male orientated interpretations. Even if the hysterical feminine body of the nineteenth century was viewed as a "privileged object of knowledge" (Foucault, 1976: 104-105) she was, nevertheless, subordinate to man.

Eminent British psychiatrist Dr Henry Maudsley, stated very definitively in his article "Sex in Mind and Education" (1874) that men were of the mind and women of the body. Inspired by American doctor Edward H Clarke's "Sex in Education: or, A Fair Chance for Girls" (1873), Maudsley wrote,

"There is sex in mind as distinctly as there is sex in body; and if the mind is to receive the best culture of which its nature is capable, regard must be had to the mental qualities which correlate with differences of sex" (Maudsley, 1894: 201).

He stated that women should not seek out an education but should rather concern themselves with domestic matters. Women were simply physiologically unfit for mental work and their bodies were not designed for it. Women were to be discouraged from showing an interest in anything intellectually engaging. If a

woman's energy was being used up in mental activity, her reproductive capabilities were being compromised. Gynaecologist Lawson Tait wrote that

“young girls should not play music or read serious books because it makes much mischief with their menstrual cycle and the intellect” (Tait, 1880: 813-814 cited in Studd, 2006: 411).

This was a far cry from early writers such as Poualin de la Barre who in 1670s argued that women were as capable as men in terms of their mental capacity but were denied the same opportunities as men because they had not been given an education. And even though Maudsley's views were refuted by contemporary women doctors such as Mary Puttman Jacobi and Elizabeth Garrett Anderson, his opinions counted and they carried weight because they resonated on a different register to that of pure medicine; his prescription healed the ills scored out of gender divisions.

Many societies tend to regard their women as a combination of useful procreating commodities, domesticated creatures and dangerous outsiders, whose unhygienic menses symbolise disease that could contaminate the health of a community. Whichever it is and to what degree, man's management of menstruation is central. A woman's blood can create or it can destroy a nation both on a concrete and a symbolic level. Let us turn first to the concept of woman as procreator.

## MENSTRUATION IN THE LIFE / WORK FORCE

In *Discourses of Menstruation: Girls, Menarche and Psychology* (1995) feminist Kathryn Lovering writes in her Goldsmith's thesis that historically all ideas about menstruation and the female body are

“construed by power relations. They are an aspect of the late 19th and early 20th century creation of two specific, gendered human subjects, the dominant, active male and the subordinate, passive female, who have separate spheres of activity, the one public and the other domestic” (Lovering, 1995).

As Delaney, Lupton and Toth describe in their book *The Curse: A Cultural History of Menstruation*, a woman's menstrual cycle and her achievements are inextricably linked: The greatest achievement being procreation. This in a way side-lines the importance given to increased productivity achieved through greater "cycle awareness" because at the end of the day it is not production but rather reproduction that is central to the continued existence of all species. The baby as a reproductive commodity, a human resource, will save the world.

For humans, in economic terms production depends on reproduction. Therefore a woman in childbirth is extremely valuable. Paula Treichler explains in her paper "Feminism, Medicine and the Meaning of Childbirth" (1990)

"Certainly productivity in childbearing was linked to the labor-intensive needs of both colonialism and capitalism, interests that have at once place childbirth within the realm of the public interest and given the state certain oversight responsibilities. In turn, the health of childbearing becomes a signal of the health of a state: mortality and morbidity statistics for women and infants, for example, are standardly used to evaluate a given society's social and economic development; and in the U.S., high mortality rates have frequently been the catalyst for mobilizing social and government childbearing initiatives. Many decisions about pregnancy, childbirth, and maternity have therefore long been concerns of the state as well of the childbearing woman and her family" (Treichler, 1990: 120).

Let us turn to nineteenth century Europe in which many women had to find the balance between their reproductive and productive lives. As wives and mothers they were responsible for the home and children but they also contributed financially to the family income by working. There were those women for whom lactational amenorrhea took them out of the procreating market whilst not hindering them from work such as sewing, laundry, cleaning etc. In Germany, the overall number of women in the industrial workforce rose from 400 000 in 1882 to 1.5 million in 1895 and by 1907 the number reached 2.1 million. There was a similar trend in other European countries but many governments viewed industrial work for women as being harmful to their reproductive capabilities. But

it wasn't just in their best interests that policy changed forcing women to spend less time at work and more time at home. Men had to be seen as the breadwinners and women the homemakers. In England for example, the 1874 and 1878 Factory and Workshops Acts stated that women were only allowed to work fifty- four hours per week. Less time at work would hopefully reduce the number of cases of infertility, amenorrhea and miscarriage (Fuchs & Thompson 2005). These Acts seem to be treaties drawn up alongside the medical proposals of Maudsley & Co.

If we turn our attention to post war economic recovery we can wonder to what extent a woman's contribution was acknowledged as equal to a man's during a time when women, many of whom again were married and were mothers, worked. The resurgence of the economy depended on an efficient workforce; all hands to the deck so to speak. Perhaps we could take it that women put their procreating duties to one side so as to perform labour-force tasks, contributing as equally as men. In other words, "nature" took to the backbenches in times of political, economic, cultural and social revolution. Of course the working conditions were very poor in the mills, factories and mines and women did suffer from malnutrition, miscarriage, stress amenorrhea and ill health. But these states were deemed easily reversible and when the external conditions improved, so too did a woman's health.<sup>xxxiv</sup>

It appears that the real enemy holding a woman back from "objective" pursuits and from becoming independent and accomplished producers was not her biology per se but the manmade cultural interpretation of its constitution being inferior and different to the body, mind and soul of a man. She must be debased if man is to conquer. As psychoanalyst Karen Horney (1967) writes, she is characterized as a debased love object.

"She is said to be at home only in the realm of eros. Spiritual matters are alien to her innermost being, and she is at odds with cultural trends. She therefore is...a second rate being...[She is] prevented from real accomplishment by the deplorable, bloody tragedies of menstruation and childbirth. And so every man

silently thanks his God, just as the pious Jew does in his prayers, that he was not created a woman” (Horney 1967: 114).

Julia Kristeva (1982) explains this in the context of the abject (disgusting and gross) body that threatens a breakdown to a patriarchal system that has a clear distinction between the self and the other. As Breanne Fahs interprets Kristeva in her books of essays *Out for Blood – essays on menstruation and resistance* (2016)

“Prior to when people can establish a clear separation between themselves and others, before people can understand their objects of desire, before they conceptualize the notion of representation, before they can clearly demarcate themselves from their opposites, before they can divide animals and humans or the primitive from the cultured, they had only the abject: shit, piss, vomit, decay, sweat, blood, pus, animality, murder, sex, leaks and rupture” (Fahs, 2016: 33-34).

Kristeva’s idea is that bodily fluids erupt the “Real” and show us the inevitability of our dying bodies and of death itself. The abject evokes danger to an ordered system. It symbolises a power that can weaken and soil. This continues to resonate on both conscious and unconscious registers against a changing landscape in the workplace where women are now widely celebrated for their contribution and yet there is a sense that something has gone awry. Let us take for example Great Britain’s National Health Service. In 2014, a catchy NHS infographic to illustrate key headline employee numbers showed that seventy seven percent of the NHS workforce was made up of women. Forty one percent of chief executives were women. Forty-three years was the reported average age of female employees, the same as that for men. Eighty one percent of non-medical staff were women and seven percent of female staff were doctors and dentists. In January 2014, *The Daily Mail* newspaper in the UK ran the headline “Why having so many women doctors is hurting the NHS: A Provocative but powerful argument from a leading surgeon.” (Meiron Thomas, 2014). In this article, Professor Meirion Thomas wrote that by 2017 female doctors would, for the first time, outnumber male doctors in the UK. He goes on to explain that sixty

per-cent of medical students selected each year were female because they achieved slightly better grades than male applicants. Meirion Thomas, who describes himself in the article as a “feminist”, writes that a gender imbalance is having a negative effect on the National Health Service.

“The reason is that most female doctors end up working part-time – usually in general practice – and then retire early...Instead of taking on a specialist career, many women prefer to look for a better work-life balance when they have young children of their own” (Meirion Thomas, 2014)

One of the points being made is that to receive an expensive medical training and then to work part time after starting a family was putting a huge burden on the NHS. Dame Carol Black, former president of the Royal College of Physicians, is sourced for her comment that women can undoubtedly do the job but the issue was whether they were willing to commit beyond their clinical responsibilities in the fields of research and committee work. The conflict between professional and domestic fulfilment is as ever unresolved. The delicacy of its nature is testified by the fact that Anna Soubry, a health minister at the time, had to retract her comment that women doctors were a drain on resources, having faced opposition from members of the British Medical Association and the Royal College of GPs. As expected, the article in *The Mail* invited much criticism from organisations such as the British Medical Association and the Medical Women’s Federation, stunned at such a

“backward view in the 21<sup>st</sup> Century. It is well recognised that having women as part of the mainstream workforce is key to the success of organisations. Organisations that recognise this and provide the flexibility in their workforce plans to ensure that they keep this talent pool are those that are successful” (Medical Women’s Federation, 2014).

Another sticky issue is how best to place the role of motherhood in this new, modern socially and culturally developed country. Following the magnanimous Brexit vote, when the majority of UK citizens voted for Great Britain to leave the EU, there was a vacant seat left at number 10 Downing Street, following the

resignation of the then Prime Minister and Pro Remain campaigner David Cameron. Amongst the candidates battling it out to become the new Leader of the Conservative Party and subsequently Prime Minister, two women threw their hats into the ring. One was Theresa May, a prominent cabinet minister with a relatively quiet voice on Brexit and the other was Andrea Leadsom, a vocal pro Brexit campaigner and less well known junior energy minister. With not much experience but with lots of political passion especially on the referendum she was gaining momentum and supporters. Leadsom represented the clean fresh air as yet untarnished by the political smog of Westminster. All was going well especially as everyone was fed up with the familiar Shakespearean traits of betrayal and deceit that were unravelling amongst the male contenders. But it was in her first interview on the leadership race that Leadsom showed her inexperience and her naivety for which she was hunted down and vilified resulting in her swift exit from the race. In an interview with *The Times* newspaper headlined “Being a mother gives me edge on May” Leadsom was quoted

“I feel that being a mum means you have a very real stake in the future of our country, a tangible stake” (Coates, 2016).

Leadsom said that she thought Theresa May must be “really sad” about not being able to have children. All hell broke loose and Leadsom, the outsider, mother and woman (attractive and feminine in her appearance) was ousted for her comments on her opponent. Theresa May went on to win the vote and become prime minister and speculation about her allegiance to the woman’s movement has not really abated.

Following the presentation of her paper “Experiencing the Phallus as Extraneous, or Women’s Twofold Oedipus Complex”, Julia Kristeva reflected on the concept of *le mère au foyer* (the mother in the home). Kristeva noted that women were rediscovering their femininity through motherhood and with regards to feminism,

“although we have a dominant discourse on rights, we have no discourse on the necessity for the human race to guarantee its transmission, its reproduction.

Thus we have a discourse on rights, but no discourse on history” (Kristeva cited in Pollock 1998: 38).

It's all very messy in this modern world of democracy. Things are much more sanitized and immune to infection and contagion in the more ordered states. Or are they? We can look at the People's Republic of China governed by the Communist Party of China: Characterised as a great power and unity sovereign state, how central are its women?

## FEMALE PROTAGONISTS IN CHINA

In modern day China, Chinese women are regarded as procreators, carers and contributors, never to be seen as a drain on resources. Furthermore, the balancing of this nation's books is projected and mirrored onto the balancing of a woman fertility / menstrual cycle. China depends on its women.

On October 29th 2015 China announced its plans to overturn its one-child only policy in favour of legalising the rights for families to have two children. The controversial one-child only programme, designed by a small committee of men, was introduced in 1979 and was designed to curb the country's population growth rate. According to Government figures, it is estimated to have prevented around 400 million births in China. It has been argued that China's fertility rate was dropping anyhow, with the rate falling from 5.8 children per woman in 1970 to 2.7 children in 1978. Similarly, many developing countries saw a reduction in their population as they became more urbanised and richer with families choosing to have less children as it made more economic sense with rising costs notably in property and education (Fong, 2016). The 2015 announcement from the Community Party's Central Committee, released by the official state-run Xinhua News Agency stated that the decision to now allow families to have two children was to “improve the balanced development of the population.” The hope is that China will produce more youngsters to help take care of its ageing population. Around thirty percent of China's 1.36billion people are over the age of fifty. It is a country becoming older than it is wealthier.

Child-bearing women have become essential in China's strategy for future economic prosperity, although critics have said it is a plan that will probably fail. This is because one child only families have become for many a cultural norm: one that will be hard to overturn. Many urban, middle class Chinese couples are likely to stick with having only one child to offset rising costs. According to a survey at the end of 2016, more than half of the 10,155 parents with children under fifteen questioned said they did not want a second child. Many Chinese women are angry at the government's recent campaign offering them free removal of the intrauterine devices they were forced to have fitted after their first child was born. The offer came with no apology. Of those who are now eligible to have another child, half of them are aged between forty and forty-nine making a second child less likely. Women seem to be kicking back against China's interference in family matters. Nevertheless, a woman's freedom from the state is non-contestable. As Maya Wang of Human Rights Watch told AFP, "As long as the quotas and system of surveillance remains, women still do not enjoy reproductive rights"

This is quoted in the BBC News Online article "China to end one-child and allow two" (BBC, 2015). It goes on to reference a report in *The Economist* that had worked out that China's government had collected two trillion yuan in extra child fines from those wealthy families who broke the one-child policy. Described by Jonathan Cave, an economist at Warwick University, "It represents a monetising of the reproductive age."

Some demographic experts have suggested that Beijing drop all restrictions on family size but many believe it's too late to reverse the trend for China becoming an ageing society. China is now a country in which it is estimated that there are thirty three million more men than women. It is the world's most populous country with 1,383 billion people. Over sixteen percent are aged sixty or above and the care for elderly relatives is taken on by the women in the family. Having once been regarded as a sex useless and unwanted in the continuing development and growth of the nation, even to the point when newborn baby girls were done away with, China now depends on its healthy menstruating females. Their blood is vital.<sup>xxxv</sup>

## WOMANHOOD TRUMPED IN AMERICAN POLITICS

I write now, November 10th 2016, the day after Donald Trump was announced the forty-fifth President of the United States of America, democratically elected. The businessman, the maverick, the outsider with no political experience whatsoever, elected over Hillary Clinton, a woman who represented the establishment and the centralised government. She was a career politician, he a reality television star. Much analysis will come about because of this Trump win as it signifies the greatest political shakeup in American politics of all time. Commentators say he won because he was emotional and passionate, Clinton dispassionate and fraudulent. This is particularly poignant for those who follow British politics and witnessed the female candidate for Prime Minister, Andrea Leadsom, fall at the first hurdle for being unable to edit and reword her passion and emotion. Classist Mary Beard observed that men like Trump could get away with bluff ignorance but women like Leadsom “just looked thick.” (The Times, 2017: 13).

Trump was championed for speaking the unspeakable on behalf of many Americans who had for too long felt repressed and silenced under a blanket of political correctness and global neighbourly love. Whilst Clinton stood for globalisation, integration, equality, the rights of the minority groups and those who felt marginalised, Trump was speaking on behalf of society that had somehow found themselves pushed aside and forgotten. How was it, they asked, that they were the ones marginalised, recast as The Other? Trump voters understood his rhetoric as he voiced on their behalf all that was wrong with tolerance and assimilation. He made them feel that American could indeed be great again. Having felt displaced and dislocated, the euphoric rainbow of potency had a gold pot at the end of it. Trumps rallies were populous, colourful and proud. Male was back on top.

“The forgotten men and women of our country will be forgotten no longer.” All those who did not identify with Clinton and all those for whom Obama had not delivered were invited back onto the Ark. This was not going to be A Clinton Mother ship. Trump was going to enable the American people to reclaim their

country as their own, and as their hero he would stand at the front of the helm, unafraid and intimidated by no one.

In his acceptance speech, after an extremely divisive and hostile campaign led by both sides, Donald Trump announced to the world that he would set about uniting the people. "Now it's time for American to bind our wounds." So not only was Trump a magnificent warrior, he was also a healer: A man extraordinaire. On the political battlefields, in the immediate aftermath, Clinton's scars were laid bare and to emphasise his own victory, Trump congratulated Clinton on her "very, very hard fought campaign." As the campaign had been drawing to a close many allegations of sexual abuse and misogyny were filed against Trump but for some this only seemed to make him the stronger candidate. It seemed the more that Trump was revealed as uncontained, narcissistic, shooting from the hip, the more voters and admirers he acquired. Clinton was hidden, closed, divisive, secretive, and deceptive. She covered up her husband's affairs and was accused of trying to silence any woman that wanted to speak out about Bill Clinton's sexual misconducts. She was repressed. Trump was driven, the libidinal force, a new energy. As Trump himself said, his was not a campaign "but rather an incredible and great movement." Importantly looking at the exit polls indeed he not only had the largest percentage of the male white vote but 53% of white women voted for him too. Hilary Clinton had repeatedly claimed she was representing women, but many did not identify with her, they couldn't reach for dreams and goals, they were too busy surviving from day to day, watching external forces threaten their internal landscape. They gained comfort from the fact that Trump as well as representing a new hope was a man who symbolised a lost era, one that many wanted to resurrect. This was not simply a matter of the underclasses supporting a remote elite through an unconscious identification with the aggressor (as was originally thought) because many of the middle class, middle earners voted for him too.

Trump said he wanted to build a wall, which for him meant splitting Mexico from the USA but symbolically it represented the need for the boundary, to clearly demarcate who is in and who is out. No blurred lines. This was a form of control and it was not going to be unhinged by anything that symbolised free flow,

erraticism, danger and impurity. American was certainly not ready for a female president. Clinton might have presented as buttoned up, tight-lipped, pure and patriotic in words and intent but she never came clean about the rumours of wrongdoing. She was a “woman unhinged”. Her biology and her gender made it so. Trump went on the attack. He described Clinton’s bathroom break during a Democratic debate as “disgusting.” He even concretely sniffed out a woman’s blood with the intention of revealing her danger and her deception. Whilst on the campaign trail, early on when seeking the Republican candidacy, he described the Fox News anchor Megyn Kelly as having “blood coming out of her eyes, blood coming out of her wherever. In my opinion she was off base” (Rucker, 2015).

The media leapt on this, some more than others looking to offer a deeper interpretation on what led to Trump’s own outburst.

“As the social psychologist Jesse Graham has noted, Trump appeals to an ancient fear of contagion, which analogizes out-groups to parasites, poisons, and other impurities. In this regard, it is perhaps no psychological accident that Trump displays a phobia of germs, and seems repulsed by bodily fluids, especially women’s...Disgust is a primal response to impurity. On a daily basis, Trump seems to experience more disgust, or at least to say he does, than most people do” (McAdams, 2016).

This sanitised ideology and irrefutable mind-set we know exists in right wing movements. And indeed some commentators have asked that we be mindful of this Trump victory in terms of it being a precursor to a more fascist, anti Semitic movement that runs ahead of Trump himself and takes on a life force of its own. There has already been an upsurge in open right wing rhetoric, marches and organisations that now feel empowered to speak freely in countries such as American and notably in the UK following the Brexit vote. That a current of racism, that has always existed, paved the way for Trump’s rhetoric to be deemed “acceptable” is hard to dispute. We shall see this type of ideology at its most vicious when we look at the politics of Nazi Germany in which the themes of blood and purity run thick.

Many commentators read Trump's inauguration speech as Nationalistic with "America First" and "Lets make America Great Again" his chosen mantras that he kept repeating. The Anti-Defamation League, amongst others, linked the "America First" phrase with The American First Committee's movement that was set up in 1940 to stop the US becoming involved in the war with Nazi Germany. Its founder, Charles Lindbergh was considered to be a Nazi sympathiser writing that "racial strength is vital" and must be protected from "the infiltration of inferior blood." So when Trump closes his speech with "Whether we are black or brown or white, we all bleed the same red blood of patriots" one can't help but wonder if this is as ominous as it sounds. If Trump is trying to invert on a familiar and frightening fascist slogan in his use of blood rather than race as the indicator of those who are with us and those who are against us how does he intend to measure the degree to which one is American? To suggest that he make America Great Again implies a turning back of the clock when the purity of one's patriotism was simply defined. One such manifestation of the purity culture, with roots in the period following the Civil War, was that of an idealised version of women as being on the trajectory of girl to married woman to mother. Is the subliminal message here that man will control the fate of women if nationalism in its purest and most successful form is to return? Man, in this guise has free access to a woman's body. The now infamous 2005 recording of Trump talking to Billy Bush, obtained by the Washington Post, aired whilst Trump was the Republican presidential nominee. Part of it is as follows:

"Yeah, that's her. With the gold. I better use some Tic Tacs just in case I start kissing her....Just kiss. I don't even wait. And when you're a star, they let you do it. You can do anything...Grab 'em by the pussy. You can do anything" (The New York Times, 2016).

Many women and men dismissed these comments as locker room banter. Some commentators said that this sort of passivity by women reflected their acceptance of a society that did not dispute the numbers that showed one in five women was destined to be a victim of sexual violence. In Trump's defence, The Trump campaign cleverly attacked the Clintons, not Bill so much for his infidelities, but

Hillary for not leaving her husband and thus, according to New York City Mayor Rudy Giuliani, proving herself “too stupid for president.”

One of the first things that Trump did as president was to redraw the abortion laws, curtailing the Pro Choice Movements. This pleased many Evangelical supporters. Significantly content was Vice President Mike Pence. As Indiana Governor, Mike Pence had signed a law imposing new limitations on abortion. In a statement Pence describe the law as “a comprehensive pro-life measure that affirms the value of all human life.” Many women under the activist banner “Periods for Pence” were outraged. Some of their posts collected for a piece in npr (National Public Radio)

"Fertilized eggs can be expelled during a woman's period without a woman even knowing that she might have had the potential blastocyst in her. Therefore, any period could potentially be a miscarriage without knowledge. I would certainly hate for any of my fellow Hoosier women to be at risk of penalty if they do not 'properly dispose' of this or report it. Just to cover our bases, perhaps we should make sure to contact Governor Pence's office to report our periods. We wouldn't want him thinking that thousands of hoosier women a day are trying to hide anything, would we?" (Domonoske, 2016)

They suggested that women should call Pence’s office to inform him of their periodic movements. Here are some transcripts taken from their Facebook page (March 31<sup>st</sup> 2016).

Me: "Good morning. I just wanted to call and let the good Governor know that I am still not pregnant, since he seems to be so worried about women's reproductive rights."

Irritated lady on the other end of the phone: "And can I get your name, please?"

Me: "Sure, it's Not Pregnant Laura."

Them: "Good Morning, Governor Pence's office"

Me: "Good Morning. I just wanted to inform the Governor that things seem to

be drying up today. No babies seem to be up in there. Okay?"

Them: (Sounding strangely horrified and chipper at the same time) "Ma'am, can we have your name?"

Me: "Sure. It's Sue."

Them: "And your last name?"

Me: "Magina. That's M-A-G-I-N-A. It rhymes with — "

Them: "I've got it."

\*Click\*

In 2015 in Ireland, campaigners calling the country to repeal its restrictive abortion laws encouraged women to tweet Prime Minister Enda Kenny and share their period stories. The point being made was that whilst this would appear “undignified,” to deny a woman autonomy of her own body and her menstruation was undignified. The common theme in all of these political scenarios is that a man must control a woman’s reproductive rights and her menstruation to become the master of both her body and mind. It’s a clear, clean system of the allocation of power and control. In Trumps rhetoric it presented itself in more abstract forms such as the building of a new boundary wall separating America from Mexico; separating them from us. The idea that a boundary would restore power in the wake of a flood called globalisation that drained and disenfranchised many, caught the imagination of American voters.

And so to return to the first day in office for Trump and blood becomes a central theme in the wake of the inauguration with a protest march by women in Washington DC drawing in at least 500 000 people. Whilst it was reported that this march was designed to affirm women’s rights, after some unpicking one discovers that it was meticulously organised and sponsored by pro-choice groups, Planned Parenthood and NARAL Pro-Choice America. The march’s official slogan was for “open access to safe, legal, affordable abortion and birth control for all people, regardless of income, location or education.” It seemed that a couple of pro-life organisations who were on the partner list were quietly removed but where did that leave women who identified themselves as pro-life and feminists? Some felt excluded from the “Women’s March.” Others saw

common ground and held up slogans such as “abortion is a symptom of women’s oppression not a solution to it” (New Wave Feminists). The consolatory factors were choice and freedom with a desired move by many towards intersectional feminism.<sup>xxxvi</sup>

How interesting then that the word “freedom” popped up only once in Trump’s speech and “liberty” was mentioned zero times. Their exclusion was noticeable as was the presence of those much-used words such as “loyalty” and “patriot” which expressed all that Americans owe to their nation.

#### FEMALE RESISTANCE IN NORTHERN ISLAND – “DIRTY PROTESTS”

Female political prisoners in Northern Ireland whose bleeds represented a mode of resistance against the state used the symbolism of the menstrual bleed as a powerful weapon in political and religious warfare. Women PIRA prisoners who took part in the “dirty protests” would add their menstrual blood to faecal matter and smear it on the walls and ceilings of their cells, sometimes around the picture frames that contained holy images of the Virgin Mary. They were protesting at the lack of sanitary wear provided by the authorities. “Theresa” (2006) writes in her paper “Menstrual Blood as a Weapon of Resistance”,

“the use of menstrual blood in resisting the state is an act so subversive that it effectively disrupted staunchly entrenched gender norms in Northern Irish society prior to the height of the conflict. This in turn provoked the rise of a distinct form of feminism rooted within the republican movement” (O’Keefe, 2006: 535).

The prison authorities would try and humiliate its female prisoners by refusing to provide sanitary wear whilst they were menstruating. Sophie Laws, in her book *Issues of Blood* (2000) quotes Teresa Thornhill’s description of how one Republican female prisoner was interrogated for the week that she was menstruating. She was made to sit in front of them in the same pair of blood soaked jeans (Thornhill, 1985 cited in Laws 2000: 65). In her memoir, *Tell them Everything* (1981) writer and activist Margaretta D’Arcy describes her time as a prisoner in the H-Block in Northern Ireland. D’Arcy writes

“While they thought the authorities were indifferent to their appeals for help when their periods were too heavy or too frequent, a new area of sympathy and understanding had been discovered, from the men in the Blocks. Some of the girls said that they preferred too many periods than none at all: “It is healthier,” – anything to indicate that their bodies would not let them down over the no-wash protest” (D’Arcy, 1981: 80).

Interestingly, the public were not given images or visual displays of the way in which female prisoners used menstrual blood by way of protest. Perhaps regarded as too offensive for the public eye, the pictures painted on walls, printed on leaflets and in the press used instead the images of the starving male prisoners, reminiscent of the suffering Christ of Northern Ireland’s Catholic community. As Dearey writes in *Radicalization: The Life Writings of Political Prisoners* (2010) there is a shortage of written accounts by Irish Republican women prisoners perhaps due to

“the deeply entrenched cultural idealizations of women and the importance of cleanliness and purity in the public maintenance of their identities” (Dearey, 2010: 139).

Dearey understood that

“the linkage in the public imagination of female sexuality with dirt and the commodification of the female nude (e.g. as bather or odalisque) represents an established cultural mechanism for encountering and negotiating the body and its boundaries” (Dearey, 2010: 139).

When the public were made aware of the female prisoners of Armagh protesting, many reacted with disgust or with disbelief. The public found it difficult to negotiate this image of women alongside the more dominant image that they were supposed to uphold; that of the pure, delicate Irish Republican activist. Female guards inside the prisons did not want to be contaminated by the “filth.” Male guards upheld the view, often with violence. In the short story *A Curse*

(1985) Republican ex-prisoner Brenda Murphy describes a female prisoner getting her period in between interrogations. She has to tell a male officer:

“‘I’ve taken my periods” she said simply. ‘I need some sanitary napkins and a wash.” He looked at her with disgust. ‘Have you no shame? I’ve been married twenty years and my wife wouldn’t mention things like that.” What is the color of shame? All she could see was red as it trickled down her leg” (Murphy, cited in Hooley 1985: 40-41).

Women and men are divided as to whether these protests were wholly political or whether they were acts by women against male oppression and against cultural stigma. Women, to this day continue to use their menstruating bodies to make statements.<sup>xxxvii</sup>

#### MENSTRUAL TABOOS, RITUALS AND SEGREGATION

“Wherever primitive man has set up a taboo he fears some danger and it cannot be disputed that a generalized dread of women is expressed in all these rules of avoidance. Perhaps the dread is based on the fact that woman is different from man, forever incomprehensible and mysterious, strange and therefore apparently hostile” (Freud, 1918 [1917] SE 11: 198).

As we have seen a woman’s body is used as “a model which can stand for any bounded system” (Douglas, 1966: 115). The regulation and examination of a woman’s menses is a way for patriarchy to exert its authority and impose the belief that through man’s mastery all is under control. Developed and developing countries cling on to this “ideal” against the waves of modernisation and globalisation. They appear plagued by the riddle of what constitutes living in a “free” world. In contrast, many tribal communities are unburdened by this. Their carefully crafted menstrual taboos and rituals are implemented to maintain order and cohesion to the group. Effective management symbolises effective leadership under which people cohabit peacefully. These are sophisticated systems, by no means primitive. From the remotest of villages to the greatest of civilisations, this sophistication is in the detail. Nothing is ambiguous or open to

misinterpretation. The boundaries are clear and uncontested. In reference to tribal communities in West Africa, Ogundipe writes,

“Menstruation is considered sacred and powerful, believed to have the power to interrupt, interfere with, and cause to happen (Ogundipe cited in Pollock & Turvey Sauron, 2007: 102).

This does not always mean that menses is bad and needs to be hidden far away from man’s eye. In fact, amongst the tribal men of New Guinea, menstrual agency is sought after. The men perform periodic ritual bloodlettings in what anthropologists call “male menstruation” or “imitative menstruation”. As David Gilmore writes in his book *Misogyny: The Male Malady*,

“By doing this, the men believe they can capture not only the potency but also the fertility that nature bestows upon women. The men want this sexual transfiguration desperately because they feel that men are weak and need woman’s attributes to thrive” (Gilmore, 2001: 184).

Across Melanesia, there are accounts of male nose bloodletting as a way to initiate and imitate the female menstruation. Less common is the practice amongst Wogeo men who access menstrual powers and cleansing rites through incising the tongue of young boys and through cutting the penis for older youths and men as described in Ian Hogbin’s *The Island of Menstruating Men* (1996).

The life force of menstruation is often compared to the dulled amenorrheic state that for the Ebrié Tribe of the Ivory Coast indicates a woman’s lack of potency. If a woman picks fruit from a tree, which is mystically protected by its owner, she will become amenorrheic. A man can be inflicted with impotence if he too takes fruit from this tree. Both states are reversible when the “criminal” confesses. The study by Niangoran-Bouah reports how menses is like the erection “associated with fertility, not pollution; desirable, and traumatic to lose” (Niangoran-Bouah, 1964: 54).

This however is more the exception than the rule and menstruation as a stand alone “system” is predominantly and unquestionably vilified and feared. As anthropologist René Girard explains in *Violence and the Sacred* (1979), the violence implied by menstrual blood is far greater than blood connected to wounds or aggressive acts. This is because of its connection to sexuality and the generative process. It can lead to rivalry and incest inside a community. Anthropologist Mary Douglas, in her book *Purity and Danger: An Analysis of Concepts of Pollution and Taboo* (1966), writes about The Mae Enga who believe that to come into contact with a menstruating woman will cause a man to become sick, causing him to vomit, turning his blood black. If there is no counter-magic, he will eventually die. Referring to the 1963 study by Dr Meggitt, Douglas writes

“it is argued that this reflects the strain bought about by inter-clan marriages and exogamy – “we marry the people we fight.” - this Delilah complex is that women weaken or betray” (Douglas, 1966: 148).

Anthropologist William Stephens attempted a cross-cultural study of menstruation from a psychoanalytic point of view and wrote that

“the sight or thought of a person who bleeds from the genitals (a menstruating woman) is frightening to a person who has intense castration anxiety” (Stephens, 1962: 93).

Some saw Stephen’s study as flawed arguing that he could not have actually recorded or located castration anxiety as it is an unconscious process. So too, many critics argued that his claims overstated the importance of the Oedipus Complex in non western societies. Similarly, the idea that menses evokes man’s envy of a woman possessing a womb is likely to linger on an unconscious register and far closer to conscious thought is the idea held in the Swazi culture that

“menstrual blood is...considered part of the foetus that grows within the womb – its discharge is analogous to a miscarriage” (Kuper, 1947: 107).

Menses represents a missed chance at procreativity and a missed chance to “assure the legitimacy of a man’s seed” (Buckley & Gottlieb, 1988: 86). A woman is a liability and furthermore,

“the periodic flow of blood exemplifies the waxing and waning of earthly existence, its temporality and ultimate perishability. Menstruation condenses the conceptual cluster having to do with corporeality, time and decay – unlike seed, which carries meanings of creativity, spirituality, and the eternal” (Buckley & Gottlieb, 1988: 88).

Separating and disparaging the women in the group as the most impure of all has been the way in which man has reclaimed for himself power and position. It is he who will manage and dismantle the threat that a woman might bring to the community. One of the most sophisticated and successful examples of this comes from Ancient Greece.

The Ancient Greeks were ingenious in managing to contain any rumblings of a female revolt borne out of their frustration at being so markedly segregated from public view. Women were forced to stay in their homes for much of their lives. The Greeks created an annual autumn festival, Thesmophoria, designed specifically to celebrate menstruation and puberty. Free adult women would leave their homes and congregate in makeshift tents for three days. In Athens they would meet on the Acropolis and carry out sacred rituals, which were led by women for women. Men were completely excluded. Importantly though, many scholars agree that this was not a shining example of mankind celebrating the totality of women. It was more a case of

“nothing else but the periods of the Greek women elevated to an annual festival accommodated with this name in the sphere of Demeter Thesmophoros” (Kerenyi.1975: 157).

It was even perhaps a vehicle, created by the male citizens, to allow the women to let off steam. Men was merely placating their women. Barbara Goff explains it

well in her paper “The Priestess of Athena Grows a Beard: Latent Citizenship in Ancient Greek Women’s Ritual Practice” (2007). Goff writes,

“women’s latest citizenship emerges and becomes prominent in ritual...To the women who perform it, the Thesmophoria offers the contours of a kind of citizenship, although it can also be read to construct its female participants as the outsiders who define male citizenship by contrast” (Goff cited in Pollock & Turvey Sauron, 2007: 51).<sup>xxxviii</sup>

If we look at a more contemporary study, “Reconsidering the Menstrual Taboo: A Portuguese Case” (1992), anthropologist Denise Lawrence illustrates how the menstrual taboo is engrained within civilizations. Lawrence observed the extent to which a town in southern Portugal adhered to strict taboos relating to the curing of pork and the preparation of pork sausages. The fixed gaze of a menstruating woman on the pork would cause it to spoil. Her contaminated body could contaminate the meat. When a woman arrives at the site of meat preparation she is asked if she is able to see and she can only enter if she replies “I can see.” One can ask the question if a woman can ever be completely sure she is “clean” in which case is she intentionally or unintentionally being deceitful? In “Menstrual Politics: Women and Pigs in Rural Portugal” Lawrence explains that these women maintain the prohibitions in their own interest and that

“women’s behaviour can be explained not be reference to assumptions of male dominance over women but to women’s conscious choice of modes of behavior reflecting strategic goals important to their own perceived self-interest. Women are the principal actors in maintaining the menstrual taboo because it allows them to control certain social interactions within and outside the household and affords them a rationale for protecting the economic privacy of their homes, for which they hold primary responsibility” (Lawrence cited in Buckley and Gottlieb, 1988: 117).

It might be that all of this props up and colludes with the punishing menstrual taboos and rituals that are principally driven by a man’s envy of women (Montagu, 1940). But at least, Lawrence’s understanding of these women

challenges this earlier and more readily accepted view. If the menfolk do feel undermined, then perhaps concentration and focus on a task as important as food preparation can dissolve that tension, “when moral principles come into conflict, a pollution rule can reduce confusion by giving a simple focus for concern” (Douglas 1966: 133).

In this way, the rules that are practical compliment and contain the more mystical and spiritual aspects enveloped in the taboo. It is all rebranded as a positive movement to bring a sought after order to the group. What is being protected is “perceived creative spirituality of menstruous women from the influence of others in a more neutral state, as well as protecting the latter in turn from the potent, positive spiritual force ascribed to such women. In other cultures menstrual customs, rather than subordinating women to men fearful of them provide women with means of ensuring their own autonomy, influence and social control” (Buckley & Gottlieb, 1988: 7).<sup>xxxix</sup>

There are accounts of women, like those of the Mogmog Island in the Pacific atoll of Ulithi who enjoy being separated out into shelters and huts during their time of menstruation. They talk and weave, taking a break from routine labour. The idea that women self select their segregation (Ford and Beach, 1951) makes me think of primatology studies of baboons in Kenya which found that in the days leading up to menstruation, the females would seek out a quiet place and reduce contact with group members, spending around thirty percent of their time up in the trees. Analysis of the data found that premenstrual and perimenstrual behaviour changes among female yellow baboons showed “some intriguing similarities to several commonly reported behavioural symptoms of premenstrual syndrome” (Hausfater & Skoblick, 1985: 165).

Choosing to separate themselves out from the social group, human females have similar hormonal systems to the baboon in their seeking out “menstrual quietude” (Hood, 1992).

The system of segregation is interesting when it comes to groups migrating and relocating. The Ethiopian Jews that settled into Israel in the early 1990s had to renegotiate the customs of menstrual segregation, cohabiting in small apartment blocks. The lack of space and the basic structure could not allow for the complete separateness that they were used to in the “hut of curse” (Anteby cited in Wasserfall, 1999: 169). Some women slept in the corridors of the apartment blocks giving a semblance of segregation at a community level.

Whilst the formation of strong collegiate female groups is evident in many patriarchal systems, it would be naïve to think that all is harmonious between different groups of women. As Ed Butler reported for BBC Radio 4 in his programme “Stealing Innocence in Malawi” (2016) in some remote parts of southern Malawi, girls are made to have sex with a male paid sex worker, called a “hyena”, once they reach puberty. This ritual of sexual “cleansing” which takes place over three days, after their first menstruation, marks the passage from childhood to womanhood. Many of the girls are twelve or thirteen. In the village of Nsanje, one girl tells Butler

“There was nothing else I could have done. I had to do it for the sake of my parents...If I’d refused, my family members could be attacked with diseases – even death – so I was scared” (Butler, 2016).

What is significant is that the custodians of these initiation traditions are the elder stateswomen who inform the girls of their duties as wives and as sexual pleasers. Butler informed these women that the man who had been assigned to carry out the sexual cleansing ritual was HIV positive and that because he was not using condoms the risk of infection was epidemic. Strikingly, Butler reports that these women remained “defiant.”

The ancient ritual was designed to pass the children into the “heat” of adulthood with a sexual act. In the past, when girls would reach puberty at the age of fifteen or sixteen, it was a selected future husband who would often carry out the ritual. Now though girls reach the age of menarche much younger and the sexual initiation happens with a male “sex worker” regardless of the age of the

menarcheal girl. Following Butler's report, the President of Malawi Peter Mutharika ordered an investigation into this sexual initiation practice. In a statement he declared that

"All people involved in this malpractice should be held accountable for subjecting their children and women to this despicable evil" (Butler, 2016).

#### FROM ANOMOLOUS TO MAINSTREAM

The government of Malawi must be seen to be responding and reflecting a change in the way that society at large regards women and girls. Notably in the twenty first century there has been a move away from younger women readily adopting the cultural and traditional practices of their older female relatives and ancestral fore-bearers. One of the ways to achieve this is in the way in which mothers encourage their daughters to talk about their menstruation. Even in an age where menstruation is on a wider platform less of a taboo subject, in many cultures, in the home it is deemed wise not to mention it. In 2015, a cross-sectional survey, "Menstrual patterns and disorders among secondary school adolescents in Egypt" (Abdelmoty et al.) began with a questionnaire that was sent out to 800 post-menarcheal Egyptian adolescents. 438 students completed the questionnaire, with 262 declining to participate. The overall response rate of 51.5% was

"considerably low compared to other studies. This was mostly due to mothers and girls refusal to participate and is related to cultural menstrual taboos – that menstruation is "dirty," that it must be hidden and should not be discussed in public" (Abdelmoty et al., 2015: 74).

The authors stress the need that girls seen menstruation as a maturational event rather than a hygienic crisis that is shameful. Furthermore, with the results of the study being consistent with others reporting a higher than expected prevalence of menstrual disorders, the study highlights a need for re-education by schools and health specialists.

Across the globe, it is estimated that every month two billion women bleed. It is widely known that around sixty percent of girls in developing and third world countries miss school when they are menstruating because of the stigma attached to menses and because practically speaking they do not have sanitary wear. But in the UK too, for example, girls are skipping school because they don't have the money to buy pads or tampons. Sara Barrie, safer schools officer for West Yorkshire Police discovered that the girls who were truanting were from low-income families and sanitary wear was far down on the list of priorities. An eleven year old girl told BBC Radio Leeds (March 2017)

“I wrapped a sock around my underwear just to stop the bleeding, because I didn't want get shouted at...I once Sellotaped tissue to my underwear. I didn't know what to do” (BBC Radio, 2017).

Barrie contacted the UK-based organisation freedom4Girls, which provides sanitary products to girls and women in Kenya. There are many organisations and charities that work to de-stigmatise menstruation. Websites like the Museum of Menstruation posts a whole array of information on menstrual activism. I recently saw a post by university students from Bangladesh who were creating biodegradable sanitary pads made out of water hyacinth. The Society for Menstrual Cycle Research organised conferences such as “Making Menstruation Matter.” Mass media can be used to impart information on menstrual health to young women. It is a powerful tool that can reach and connect opinion from around the globe. It can expose more fully the generational shift in opinion with women today being more vocal in their protest and campaign for the rights of young girls and women.

In all transformative processes, it takes time for what was once anomalous to become accepted as the norm. In the most recent of times we have seen the promotion of a much more positive regard for choices that would have once been abhorred and delineated as evil and illegal – homosexuality, interracial relationships (which have been fully legalised in all US states since 1967 thus testifying to the fact that they needed legalising as if somehow wrong and anomalous in the first place).

What then do we do with an anomaly? Anthropologist Mary Douglas writes

“Negatively we can ignore, just not perceive them, or perceiving we can condemn. Positively we can deliberately confront the anomaly and try to create a new pattern of reality in which it has a place” (Douglas: 1966: 39).

In a short space of time the word transgender has become mainstream. That someone could “be” born into the wrong body is currently a statistic of one in ten thousand young people but the word transgender is common place in our language today and is slowly filtering into our daily lives via the media. The cover story in *The Sunday Times Magazine* in November 2016 ran the headline “Mummy, I Don’t Want To Be A Boy Any More – Inside Britain’s Clinic For Transgender Kids” (France, 2016). It might not yet be acceptable by many as normal, but it is no longer defined as anomalous for it is no longer hidden. The Gender Identity Development Service at the Tavistock and Portman NHS Trust is Britain’s only multidisciplinary clinic specialising in children who question their sex. Eighteen years ago when it began it received thirty referrals a year. In 2016 around 1,419 children were referred by their GP to the clinic. About 80% who come to the clinic before adolescence change their mind and 80% who come during adolescence do pursue ex reassignment. The difficulty is trying to assess if the gender dysphoria “is real or an obsessional fantasy” especially with the body clock ticking, things can get emotionally fraught as menarche is in site. To prescribe cross sex hormones leaves these teenagers infertile. Critics of the clinic suggest that we as a society should consider not that girls want to become boys but that they don’t want to become women. In other words, it’s about physical changes representing the extent to which one fits in and feels accepted by others. Of an eleven months’ Surveillance Study of Gender Identity Disorder in Children and Adolescents aged between 4-15.9 years in the UK and Republic of Ireland, forty five percent of the 105 cases (56 males) had been victims of bullying requiring school attention. There are high levels of psychiatric co-morbidity at presentation: Depression (n=19) anxiety (n=13) Asperger Syndrome / autistic spectrum disorder (n=17) and previous self harm (n=35)

Conversations about menstruation are increasingly becoming commonplace but many Trans people feel left out of the binary discourse of menstruation. Despite the argument that uses de Beauvoir's famous quote "One is not born, but rather becomes a woman" (de Beauvoir, 1949: 9), many transgender people feel excluded from the conversations taking place in many feminist movements who regard transgender people as atypical with no real experience of what it's like for "real" women. There was uproar when Dame Jenni Murray wrote that it takes more than a sex change and make up to be a woman. To support her argument in "Be Trans, be proud but don't call yourself a "Real Woman"" (Murray, 2017), the journalist and broadcaster interviewed trans women who claimed that they still felt like men because of the male traits and habits engrained in them. Analysing de Beauvoir, Murray wrote that the feminist plight was about gendered socialisation and the life experience of women who are put upon to fulfil the societal template of what a woman should be, think, do, say or feel.

From another perspective, trans people feel that they too have been unable to find the right voice that puts into words the experiences for them. The experience of menstruation is a significant one, as essayist Morgan Jerkins describes:

"While anyone of any gender who menstruates can establish a rapport over mood swings, blood flow, and exhaustion, trans and gender-nonconforming people have specific needs around menstruation that often go unheeded. Only when we take the steps to hear others' stories about the violence — both covert and overt — that they experience due to their periods will we be able to truly begin transforming public perception" (Jerkins, 2016).

In the US there are about 700 000 transgender people, and half of them identify as male but have female bodies with reproductive systems and menstruation. They are increasingly visible as a new component in the Feminine Hygiene Market currently worth \$15 billion dollars. For an article in *Forbes Magazine* "Period Panties Answer: What Do Trans Men Do About Their Periods" (2015) Emma Johnson interviews trans male DeVuyst who says that having periods is unsafe. Afraid of being outed, he considers himself a possible target for violence.

“Here I was trying to live a life as a trans man, yet I had my period every month. I’d be in the men’s bathroom with guys around me peeing while I changed my tampon. It made my discomfort with my body that much worse” (Johnson, 2015).

Whilst homosexual men are now recognised as a risk group for eating disorders, the research for those who are transgender is still scarce. The general view is that for trans men the desire is to suppress that which is a sexual characteristic of womanhood such as the shape of the woman’s body and her menstruation. Weight restriction will take away any connotation of feminisation (Hepp & Milos, 2002). Interestingly, following a study of identical twin boys who both developed anorexia, the conclusion was that gender dysphoria did not cause the eating disorder. One of the twins considered himself to be gay and one identified as a straight woman. It was more about their start in life: they were underweight at birth and needed intensive care, they both had developmental delays and both suffered trauma from being with an abusive father. As the authors noted

“GID in childhood could be at least partly hereditary, whereas the development of the later phenotype of the gender identification is more determined by environmental factors. GID might be a risk factor for the development of AN” (Hepp, Milos & Braun-Scharm, 2004: 239).

In my mind, this type of research and analysis supports the view that we need now more than ever to consider what “the other” means to all of us individually and collectively. I believe (and will go on to illustrate) that psychoanalytic, psychodynamic psychotherapy can be a useful resource in getting beyond the presenting problem to access what’s at the heart of the patient’s trauma; to locate the place of anxiety and distress, what parts in all of us do we resist, detest, split off even protect as that which is not me nor belongs to me. Whilst this “talking cure” is designed to assist the patient towards better health, I believe this kind of therapy is reparative in a much wider context. It addresses a nation’s trauma and dis-ease. By speaking about, promoting and engaging with the mental health of individuals, societies will themselves benefit from the reparative work and progress that is made. Perhaps all those split off parts in ourselves and in our

group dynamics might come together to create something much more integrative and whole. As it is clear from what I have documented so far especially in the political, social and cultural arenas from ancient history to our present day, we all need it, even if some resist against it. It is precisely this fragmentation that has allowed for the depth of toxicity to spread, no more so than in political acts of fascism and in acts of Genocide.

In the next chapter I will look at the way in which the ideology of Nazi Germany created “The Other” who was scapegoated as the carrier and contaminator of filth and disease. Central to this ideology was the split between pure and impure blood. The menstruating body of the Jewess was powerful and dreadful. The Third Reich told the nation that to make Germany great again, there was only one thing for it, extermination. The anomaly of the Jewess is more than a threat. She breeds like a rat and according to the Third Reich doctrine of racial cleansing, she must be done away with. To all those who read this thesis, may they remember these women and the violence that genocide breeds.

## CHAPTER THREE

### NAZI BLOOD IDEOLOGY, THE MENSTRUATING WOMAN AND WAR AMENORRHEA

The ideology of German nationalism was constructed on a body of metaphors; the body, genealogies and blood being central themes. As described in Hinton's excellent compilation of papers entitled *Annihilating Difference – The Anthropology of Genocide* (2002)

“Nationality is imagined as a “flow of blood,” a unity of substance (Linke 1999a). Such metaphors are thought to “denote something to which one is naturally tied” (Anderson 1983:131)” (Hinton, 2002: 230).

By 1933, it was race that was more important than religion, language or birth. Race / blood was the precondition for membership into a “social speciation” (Erikson, K. 1996 cited in Strozier & Flynn, 1996: 55). The Third Reich retraced their steps back to the Germanic people from the Paleolithic period and through this bloodline a reconnection and a reawakening to a genetic superiority was on which they built their Order. Nationhood was represented by the corporeal imagery of blood and bodies and in terms of racial hygiene, blood was a marker of difference. Like dirt, disease and excrement, impure blood had to be got rid of. This ideology legitimised elimination. As South African sociologist Leo Kuper writes,

“massive slaughter of members of one's own species is repugnant to man, and that ideological legitimisation is a necessary precondition for genocide” (Leo Kuper, 1981: 84).

Hitler, in his earlier decrees, had cited the law in many American states that supported sterilisation of various physically and mentally ill people. These Western countries were working out ways to produce a lean, mean productive machine. The Third Reich added an extra dimension in that anyone who was not

eligible to classify themselves as citizens of the Master Race was to be killed. Isabella Leitner writes in *Fragments of Isabella: A Memoir of Auschwitz* (1978),

“the Germans were always in such a hurry. Death was always urgent with them - Jewish death. The earth had to be cleansed of Jews. We didn’t know that sharing the planet for another minute was more than this super-race could live with. The air for them was befouled with Jewish breath, and they must have fresh air (Isabella Leitner, 1978: 30).

The threat of contamination from an impure race, which could spawn impure offspring, was to be done away with.

“It was the Nazi view of all women as cell-bearers that condemned Jewish ones. Even within the lowest life-form - the anti-race - women ranked lower still, for spawning it. In Hitler's cliché "Every child that a woman brings into the world is a battle, a battle waged for the existence of her people." Because women in their biology held history, one gestating Jewish mother posed a greater threat than any fighting man. To be father to a child had no impact on selection. To be a mother in fact or in future - that was the final sentence (Felstiner, 1994: 207).

And so the crude selection process ensued. We have many accounts of this. Sometimes they are recollected and retold in newspaper articles intended to reach a wide and diverse mix of readers. “Pregnant in Auschwitz: Toronto Holocaust survivor recalls split-second decision that saved her and unborn son” (O’Connor, 2012) reads as follows:

“Miriam Rosenthal was four-months pregnant, starving, bone-tired, cold, filthy and afraid when an SS officer in big black boots and a crisp uniform appeared before the barracks in Auschwitz with a loudspeaker in hand.

“All pregnant women line up, he barked. Line up, line up — your food portions are being doubled.”

“Can you imagine?” Miriam asks. “Even women who were not pregnant stepped forward. I was standing with my younger cousin, but I wouldn’t go. She says, ‘Miriam, what are you doing?’ ”

“Something was holding me back. Someone was watching over me. I feel maybe my mother, maybe God. Two hundred women stepped forward and 200 women went to the gas chamber. And I don’t know why I didn’t step forward” (O’Connor, 2012).

More women than men were the first to be selected for extermination not just because they were deemed less useful workers than men but because they were the “perpetuators” of the Jewish “race” (Rigelheim, 1998: 348). Most research experts on the Holocaust agree that gender difference was significant in the selection process. Some say that a woman’s sex was the criterion, for what we “know” was an arbitrary, illogical, random selection process. As historian, writer and author of *To Paint Her Life: Charlotte Salomon in the Nazi Era* (1994) Mary Lowenthal Felstiner writes,

“What helped make the Final Solution a novum—a “new thing” in the history of humankind—was not the open all-male propaganda against a Jewish race but the stealthy intentional murder of a Jewish female sex. Once we see that women did not die of inborn physical frailty—for they lasted longer than men in the Lodz and Warsaw ghettos—then the issue becomes clear. Along the stations toward extinction, from arrest through transport to selection, each gender lived its own journey. It was the weighting of each stage of the Final Solution against women that counted at the end” (Felstiner, 1994: 138).

It is important to note here that Ravensbrück camp, the only concentration camp built just for women prisoners, is anomalous to the Holocaust story on gender selection. This was a camp that had been created for the “deviant.” Prostitutes, lesbians, political prisoners, communists, socialists, criminals, the infirm, those who had violated the racial hygiene laws etc. who were women were arrested and sent to Ravensbrück. Some were Jewish but it was the political affiliations that these women had that appeared more of a threat to the Nazi state. It has been argued that their race and their gender were secondary. In terms of gender, much of what happened to women at Ravensbrück took place at the other camps to both women and men, such as the experiments to test cures for gas gangrene by creating open wounds and infecting them with grit and glass.

Some women at Ravensbrück were trained up to become guards at other camps, others were sent for immediate selection. Olgar Benário Prestes, a Jew and a communist along with Austrian socialist Käthe Pick Leichter were among 1,600 women who were gassed over the course of a few days. They identified themselves and were identified as political prisoners. They were also in that camp as Jews and one should not overlook this, no matter how significant the politics were. Whilst Ravensbrück does attest to the heterogeneity of Nazi crimes and the indiscriminate violence, the survivor accounts from this camp and others allows us to bear witness to the attack on the female Jewish race.

As more female survivors came forward to recount the stories of life in the camps, it became clear that there were differences in experience between men and women: To use Myrna Goldberg's essay title: "Different Horrors, Same Hell" (Goldberg in Gottlieb, 1990). Until the incorporation of female voices into the catalogue of Holocaust literature, the remembering of the Holocaust was incomplete. Much of the male writing approaches the question of what happens when reliable links such as nationality, language, religion, culture, political affiliations and economic status break down and when man is reduced to an animal state. As Brener explains in his MA Thesis, "An investigation into the Intergenerational Transmission of Holocaust Effects in South African Survivors" (Brener, 1993),

"both the group and personal identity of the individual were undermined through the process of dehumanization in the camps, and through the loss of communities, heritage and culture. The estrangement from self and identity impairment, leads to severe identity problems (Niederland, 1968, Davidson, 1980a, Kestenberg, 1982). Simultaneously, the elimination of shame boundaries, privacy and deindividuation serves to erode higher ego functioning. The loss of anticipated environmental reliability, the occurrence of senseless events and lack of causality in the camps is threatening to the ego and can lead to the breakdown of internal reality (Brener, 1993: 9).

A lot of analysis focuses on idealisation, ways to restore the damaged self, guilt and reparation. After liberation, the defences used in the act of survival in the

camps remained in place such as automated ego functions, denial of loss and undifferentiation between past and present. Survivors of the Holocaust such as Bruno Bettelheim found meaning and understanding in characterising the behaviour of inmates by linking them to different stages of infantile behaviour stating that the inmates had regressed to such states. For example, Bettelheim wrote of the concept of oral regression and fixation as a formula linked to the well fed child. But critics write:

“A preoccupation with food when one is hungry is not regression. It is the body’s attempt to remain alive” (Grossman 1989: 220 cited in Brener, 1993: 11).

Furthermore, child like behaviour is not the same as strategies for survival,

“the former entails passivity and a preference for illusion; the latter demands intelligent calculation and a capacity for quick, objective judgement” (Des Press: 151-152 in Brener, 1993: 11).

Bettelheim (1952) wrote that surviving entailed selfishness, egocentricity and isolation but we know that the women formed social networks and groups. They would tell stories, recite poetry, share recipes and so on. For some women who had lost their relatives, this communal sharing created replacement camp families. On many levels, the experiences for women were different from men.

“That exploration and emphasis should occur not because women's voices are necessarily clearer or better than men's—though in many individual cases they are—but because they are women's voices reflecting on their own particular experiences in ways that no one else can do for them. The need, however, is not just to let women speak for themselves. Of equal, if not greater, importance is the need for them to be heard” (Rittner & Roth: 1993: 38).

Zoë Waxman’s “Unheard Testimony, Untold Stories” (2003) questions why it is that much of the literature, as she reads it, concurs with

“preconceived gender roles, patterns of suitable female behaviour, or pre-existing narratives of survival” (Waxman, 2003: 661).

Waxman wonders if historians have overlooked the accounts of the “full horrors” of experience such as women choosing their own life over their child’s or women becoming Jewish kapos? Sara Horowitz similarly argues that following one interpretative stance “erases the actual experiences of women and, to an extent, domesticates the events of the Holocaust” (Horowitz, 1994: 265).

The horror began long before these women reached the camps and it was the biological functions of the body that threatened to damage the increasingly fragile sense of self. In the trains that took them to the camps the pail overflowed with urine and waste. The stench was immense. The women, once embarrassed about urinating or defecating in front of others could no longer control their bladders or bowels. Women who were menstruating on the trains could not change their pad. The stench too of dead bodies on the trains created a toxic, hostile environment. But one of the most traumatic events that the women had to endure took place once they got off the trains. Remember too, many of them thought they were being transferred to ghettos and they expected to be reunited with their belongings and with their loved ones.

Having disembarked from the trains the women were forced to undress for the first selection process. This was for them one of the most traumatic of “gender-based wounding” (Horowitz cited in Ofer & Weitzman 1998: 336). Enforced nudity continued on for those that survived another day. A person’s clothes and possessions were taken away. They were given a number tattooed on their bare arm. It was the compulsory nudity, the attack on a woman’s modesty and privacy not just in front of the male guards but amongst one another, and importantly amongst the different generations of women (many from the same family) that devalued the female prisoners. If they became acclimatised to being subjected to undress then eventually the task of maintaining ones dignity was replaced by the task to survive. As survivor Guiliana Tedeschi writes:

“At that time women cared more than nowadays about physical discretion, body care, even about the aesthetic details of their garments, and they could not reveal their nakedness without being traumatised.” (Tedschi, 1995: 13-14 cited in Miglianti, 2015: 44).

Tedeschi’s “Qeusto povero corpo” (This poor body) recounts the sense of shame “purdore” that women in Auschwitz felt as that which represented the dreadful subversion of all that these women had once known. Their modesty, self-protection and sense of shame were attacked and they were raped of their psychological structures and defence mechanisms.

Naked, they were then made to have their hair sheared. Hair was a symbol of sensuality, beauty and femininity amongst the Jews. Having their heads shaved transformed these women into a likeness of man. Many of the accounts are written in such a way that they speak the language of an asexual, universal voice. As Bitton-Jackson writes:

“The haircut has a startling effect on every woman's appearance. Individuals become a mass of bodies. Height, stoutness or slimness: There is no distinguishing factor—it is the absence of hair which transformed individual women into like bodies. Age and other personal differences melt away. Facial expressions disappear. Instead, a blank, senseless stare emerges on a thousand faces of one naked, unappealing body. In a matter of minutes even the physical aspect of our numbers seems reduced—there is less of a substance to our dimension. We become a monolithic mass, inconsequential. The shaving had a curious effect. A burden was lifted. The burden of individuality. Of associations. Of identity. Of the recent past. Girls who have continually wept at separation from their parents, sisters and brothers now began to giggle at the strange appearance of their friends...When responses to names comes forth from completely transformed bodies, recognition is loud, hysterical. Wild, noisy embraces. Shrieking, screaming disbelief” (Bitton-Jackson, 1984: 79).

The assault on their exterior was followed by one of an internal nature; one that attacked their body and their psyche. It was the attack on their associations to

reproduction. Most prominent in female testimonies are issues surrounding reproduction. This was a matter that plagued them. Identity for women of this time and in particular Jewish women was very much linked to the body and its function as child maker. The mind was aligned to the tasks of motherhood and homemaking. The attacks on the body were attacks on self-image and identity. Having stolen everything from them, the Nazis also took away their procreating rights. As Marlene E Heinemann explains in *Gender and Destiny: Women Writers and the Holocaust* (1986),

“Because mothers were especially threatened and because a future for European Jews seemed unlikely to many camp inmates, narratives tend to place a high value on motherhood and fertility. In the context of mass death and compulsory sterility the association of women with reproduction and the preservation of life gives them unique torments and, sometimes, forms of resistance” (Heinemann, 1986: 34).

Women had to deal with issues of pregnancy, abortions, gynaecological internal examinations enforced upon them by the prison staff, amenorrhea and infertility. Women (particularly in the uniquely female environment of Ravensbrück, but also in the vast majority of cases at Auschwitz) were subjected in the early period of their camp experience to gynecological examinations. Male prisoners were also inspected but such experiences were less invasive. Women were usually examined without basic hygiene precautions. Vaginal examinations, often done to check for hidden valuables, were regularly done using the same glove or disinfected instrument. Infertility would result from such invasions as they did from the forced “surgical” sterilisations and other experiments by SS doctors such as the removal of the ovaries. There are testimonies of chemical substances such as bromide and saltpeter being put in camp food to suppress fertility and menstruation. Bitton-Jackson relates the panic amongst the women upon learning of the bromide apparently secreted in their food for sterilisation purposes:

“With amazement we all realized that menstruation ceased in the camps. The first week after our arrival there were many menstruating women...then menstruation

ceased abruptly. There is bromide in our food we are told by old-timers. Bromide is supposed to sterilize women. The Germans are experimenting with mass sterilization” (Bitton-Jackson, 1984: 80).

As it is difficult to find Nazi documentation attesting to this policy and as not all inmates experienced an interruption of menstrual cycles most experts call this evidence inconclusive. No one has been able to say in truth that they saw the chemicals being administered and put into the food. As Anna Jellyman (2012) interprets it in her doctorate “French women and Nazi concentration camps. A study of the testimonies of French female survivors,”

“the concept of mass sterilization via food was in all probability one more product of the active rumour mill which is stressed in so many testimonies. This does not, however, render it any less significant as a feature of the reality of women's concentration camp experience, given that women's belief in the existence of such a systematic structural approach was instrumental in defining their experience and therefore in determining the female testimonial emphasis” (Jellyman, 2012: 23).

We can see this paralleled in an account from BenEzer's *The Ethiopian Jewish Exodus - Narratives of the Migration Journey to Israel 1977 – 1985* (2002).

“In the course of the narratives many of my interviewees recalled that pieces of metal and of poison were inserted into pills (and other medications) given to Jews in the refugee camps in Sudan. This had been done, the interviewees explained, by the Sudanese workers in those camps, causing the death of Jews. While this is not recorded anywhere else, and most probably was not a ‘reality’ of the camps, it is nevertheless a perceived reality, a psychological one (BenEzer, 2002: 43).

BenEzer links to the work carried out by Debórah Dwork whose interviews with Holocaust “survivors” showed that many of them firmly believed that their food had been poisoned. Dwork records that the answers to “Do you think a chemical was added to your food?” were answered differently, unreliably, questionably and

inconsistently although the overall response was of belief in that it happened. Dwork changed her question to "Why do you think the Germans would have added such a chemical to your food?"

"The women's answers were clear and unequivocal, and nearly identical. Even if the Germans were to lose to war, the women said, and even if each individual speaking survived, the poison she had eaten would prevent her from ever conceiving children; thus the Jewish people would die out sooner or later...This construct rationalized their experiences...Thus, if a girl ceased to menstruate she understood this phenomenon within that context, that was the truth" (Debórah Dwork, 1991: xxxvi).

Amenorrhea represented a real threat to a woman's societal role robbing her body of its specific biological function. This then threatened her sense of self and her identity both on a physiological and psychological level. It was a long-term concern. Short term though amenorrhea did in some instances protect women from the horrific lewd jokes of the guards who laughed at the uncontrollable menstrual flow. The guards would often too beat these women up for making a "mess," the free flowing blood "...run[ning] down their legs like animals." An anonymous survivor remembers: "In order to retain the cleanliness of [the block], the Kapos beat the women [who menstruated], and force[d] them to clean their traces. Yet another denigration, another misery."

The flow of menses is reported to have been humiliating. There were no sanitary towels or suitable undergarments nor was there available water to clean off the blood that ran down their legs. Rena Kornreich Gelissen was transferred from Auschwitz where she had used newspaper scraps as sanitary wear to Birkenau where no such scraps existed:

"Once a month my period arrives without any prior warning. It is something I dread and wait for, never knowing when it will make its appearance. Will I be working? Will I be in the shaving line on a Sunday, embarrassed in front of the men? Will today be the day that I cannot stop the flow and the SS decide to beat

me to death for being unclean? Will today be the day that the scrap that I find gives me an infection?" (Kornreich Gelissen, 1995: 104-105)

Despite this, those who menstruated on the whole counted themselves lucky because it assured them of their continued fertility. The relief though was unhinged by the envy of female prisoners whose menses had stopped. Amenorrhea was the separating factor between the feminine and the defeminised. As an unidentified survivor of Ravensbrück stated, "It hurts, not to have these monthly days, one doesn't feel like a woman anymore, one already belongs to the old ones!"

This was one aspect to life that haunted many of those who survived the camps. Based on a study of 547 Jewish women freed from concentration camps and discovered at an industrial plant in Lenzing, Austria, Bloch recorded that personal rehabilitation was boosted by an improvement of the outer physical form. 'I want to be a woman again' was an expression of longing for the return of normal and natural menstruation. Writing in the American Journal of Sociology Bloch's paper "The Personality of Inmates of Concentration Camps" (1947) showed that

"The records display a constant morbid preoccupation with the destruction of the family and isolation from the rest of the world. There is strong evidence of traumatic shock, excessive apathy, an intense desire for survival, profound insecurity, and fear" (Bloch, 1947: 336).

Bloch witnessed amongst this group of people, who had been thrown together in barrack style communities, a "crude and rudimentary form of life" (Bloch, 1957: 335). They couldn't be further away from the levels of sophistication and education that they had boarded those first trains with. There was nothing as yet sophisticated in their continued existence. They were the "living dead."

In contrast, post war reflection by the Germans was built on the vigour and the energy of reinstating values of normativity, amnesty and (re) integration (Frei, 2002). Germans came to see themselves as victims of war and Nazism, not the perpetrators.

“In this manner, the perpetrators of genocide were associated with the destroyers of Germany, while the Jewish victims were associated with German victims, without, however, creating the same kind of empathy” (Bartov 1998:790 cited in Hinton, 2002: 233).

Their message was that they had all suffered an assault on human dignity and it was the use of the body as a symbol that came to represent the atrocities of the past (Linke, 1999). Leftist political protests of the 1960s reclaimed the body through demonstrations of public nakedness. The horror of the Third Reich was exposed, people were being reminded of the legacies of genocide but so too the protestors were portrayed as victims, burdened by shame, wishing to be free. They took pictures of themselves reclining naked and liberated on the manicured lawns of Munich. But in these pictures were clothed immigrants and refugees, a sign of the myth of a re-emerging pollutant. The concepts of dirt, urine, faeces, menses and blood were embodied by these clothed figures that shared the same space as the sanitised German naked people. They spoil the picture.

*In Male Fantasies* (1987), Klaus Theweleit explores the symbolic power of fluids. He examines the writings of men in the Freikorps in Germany:

“They vacillate between intense interest and cool indifference, aggressiveness and veneration, hatred, anxiety, alienation, and desire” (1987: 24)

It was from the springs of human desire that led a man to be part of the fascist movement. The acts of terror were driven by this unbridled desire. Faced against the threat of communism, emblematic of immersing blood, the soldier must not let in and he must not let out:

“For the soldier-male dam, none of the streams...can be allowed to flow. He is out to prevent all of them from flowing: “imaginary” and real streams, streams of sperm and desire... All of these flows are shut off; more important, not a single drop can be allowed to seep through the shell of the body” (Theweleit, 1987: 266).

Fluids are unpredictable in their nature and potentially dangerous with the capacity to engulf the other. But the most dangerous of all is the menstrual blood of a woman. Even though her menses means that she is not pregnant, therefore not a societal contributor but instead just a bleeding vagina, she is nevertheless unpredictable, untrustworthy, conniving and carnivorous. She can create life. She can abort life. She can kill life. And to the Third Reich it is the Jewess, the spellbinding witch, who is the “threat that is absolute” (Felstiner, 1994: 151). Male rational, ordered domination will hunt down and eradicate irrational, mystical femininity. To expunge the nation of a woman’s blood, to have a misogynist military that can control menstruation for its dangerous qualities became a vision of fascism. As the headline for Der Spiegel’s review of Theweleit’s work shouts out in print: “Women flow, men shoot” (Bielby, 2012).

#### POSTSCRIPT

In researching war amenorrhea and the prevalence of secondary amenorrhea in cases of stress, separation, trauma and conflict, I came across papers that cited the works of Hermann Stieve. Stieve was the chairman of the Anatomical Department of the University of Berlin from 1935 to 1952 and was one of the leading anatomists of his time. He studied prisoners condemned to death to consider the ways in which chronic stress impacted on their reproductive organs. Having studied male subjects up until 1933, after that time he used the bodies of executed women during the Third Reich to expand on his research (Winkelmann & Schagen, 2009). The “material” he gathered for publication focused on data such as the menstruating or amenorrheic status of these women. He also gathered information on the menstrual cycle of incarcerated women in the Women’s Prison Barnimstrasse to study the way in which stress would interrupt their cycles. Stieve’s work is starkly conclusive. He found a one hundred percent rate of amenorrhea on young women condemned to death with total gonadal atrophy at autopsy after five months of incarceration. Many refer to his work exploring the correlates between the “symptom” and the cause but of course there is the huge issue of ethics here, so violently violated by Stieve and his fellow men. With this in mind, I want to cite a paper in *Clinical Anatomy* by Sabine

Hildebrandt called “The Women on Stieve’s List: Victims of National Socialism Whose Bodies Were Used for Anatomical Research” (2013). Hilderbrandt begins:

“Bronislawa Czubakowska, Herta Lindner, and Libertas Schulze-Boysen, all had one last wish on their day of execution: they wanted their bodies to be returned to their mothers. Instead they became subjects of anatomical research and were denied a grave of their own” (Hilderbrandt, 2013: 3).

The real ethical problem is that these studies are of nameless, voiceless women. Hilderbrandt wants to correct this and in her paper she writes about how important it is to identify the persons behind the bodies. In describing their age, nationality and reason for execution she shows a range of personalities and stories behind the women who were recorded by Stieve the first time round often with mistakes and omissions. Hilderbrandt quotes Snyder

“It is for us scholars, to seek these numbers and put them into perspective. It is for us humanists to turn the numbers of people back into people” (Snyder, 2010: 408 cited in Hiderbrandt, 2013: 4).

In writing this chapter I have wanted to reprint some of the witness accounts. But this is no easy task when one considers the elasticity of language. I was mindful of what Ruth Kluger had written in *Still Alive* (2001),

“the very act of literature betrays what was experienced in the Holocaust: don’t words make “speakable” what is not?” (Kluger, 2001: 11)

We must never lose sight of the enormity of events. It is only from the witnesses that we can grasp any small sense of the experience. As Lawrence Langer enquires in *Holocaust Testimonies – the ruins of memory* (1991),

“Does a self-conscious literary voice intervene here between the experience and the effect, so that language and imagery obscure even as they seek to clarify? Perhaps; perhaps not. But as we examine definitions and redefinitions of self emerging from victim narratives, we must keep in mind that each one of them

represents a combat, more often than not unconscious, between fragment and form, disaster and intactness, birdsong and pandemonium” (Langer, 1991: 129).

## CHAPTER FOUR

### THE BODY BOUNDARY, THE EGO BOUNDARY, NON-MENSES AND PATTERNS OF RELATING IN ANOREXIA AND EATING DISORDERS

#### INTRODUCTION

The torment of the paradox described by Langer at the end of the previous chapter we can think about when we reflect on and consider forms of torment to Self. In this chapter we shall consider the pain in Anorexia and Eating disorders. These are often thought of as the body bearers of psychic contradictory states in conflict; two fold systems of submission and resistance. Anorexia, as Becker describes it, is a “confused and confusing opposition of signals” (Becker, 2008: 145).

It is a system of control, differentiation and autonomy. The more successful the anorectic is, the more she disappears. The more she disappears, the more she is seen. I am reminded of the work of poet Louis Glück. Psychoanalysis provided Glück with a frame that could replace the anorexia she had developed from the age of sixteen. She later turned to poetry, perhaps finding psychoanalytic “truths” too abstract and indeterminate to digest. Poetry, like anorexia, focuses on form. In one poem “Widows” she writes about a card game that her mother and her aunt are playing. The aunt wins the game and the final lines of the poem read

“Her cards evaporate: that’s what you want, that’s the object: in the end,  
the one who has nothing wins” (Glück, 1990).

To what extent is the form of amenorrhea a game changer in the developing patterns of anorexia and eating disorders? The following chapter will consider this.

## MENSTRUAL MARKERS

This chapter will consider the position and place of secondary amenorrhea in the identities and subjectivities of women presenting with anorexia (AN) and with other eating disorders, secondary amenorrhea being a key component in these complex systems. In looking at both historic and current analysis on this subject I hope to enable an easy transition into a way of thinking that supports the view that some patterns of relating, as exemplified in this case with food, can serve as a framework in which an autistic mind can find some sort of container. Whilst looking at the most recent research that links eating regimes with autism, might we also consider that the non-menstruating body is itself another way in which an autistic state of mind can find representation? The neat, clean, unblemished, untarnished, consistent attributes of the non-menstruating body can house a psyche that fastidiously demands a body that mirrors a psychical method of thinking that operates with clear and exacting parameters. It's a match made in heaven. But this pathway to heaven, as we see with anorexia, can be deadly.

After much resistance, what we have come to accept more widely now is the fact that eating disorders are deadly diseases. Research into the National Death Index clearly shows that the cause of death extracted from death certificates and the monitoring of crude mortality rates are such that they underscore the severity of all types of eating disorders. A review of nearly fifty years of research by Arcelus et al. in their paper "Mortality rates in patients with Anorexia Nervosa and other eating disorders" (2011) confirms that AN has the highest mortality rate of any psychiatric illness including major depression.

Important conversations are constantly taking place as to what are the most effective ways to treat anorexia, bulimia, and other eating disorders. Researchers are rightly challenged to validate their mathematical data with narratives, placing the issues in the wider context of mental as well as physical health. Often conflicting and contradicting evidence emerges but most experts agree that a patient treatment plan that includes offering psychotherapy or a talking therapy is best practice. One of the linchpins in the success of the

psychotherapeutic model is that an alliance is formed between therapist and patient,

“not an alliance designed to control symptoms, but an alliance designed to understand the emotional meanings of the patient’s verbal and somatic expressions” (Levin, cited in Siegal, 1992: 48).

In “Somatic Symptoms, Psychoanalytic Treatment, Emotional Growth” (1992), Ronald Levin comprehensively illustrates the alliance by presenting a case study of a twenty two year old suffering from seizures and an eating disorder. He introduces his chapter with a firm position on the fact that a technological treatment approach can actually be harmful.

“Technological medical care leads caretakers to conceptualize physical and behavioural symptoms as disease, while overlooking the level of emotional development of the patient; the unconscious meaning of the patient’s words, actions, and somatic processes are also ignored...patients treated technologically often do not develop emotionally. Conflicts remain unresolved and actively contribute to symptoms” (Levin 1992 cited in Siegal 1992: 44).

Perhaps the patient also needs to experience the therapist as someone unafraid; important when the patient is demonstrating her defiant stance against moving away from the place that she knows might eventually kill her. Perhaps it’s about sitting alongside her on that ledge, however many storeys (stories) up for as long as it takes. I think it’s right and proper for the medics and not the therapists to be concerned with the details of a patient’s weight and other physical indices. The therapist is there to deal with matters of the psyche. Paradoxically they are not there to cathect the bodily state into an emotional one but rather to use the act of interpretation to reach the patient and for them to find a common language. Not just “what are you telling me” but “what are you trying to do to me?” This is a question that acknowledges the severity of the illness and allows room for the exploration of that which supports and that which opposes the illness. We are with that old and crucial adage – Ambivalence.

To serve as an example, a twelve year old, “Rachel” who was an outpatient at an eating disorder clinic was presenting with very erratic eating patterns. After a couple of menstrual cycles, her periods stopped altogether. Neither anorexic nor bulimic with no clear plan or execution in terms of dieting, her eating mirrored her thinking. Her emotions were all over the place, as was her eating with swings from days of not eating to days of replenishment and refuelling. The transition from primary to secondary school was the catalyst for her discombobulation and the new social politics and game playing amongst her peers threw her. The process of transition had profoundly upset her. The details of the treatment plan are with the clinic but I was able to speak with Rachel when she was fifteen about what she thought was going on. Her first response was that her experience at the eating disorder clinic made her fear endings because the trainee psychologist who she was working with had left to move on to another placement. It seemed to me that Rachel was demonstrating a healthy dose of narcissism when talking with me. She explained that she and the psychologist had been given a set amount of time together and they both met weekly right up to the end. At the last session, Rachel gave the psychologist a thank you card. With regards to her menses, when I asked her what she felt about her periods returning she replied, “What do you mean feelings? I don’t like how they come back because it meant I was eating enough for it to happen...Is that what you mean?” When I asked what her periods symbolised she replied

“End of cycle, no?...I’m not scared of getting it, I just don’t like how it relates to my weight...The clearing out of your body yes but the weight no” (pers. comm, 2017).

Here we have a classic and useful case of a young woman making progress, more able to hold feelings of ambivalence. That the tension between love and hate, that can be so powerful so as to destroy, is being managed by this young woman is a good thing. In my mind the practice of psychoanalysis accommodates this ambivalence. I think it useful to consider Bleger’s (2013 [1967a]) work that describes the difference between ambivalence and ambiguity. Ambivalence acknowledges that there are contradicting and conflicting associations whereas ambiguity (a pre-ambivalent state) does not allow for

discrimination between several possible meanings existing at the same time. To consider the way in which a patient thinks about her menses is a useful tool in our assessing her capacity to be in a state of ambivalence rather than ambiguity. It might be a useful part of the eating disorder puzzle for therapists to become more acquainted with.

Let's consider the puzzle at large. Puzzle one: Is anorexia a wish to be thin or the repulsion against being fat? – Clue, refer to Bruch (1973). Puzzle two: To what extent is anorexia, like hysteria, a language used by the patient because she knows no other? – Clue, refer to Shoenberg (1975) Puzzle three: How can one ascertain any meaning in the patient's experience when obsessional ways of behaving transform any possible communication into something abstract and beyond the spoken word – Clue, refer to Story (1976) Puzzle four: what are the multifactorial aspects to the aetiology of eating disorders? Clue, refer to Hsu (1983).

What I want to suggest is that the cessation of menses is a clue too often overlooked or dispatched with. It is a relevant and meaningful symbol that partners the eating disorder. However, it is too often engaged with in a concrete way along with the monitoring of the patient's weight and body mass index. When a young girl stops menstruating and when she regains her menses are dates that are noted down as markers at two polar points along a patient's journey, bookending like an entrance and exit. As Specialist Psychotherapist Cynthia Rousso clarified, menstruation is often used as a benchmark indicator to assess a patient's health. At the time of interview (November 2016), Cynthia Rousso was working in The Child and Adolescent Mental Health Service at the Royal Free Hospital in London, UK, one of the largest eating disorder services in the country, with up to 11 referrals a week. Often, even when eating disorder patients achieve their minimum required weight it is only when their menses return that the clinic is confident enough to discharge them. One anecdotal clinical motif Rousso gave me was of young women preparing to go to college or university. They had gained their minimum weight and wanted to be discharged from the clinic but they were being asked to put more weight on to trigger a menstrual cycle. Many agreed to increase the weight incrementally as they

wanted to move on. Menstruation was “a marker of good health.” This compromise and working together between patients and clinicians was a statement of better health reflecting a more developed intra-psychic system more indicative of reality. It goes without saying that decisions are made on a case by case basis as it cannot simply be stated that a return of menses, relating to body mass index and biological variables necessarily means that the patient has recovered completely from the eating disorder. What I took away from my meeting with Rousso and from my observations of the service was that the conversations provided by menses and non-menses on one level acted as a line of discourse, a container and clearly demarked boundary with which the multi disciplinary staff and the patients engaged in the treatment. But to what degree were opportunities to unpack the meaning of menstruation taken? And whilst discharged and free from the clinic, to what degree were some patients really well enough, psychically stable for the long-term challenges ahead of them? A return of menstruation does not necessarily mean a return to better health. More specifically for Rousso,

“while a return of menstruation is a return to better physical health, this does not necessarily apply to emotional health” (C. Rousso, pers. comm., 22<sup>nd</sup> May 2017).

## THE REFERRAL PROCESS

It is widely accepted that early treatment of eating disorders leads to better prognosis (Hay, 2013). However a systematic review carried out in 2011 showed that only twenty three percent of those with eating disorders sought help and most of them did so because they wanted support to lose weight (Hart et al. 2011). In “Stigmatizing Attitudes and Beliefs About Anorexia and Bulimia Among Italian Undergraduates” (2016) Caslini, M. et al. argue that these diseases are still heavily burdened by stigma, which creates social distance between “us and them.”

“Dimensions of stigma in relation to AN and BN are different as compared with other mental health disorders. Although stigma about mental illness generally includes avoidance of social interaction, perceived dangerousness,

unpredictability and poor prognosis...For EDs it mainly involves guilt and blame, personal responsibility and minimizing attitudes regarding the seriousness of the illness” (Caslini et al. 2016: 216).

Out of a study of 10,123 adolescents aged thirteen to eighteen years old in the United States, the majority (73-78%) with eating disorders reported some contact with services providers such as their GP, school services or mental health speciality care unit. However only between 3 to 28% had specifically talked with a professional about their eating or weight problems. This study by Swanson et al. (2011) was picked up by many eating disorder prevention and treatment organisations because it clarified the situation in terms of the difficulties sufferers face to be seen

“whether this is due to denial, shame or stigma, or a lack of recognition of eating symptoms by professionals treating other targeted problems, it shows that adolescents do use services. This suggests possible avenues for prevention and early intervention if recognition could be improved” (national eating disorders association n.d).

In the UK, around 15% of middle aged women had experienced an eating disorder at some point in their life (NHS online) with three in one hundred middle-aged women affected in the last twelve months. Whilst we are increasingly more aware of the prevalence amongst forty and fifty year old women, we also learn that few in this age bracket access healthcare provision, as shown in the study “Lifetime and 12-month prevalence of eating disorders amongst women in mid-life: a population-based study of diagnoses and risk factors” (Micali et al. 2017). The results of this study showed that

“Although some risk factors differed across ED subtypes, childhood sexual abuse and poor parenting were associated with binge / purge type disorders, whilst personality factors were more broadly associated with several diagnostic categories...The evidence that lifetime and active EDs are common amongst women in mid-life, compounded by the lack of healthcare access and treatment,

highlights the likelihood of high disease burden and unmet needs” (Micali et al. 2017).

The key factor is making sure that the experts are alert to this. The advice is reminiscent to that given back in the 70s, for example in Fries’ “Studies in secondary amenorrhea, anorectic behaviour and body image perception.” Fries wrote

“We know that every woman with anorexia nervosa has had a starting point. Thus it is important that physicians, and especially gynaecologists, pay great attention to a history of dieting behaviour and weight loss in women who consult them for secondary amenorrhea” (Fries, 1977).

With this as a backdrop to the referral process, historically amenorrhea has distinguished patients that need to be referred to a specialist eating disorder unit from their thin (but healthy) counterparts. By the time most patients get to the clinic, they are of a low weight. They display a disordered way of relating to food and have individual persistent and strict ideas of the body beautiful. Most have stopped menstruating. This is very interesting because the newly revised, 5th Edition Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (DSM-5) removed amenorrhea as a diagnostic criteria for anorexia, challenging its diagnostic usefulness. Reasons for this included that men have anorexia as do postmenopausal women, some women take contraceptives and some girls are anorexic pre-menarche.

“Amenorrhea does not distinguish between groups on a number of important measures of clinical severity” (Roberto et al. 2008: 559).

The chart review of two hundred and forty inpatients carried out by Roberto et al. (2008) found that 25% of underweight eating disorder patients did not have amenorrhea and in applying the DSM-5 criteria, 36% of female anorexia nervosa patients did not have amenorrhea. The “prognostic value of menstrual status” does impact and complicate the original set of attitudes towards treatment. For example,

“the presence / absence of menstruation does not influence the procedures and the therapeutic strategies used to address the eating disorder psychopathology and behaviors, as well as the treatment of psychiatric comorbidities. Secondly, the inclusion of amenorrhea as one of the criteria for the diagnosis of AN could delay the diagnosis and the beginning of an appropriate treatment” (Dalle Gave et al, 2008: 1293).

In the UK, waiting times for eating disorder units in some areas of the country are up by 120% over the past four years and girls are having to be treated hundreds of miles away from their families. One argument (Dalle Grave et al. 2008) for taking amenorrhea off the clinical criterion is that many clinics are flooded with too many cases that are “not specified.” Surely though, a referral is made by a GP let’s say, because the patient is clearly displaying some character and behaviour traits that are a cause for concern. “Not-specified” cases are imbued with psychic angst and to catch these patients before they slip further away from good health is imperative. For example, if we consider the impact of menarche on the developing body of a young woman, it is widely accepted that this new arrival of menstrual bleeding has the potential to overwhelm. As shown in many studies such as “Time since menarche, weight gain and body image awareness among adolescent girls: onset of eating disorders?” (Abraham et. al, 2009) “menarche and subsequent weight gain appear as a risk factor for the onset of eating disorders” (Abraham et al. 2009: 89).

We can consider this alongside another paper from the Journal of Psychosomatic Obstetrics and Gynaecology, “Assessment of the menstrual cycle, eating disorders and self-esteem of Polish adolescents” (Drosdzol-Cop et al. 2017), which concluded that low self-esteem in adolescents might be a risk factor for eating disorders that can then interrupt the menstrual cycle.

Let us now consider the wider picture. Certain ideas of body image bombarding the young girl motivates her to drive an imposing ban on eating so as to lose weight. This coupled with a weakening sense of self and with low self-esteem can start to erode the body boundary. Consider now that girls are often at this

point transitioning from primary school to secondary school and like Daniel going into The Lion's Den often the motto of survival of the fittest leaves many in a precarious position, injured and scarred. An eating disorder might just be sought as a place of refuge. One example of this comes from my talking with thirteen year old non identical twin girls. Twin A had not started her periods and was upset as she was the last one in her class to do so. Wanting to be like her peers and curious to know what having periods felt like she went with her mother to a specialist. She was told not to worry and to come back if she hadn't started menstruating by sixteen. She did in fact get her first period by fifteen. Twin B, by contrast, had started menstruating at thirteen but her sporadic, non uniformed bleeds with the accompanying weight gain and bloating made her want to lose weight. Desiring a body for herself that was thin and not fat, she stopped eating, stopped going to school and soon developed body dysmorphia, claiming that she could see her legs getting flabbier right before her very eyes. She could feel the fat piling on. Her accompanying aggressive verbal attacks and her physical demonstrations of a young girl at war with herself resulted in her and her twin feeling miles apart from one another for the first time ever. This sense of separation was overwhelming. Additionally, the queen bee of primary school had lost her place in secondary school and she did not have the why nor wherefore to cope with a perceived coup. The eating disorder symbolised the degree to which Twin B was struggling with individuation and it served as a self-imposed exile. She exchanged one war zone for another that she felt she could have more control over. She was referred to an eating disorder unit. After two years of treatment, having escaped the clutches of a severe and aggressive type of eating disorder, she was discharged. Her mother believes it was because everyone in the family kept talking.

I would describe Twin B as a "non specified" case of disordered eating with associated secondary amenorrhea. This patient eventually displayed the capacity to give up her obsession with food and her self-objectifying for a more authentic version of reality. The twins settled into a new pattern of relating and are both doing well. But there is a twist to this tale. It was at the first meeting at the doctor's surgery that the GP wrongly measured Twin B's height set against her weight. The GP put the figure much lower than it actually was, thus causing

alarm and fast tracking the girl to get support from CAMHS. Once the girl was in the system could we argue that this propelled her into an illness that might never have taken shape? What if this was a teenager displaying typical teenage foibles? Was it the GP's anxiety being projected onto the child, the child having to metabolise it all? Was the outcome of this slip two years of misery and heartache for the family or was it on the horizon, caught early, unconsciously so, by the GP?

#### AMENORRHEA – A BADGE OF TRUISM?

Amenorrhea has always been thought of as a central feature of anorexia nervosa, despite revisions of definitions and changes to diagnostic indicators. One of the most important aspects of this is that for many patients secondary amenorrhea is the marker of “true” anorexia. We see this in Karin Eli's paper “An Embodied Belonging: Amenorrhea and Anorexic Subjectivities” (2014). Eli had interviewed twenty three women aged between seventeen and thirty eight, all of whom had anorexia nervosa, bulimia nervosa or sub-threshold anorexia or bulimia. Her study showed that

“Notably, although the participants invoked amenorrhea as a defining sign of illness, they did not cast menstruation as a sign of health, rather, they spoke of their menstrual periods as contradicting their anorexic-identified selves” (Eli, 2014: 1).

Eli, a medical anthropologist, explains that neither menstruation nor its lack were key points to the study and the participants were not directed to discussing it. Nevertheless, eighteen of the thirty-five women volunteered the discussion of it at least once. It was used as a way to help narrate their illness. Whilst amenorrhea indicated the difference between the healthy and the fertile from the anorexic and infertile, which mirrors the cultural national narrative and official diagnosis of anorexia, more significant from the findings was that

“For thirteen of the eighteen women who mentioned menstruation in their narratives, amenorrhea was directly linked to disorder, invoked as a clearly recognizable indicator of illness, and used as a near synonym of anorexia.

Amenorrhea thus became a crucial component in the articulation of an anorexic identity” (Eli, 2014: 10).

Furthermore, in Eli’s study, some of the women’s narratives showed that a return of menstruation did not signify recovery. In fact it frightened some patients into believing that they were getting fat. As one interviewee “Oryan” told Eli, her menstruating body was now “acting in opposition to her will, imprisoning her disordered wish within an unrelenting, deceptively recovered frame.”

Perhaps what is also meant here is that in the either / or tussle there is a middle linked idea of womanhood that is lost. From my scouring of the internet boards I found several posts in a similar vein to “Oryan.” For example,

“When I got my period back, I felt kind of happy at first in a yay-my-body-isn’t-screwed-up kind of way, that went away really fast. It was really hard to cope with the fact that I had to let go of my obsession, and accept my weight, and I also felt like I had lost control. Eating disorders are all about control, controlling what and how much you eat, controlling exercise, and controlling your appetite. Recovery is about letting that go a bit, and for me it was really stressful to eat things without counting calories, and getting my period back was this glaring sign that I had lost most control over what I ate. However recovery is a process, and it does get better” (“emmakatie” posted on [nationaleatingdisorders.org](http://nationaleatingdisorders.org), 2015).

Anorexics often take pride in their skeletal frame and a shift from a split between body and self to something more integrated is a painful and often slow process. The move from early childhood concepts to a more developed way of thinking, characteristic of adolescence, brings with it a more self regulating, autonomous structure. Imbued with the menstrual bleed, the tyrannical system makes way for a conglomeration of variables.

Those that advocate using secondary amenorrhea in pre-evaluation of anorexia nervosa have convincing statistics. One example is a study of forty-four female anorexia nervosa patients who were assessed during a seven day pre-treatment period and the information gathered on their menstrual history showed that

“One half of the patients had fairly regular menstrual cycles before the onset of anorexia. In 23% amenorrhea occurred before and in 14% at the onset of anorexia nervosa before an appreciable amount of weight had been lost; 55% of patients had amenorrhea after the onset of anorexia nervosa (Halmi et al. 1977: 48-49).

In “Studies on Secondary Amenorrhea: Anorectic Behavior, and Body-Image Perception: Importance for the Early Recognition of Anorexia Nervosa”, Hans Fries writes in the introduction that a characteristic feature of AN is the endocrine disorder which is signalled by the loss of menstruation. Analysing the data of several leading research papers Fries shows how secondary amenorrhea is an early symptom (70% of 628 cases) that either coincides with other symptoms such as weight loss and changes in eating patterns or precedes them.

“However most authors have difficulties differentiating retrospectively between the onset of the feeding disorder (i.e., the anorectic behavior) and the onset of weight loss, which causes uncertainty regarding the amount of weight really lost before the onset of amenorrhea. It has been concluded that menstruation ceases early in anorexia nervosa but usually after some real weight loss, which would be in agreement with the hypothesis of a “critical body weight” necessary for the maintenance of regular menstruations” (Fries, 1977: 163-164).

I wonder, even if the GPs pick up something in their patients that causes concern, not just the secondary amenorrhea, to what extent would these patients co-operate? A young girl of twelve would perhaps resist exploring a possible psychological component to why her periods have stopped. A woman with secondary amenorrhea planning to get pregnant would more likely want to explore issues of fertility and her chances of conception. In fact many do consult gynaecologists of their own free will, which is in sharp contrast to women who have been diagnosed with anorectic behaviour who are often unwilling to co-operate with the psychiatrist. Similarly, in a society where future fertility is the goal of treatment, mothers of young girls on wards being treated for anorexia celebrate (sometimes with the nurse staff) the return of menses as the restoration

of reproduction potential (Goldin, 2002). Much is involved in the treatment and care of patients with eating disorders. Whilst the clinicians and dieticians and eating disorder unit specialists are busy providing meal planners and calorie counts and weighing in sessions, hospitalizing and tube feeding, getting consent forms filled in, alleviating the anxieties of other family members etc. etc. the psychotherapists and psychologists are privileged in that to some extent they are free to walk around the disease with the patient and to think about what “psychic retreat” (Steiner, 1993) the cessation of menses offers. They offer an alternative vision for the patient whose eyes are locked onto the same target.

## PSYCHOANALYTIC EXPLORATIONS OF EATING DISORDERS

In an email correspondence with psychoanalyst Christopher Bollas, I was able to glean his thoughts on menstruation and amenorrhea. Much of the detail of our private correspondence cannot be published but beyond the detail, the key theme was of how we reach the anorectic through the “act” of interpretation. Her strategy has been to refuse the newly imposed body thrust upon her through biology. How does the psyche respond to that bodily challenge and how do we then respond to all of that? Bollas wrote in our email exchange

“We” no longer know what a child is. So we do not know the incredible challenge for our self during that era to comprehend the biological demand of adolescence. I totally understand an adolescent boy who feels he does not know how to be a man much less that he wants to be one. I think the pressure on the girl is far greater. Why should she accept the push into menses????

Given all that the means in the eyes of the others?

Why not say “nope, I am staying here and I am prepared to die for it”.

I think that unless we get this basic fact – for both “genders” - we miss the core point.” (C. Bollas, pers. comm., 12<sup>th</sup> Sept 2016).

Many analysts take the approach that if the doctors “deal with the weight” then they can concentrate on trying to reach the patient in the psychic realm. For females, what does a cessation of menses offer the patient? How is the unconscious of the patient using food to feed its own hunger? This type of

exploratory questioning opens up our minds to a broader picture that frees us from the rigidity of the disease and the way that it is treated. The problem with this though is that we now have an exhaustive list of possible interpretations that in more than one way intersect. Here is one such list:

“Eating may be equated with gratification, impregnation, intercourse, performance, growing, castrating, destroying, engulfing, killing, cannibalism. Food may symbolise the breast, the genitals, faeces, poison, a parent, or a sibling” (Minuchin, Rosman & Baker, 1978: 15).

More broadly speaking, bulimia can be interpreted as “an elaborated habitualised impulsive action” (Habermas, 1990 cited in Shipton, 2004: 51). Bulimia is thought to be an unconscious wish for repetitive masturbatory activity and a resolution to some sort of conflict. In “Bulimia: psychoanalytic perspectives” (1986), Schwartz focuses on

“the pathology of early object relations and later intrapsychic conflicts over incestuous impregnation fantasies...and associations with masturbatory conflicts and early adolescent phallic activity” (Schwartz, 1986: 439).

Also suggested in the paper is the theory that some children who witnessed “primal scene stimuli” (1986: 447) react to this by doing to themselves what was done to the parents; in other words sticking a finger down the throat to induce vomiting. I wonder if perhaps the anorectic’s abstinence and fasting represses the greedy monster within who she fears will savage and ravage leaving rotting, bone corpses; an urge suppressed and caged in by her own decomposing skeletal frame? And if there is no trace of blood, symbolised by the cessation of menses, then to what extent are we colluding with the patient on a trajectory of a psychic death if we do not speak of any of this? Why perceive the discussion of amenorrhea as an untouchable? Only through elucidating the language and the meaning of symptoms can we reach the truth of the matter. Papering over the cracks, getting the patient to put on weight or to stop certain behaviour patterns or to agree to follow certain diet and lifestyle plans are no measure and no match for the will of the unconscious mind.

Often the rally cry is that eating disordered patients are concrete thinkers. Many experts advise that psychoanalytic treatment should either start when the patient has put on weight or should even be avoided altogether. They imagine that the silences in the consulting room would be unbearable and annihilating and if many of these patients are concrete thinkers unwilling or unable to symbolise, the emerging out from such a chrysalis could result in damage. But this is only one strand of thinking, perhaps in itself too concrete. I have never underestimated the reparative potential of the analytic rapport. A patient can feel truly empowered.

Issues of power and control are often sited within the idealised, fictitious mental picture of the anorectic. To imagine that she can successfully emerge from her chrysalis requires that we think about the paradox of the way in which her symptoms and her condition both give and deny her control. Her power is both real and imagined.

“For a human being to experience his or her *self* as powerful requires that s/he experience being in the world as meaningful. We can note two significant consequences of this conception of human agency. Firstly, it entails that an increased feeling of power may denote a decrease in actual power and *vice-versa*. In other words, my way of rendering my experience as meaningful may generate an increased feeling of power, yet this may undermine my actual capacity for autonomous agency” (Owen, 1995: 44 cited in Hauke, 2000: 179).

In *Jung and the Postmodern: The Interpretation of Realities* (2000), Hauke refers to Elizabeth Grosz’s book *Volatile Bodies: Toward a Corporeal Feminism* (1994) to emphasise the care needed in analysis when we extrapolate the “I” out from that which is still “tangled up with the “reactive forces in the governance of the body” (Hauke, 2000: 184).

The perilous journey to the realisation of a “speaking I” must take into account the reasons why the body in the first instance served as the choice communicator. I would add that to enable the patient to transcribe and translate that which her body speaks into actual words requires a fluent communicator. But most importantly, the transition requires precision and skill so that the analyst not be

seen as yet another intruder. He needs to be experienced as a benign interlocutor. As Rizzuto explains

“The patient’s most persistent defence is an ever-present attempt to control the analyst. The motive for the defence seems to be to prevent the analyst from making emotional contact with the patient. In fact, if such contact is not introduced very gradually it evokes massive anxiety” (Rizzuto 1988: 371).

When considering this alongside “restrictor or bulimic fat phobia” Wilson warns that

“these patients do not suffer from a lack of appetite but the opposite, a struggle to avoid being overwhelmed by their impulses, including voraciousness” (Wilson, 1988: 443).

It goes without saying that the analyst needs to demonstrate the skill and dexterity to withstand the might of the patient’s pull. Control can be explosive. Impulse (like perversion) can be catchy. As Thomä expertly writes:

“Instead of becoming aware of any positive or negative transference, they try to lure the physician into assuming certain roles. The more successful they are in inducing him to pamper or punish them, the more chaotic the situation becomes. For in “counteraction,” the analyst now represents those very emotional impulses which the patients have to fend off within themselves” (Thomä, 1967: 309).

Perhaps what the patient in analysis wants to know from the outset is who goes first? Where I lead, will you follow? What will the analyst put words to that others have not? How do we help in the transferring of the patient’s taking in of our interpretation from nil by mouth to liquids to solids to then independent feeding as demonstrated by their willingness to challenge the analyst and show willing towards doing it for themselves? Will the analyst be able to get over his own narcissism and offer the patient meat and two veg even though the projective identification instils in him his own ravishing desire to provide a flamboyant sickly rich analysis that could choke them both? Remember, she knows how to vomit it

up and expel it. He might not! It is tempting to get busy interpreting eating disorders and to tidy up the mess, unconsciously displaying a mastering of a technique that can rival hers but the patient, sick of the sight of this, with bolt.

#### AMENORRHEA AS A DENIAL OF FEMALE SEXUALITY

In “The Psychoanalytic Treatment of Anorexia Nervosa and Bulimia” (1988), Wilson illustrates how anorexia is

“an emotional disturbance that emerges as a retreat from developing adult sexuality via a regression to the prepubertal relation to the parents” (Wilson, 1988: 443).

For Wilson, psychoanalysis and psychoanalytic psychotherapy are the treatments of choice because they seek to understand the symbolism in anorexia, which then enables the bringing to the surface of the patient’s conflicts.

One of the most widely held psychoanalytic opinions is that the conflict and confusion acted out in anorectic behaviour represents a deep distress towards maturation and impending hurdles associated with female sexuality. As Freud noted in “From the history of an infantile neurosis” (1918), neurotic tendencies in adolescent and pubertal girls expressed an “aversion to sexuality by means of anorexia” (Freud, SE: 17, 7:122).

Bearing this in mind, it is easy to see how secondary amenorrhea would signify a successful protest against growing up. It fits with the anorectic’s model. “Put simply” says Dr Arcuni, the Admitting Psychiatrist at New York’s Hospital’s Payne Whitney Psychiatric Clinic at the time of interview,

“the child with anorexia nervosa is trying desperately not to grow up. Her body is becoming a woman’s against her will. That’s got to be stopped. It’s more terrifying than the logical fact that if she doesn’t eat, she’ll die; because she experiencing it at a far more primitive level. The problem originated well before the classical Oedipal problems even came up in her life. The damage had really

been done at about 18 months. That's when her development arrested" (The New York Times Archives, 1974).

This implies that predisposition for anorexia nervosa is established when the child is close to the mother, in early childhood. A disturbance in the symbiotic dyad between mother and child can even result in conflict at a young age that finds a place for representation in the eating disorder. As Arcuni illustrates

"It's an extraordinary difficult thing to treat because controls are completely at the patient's disposal. Even in the hospital. For example, it's been quite fashionable at other hospitals to use tube feeding. That might or might not work. I've seen patients get into very bizarre love affairs with the tubes. As soon as you stop the tube feedings, they don't eat" (The New York Times Archives, 1974).

We can continue to think about secondary amenorrhea as a symbol of a girl's resistance to maturation after all, non-menses often means she is exclusively out of that club which is exclusive to women. What I would like to emphasise is the way in which amenorrhea enables a symbiotic union which defends the girl from a deep-rooted and steadfast fear of separation and individuation. Secondary amenorrhea not only assists but (if we transfer across and use here the title from Modell's paper), it provides "a narcissistic defence against affects and the illusion of self sufficiency" (Modell, 1975: 275).

I would like to continue this line of enquiry by referring to *Anorexia Nervosa* (1967), written by German psychoanalyst Helmut Thomä. Thomä was a big advocate of using secondary amenorrhea as a reliable early indicator that anorexia nervosa was more than just a matter of weight loss. His analysis led him to strongly believe that many anorectics were still living unconsciously as though tied to their nursing mother. In one of the "Case Studies", of "Henrietta A", a nineteen year old who had 289 sessions of psychoanalysis over 2 years, Thomä writes:

"Torn between her inability to be a boy and her dislike of being a girl she bolstered up her confidence with a new ideal of sexuality...By denying

“dangerous” aspects of the outside world and by repressing her drives, the patient eventually attained a state of the ego that was free from anxiety...” (Thomä, 1967: 20)

This regression to the magical childlike body that avoids psychobiological maturity brings relief from turmoil and from anxiety. Some connect this repudiation of sexuality with “oral impregnation fantasies” that must be surmounted, as we saw earlier. Unresolved pre-oedipal fixations to the mother arrest the child’s development and sexual and masturbatory conflicts from the genitals are displayed to the mouth with food and eating being forbidden sexual objects and actions (Sperling, 1978: 139-178). Others suggest the issue lies in early dependency needs that were not sufficiently gratified (Fairbairn 1952; Guntrip 1969). Non-menses and the amenorrheic body can serve both as a container and as a symbolic representation of a successful repudiation of psychosexual conflict. It is a display of a successfully crafted rigid, non-erratic, non-erotic body boundary. The body boundary and the ego boundary are in unison with one another. It is an important component in anorexia nervosa, which, as Shalit describes, can be seen partly as

“an attempt at constricting and rigidifying the psychological and body boundaries in order to avoid being penetrated from the outside (unconsciously, by the mother; (see for instance Selzer 1984). The adolescent (girl) closes off, refuses to take in, keeps herself internally pure in order to ward off the intrusion, for instance of mother’s food or feminine identity” (Shalit, 2004: 70).

Shalit reminds us in *The Hero and His Shadow* (2004) that many obsessive and compulsive traits are linked with a rigid ego boundary. This structural containment is found not only in cases of OCD and obsessive symptoms but also in other anxiety disorders. Furthermore, studies that look at these traits in those who have been referred to specialist units for treatment suggest that there is a high prevalence of disordered eating amongst them. There is a paper, which dates from 1962, that brings obsessive behaviour, anorexia and amenorrhea all together. It is Thomas A Loftus’s “Psychogenic Factors in Anovulatory Women III. Behavioral and Psychoanalytic Aspects of Anovulatory Amenorrhea” (1962).

Loftus studied the data of five anovulatory amenorrhoeic patients who had entered or completed psychotherapy. They were aged between fifteen and twenty five and displayed obsessional behaviour. Two had anorexia (one in remission). The analysis of psychodynamics revealed a pattern of the following

“1. Repressed rage at mother as manifested by infantile sadistic fantasies and impulses;

2. Guilty fear, due to the assumed inevitable loss of parental “love and protection” (i.e., gratification of stronger-than-usual dependency needs) through one’s own misdeeds. This guilty fear, in turn, causes further repression and intensification of the aggressive energy absorbed by the non-reporting fantasies of enraged behavior. The developing child finally escapes imperfectly from this vicious cycle by the adoption of exactly opposite traits of gentleness (reaction-formation) or by isolation (obsessional thoughts and actions without the proper emotion). When therapy has been successful, this pattern has been corrected.” (Loftus, 1962: 26).

Four of the five responded to psychoanalytically orientated psychotherapy with spontaneous menstruation. Similarly, in the case studies presented in Engels et al. (1964) (referred to in chapter 1) menses resumed during the patients’ work with the psychiatric investigations. The summary of case study number three (of six) in Engels reads:

“This 30 year old spinster with an obsessional personality, and an 11-year history of anorexia and amenorrhea was diagnosed “emotional anorexia (obsessional).” Her relationship with her family bespoke an unresolved Oedipal complex and a pregenital level of psychosexual adjustment. She sought to avoid conflictual anxiety by renouncing her femininity and its attributes” (Engels et al. 1964: 690).

Similarly, patient five was diagnosed as being “emotional anorexia (obsessional)” with amenorrhea and compulsive dieting coinciding with her sacrifice of a normal life for one in an “ascetic role as a hardworking student nurse” (Engels et al. 1964: 692).

Of all six cases of amenorrhea, the emotional origins have a commonality. To pull together all the components of these studies, we might be able to observe in their totality that there is a need for control. This might be desired to ward off sexual and libidinal impulses but it can also be interpreted in a wider sense as a need for self-regulation and autonomy. The key component here is that at the heart of the matter is a deficient sense of self. If we consider a sense of self-cohesion based on the principle of successfully differentiating between inside and outside (Lichtenberg, 1978), we can suppose then that secondary amenorrhea in anorexia represents the ego's flawed pursuit of self-cohesion. Just as narcissistic personality disorders are driven by a fear of the threat or loss of a sense of self with an ego boundary between inside and outside too confining or too capacious then perhaps similarly anorexia with its associative need to split rather than distinguish between has a rigidity and non permeability to its ego boundary that serves a purpose. Thus, I would add that the exacting absence of menstruation is highly symbolic of that which lacks movement and flow. It is a declaration of absolute control and is a sign of non-entry to the outsider that compliments, through mirroring, the statement of intent as declared by the anorexic's body and mind. I tend to think that we have a combination of the repressed unconscious fantasies, needs and fears along with a disorganised ego and a more conscious communication such as a cry for help or a wish for revenge. Either way, the anorectic's relationship, real or imagined, with external objects is central. As Thomä explains:

“Both in fact and in subjective experience, the biological act of taking in, of incorporation, is a prototype of object finding, of making contact and of assimilating an outside thing onto oneself. In the subjective experience of hunger, the ego depends on nature in a twofold way: the need which is satisfied comes from the inside, whilst the satisfaction of the drive is provided by an object, which in early life is supplied by another person, usually the mother. This dependency of the inside on something outside brings about an unbearable conflict in anorectic patients and explains why they do not acknowledge any needs or bodily desires” (Thomä, 1967: 441).

Hilda Bruch mirrors this in her findings and states that the patient has

“the basic delusion of not having an identity of their own, of not even owning their body and its sensations, with the specific inability of recognizing hunger as a sign of nutritional need” (Bruch, 1973: 50).

Thus, the repudiation of maturation is a statement of an unwillingness to separate and carve out an identity for oneself. Whatever the root cause, anorexia is a statement of an impairment of the developmental phase of separation-individuation.

If we consider the way in which amenorrhea promotes this set up, there is a symbiotic tie between mother and daughter and it is separate from the narrative ascribed by society that mothers and daughters are linked through their procreating qualities and duties. I think the most important aspect to this is that procreation requires a third other. It is the man that completes, even makes the story. Not so with the dyad we are looking at. Anorexia does away with any cyclical menstrual expulsion that severs the link between a foetus and its mother (for both boys and girls). Amenorrhea is the un-cut non-bleeding umbilical chord, the pathway on which an uninterrupted symbiotic state can settle. Their story is not that of “modern daughters, living like hysterical Medeas” (Pollock 2007: 26).

What I think is too often overlooked is the way in which the daughter draws in the mother to display her wishes and capacities to feed, rescue and save her daughter, to contain and to withstand all that is thrown back at her. Through the management of the disorder they become attached, control or semblance of control oscillating between them. I think it is imperative that the daughter cannot smell the fear in her mother. In “Attacks on linking: stressors and identity challenges for mothers of daughters with long lasting anorexia nervosa” (Tuval-Maschiach, 2014), the subjective experience of ten mothers of daughters with chronic eating disorders were explored. It was found that the quality of the network of relationships they had with others was an important aspect as was the mothers’ relationships with themselves. It was difficult for them to feel that they were “good mothers” or to maintain a “positive maternal self-perception” (Tuval-Maschiach et al. 2014: 613). They felt incompetent, ill equipped and powerless to

help their daughters as they could no longer identify or connect with them or their illness. We could question if this is precisely the purpose of the child; to force her mother to scrap the well-worn template and contemplate a new reality that challenges perceptions, stigmas and dogmas associated with a woman's body. A mother might menstruate but perhaps the daughter does not want to replicate this on any level. Michelle Doughty writes about this in *The Bath*, which won her Best Undergraduate Writing Prize in 2014.

"I am in seventh-grade biology class when I feel a release of pressure just below my stomach. I hate my period immediately. Not just the inconvenience or even the brutal pain—I hate the entire concept that I am a woman now and a part of me is ready to have a child.

I am a cross-country runner; I already exercise too much, and with just a hint of dieting I become amenorrheic. The less I eat, the less I bleed, and I love it. I refuse to be the latest in a long line of Russian dolls, another child inside a child inside a child. Each mother creates a daughter, and each daughter fits perfectly inside the mother to whom she belongs.

For months in middle school, I still cramp once a month, but the sensation blends into hunger pains. Again and again I dream of sticky red blood pooling over my hips, so thick it sinks me into the mattress and glues me to the bed. I wake up hungry, but that doesn't mean that I have to eat. I am anorexic for many years" (Doughty 2014).

Thus, Doughty does not want to be shelved in the baby factory and she does not want to be part of a process by which each expulsion of menstrual blood is an expulsion of a part of herself. That bodily fluids is the stuff of life is not the "mattress" upon which she wants to make the bed that she will lie on.

Many women who come for psychotherapy presenting with secondary amenorrhea, speak of how they have inherited this state from their mothers, with it happening usually around the same age. As described by Charles Shepherdson, whose research looks at the intersections between psychoanalysis, literature and culture, this handing down of a phenomena is an

“intimate transmission of the signifier, inherited at the level of the flesh...An inheritance between generations of women, which functions at the level of the body, without answering to physiology; a history, then, which at the same time is not susceptible to the usual, broad cultural analysis...” (Shepherdson, 2000: 18).

This is an important point if we consider the lack of female authorship in medical and gynaecological accounts. As it is clear from testimonies like Doughty’s, they do not want the meaning of their lives to “dissolve into one enormous, universal uterus” (Poovey, 1988: 35).

By way of contrast, discussions in psychoanalysis can enable women’s bodies to “emerge as critical matters of concern” (Butler, 1993: 4). And we find that what they are concerned with are issues that have a strong psychic component, often inherited and of a “haunting” (Rashkin, 1999: 447) nature.

Em Farrell’s book *Lost for Words: The Psychoanalysis of Anorexia and Bulimia* (2000) interestingly describes the medical and psychoanalytic theories surrounding eating disorders from their emergence in the eleventh century to present time and one aspect she shows is the way in which anorexia and bulimia re-enacts a connection with mother as transitional phenomena “when the echo of a good enough experience of mother is still internally available.” This is difficult when unconsciously the mother has her own drives and her own pathology with ways of using her child, specifically as an intermediate object. Transitions are outlawed by the biological unequivocal shut down of the menstrual bleed. Secondary amenorrhea helps to bridge a gap between the phantasy of an unchanged state and the reality of moving variables that signify change and decay. As Rizzuto writes “Food, faeces, menstrual blood, the penis, and finally the foetus can all be experienced as the “other” within” (Rizzuto: 1988: 59).

What though of the outside world? On a conscious level, the anorexic experiences toxicity and disharmony in her environmental or family setting that she tries to override and solve with her minimalist, ordered, strict regime: With her absent menstruation she unconsciously provides the boundaries that those around her so desperately lack and so desperately need.

In the NICE guidelines “Eating Disorders – Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders” under the heading “The aetiology of eating disorders”, it reads

“The aetiology of eating disorders in common with most other psychiatric disorders is generally considered to be multifactorial...Whether or not a person develops an eating disorder will depend on their individual vulnerability, consequent on the presence of biological or other predisposing factors, their exposure to particular provoking risk factors and on the operation of protective factors...Where the onset of disorder is insidious, it is not always clear whether such factors are causes or consequences of the disorder. This is particularly true of family or life event research where the independence of any event may not be clear. Finally, few studies have included the person’s own perspective about his or her eating disorder. One recent study (Tozzi et al., 2003, suggested that those with anorexia nervosa perceived dysfunctional families, dieting behaviour and stressful life events as the main causes of their condition” (NICE, 2004: 24).

If this is a dis-ease that is screaming “conflict” in the patient then we have to turn our attention to the parents to widen the scope. There is substantial evidence to show that often the children are caught up in parental marital disharmony with the illness serving as a means to minimize the conflict or locate it elsewhere, away from the marriage. It is also common that the anorectic is in an “enmeshed relationship...especially when the parental relationship (is) poor” (Crisp et al. 1980: 186).

A sick child can bring about stability and harmony as family members regroup to help and battle the illness. In some cases much of the reasoning and understanding behind the eating disorder in the adolescent can be traced back to a time before the subject’s birth. For example, an earlier traumatic obstetric tragedy in the family predates the onset of the eating related illness (Shoebriidge & Gowers, 2000). One theory for the disturbance in the early identification process of anorectics is that their mothers identify their child with a dead sibling

or parent “to whom death wishes and ambivalence had been entertained.” (Falstein et al. 1956: 766).

To complete the package of the ideal replacement, the child freezes in time like a perfect picture, capturing a time that once was. Although Falstein was referring specifically to males, is it not the case too amongst the many anorectics who are “good” girls? Professor of psychiatry, eminent researcher and the authority on anorexia nervosa Arthur Crisp (1930 – 2006) found that in a study of 102 female anorectic patients, “81 patients were described as “good” and compliant children with no discipline problems” (Crisp et al. 1980: 183).

I often wonder to what degree a patient mirrors this compliance whilst undergoing treatment. To what extent does she feel able to speak, free associate, talk freely and unedited whilst those around her, in charge of her care, wave forms around for signing, book appointments, get out the blood pressure monitor and weighing scales, manage calls from hysterical (understandably) worried parents etc? To what extent does the compliant girl become the compliant patient? To what extent does the clinic act in to the role of hysterical mother whose reason for being takes centre stage? It is quite hard to rebel in an eating disorder unit when you are being told that there are hundreds queuing for your place. In a setting where compliancy is key, can these young girls actually feel brave enough to rebel and demonstrate a defiant, non-cooperative stance of a “normal” disgruntled teenager? Then again, if she does, maybe she is being compliant in that she is acting out what is expected of her, what we want to see in her so as to believe she has shifted within the range of “normality.” Is this not potentially the stuff of madness? And all of this goes on against the backdrop of cyberspace which is often experienced by young women as a confusing, conflicting, exciting, rejecting, loving, hating, lonely world. Here, young women are exposed to the wider narratives of eating disorders. Body image is key. Here too, secondary amenorrhea features.

## SECONDARY AMENORRHEA IN WIDER NARRATIVES OF EDS

In “Body appreciation and attitudes to menstruation” (2015), Chrisler et al. (2015) write up their study having sampled seventy-two women across the US. The broad results of the survey show that

“women with the most positive attitudes towards the body also have more positive (and less negative) attitudes towards menstruation” (Chrisler et al. 2015: 79).

However, the study, as the authors state, cannot determine whether negative attitudes towards menstruation lead to negative views about the body. An earlier study, “Body image in secondary amenorrhea” (1997) compared twenty-one women with secondary amenorrhea of at least six months with a control group. Interestingly the outcome of the study was that the data

“did not confirm the body overestimation previously found among amenorrheics....The lack of significant differences in ideal body values and in dissatisfaction indices between the two groups could confirm that all women are influenced by cultural models, following the “thin body cult” promoted by mass media” (Orlandi et al. 1997: 50).

An important question for many researchers is whether anorexia, as with other eating disorders, is a reaction or a syndrome? And in a choice of “language” with the dictum to be thin, to what extent are these women influenced by the language and the desires of those around them? Paradoxically, the anorectic is serving a purpose beyond that which is her own especially so long as society views thinness as perfect. Social critic and psychoanalyst Susie Orbach, in the 1980s, put forward the explanation that in opting out of one system the anorectic is in fact “conforming to society’s demand for women to be thin” (Orbach, 2016 [1982]: 155).

And for author and political activist Naomi Wolf, our interest in the bodies of women exists

“in order to take over the work of social coercion that myths about motherhood, domesticity, chastity, and passivity no longer can manage” (Wolf, 1991: 11).

We partake in a new political script in which

“the cultural fixation on female thinness is not an obsession about female beauty but an obsession about female obedience” (Wolf, 1991:187).

I find that this links well with French philosopher Jacques Derrida’s observations on society’s interest in those who are excluded and those who make up the margins (as we shall see later, this occupied the writings of George Bernard Shaw). Derrida wrote:

“Every culture and society requires an internal critique or deconstruction as an essential part of its development...Every culture is haunted by its other.” (Derrida, 1984 cited in Kearney 1984: 116).

What haunts many societies at the moment is the rapid growth of obese populations. Politicians, medics and think-tanks have declared a war on obesity saying it should be put up to the top of the to do list along with terrorist attacks that seriously threaten society. A global report published in *The Lancet* (2016: 1377-1396) analysed the trends in mean body-mass index of over nineteen million adult participants in 200 countries from 1975 to 2014. The numbers clearly revealed a change in tide:

“Over the past four decades, we have transitioned from a world in which underweight prevalence was more than double that of obesity, to one in which more people are obese than underweight, both globally and in all regions except parts of sub-Saharan African and Asia” (The Lancet, 2016: 1389).

This ‘epidemic of severe obesity’ is often linked to poor diet, lack of exercise and low levels physical activity. That it is a mental disease about which we are too ill educated is a fact less readily accepted. Uncontested is the burden and the threat that obesity brings on a nation. It is estimated to cost the National Health

Service in Great Britain over six billion pounds a year. Whilst obesity rules the medical headlines these days, the anorexic, is nevertheless still a key “other” upon which that which is projected onto her is perceived as unattainable. We can see this with the super skinny fashion models and the way they are both vilified and worshipped. Their “beautiful” bodies are believed to supersede the bodies of normal women who bloat, menstruate, give birth, tear, leak, break down etc. They model the clothes and they peddle the images many women aspire to buy into. At the same time, they are accused of being dangerous role models for those who desire to enter the industry and for those who use them as a benchmark for ideas on perfection. What intrigued me in 2015 was the sudden removal of Playboy playmates from the infamous “men’s magazine.” Women once so abhorrent to many feminists and deemed a danger to the health and wellbeing of every young girl’s psyche seemed to have been binned off. In 2015, Playboy took a radical decision to stop printing pictures of completely nude women in its magazines. Playboy had realised that men were not necessarily buying the magazine for pictures of nudity because they could access whatever they liked for free online. As the media bombarded women with the idea that a thinner, leaner, manicured woman was one of greater feminine beauty, Playboy magazine had been mirroring this by showing much thinner women in their centrefolds. But the men were put off. In “Cultural Expectations of Thinness in Women” (1980) the concept of societies aspiring towards a “thinner standard” (Garner et al. 1980: 483) was evident and both the Playboy models and the Miss America Pageant contestants had become significantly thinner over a twenty-year period. Playboy centrefolds “changed shape” and had a smaller bust, larger waist and smaller hip measurements. Meanwhile, in terms of the actual sizes of young women’s bodies, the opposite was happening and the expected weight for women under the age of thirty was increasing at about the same rate that the average weight for the centrefolds was decreasing. So, just as “real” women looked nothing like the centrefolds, men too were turning away from what was being put in front of them. With regards to Playboy’s new marketing strategy it failed to offset falling sales and within less than a year the “pics” were reintroduced into the magazine and the brand declared itself to be shifting back to its former glorious self.

Now in 2017, I wonder to what extent women really care? Perhaps we have emerged out of the days of Orbach and Wolf in that a woman's embrace for thinness is a defiant protest and a refusal against the objectification of women by men, not a statement of collusion with it. Is it a protest against the child-bearing body of a woman that can satisfy man's archetypal fantasy? Perhaps the thinner they are, the more desirable they are to women and the less they are desired by men? The more they are unencumbered by the child-bearing outline and all that it represents, the more they can experience themselves as autonomous and separate from he whose gaze she no longer seeks. It is not in the remit of this thesis to get caught up in this particular area of discourse but for me, I hope for a more gender-neutral perception of both women and men and a more open and fluid way in which we approach one another whatever our orientation.

A far more sinister example in our culture, arising I assume through ignorance more than anything else, came my way when I was on the internet with my teenage daughter looking for a Halloween costume. Up popped "Ana Rexia." It was a black dress on which a white skeleton had been transferred onto the front. It was modelled by a buxom blonde two sizes too big for it. Thankfully my daughter found this ridiculous. Later on, I began my own search on the pro anorexic sites and found girls posting pictures of themselves, in which their bodies were "down to the bone." They celebrated their protruding back and collar bones, their hollow cheeks and their visible thigh gaps. Many of the photos were artistic, the compositions creative. The pictures told a story. Young women on social media are trying to sort out and sift through the good, the bad and the ugly; undecided, misguided, easily influenced dreamers but at the same time demonstrating a fickle, disloyal judgemental attachment to any one brand, image or message, as ready and as quick to drop it as they were to run with it in the first place. The anorectic image, though, has an enigmatic, powerful, hypnotising look. It is hard to turn one's gaze away and many women are seduced by both the extreme omnipotence and the impotence represented in these figures.

In our daily lives, we see images of "powerful" women such as the Olympian Jessica Ennis and Tennis champion Serena Williams whose ambition and success and beauty are not compromised but rather enhanced by their desire to

be wife, mother and woman. And then there are those that strive to be the best in a totally different way: Athletes that don't menstruate due to stress and low body weight and performing artists and dancers who find themselves often embodying the tragedy of the characters that they play. Their bodies mirror the narrative of a romanticised struggle. As principle ballerina with the Kremlin Ballet Joy Womack revealed in an article in *Der Spiegel* in 2015:

“Many people will be angry when I say this, but I was anorexic and bulimic for years. It's a widespread problem among female dancers. A ballerina is a weightless, ethereal being – none of it can wobble when it springs into the air” (Shafy, 2015).

Would Joy have become anorexic and presumably amenorrhic (I cannot envisage her bleeding whilst in hold) if she hadn't become a ballet dancer? Is there a need in her and in women like her to find shelter in a profession that can house something the outside world labels as ambiguous and anomalous, split off from ordinary folk? On her Twitter page, Joy describes herself as a “barrier breaker.” We can turn to psychoanalyst Joyce McDougall's paper “The Artist and the Outer World” (1995) to think further about forms of creativity such as ballet that are unconsciously experienced as acts of transgression. McDougall writes,

“one has dared to play alone through one's chosen medium of expression in order to fulfil secret libidinal, aggressive, and narcissistic aims; one has dared to display the resulting product to the outer world; one has dared to exploit pregenital sexuality with all its attendant ambivalence; and, finally, one has dared to steal the parents' generative organs and powers in order to make one's own creating offspring” (McDougall 1995, 60).<sup>xi</sup>

We can turn to another psychoanalytic passage to see how sometimes this act is thwarted by an over zealous mother and a disorientated daughter whose move away from the maternal and pre-oedipal towards the paternal phallic order leaves her lacking and unfulfilled. In “The Trauma of Language” included in *After Lacan: Clinical Practice and the Subject of the Unconscious* (2002), Lucie Cantin introduces us to Myriam, a dancer who has been accepted into one of the finest

schools in Paris. Her dreams of becoming a dancer are about to be realised. Myriam tells her therapist that she has discovered that her parents “wish her to be sick” with her hospitalisation at seventeen coinciding with her dancing ambitions taking off. Her father is presented as a child who needs looking after and her mother, preoccupied with her looks, flaunts her beauty. Myriam’s elder sister is a top international model perpetuating her mother’s youth and beauty “but the mother never fulfilled the dream of her life, which was...to be a dancer.” (Cantin, 2002: 43).

Myriam is amenorrheic until the age of twenty five which Cantin interprets is Myriam’s unconscious response to her mother’s demand that puts her “out of play.” Myriam must not succeed where her mother did not because this would mean a lack in the mother. At the same time, “the impossibility of becoming a woman, expressed by her amenorrhea, forced her to remain a little girl, both guardian and servant of her father” (Cantin, 2002: 44).

Myriam’s case also fits into the model of thinking about the symbiotic unions forged through familial narratives presented earlier in this chapter. To round up this section, disordered eating can be seen as symbolic of that which defies the demands put on a woman by other women just as much as it is a stand against “the rights and prerogatives of male society” (Chermin, 1986: 19).

Can her own everyday battles, both with herself and with those around her, take centre stage (not too much that it self perpetuates a narcissistic retreat)? She must not be swallowed up in the socio-cultural discussions. Each and every one of these patients have their own story and this is the point – too long ascribed the role of narrator in other people’s lives, she must now have the right to tell and to live her own tale. This is quite a contentious thing as many patients want to find themselves within the context of a social narrative or they find it helpful to speak about issues of gender and sexuality. This was found in a study for Beat (Beating Eating Disorders Charity, UK). “The role of gender in the treatment of EDs” described

“The shift away from the (“crazy”) individual as the locus of dysfunction and “blame” to seeing one’s experience and subjectivity as shaped by wider social structures is framed as empowering here, whilst it is also positioned as potentially facilitating a distance from the ED itself.” (Holmes, 2017)

Of the fifteen women who had experienced anorexia and / or bulimia (age range 19-45 with the majority between 23-34 and with a white bias) many made it clear that they did not want their eating disorder to be part of a context used in normative femininities. As one patient said

“I don’t want eating disorders...to be on a spectrum with basically what it is to be feminine...I guess I am quibbling with the feminist theorists on that...but that almost makes me feel more stigmatised as someone who suffered from it, like why wasn’t I on the normal part of the spectrum” (Holmes, 2017).

Holmes study was designed to explore interlocking themes between gender identity and treatment. The data showed that discussions on feminist issues were far too non evident in the treatment. Although the NICE guidelines advocate the inclusion of talking about wider psychosocial issues, many of the participants were frustrated at the lack of this in their treatment experience. One patient in two years of “talking therapy” said

“In my treatment it was never really raised about gender. I think there were some talk about media images but even this wasn’t [related to] gender specifically...I was just told, um, try and not notice images of bodies” (Holmes, 2017).

Many participants had wished that they had read books on feminism and had talked through them with their therapist and would have welcomed gender to be explored more “explicitly.” Perhaps the books would have provided a framework in a similar way that poetry provided a safe house for Louise Glück, more so than her analytic home. Frameworks are tantamount in the analysis and treatment of eating disorders. Of those relating to autism I think this is key.

## AUTISM, MENSTRUAL IRREGULARITIES AND DISORDERED EATING

Some of the latest research links menstrual irregularities with autism spectrum disorder (ASD), which can then be linked to eating disorders. If we start first with autistic traits in women with menstrual irregularities, a recent case-control study of seventy females with primary dysmenorrhea and seventy females without primary dysmenorrhea showed an association between autistic traits and dysmenorrhea in typically developing females (Toy et al, 2016: 2319). One theory is the androgen theory that links elevated prenatal androgens as a precursor for autistic traits. Women with ASD are more vulnerable to medical conditions associated with elevated androgens and excessive androgens are typical in menstrual problems including amenorrhea, dysmenorrhea and irregular cycles. Now, we can put this alongside ASD characterised by

“deficits in social communication and social interaction across contexts, as well as restricted and repetitive patterns of behavior, interests or activities” (Toy, 2016: 2320)

What we have here is a prism of autism that reflects similar patterns in eating disorders and both autism and eating disorders, notably restriction, encompass secondary amenorrhea, the long-term restriction of menstrual flow. The results of “Exploring autistic traits in anorexia: a clinical study” (Tchanturia, K. 2013) revealed links between anorexia nervosa and autism spectrum condition. This was uncovered

“in socio-emotional and cognitive domains; this includes difficulties with empathy, set-shifting and global processing” (Tchanturia, et al. 2013: 44).

In this study, 66 participants with AN and 66 in a control group completed self-report questionnaires including the Short Version Autism Spectrum Quotient (AQ-10) and the Eating Disorder Examination Questionnaire. The results showed that in the AN group, autistic traits correlated to levels of anxiety and depression greater than in the control group with a greater difficulty in maintaining close

relationships. Importantly, the association between symptoms of eating disorders and autistic traits was subtle.

“Women with anorexia possess a greater number of autistic traits than typical women. AQ-10 items that discriminated between groups related to “bigger picture” (global) thinking, inflexibility of thinking and problems with social interactions, suggesting that autistic traits may exacerbate factors that maintain the eating disorder rather than cause the eating disorder directly” (Tchanturia, K. 2013: 44).

The prevalence of eating problems is higher in those who have ASD or ADHD as testified by the increasingly rich body of research into this whole area. In fact some researchers suggest that anorexia be included within the spectrum of autistic disorders based on the literature that draws parallels in the cognitive, behavioural and pathological features of both. As found by lecturer in psychology and researcher Clare Allely in her paper “Anorexia nervosa – on the autistic spectrum”

“The findings also indicate that they may both all on the same neurodevelopmental trajectory which leads us to suggest that if this is indeed the case, there may be some value in comparing therapeutic approaches across the two conditions” (Allely, 2013: 658).

Allely refers to Kerbeshian and Burd’s paper “Is anorexia nervosa a neuropsychiatric developmental disorder?” (2009) to emphasise that

“treatment approaches for AN could all benefit if a NPDD (not-otherwise-specified pervasive developmental disorder) perspective were to be applied to AN in addition to the already existing rich and fruitful research and clinical agenda” (Allely, 2013: 658).

As Simon Baron-Cohen writes in “Do girls with anorexia nervosa have elevated autistic traits? (2013), it would be useful for clinicians to consider that some patients with anorexia can have a different cognitive style and recognition of this

might open up new avenues for both treatment and etiological research. Baron-Cohen and his team at the Autism Research Centre at Cambridge University found amongst patients a love of systems:

“There are several reasons for considering that anorexia and autistic traits may be linked. First, anorexia involves rigid attitudes and behaviour, which can be seen as resembling the unusually narrow interests and rigid and repetitive behaviour in autism, but in anorexia happen to focus on food or weight. Secondly, patients with anorexia are often extremely self-preoccupied (about their own weight, or their right to do what they want) and the word “autism” literally means an exclusive focus on the “self” (Baron-Cohen et al. 2013, online).

As more studies reveal eating disorders in adult women with investigations linking neural mechanisms to the stubbornly entrenched habits that are difficult to treat (Foerde, K. et al. 2015), it is understood that treatments such as antidepressants and cognitive therapy don't work well. It makes sense that the underlying issues such as anxiety be thought about and brought to light rather than mechanically changing a habit resistant to change. If we consider this alongside the new research that links selective eating in young children with psychopathological symptoms such as anxiety, depression and attention hyperactivity disorders both concurrently and prospectively then again we must take seriously what it is that the patient is trying to communicate via her demonstrating a way of relating to food. Zucker's study “Psychological and Psychosocial Impairment in Preschoolers With Selective Eating” (2015) revealed that as the selective eating became more severe so too did the severity of the psychopathological symptoms. Furthermore,

“Impairment in family functioning was reported...as was sensory sensitivity in domains outside of food and the experience of food aversion” (Zucker et al. 2015, online).

Sensory sensitivity has been studied within the context of autism spectrum disorders but Zucker's study demonstrates that it can on its own be an important basis for the emergence of pathology. The concept of “picky” eating is now

better characterised by the diagnostic category of avoidant / restrictive food intake disorder (new to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition). As clinicians, we need to look at the bigger picture.

Food is not the stand-alone concrete issue. It symbolises and brings to consciousness representational parts of the sense of self and perhaps an attempt at conflict resolution whose origins lie deep in the realms of the unconscious. American psychologist and psychoanalyst Bromberg, explores the way in which patients use their symptoms to seek out affective self-regulation through dissociation amidst a war between self states. In his paper “Treating Patients with Symptoms—and Symptoms with Patience: Reflections of Shame, Dissociation and Eating Disorders” (2001) he writes that most symptoms including those associated with eating,

“represent the basic adaptational function of dissociation in foreclosing the possibility of holding in a single state of consciousness two incompatible modes of relating. As Freud put it, “it is impossible to eat with disgust and pleasure at the same time” (Breuer and Freud, 1893-1895: 89)” (Bromberg, 2001, online)

Bromberg’s work integrates psychoanalytic, developmental, trauma and neurobiological research and in considering the therapy offered to patients who seek a solution in destructive states he refers to Erikson. For Erikson, these patients display

“a self –decreed moratorium, during which they often starve themselves, socially, erotically, and last but not least, nutritionally, in order to let the grosser weeds die out and make room for their inner garden. But often when the weeds are dead, so is the garden” (Erikson, 1968: 41-42).

There is much to consider when working with patients whose presentation of non-compromising, inflexible systems and resistances are seemingly unyielding. As exemplified in the autistic spectrum, in eating disorders, notably anorexia, in ritualistic behaviours and in self regulatory behaviours, the organisational models are fortified by clear boundaries that separate in from out, I from you.

Furthermore, the difficulty often lies in crossing a boundary, making the transition from one state to another. Trust must be reimagined. Successful transitions are developmental markers. Object relation theorists write extensively about the passage from one to three from the normal autistic phase to the symbiotic phase to the separation individuation phase. It is at any one of these transitions that the person might revolt or retreat seeking out clarity and rigidity in a way of being or relating to oneself and others. Secondary amenorrhea might be thought of as a closed system and as a symbol of non-transition disabling the passage from the pre-pubescent girl via menarche to womanhood. It represents that which overrides gender and halts a general transition from infancy to adulthood. We can think too intra-psychically about the way in which its cessation might contain psychosexual conflict and associative emotions such as desire, revenge, shame, fear etc. by offering an alternative system of severe regulation in which all variables are wiped out. It allows for a reality that sits comfortably with the patient's sense of self that is dependent on what is understood as

"isomorphism between inner and outer reality, mind and body. The patients demonstrate a closeness, a more or less immediate connection between physical and psychological realities; for example restrictive control of food represents psychological self-control. The "as if" of mental representation is turned into an "is" (Skårderud, 2007: 324).

Secondary amenorrhea represents "is" and much more. It is not only a body boundary signifier with its absolute cessation of menses that has the power to override messy unpredictable bleeding but it also signifies the threshold of both the benign and the malignant aspects of the self. It is perhaps both friend and foe. The problem in therapy is that sometimes a patient's menses will return during treatment and this is often followed by a breakdown. We shall see examples of this in the following chapter, here though we can understand this as the patient's sense of self, already tenuous, being further weakened by change, as consciously experienced in her regaining of menses. If these patients are already deficient in their capacity to self regulate, then clumsy work by the therapist creates destruction to this very system without providing a viable and secure alternative. The very practice of psychoanalysis itself might be

experienced as a path made up of crazy paving stones beyond which lies famine, isolation and disassociation. Yet, this is often a well-worn path, one that has been travelled too many a time for our patients. If we want to reach them, we need to illuminate our thinking about the boundaries that intersect all of our lives. One way is through poetry, prose, and myths. This is where we are heading.

## CHAPTER FIVE

### **METAMORPHOSIS – THE STORY OF PYGMALION AND THE PROCESS OF CHANGE IN THE PSYCHOANALYSIS AND TREATMENT OF SECONDARY AMENORRHEA**

#### OVERVIEW

Having established what Secondary Amenorrhea is, both as a concrete and a symbolic entity, its relevance within historical, cultural, and social contexts and what it represents for women, both menstruating and non-menstruating, we can now go on to explore, examine and consider it through the particular lens of psychoanalysis. The purpose of this is to discern the characters, communications, structures, organisational patterns, divisions and bonds within the psyche that have sought solace and respite in the settlements of the State of Amenorrhea. I intend to do this through the application of psychoanalytic thinking into the reading and interpretation of the story of Pygmalion. My research into patients with secondary amenorrhea through the psychoanalytic model has led me to themes of transformation, identification, separation, alienation and loss, both consciously and unconsciously experienced. These are prevalent themes in the narrative – themes shared in the story of Pygmalion and we shall look at them in detail as we go on.

I shall be first using Ovid's version and then George Bernard Shaw's retelling of the classical myth for analytic enquiry and discussion. I will demonstrate how we can interpret Ovid's work as a presentation of a pre-oedipal, pre-verbal world in which the ambiguity between what is illusionary and what is real is at its most heightened. Unconscious phantasy is communicated and defended against through the body and through the gaze. The creation of his mute statue in some ways enables Pygmalion to live in a society that he does not feel part of. So too Eliza Doolittle in George Bernard Shaw's play feels alienated from the people around her but in stark contrast to Pygmalion, she enters into a linguistic process attempting at some level to resolve her inner and outer conflicts. She can see that the strangeness is within her and does not project it all onto the outside world

like Pygmalion does. Eliza wants to find out who she really is and who she could be and she seeks help from Higgins and others to realise this. Shaw's play, from a developmental point of view, is analogous to an oedipal / post-oedipal set up in which ambivalence, conflict, individuation and inter-subjectivity are communicated and, to a degree, worked through. We shall unpack this carefully as we go through the text making links with the bodily text of secondary amenorrhea through the presentation of clinical overviews including case study material and analysis.

### WHY PYGMALION?

I am often asked why I chose as my starting point Ovid's tale of the male Pygmalion when my thesis is essentially about women. The answer is four fold. Firstly, I think in the preceding chapters I have given plenty examples of amenorrheic women; Lilith, Lady M, Joan of Arc to name a few. The quintessentially bombastic and powerful warrior narratives are rich and evocative but their omnipotent impotent split leaves only the slightest of awkward wriggle room for empathy. In contrast to these narratives, which are encumbered by societal and cultural pressures, Pygmalion is more of a private affair. It takes place in the privacy of Pygmalion's own quarters, concretely as in his home and allegorically in that the house stands for the mind. The reader as voyeur has the chance to engage directly with the text and has the chance to process in his / her own way Pygmalion's own processing of events as they unravel. It is for many a bizarre tale, indeed Pygmalion behaves bizarrely at times but one can't help but feel for him. In fact I can't help but feel that he wants me, even needs me to feel empathy for him. Feeling is welcome. In our line of work, we can't just think and do. We must feel.

Secondly, gendering the work limits our thinking. Instead we can apply the themes from the tale not only to different gendered identities but we can also think about these themes at a time even before issues of gender creep in to the shaping of one's identity. Psychoanalytically speaking, Pygmalion personifies a construct of psychic organisation and psychic fragmentation which affords the subject, whether he / she be male or female, a certain way of coming into being,

of being and of relating to self and to other. One could read it as quite an autistic way of relating, richly creative on the one hand and narrow in field on the other. High spec, we are at a time when normal limits are challenged and the “laws of life and matter” (Segal, 1998: 11) are suspended.

Through his artistry, Pygmalion creates a new reality for himself so that he can go on living in the world that he rejects and experiences as rejecting. He doesn't understand the world around him. The realities of life are unpleasant but Pygmalion creates an illusionary world that corresponds to his needs. He “transfigures reality” (Winckelmann, [1764] 2006: 161f). And, as Freud would write of artists, like magicians, a new reality is created that satisfies the subject's unconscious need for magical omnipotence (Freud, 1913:10). As we have seen in earlier chapters, secondary amenorrhea is an art form that assists women who want to transfigure reality. Pygmalion protests against all that he is surrounded by but is he delusional? So too, as secondary amenorrhea embodies both the illusionary and the real to what extent are we dealing with protest and with delusion?

Thirdly, I see it that all this magical thinking shows Pygmalion to be at a stage in his psychic development similar to that of a very young infant at the very beginnings of life; “the psychological birth of the human infant” (Mahler, 1972). We know that many studies of secondary amenorrhea find the subject in a place of arrested development, paralysed at the point of maturation, rooted in between two stages of development. If we think about the baby, at the outset, it does not see the difference between I and not I. Pygmalion symbolically represents the infant who resides in a state of total fusion with mother, symbiotically tied to her and to this stage of development, wrapped up in an embodiment of illusion and magical omnipotence. The developmental stages of separation-individuation, differentiation and rapprochement (Mahler, 1972) are frightening and dangerous prospects, placed far away from Pygmalion and his statue. His artist's studio is a safe house, representing sanity in what appears to be a mad world on the outside. I think so too secondary amenorrhea provides the safe house, a body that affords relief. It manages frustration and tension like a mother who presents herself to her baby to offer comfort. Pygmalion seeks this out and finds relief in

the creation of his statue. In his case, his fetishism and tendency to re seek pleasure from his caressing of the statue represents a psychosexual infantilism. He behaves like a young masturbator, needing no one but himself and his tools. It's not erotic, more eroticised. The more he keeps at it the more he seems frustrated. Yes he created it, clever boy, but she is after all just a lump of ivory. The coming to life of the statue propels him into having to move on. Now he will be required to be a "real man." Similarly, secondary amenorrhea can represent the paralysis of a maturing body, menses arrested, allowing the female to avoid the pressures of womanhood and motherhood and all that society demands of its "real" women.

Fourthly, what of the statue? It is an object with which Pygmalion identifies, representing an internalising aspect of himself? Jungians might describe this as Pygmalion finding the anima, the internal female part or "soul" of psyche, for his animus, the masculine (Jung 1990a; 2001: 282). Pygmalion goes one step further and creates his anima into a "form" shaping it with ivory. We could read this as Pygmalion attempting to find a wholeness of self. It is up to the reader to decide whether he is creating on the outside all the things he loves about himself or whether he is evacuating and splitting off his feminine side that he can't bear to house within. If he were to have allowed himself to unify the two more fluidly and less concretely, he would have made a wonderful precursor to Dustin Hoffman's Tootsie (1982)! We can understand the statue in Winnicottian terms, as a transitional object, separate and outside of Pygmalion but in part belonging to him, part of him. He needs it. He is incomplete without it. So too with secondary amenorrhea, it meets a woman's unconscious needs and as we see in the analyses, when it goes and is replaced with menses, she is lost without it, left now dangling in a middle space without her safety net. Her container for holding the tension between opposite states of omnipotence and impotence, defiance and delusion, the illusionary and the real is gone, puff like the smoke at the end of a magic trick.

## WHY MYTHS AND STORYTELLING?

Pygmalion's story has been re-incarnated and re-interpreted many times in literature, art, film and music. From Shakespeare's *A Winter's Tale* to Shelley's *Frankenstein*, from films *Blade Runner* to *Pretty Woman*, Disney's *Pinocchio*, the ballet *Coppélia* and paintings by Gérôme and Goya, its cultural legacy lives on, deservedly so. But, in the field of psychoanalysis, Pygmalion hardly features. In fact, it is not even an Echo to the infamous Narcissus, whose tale is resplendent across the field. Similarly, the psychoanalytic work on the subject of amenorrhea, both primary and secondary, is thin and scantily clad whilst that on menstruation continues to take shape. I hope to redress this imbalance by using the Pygmalion myth as a way to elucidate further thinking and understanding of the way we engage analytically with patients who present with secondary amenorrhea, for whom menses has been interrupted or has stopped.

A hallmark of Ovidian poetry is that of transcending and transgressing boundaries (Hardie, 2002a). The genius of Ovid's *Metamorphosis*, in which Pygmalion features, is that it

“creates an analogous freedom, releasing the creative energy in which new forms are continually coming into being and normal limits are suspended. Human and bestial, animate and inanimate, male and female can flow into one another...this suspension of the laws of life and matter can produce a golden age or a nightmare, miracle or monster” (Segal, 1998: 11-12).

The artistry of Pygmalion the sculptor, whose statue comes to life, and the technical accuracy of Professor Higgins the linguist who transforms a girl from the gutter into a duchess, demonstrates how in art, philosophy, language and religion we can make “real” the fantasies of omnipotence whereas in science and religion, society and culture we have to accept the forces of circumstance, the reality of our world and our place in it. As psychoanalyst Sandor Ferenczi states in his 1913 paper “Stages in the Development of the Sense of Reality”, it is in fairy tales that

“man has wings, his eyes pierce the walls, his magic wand opens all doors...in the fairy-tale a magic cap enables every transformation...” (Ferenczi,1999, [1913]: 80-81).

Bruno Bettelheim (1976) mirrors Ferenczi’s understanding of fairy tale “motifs”

“experienced as wondrous because the child feels understood and appreciated deep down in his feelings, hopes, and anxieties, without these all having to be dragged up and investigated in the harsh light of a rationality that is still beyond him” (Bettelheim, 1976: 19).

Whilst we might view the rational world as being driven by a dominant consciousness, the world of myths and fairy tales can offer us a legitimate route to transcend and transgress boundaries. As described by Zipes (1991) they can be used as templates for social and cultural codes of conduct. If we look at how many ways the Pygmalion myth has been reinvented to reflect the needs and wishes of mankind at certain periods of time, we see how it has its own magical capabilities. With each transformation, with each retelling of the story and in our interaction with it, we can pursue a deeper understanding of our own unconscious and internal psychic processes. Challenged and hopefully enriched by this, we can learn more about ourselves and each another.

The myth of Pygmalion is a great example of how, according to the psychology of Jung, it is precisely through the mythical, symbolic tales that we can approach and express our psychic reality. As understood by Guggenbühl-Craig,

“...it is not ruled by causes and does not follow the law of cause and effect...To put it in extreme terms; all psychology is mythology or: psychology is modern mythology” (Guggenbühl-Craig, 1995: 65).

Whether you agree with this or not, we find ourselves suspending belief when we read the Pygmalion myth which allows us to question and perhaps reformulate certain truths. After all, we go along with the presented fact that a statue really

does come to life. It is an emblem for one of Freud's earlier discoveries, expressed in a letter to Wilhelm Fliess on February 19th, 1899. Freud writes,

"reality-wish fulfilment. It is from these opposites that our mental life springs" (Freud, 1899 cited in Mason, 1985: 345).

With this in mind, we can consider the ways in which clinicians engage with amenorrhic patients and their narratives and we can look to the story of Pygmalion for guidance.

Just to remind the reader, secondary amenorrhea might result from a biological or physiological remodelling of a woman's body such as that undertaken by female athletes and dancers. So too a reproductive schism, such as the development of cysts on the ovaries and a hormonal flux, might interfere with the menstrual cycle. Secondary amenorrhea might also be caused by conscious psychological factors such as anxiety or stress. Psychiatrists and gynaecologists also acknowledge what we have been exploring in this thesis in that something of a more intra-psychic nature is likely to be at play. As Kuri and Gehi write in "Psychogenic amenorrhea: An integrative review"

"Psychogenic amenorrhea results from the interaction of intra-psychic vulnerability, external stress, and neuroendocrine disturbances. It may result from exposure to a known stress or may be associated with a major psychiatric disorder" (Khuri & Gehi, 1981: 883).

Whilst all this must be held in mind, there are many patients for whom secondary amenorrhea does not remit "spontaneously" and is not simply a short-term disorder that is easily reversible. On the contrary: For many patients, secondary amenorrhea is a long term, deep rooted state of being; one that represents and communicates an engrained state of mind. I believe that through the application of psychoanalytic thinking, in considering the unconscious elements and processes that might find expression and even relief through the cessation of the menstrual bleed, we can reveal what possible types of internal psychic conflicts, defences or states bring forth an absence of menstrual blood.

## OVID'S PYGMALION AND THE PLEASURE PRINCIPLE

Ovid's Pygmalion features in Book Ten, verses 243-297, of *The Metamorphosis* (Melville, 1986). It tells the tale of a sculptor who creates the most perfect statue of a woman out of snow-white ivory. Enamoured by her beauty, and by his own artistic mastery, he adorns the statue with clothes and jewels and he relates to her as if she were real. He prays to Venus for a wife just like her and the goddess grants him a wish and brings the statue to life.

The mythical character of Pygmalion can be used as a representation for all that is navigated and negotiated in the very early stages of life with much investiture in the realms of the Pleasure Principle (Freud (1920). How Pygmalion views himself and the world around him is comparable to the infant who turns his back on the actual reality of things and through insistent wishing magically creates what he needs. In doing so, he can preserve his feelings of omnipotence. He can fulfil his wishes and think himself to really be in possession of magic capacities.

Shut away from everyone and everything, Pygmalion chooses to engage with his inanimate statue in a way that symbolises sexuality as being independent of the outside world, chiefly because man can satisfy himself auto-erotically. The period of unconditional omnipotence with regards to sexuality can last so long as one does not give up on the autoerotic means of satisfaction. In other words, it can last a lifetime. With regards to narcissism, if we confine ourselves to self-love we can retain the illusion of omnipotence throughout life. We do not need another to be our love object.

When the statue comes to life, Pygmalion is forced to renegotiate the way in which he relates to this new other, thus marking a developmental shift away from the Pleasure Principle towards the Reality Principle. Furthermore, as the statue transforms into a human being, a "she" who is now separate from him and who we imagine will have needs and wants of her own replaces an "it". We shall consider their new relationship later on in the chapter.

In Ovid's *Pygmalion*, we have unedited, raw instinctual life pulsating throughout, from start to end. Eroticism bleeds across the margins into the previous and following lines and verses. We have symbols of the unruly id and the way in which the ego defends against it. We also witness, at times, an overwhelmed *Pygmalion*. To assist in our thinking about *Pygmalion's* ego functioning, psyche and bodily processes and in consideration of the links made to amenorrhea, we can turn to Freud's formulation of the ego. He wrote that the ego is derived from bodily sensations and is always a body ego.

"The ego is first and foremost a bodily ego; it is not merely a surface entity, but is itself the projection of a surface" (Freud, 1923, SE XIX: 26).

Freud leads up to this statement with,

"A person's own body, and above all its surface, is a place from which both external and internal perceptions may spring. It is seen like any other object, but to touch it yields two kinds of sensations one of which may be equivalent to an internal perception" (Freud 1923, SE XIX: 25).

The Amenorrheic can use her body in two ways. Her female outer bodily form, whose zones are sensitive to touch and yield sensations allow that she makes herself available to her own libidinal strivings and the libidinal searching of another. At the same time, her inner bodily form that is non menstruating and non procreative yields not to the touch of another's external seed and contains some of her "internal precepts" that she wishes not to externalise onto the outer contours of her body.

Drawing on the work of Freud, Melanie Klein correlated the body to the instinct with the instinct essentially being a biological entity. As psychoanalyst Thomas Ogden explains in his 1984 paper "Instinct, Phantasy, and Psychological Deep Structure – A Reinterpretation of Aspects of the Work of Melanie Klein",

"From the perspective of the concept of inherited codes, or templates, by which actual experience is organized, the Kleinian concept of inborn

“knowledge...inherent in bodily impulses” (Isaacs, 1952: 94) can be understood not as inherited thoughts, but as a biological code that is an integral part of the instinct” (Ogden, 1984: 501).

With psychic phenomena having at its root the bodily instinct, Klein described psychic representations of the instinct as “phantasies” (Klein, 1952b cited in Seymour Lawrence 1975: 57-60). Furthermore, as emphasized by Ogden (1984)

“Phantasy content is always ultimately traceable to thoughts and feelings about the workings and the contents of one’s own body in relation to the working and contents of the body of the other” (Ogden, 1984: 11).

For me, these definitions are containers and boundaries akin to the mast that Odysseus ties himself to whilst looking at and listening to the Sirens. In book twelve of Homer’s *Odyssey*, the Sirens and their songs are so enchanting that they can drive a man mad, causing him to jump perilously into the sea. To avoid this, Odysseus ties himself to the mast of his ship thus allowing him to experience their beauty whilst at the same time narrowly avoiding both a physical and psychic death. For Pygmalion, this concrete and symbolic holding in the face of internal and external positions untamed, comes in the form of the hard, white, ivory substance. It allows him to work on

“the project of the body and knowing through the body, essentially by way of erotic experience, since eroticism makes the body most fully sentient and also most “intellectual,” the most aware of what it is doing and what is being done to it (Brooks, 1993: 278).

The pendulum of activity carried out by Pygmalion is narrow. We are constantly moving within a short range between asceticism and self gratification and as we travel along the body of work, we find ourselves stone stepping between what is real and what is illusionary, what is present and what is absent, what is tragic and what is comic. One is constantly oscillating between them. We have here, an allegory for the sexual configurations of early infantile, adolescent and adult life and we have a template of entanglement that often dominates the clinical work

between the analyst and the analysand with secondary amenorrhea. It remains imperative for the analyst to distinguish between each of their own individual needs and wants.

We shall now look at the Ovid text in sections.

## THE PROMISCUITY OF THE PROPOETIDES AND THE PARANOID SCHIZOID POSITION

*“Pygmalion had seen these women spend  
Their days in wickedness, and horrified  
At all the countless vices nature gives  
To womankind lived celibate and long  
Lacked the companionship of married love.”*

These, the first lines of the Pygmalion verse, refer to the Propoetides, the daughters of Propetus, whose narrative Ovid ends the previous verse with. We could say that what we have here, carried over, is unfinished business with women and with Pygmalion's attitude towards them. In finding their actions abhorrent, Pygmalion retreats into celibacy and misogyny. But things are not that straightforward. The Propoetides are prostitutes because the goddess Venus forced them into it. They had once denied her divinity and Venus, enraged, declared them impious and subsequently punished them with a life of impiety. If a life of prostitution was the punishment and not the crime, what then was the actual crime? Non-conformity? Celibacy even?! The final outcome of their transgression is that they are turned to stone and thus rendered impotent. I would interpret this as Pygmalion's aversion to his own state of impotence, unconsciously and unapologetically projected far from him and onto the whole of the female sex. The Propoetides have become both physically and mentally deadened from what has become an intolerable state of being; one full of helplessness, anxiety, shame and mourning.

*“As shame retreated and their cheeks grew hard,  
They turned with little change to stones of flint.”*

They have died. As readers, are we being asked to turn a blind eye to all of this? After all, their story trails at the end of the previous verse and can be easily overlooked. What is it we are not supposed to see? We could interpret this as Pygmalion in the paranoid schizoid position; a position in which man, as Ronald Britton (1998) describes

“has buried his unacknowledged thoughts in others, in his actions or in his perceptions, and though they are symbolic in form they are treated as things” (Britton, 1998: 35).

In describing the treatment of such patients in his *book Belief and Imagination: Explorations in Psychoanalysis* (1998), Britton goes on to refer to psychoanalyst Betty Joseph:

“As Betty Joseph pointed out in her paper on “Different types of anxiety and their handling in the analytic situation”, analysis in such cases is likely to be a scene of action rather than a thought (Joseph 1989b). It is then the analyst’s task to reclaim for thought what may otherwise be dispersed in action and reaction” (Britton, 1998: 35).

In Pygmalion’s case, the disgust that he shows the Propoetides perhaps disguises self-disgust which is in conflict with an unruly and an insatiable id from within. Perhaps his idea of a perfect wife is one who is a whore in the bedroom thus legalising prostitution through the order of marriage. Pygmalion goes about creating a statue of his perfect woman. Clearly there is a split between what is hated and what is idealised. The Propoetides are bad as are the bad parts in Pygmalion’s psyche that register the experience as bad and which must be got rid of in the face of “a dread of imminent annihilation” (Bion, (1967) 1984: 37).

Frustration and anxiety are intolerable concepts and reality is to be hated which “as Freud pointed out, is extended to all aspects of the psyche that make for awareness of it” (Bion, (1967) 1984: 37).

The further Pygmalion moves away from The Propoetides and the closer he moves towards his perfect statue, the more he seems to lose the capacity to live in the real world. Pygmalion exemplifies a man unable to think. He has been unable to, as Bion describes it, start with the “preconception” which is not an idea but a potential for an idea of something dangerous and fuse it with the actual “realisation” of what is experienced as dangerous. It is from this that a conception or thought will come about (O’Shaughnessy, 1992: 89-91). Bypassing this, we have Pygmalion with his immaculately conceived statue: She who has no name. By way of summary we can turn to Jung:

“The effect of projection is to isolate the subject from his environment, since instead of a real relation to it there is now only an illusionary one. Projections change the world into the replica of one’s own unknown face. In the last analysis, therefore, they lead to an autoerotic, autistic condition in which one dreams a world whose reality remains forever unattainable. The resultant sentiment d’incomplétude and the still worse feeling of sterility are in their turn explained by projection as the malevolence of the environment, and by means of this vicious circle the isolation is intensified” (Jung, 1951, CW 9ii: para.17).

The castrating sense of the Propoetides makes me wonder about the impotent penis and perhaps this is what is at the root of Pygmalion’s celibacy. Did the eroticism of the Propoetides prove just too overwhelming for him, forcing his hands into that of an artistic (masturbatory) project? Masturbation can be viewed as an ersatz and a replacement for intercourse. However, the act of masturbation often comes with persecutory thoughts and feelings. Perhaps Pygmalion was inhibited by the prohibition, fantasy and guilt associated with masturbation and he found relief in his artistry. The ivory white substance he uses for his statue might have made up for the insufficient discharge. He might be lacking in actual semen but with the artist’s materials he still creates life itself, one of an immaculate conception. And he does so without the need or use of a woman or a womb.

There are dynamic links between the systems that Pygmalion implements and the states of amenorrhea and anorexia that circumvent the subject away from

procreation, into a state of self-containment and singularity. Pygmalion found creative, imaginative ways, via his statue, to circumvent both external tension and internal psycho-sexual conflict. Amenorrhea, as a different sort of artistic expression, does the same.

## SUBJECT AND OBJECT IN THE ARTISTRY OF PYGMALION

*“Meanwhile he carved his snow-white ivory  
With marvellous triumphant artistry  
And gave it perfect shape, more beautiful  
Than ever woman born. His masterwork  
Fired him with love. It seemed to be alive,  
Its face to be a real girl’s, a girl  
Who wished to move – but modesty forbade.  
Such art his art concealed. In admiration  
His heart desired the body he had formed.  
With many a touch he tries it – is it flesh  
Or ivory? Not ivory still, he’s sure!”*

Pygmalion’s statue is a masterpiece of both technical and visual virtues, which we might expect from a man who came from a sculpting dynasty that, according to Homer, made Agamemnon’s shield. His statue is that of “Womanaufacture” (Sharrock, 1991) representing an art-object moulded by the ideas and reflections of women as perceived by a man. But this is not just about Pygmalion’s love for his art-object, that which is the product of his own imaginations. According to Elsner and Sharrock (1991b) Pygmalion is smitten

“with his own creative and erotic process. Such are the erotics of the art-text. As “reader” of his own art-text, Pygmalion is seduced by it and enticed to penetrate its meaning” (Elsner & Sharrock, 1991b: 169).

I would agree with this and suggest that we have the continuation of a masturbatory process of part object rather than whole object relating. The statue mesmerises Pygmalion. We too as reader can become mesmerised by Ovid’s text and by Pygmalion’s handling of his statue. Even Goethe, who said that only a “brute” would take sexual interest in a material object, went to church one day

and got an erection whilst looking at a nude body of Christ gazing down towards one of his saints (Hersey, 2009: 6). The pose of kneeling towards the onlooker, as Pygmalion's statue does, was copied many times.

Freud only once refers to Pygmalion in all of his writings:

"We should hardly call it uncanny when Pygmalion's beautiful statue comes to life" (Freud 1919, SE XVII: 246).

The above quote is from Freud's paper "The Uncanny." Borrowing from Ernst Jentsch's 1906 paper "On the Psychology of the Uncanny" Freud wondered about the power of wax figures, dolls and automata. Of dolls that appear alive, Freud writes

"Jentsch believes that a particularly favourable condition for awakening uncanny sensations is created when there is intellectual uncertainty whether an object is alive or not, and when an inanimate object becomes too much like an animate one" (Freud, 1919, SE XVII: 233).

Freud remarks that for many children

"...the idea of a "living" doll excites no fear at all; the child had no fear of its doll coming to life, it may even have desired it" (Freud, 1919, SE XVII: 233).

Feminist writers have argued that Freud swiftly moved from an incomplete exploration of the female "doll" on to analysing male characters in Hoffmann's story *The Sandman*, thus replacing the female, the female body and even the maternal body, in favour of a more masculine symbol. Hélène Cixous accuses Freud of discarding the doll:

"The doll is not, however, relegated to some more profound place than that of a note [footnote], a typographical metaphor of repression which is always too near but nevertheless negligible" (Cixous, 1976: 537).

*The Sandman* was first published in an 1817 collection of stories called *Nachstücke* (Night Pieces). It tells the story of a university student called Nathanael who becomes infatuated with a beautiful, young woman called Olympia. He does not realise or consciously cannot acknowledge that she is in fact a wooden doll. She moves and she talks but whereas other people notice that she is “strangely stiff and lacking in animation” he does not. His friends describe her as “cold and prosaic” but Nathanael refuses to accept this, preferring the blank screen that she offers him with her lifeless eyes, onto which he can project his own self. She is his ideal woman, “a perfect listener” unlike his fiancé Clara whose intellect and opinion results in him calling her a “lifeless automaton.” When Nathanael eventually learns the truth about Olympia, he goes mad.

Freud’s analysis of this story all but ignores this central plotline in favour of focusing on Nathanael’s relationship with a man called Coppélius. Coppélius, whom Nathanael identifies with the monstrous Sandman, was thought to have been a cruel figure from Nathanael’s childhood, complicit in the death of the young boy’s father. Freud, interpreting the interplay between these men, uses the story to symbolise male castration fears. Interestingly, Freud overlooks Clara as a figure who has the potential to castrate with her superior intellect and discriminating mind. I am reminded here of Freud’s work as a psychoanalyst with one of his early hysterical female patients Dora. As Jane Gallop describes it,

“Dora is Freud’s Dora, the name Freud gives to the heroine of his “Fragments of an Analysis of a Case of Hysteria,” published in 1905” (Gallop cited in Benheimer & Kahane, 1990: 201).

Dora is Freud’s dolly then? Dora and her presenting narratives were nullified or at best reconfigured to fit in and to accommodate Freud’s own hypothesis on her condition and situation. Whilst she remained silent for long periods of time, lying on his couch (as Pygmalion had “laid her on a couch of purple silk...cushioning her head) Freud designed a reality for Dora, penetrating her with his interpretations. He wrote,

“I can only repeat over and over again – for I never find it otherwise – that sexuality is the key to the problem of the psychoneuroses and of the neuroses in general. No one who disdains the key will ever be able to unlock the door” (Freud 1905: 15).

Jane Gallop brilliantly asks in her own analysis of Dora’s Case

“Is this not the worst sort of vulgar, predictable “Freudian” interpretation? The predictability of Freud’s line about keys offends Dora by denying the specificity of her signifiers (by not attending to her but by merely applying general formulas)...What woman wants to be opened by a skeleton key?” (Gallop in Bernheimer & Kahane, 1990: 206).

Poignantly, Dora eventually walked out on Freud and their analytic relationship abruptly ended. Challenging the prerogatives of his male gaze and voice, this woman killed the analysis off. We might even say she castrated him, the thing he feared most. Freud wrote about Dora and continued to reflect on her case during his lifetime, perhaps by way of sublimatory redemption and retribution and perhaps as a means to feel in control. For as Madelon Sprengnether writes,

“Freud’s attempt to enforce an oedipal interpretation on Dora’s desire coupled with his repeated attempts to achieve narrative closure point finally to a fear associated with that of castration, although not identified with it: that of not being in control...Finally, however, he does not even have the power of a Pygmalion to make a woman who will love him. She is more like Spenser’s False Florimell, a seductive but empty image, composed literally of dead metaphors” (Sprengnether cited in Bernheimer & Kahane, 1990: 270-271).

Pygmalion with his inanimate statue need not concern himself with the issues that come with relating to women like Clara or Dora (or even to men like Freud!) He has found a solution to avoid issues of separateness, individualisation and autonomy. He is in control, more so than Nathanael from *The Sandman* whose doll moves and speaks. Pygmalion has total power over the desired object and all of his omnipotent wishes can be fulfilled.

We can contrast this with Winnicott's model of the transitional object where the subject assumes rights over his object, let's say a doll, but at the same time, this doll will often represent an "Other" in that

"it must seem to the infant to give warmth, or to move, or to have texture, or to do something that seems to show it has vitality or reality of its own" (Winnicott, 1971: 4).

Playing with the transitional object provides the infant with a paradoxical experience in that the infant can believe he magically creates this object and at the same time he can discover the object thus acknowledging its separate existence. In the realm between the "me" and "not me" the infant negotiates between the concept of having and losing and reclaiming what is both part of the self and separate from the self. When the child fixates on the object as a pacifier or when, translated into adulthood, the object become one that satisfies fetish tendencies, we have a way of relating that is exemplified by Pygmalion's caressing and adorning of his statue.

*"Kisses he gives and thinks they are returned;  
He speaks to it, caresses it, believes  
The firm new flesh beneath his fingers yields,  
And fears the limbs may darken with a bruise.  
And now fond words he whispers, now brings gifts  
That girls delight in – shells and polished stones,  
And little birds and flowers of every hue,  
Lilies and coloured balls and beads of amber,  
The tear-drops of the daughters of the Sun.  
He decks her limbs with robes and on her fingers  
Sets splendid rings, a necklace round her neck,  
Pearls in her ears, a pendant on her breast;  
Lovely she looked, yet unadorned she seemed  
In nakedness no white less beautiful.  
He laid her on a couch of purple silk,  
Called her his darling, cushioning her head,  
As if she relished it, on softest down."*

The eroticisation of the prose mirrors the eroticisation of the libidinal impulses. The non verbal cues, the sensory processing and the rituals can be decoded

within the framework of all that has sexual meaning, as they can be for early infantile experiences. But it appears as if there has been a break or a fixation in Pygmalion's development resulting in fetish tendencies. Fetishistic scopophilia "builds up the physical beauty of the object, transforming it into something satisfying in itself" (Mulvey, 1975: 14).

Laura Mulvey, writer of feminist film theory, explains in her paper "Visual Pleasure and Narrative Cinema" (1975) that, in psychoanalytic terms, the female figure with her lack of penis implies a castration threat. Fetish tendencies provide the male's unconscious relief or even

"complete disavowal of castration by the substitution of a fetish object or turning the represented figure itself into a fetish so that it becomes reassuring rather than dangerous (hence over-valuation, the cult of the female star)" (Mulvey, 1975: 21).

We can also interpret Pygmalion's decorating of his statue with excess visible adornments as a way not only to alleviate castration anxiety but also to compensate, replace or eradicate an imaginary lack, embodied in the statue's female form. In *The Trauma of Birth* (1924) early psychoanalytic pioneer Otto Rank had explained the mechanism

"of which Freud long ago described as a partial repression with compensatory substitute formations. The repression quite regularly concerns the mother's genitals in the meaning of the traumatic anxiety-cathexis, and the genitals are replaced by a pleasure-invested part of the body or its aesthetically still more acceptable covering – dresses, shoes, corsets, etc" (Rank, 2010 [1924]: 34).

By turning her into a figure of fetishism the risk of annihilation can be done away with, just as it was with the Propoetides. We are not told if the statue has been crafted with genitalia. Her gesture implies sexual availability and we know that she is beautiful, a concept which has its roots in sexual excitation.

“This is related to the fact that we never regard the genitals themselves, which produced the strongest sexual excitation, as really “beautiful”” (Freud, SE XIII: 156).

Freud added this statement as a footnote in 1915 to his paper “Three Essays on the Theory of Sexuality.” If the inanimate statue has genitals, their artificiality would be non-threatening to Pygmalion. As Freud writes,

“It often happens that neurotic men state that to them there is something uncanny about the female genitals. But what they find uncanny (unheimlich” = lit: unhomely) is actually the entrance to man’s old “home”, the place where everyone once lived...this place can be interpreted as representing his mother’s genitals or her womb. Here too, then, the uncanny [“the unhomely”] is what was once familiar [“homely,” “homey”] (Freud, (1919) SE XVII: 150-151).

In other words, if Pygmalion’s statue has new, ready-made genitals, they are non threatening in terms of their potential to annihilate man because there are not of where man first originated.

We could say that Pygmalion represents the man who objectifies and sexualises women as a way to render their genitalia impotent. We have the artificial concrete, non-changing ivory in contrast to human flesh that changes in between soft and hard, moist and dry. And sometimes these changes, notably the erection of the man’s penis and the lubrication of the woman’s vagina, are beyond our control.

In a way the feminine statue can be turned into a masculine version with these signifiers. Similarly turning away from the menstruating female form and embracing the way of a woman who like a man does not bleed menses, the Amenorrhic creates the space to avoid issues of femininity; those seen, experienced and commented on through the eyes of both the female and male gaze. (This we can link to the idea that a young girl transforming into a tomboy allows her the chance to escape the clutches of her mother, father and their

combined already conceptualised ideas of what it means to be a woman and / or a man.)

Another way to look at what Pygmalion might be doing is to suggest that he is sublimating his envy of her and of her potential as a child bearer. Thus, as Kaplan suggests in "Is the Gaze Male?" (1983), man's gaze might not be as pleasurable as he would first have us believe.

For Freud, man endeavours to find the penis in the woman because he fears his own castration. For Karen Horney it's because he wishes to deny the existence of female genitalia, which are threatening and so, if we apply this "logic" to the story, Pygmalion's idealised beautiful creation conceals a "dread that through her he might die and be undone" (Horney, 1932: 134).

Interestingly, the reader of the Pygmalion verse is not given any details about the statue's face, her figure, hair, the shape of her breasts, her height etc. As we are not supplied with conscious images drawn through the male gaze of Ovid, we can fill her body out with our own unconscious projections just as Pygmalion (and Nathanael) do. We shall see in the section on Shaw's Pygmalion how we as the reader have a chance to imagine what Eliza Doolittle looks like when she views herself in a full-length mirror for the first time. As readers, we can negotiate some space for ourselves in terms of putting authorship to one side and imagining what we each suppose she looks like and in what way we might imagine relating to her. This process of "visualisation" (phantasia) by which images are transformed by the mind's eye was very popular in the philosophy and literature of antiquity. Ovid's talent for this was greatly admired by his peers.

"By them, images of things absent are represented to the mind so that we seem to see them with our own eyes and have them with our presence. Whoever has the mastery of them will have a powerful effect on the emotions" (Quintilian, Inst. Or. 6.2.29 in Butler 1921: 433-435).

In the Appendix, I have included Ovid's love elegy from Amores 1.5 to show by way of comparison with Pygmalion, another man's love for a woman whose name

is Corinna. It is a celebration of love poetry at its most beautiful and most accomplished. It is of its time but is unique because *Corinnae Concubitus* describes a successful sexual encounter, a rarity in ancient works.

And what then of the female gaze? In mythology the forecast is not good, as best exemplified by the fate of Medusa. According to Ovid she was ravishingly beautiful. Raped by Poseidon in the temple of Athena, the goddess punished her and made her repellent. The snakes in her hair represented castration and her gaze acquired the power to turn her onlooker into stone. She possesses both phallic power and the power of female genitalia. Here is Freud's interesting account of the decapitated head of Medusa:

"To decapitate = to castrate. The terror of Medusa is thus a terror of castration that is linked to the sight of something. Numerous analyses have made us familiar with the occasion for this: it occurs when a boy, who has hitherto been unwilling to believe the threat of castration, catches sight of the female genitals, probably those of an adult, surrounded by hair, and essentially those of his mother. The hair upon Medusa's head is frequently represented in works of art in the form of snakes, and these once again are derived from the castration complex. It is a remarkable fact that, however frightening they may be in themselves, they nevertheless serve actually as a mitigation of the horror, for they replace the penis, the absence of which is the cause of the horror. This is a confirmation of the technical rule according to which a multiplication of penis symbols signifies castration. This sight of Medusa's head makes the spectator stiff with terror, turns him to stone. Observe that we have here once again the same origin from the castration complex and the same transformation of affect! For becoming stiff means an erection. Thus in the original situation it offers consolation to the spectator: he is still in possession of a penis, and the stiffening reassures him of the fact. This symbol of horror is worn upon her dress by the virgin goddess Athena. And rightly so, for thus she becomes a woman who is unapproachable and repels all sexual desire - since she displays the terrifying genitals of the Mother. Since the Greeks were in the main strongly homosexual, it was inevitable that we should find among them a representation of woman as a

being who frightens and repels because she is castrated” (Freud, 1922, SE XVIII: 273).

Freud goes on to say that for a man to display the erect penis he is essentially declaring his fearlessness. Let us presume that Pygmalion is impotent, already castrated by internal and external forces, what better way to regain control than by creating an inanimate female figure whose artificial genitals, if she has any at all, cannot threaten him. He can split off their potential to do harm from their capacity to give pleasure in the same way that Freud describes Medusa’s head which

“takes the place of a representation of the female genitals, or rather if it isolates their horrifying effects from the pleasure-giving ones” (Freud, 1922, SE XVIII: 273-274).

Pygmalion is having a hard time, (or so he wishes!) If we can look more favourably at what Pygmalion does achieve, we can return to one of Freud’s more desired and most perfect vicissitude of the sexual drive; the art of sublimation. In the context of pleasure ego and the reality ego, Freud states in “Formulations of the Two Principles of Mental Functioning” (1911b).

“Art brings about a reconciliation between the two principles in a peculiar way. An artist is originally a man who turns away from reality because he cannot come to terms with the renunciation of instinctual satisfaction which it at first demands, and who allows his erotic and ambitious wishes full play in the life of phantasy...Thus in a certain fashion he actually becomes the author, the king, the creator, or the favourite he desired to be, without following the long roundabout path of making real alterations in the external world” (Freud, 1911b: 41-42).

Many find it difficult to stay with Pygmalion’s commitment to his statue. This probably explains why it is sometimes seen as comical. With the Pygmalion text, it feels as if the art of sublimation is unable to adequately contain the unconscious emotions repressed within. I think respite is indicated in the use of

the lilies that we normally associate with death and commemoration. We know though that they soon will wither and die. What's to be done? Well, if this was a tale of our time we would anticipate the intervention of the all-knowing psychiatrist / psychoanalyst. Cue the entrance and intervention of Venus into Ovid's story.

### IN THIRD SPACE

*“Pygmalion, his offering given, prayed  
Before the altar, half afraid, “Vouchsafe,  
O Gods, if all things you can grant, my bride  
Shall be” he dared not say my ivory girl –  
“The living likeness of my ivory girl.”*

The fact that Pygmalion asks for a “living” girl shows that he is at least attempting to engage with the external world and its associated realities. Perhaps through lack of experience and insight he has not fully anticipated and thought through all that this might involve. In granting his wish, Venus is forcing Pygmalion to abandon his concrete ideal in favour of a real woman with whom he must learn a new way of relating. What is important here is the fact that Venus does listen to the prayers of Pygmalion but she grants them with a twist. He asks for a woman like his statue and Venus brings the actual statue to life. We are told that he did not dare ask such a specific request and most scholars interpret this as a display of his respect and timidity in the face of the gods. Pygmalion would not have dared incur their wrath. I propose a different interpretation in that unconsciously he did not dare himself to ask that it be turned into a real woman for that would result in a complete overhaul of his comfortable, uninterrupted narcissistic set up. As a statue she can be used as a mirror image or a double through which he can gain an “I” whilst at the same time regaining his own self-being. He can circumvent any castration anxieties and he can use her as a representation of immortality, which will protect him against any thoughts about the realities of death and indeed death itself. But as Freud warns us in his reference to Otto Rank's 1914 work

“The “double” was originally an insurance against destruction to the ego, an “energetic denial of the power of death” as Rank says; and probably the

“immortal” soul was the first “double” of the body...Such ideas...have sprung from the soil of unbounded self-love, from the primary narcissism which holds sway in the mind of the child as in that of primitive man; and when this stage has been left behind the double takes on a different aspect. From having been an assurance of immortality, he becomes the ghastly harbinger of death” (Freud, 1919, SE XVII: 235).

Just as the statue’s coming to life will jolt Pygmalion out of a state of primary narcissism, with a real, mortal woman in front of him, he will now have to rewrite a more complicated, reality orientated destiny for himself and for the two of them. It will include his witnessing of her aging process, and of his own. Furthermore, this Other person will be seeking out her own mirror image and in doing so will never be completely available to him. And so what Pygmalion might be faced with now is a relationship between viewer and scene which

“is no longer a relationship of plenitude but one of fracture, partial identification, pleasure and distrust” (Rose, J. (1986) 2005: 227).

I think what Pygmalion had in mind was to have a real woman to marry who would share in his day to day ordinary life whilst at the same time keeping his inanimate statue hidden behind closed doors. Hidden from view he could continue to engage with it in a way that a real woman might take offense to. Or she might not and that is precisely the point I want to make. Up till now Pygmalion has viewed her and related to her in a specific, ritualistic way that suits and works for him. What if it doesn’t suit or work for her? What if she has needs of her own, different to his, and she desires to be gratified in different ways? To what extent will they influence each other’s choices? Thus they are propelled into the stuff of relationships; the matter and composition of which is in constant flux and flow, unlike the hard ivory substance. (We can refer analogously to the waxing and waning of the physiology of the menstrual cycle as opposed to the amenorrhic phenomena that is constant, consistent and still).

Once Venus brings the statue to life, presumably it has no traces of memory, but Pygmalion does. Should he continue to have ownership and authorship of her?

Will he continue to use her as a canvas for his projections? I believe that Venus will have granted this “living” girl a psychology of her own with the necessary cognitive tools required to live as a human. If she chooses to remain solely as a machine for sexual activity, then let’s hope it is her choice. She might develop a creative mind of her own in which case she might ironically become for Pygmalion what Clara was for Nathanael in *The Sandman*; a “lifeless automaton.”

We don’t have the answers, which allows our minds to wander freely. We must though show sympathy and empathy for Pygmalion who has to restart from a position that requires a new way of thinking and relating. Similarly, the analyst must have compassion and remain attuned to the route that his patient takes, especially the patient who presents with secondary amenorrhea. Her coming to life via a return of her bodily menses comes not only with the threat of the analysis breaking down but also with the threat of her own psychological breakdown.

I would like to end this section with a note on symbolisation. Many see Venus as the “third” without whom there would be no advancement. But perhaps the third space has and will always belong to Pygmalion’s own artistry and what Venus represents is the potential for growth from creative doing to creative thinking through the process of symbolisation. I want to quote one of Winnicott’s skilfully observed and documented patient encounters, to highlight the coalition of the illusionary and the real in bodily terms and to suggest the level of difficulty I suspect Pygmalion will have with his newly animated companion. Winnicott writes,

“it seems that symbolisation can only be properly studied in the process of the growth of an individual, and that it has at the very best a variable meaning. For instance, if we consider the wafer of the Blessed Sacrament, which is symbolic of the body of Christ, I think I am right in saying that for the Roman Catholic community it is the body, and for the Protestant community it is a substitute, a reminder, and is essentially not, in fact, actually the body itself. Yet in both cases it is a symbol. A schizoid patient asked me, after Christmas, had I enjoyed eating her at the feast. And then, had I really eaten her or only in fantasy. I knew that

she could not be satisfied with either alternative. Her split needed the double answer” (Winnicott, 1975: 234).

Presumably the answer is that he does eat her both in fantasy and in reality just as the Roman Catholics eat the wafer.

We can conclude here that Pygmalion had wanted both his concrete, idealised statue along with a real woman. He had wished for “the double answer” but Venus, sees fit to accommodate him differently.

As an addendum, might I suggest that Venus be used as a representation and a reminder to clinicians of how important and creative it is that we have our own third other; by this I mean to have the presence and use of our own analyst or supervisor. When analyst and patient are in danger of merging, when during the mirror phase it is difficult to extrapolate for whom the double is serving, self-analysis just won't do!

TRUE LOVE'S SOMETHING OR OTHER – SELF EFFICACY AND THE UNKNOWN

*“And he went home, home to his heart's delight,  
And he kissed her as she lay, and she seemed warm;  
Again he kissed her and with marveling touch  
Caressed her breast; beneath his touch the flesh  
Grew soft, its ivory hardness vanishing.  
And yielding to his hands, as in the sun  
Wax of Hymettus softens and is shaped  
By practiced fingers into many forms,  
And usefulness acquires by being used.  
His heart was torn with wonder and misgiving,  
Delight and terror that it was not true!  
Again and yet again he tried his hopes –  
She was alive! The pulse beat in her veins!  
And then indeed in words that overflowed  
He poured his thanks to Venus, and at last  
His lips pressed real lips,”*

We have here the shift from a fused state to the beginnings of a relationship ushering in a lost state of wholeness. We might see Pygmalion as representing the mother who must re-surface from a fantasised emotional fusion which Helene Deutsch called the “psychic umbilical chord” (1945: 278) Through this chord the mother can simultaneously regress in fantasy to the early conditions in life where she was lovingly identified with her own mother. However, as far as Pygmalion is concerned, it seems that a rupture is on the horizon as he displays a “heightened sensitivity” (Winnicott, (1956) 1958a: 302) and a sort of schizoid rambling in response to the emerging other. Both Freud and Lacan wrote that a search for a reunion is symbolised in substitution and displacement. At birth we are cast out and we endlessly search to recover this lost state of wholeness. The repetition of themes in Ovid’s *Metamorphosis* symbolises the repetition of the displaced desire. As Virgil wrote,

“For the hope is that the fire can be put out by the same body that is the source of the burning. Nature protests that entirely the opposite is the case: this is the one thing, the more of which we have the more our breasts burn with terrible desire” (Virgil Aen. 1086-90).

The statue embodies Pygmalion’s desires but something transformative happens when she changes from inanimate to animate.

*“She, his girl,  
Felt every kiss, and blushed, and shyly raised  
Her eyes to his and saw the world and him.”*

She sees the world around him. In that moment I see the first stages of separateness and autonomy as she looks beyond him to the skies, the unknown. Their eyes meet but one senses the urge in her, indicated by the libidinally driven blush, to extrapolate herself away from a state of magnetic narcissism and away from the trappings of what might become mutually gratifying perversion. She is much more than this. Yes, she has no voice and yes she appears malleable but I would argue that she has the potential to be more than a symbol for Pygmalion’s lost paradise of an original unity.

*“The goddess graced the union she had made,  
And when nine times the crescent moon had filled  
Her silver orb, an infant girl was born,  
Paphos, from whom the island takes its name.”*

It is interesting how Ovid’s tale delivers a conventional ending with a pregnancy of nine months resulting in the successful birth of a child. The moon is often linked to the periodicity of the menstrual cycle.<sup>xii</sup> At the same time we are a million “crescent moon(s)” away from the unconventionality of where this story began.

From this point on we move to motherhood and we cannot deny the patriarchal slant of a romantic and idealised state as portrayed here and as written by Friedrich Nietzsche in *Thus Spake Zarathustra* as “everything in woman hath one solution – it is called pregnancy” (Nietzsche, 1891: ch.18).

When considering Galatea’s new position, we could take Freud’s pessimistic view that a baby is the substitute for a woman’s lack of a penis or as Jung would propose, the child as a mythical symbol is the saviour. But we could also consider a developmental process of change from initial symbiosis linked to narcissism (as portrayed in the fetish stage) to a new arena that includes a reality dose of individuation, separateness, mortality and loss. It is she that symbolises the capacity for change through a capacity for reverie. This is all speculation of course but how interesting that in these last lines of the verse Pygmalion is not mentioned. He has been frozen out and it is he who is now immobile. In his absence she becomes present. What will he do in the face of a stark new “reality?” How will he feel as he watches her age? How will they both negotiate the introduction of a third, which we can call female sexuality? What will happen once her childbearing days are over? Will her fate be that as described by psychoanalytic theorist Helene Deutsch when analysing the way in which society views its women?

“At the moment when expulsion of ova from the ovary ceases, all organic processes devoted to the service of the species stop. Woman has ended her existence as bearer of a new future, and has reached her natural end – her

partial death – as servant of the species. She is now engaged in an active struggle against her decline...Woman's biological fate manifests itself in the disappearance of her individual feminine qualities at the same time that her service to the species ceases. As we have said, everything she acquired during puberty is now lost piece by piece" (Deutsch, 1945: 460-461).

We might consider here how a woman with secondary amenorrhea is above and beyond all of this emotional upheaval. With her clean lines, she is more aligned with Venus in that the menstrual matters of ordinary womenfolk are of no concern to her. She will not be tortured by the sense of loss associated with each menstrual cycle and ultimately with the menopause. She need not suffer the same fate of her menstruating counterpart who

"with the lapse of the reproductive service, her beauty vanishes, and usually the warm, vital flow of her feminine emotional life as well" (Deutsche, 1945: 461).

Perhaps Pygmalion will welcome a menopausal wife so that she might serve him solely once again as a servant to him rather than "as a servant of the species" (Deutsche, 1945: 461).

In Ovid's text, Galatea soon becomes pregnant, thus recapitulating an immaculate conception and postponing the development of more developed inter-relations between woman and man. Their dynastical line continues impressively but there are no happy endings for what began with a union between creator and creation. What follows is Ovid's tale of a girl called Myrrha, who is the great granddaughter of Pygmalion and Galatea. It is a tragic and evocative tale of incest.

#### INCEST AND EXILE – THE STORY OF MYRRHA

Unlike Pygmalion who asked for something similar to his statue to be brought to life, Myrrha, the "dutiful" daughter is deeply in love with her father and only he will do as the love object. Her father is the Great Cinyras who is the grandson of Pygmalion and Galatea. Myrrha is obsessed with the fantasy of having sexual

relations with him. Absolutely no one else comes close. Her wishes are accompanied by a psychological conflict that torments her. She asks,

*“Why, other creatures couple as they choose regardless. If a heifer’s mounted by her father, that’s no shame; a horse becomes his daughter’s husband; goats will mate with kids they’ve sired themselves; why even birds conceive from seed that father them. How blest are they that have such licence! Human nicety makes spiteful laws” (X: 315-345)*

These questions precede Freud’s, in his work “Civilisation and Its Discontents” in which he writes

“The tendency on the part of civilization to restrict sexual life is no less clear than its other tendency to expand the cultural unit. Its first, totemic, phase already brings with it the prohibition against an incestuous choice of object, and this is perhaps the most drastic mutilation which man’s erotic life has in all time experienced. Taboos, laws and customs impose further restrictions, which affect both men and women” (Freud, 1930, SE. XXI: 51).

Myrrha also makes available the thinking behind Freud’s Oedipal theory. She asks of herself,

*“Will you become your father’s concubine, your mother’s rival?”*

All she can do is vehemently call herself wicked as she endlessly revisits, in her mind, this most tragic of loops.

*“But now because he’s mine, He isn’t mine!”*

The only way she envisages escaping from this trap, caught between desire and taboo, is through death. It is her nurse who, in snatching the noose away from Myrrha’s neck, prevents the young girl’s suicide. The nurse, like Venus in the Pygmalion verse, can be seen as symbolising the reparative qualities of a third other / space. She comforts her mistress and arranges that Myrrha and Cinyras lie together in the dark so that Myrrha’s identity remains hidden from him.

*“In that incestuous bed the father took his flesh and blood and calmed her girlish fears and cheered her bashfulness. Maybe to suit her age, he called her “daughter and she him father” – names to seal the crime.”*

One cannot help but be moved by this. Our own moral preconceptions become discombobulated. Myrrha’s inability to accept social constraints cast as law through the incest taboo and the way in which she and her father relate to one another, reflecting her fantasy wishes, is poignant. In her father lying with her, he facilitates an exit out of a torturous loop that until this point was infinite and unrelenting. Did he truly not know who she was? The same question can be asked of Lot when his daughters got him drunk and seduced him so that they could bear his children and continue the ancestral line (Genesis, ch.19). Many rabbinical scholars say that on one level he knew. In Myrrha’s case, we have a young girl who can conceptualise her wishes and ideas but for them to be realised, a third agent is required. The nurse partners the two of them together and then it is the father who brings her wishes to fruition. It is he who is the key developmental third and who moves the plot line on.

We have the “real” father and we have the father as lover and incest object. When he discovers who she is, he comes after her with his sword. A sword used against the skin brings forth blood. Here we can consider the menstrual taboo alongside the incest taboo. In psychoanalyst C.D Daly’s paper, “The Role of Menstruation in Human Phylogenesis and Ontogenesis” (1943), Daly writes about man’s ambivalence towards a menstruating woman. On the one hand man is repulsed by what he sees and yet at the same time he lusts after it. For Daly this goes back to the time when the infant witnesses his mother’s menstruation, which causes him great anxiety; an anxiety that precedes the castration anxiety associated with father later on. Daly sites Freud’s work “Taboo of Virginity” (1918) to show how Freud linked sadistic menstrual taboos with man’s fear of blood but for Daly, Freud does not go anywhere near far enough in acknowledging the power of the symbol of the menstruating woman. For Daly, the blood that flows from the vagina dentata means that mother is an active force in shaping man’s human psyche. If we apply this to King Cinyras we have a man who wants to master his ambivalence. On the one hand, repulsed by the

incestuous act he wants to strike Myrrha with his sword but I would suggest that unconsciously and much more powerfully he wants to penetrate her a second time round with his erect phallic object.

In fear of her life, Myrrha flees into exile. It's as if it is too much for her to witness her father's transformation from a familiar loved one into a foreign being, and the place of exile represents a middle space and a sanctuary. Where now and who now is her father?

We can view The Great Cinyras in a dual role as being similar to that of the huntsman / father that we read about in so many folk and fairy tales, most famously in Snow White and Sleeping Beauty (Bettelheim, 1976). In both these tales it is true love's kiss that breaks the spell and allows for the child's interrupted development to restart. In Beauty and the Beast we have Belle's father as the cause of her exile to the Beast. Belle indeed thrives in this new kingdom where her curiosity can be satiated. In The Handless Maiden, the first part of the story tells of a miller who is tricked into giving his daughter to the devil and fearing that the devil will take him instead, complies with the devils request. The devil is unable to become the girl's master and she wanders into a new kingdom. Coline Covington, a British Jungian analyst writes

“the concept of hero and heroine – and their different struggles – cannot be applied exclusively and respectively to men and women. Men can be under the influence of the heroine just as the women can follow the path of the hero. The anatomical difference between hero and heroine does not indicate a basic difference in the psychology of men and women; it is a metaphor of otherness” (Covington, 1989: 252).

The essential question for all of us is what does the child / patient feel when her wishes are fulfilled; when the symbolic has a life of its own? In view of a psychic breakdown following the fulfillment of her wishes, Myrrha asks the gods to

*“change me and deny me both life and death.”*

Again, we have the idea that salvation is provided in this middle space. Following her wandering in exile, the gods turn Myrrha into a tree and in mute pain she gives birth to a baby boy, of her father's seed. It is she who is burdened by the guilt. But whose guilt is it? If we use Freud's early investigations into hysteria where there is a low threshold between the conscious and unconscious worlds, we can question the location of unconscious motivation. Whilst Freud states in his letter to Wilhelm Fliess that "hysteria is not repudiated sexuality but rather perversion" (Freud, 1896: 212), Freud goes on to write that it is the father who is the seducer and the child / patient does not wholly repudiate the act of incest but has in her mind a place that yearns for this seducer; "the prehistoric unforgettable other person who is never equalled by anyone later" (Freud 1896: 213).

This is like Myrrha who cannot contemplate being with anyone other than her father. We shall consider this in more detail in the clinical discussion of the amenorrhoeic patient and in a review of Freud's treatment of Emma Eckstein during which Freud moved from his seduction theory to a language of seduction and wishes, and the interplay of reality and fantasy. These of course are emblems of the Pygmalion tale. Just as Freud's formulas were in transition, stimulated by his clinical work on hysteria, Ovid's work was written and inspired by a transition between pagan antiquity and Christianity. This phase symbolised a psychological interplay between aestheticism and gratification.<sup>xlii</sup> Ovid wrote the *Metamorphosis* whilst in exile, mourning a lost love and desiring a return to Rome. It is believed he was exiled because he witnessed either an affair or a crime committed by Caesar. This is a nice analogy for Freud's theoretical move away from an actual committed crime of seduction to a middle ground where perhaps the child witnessed or overheard something she shouldn't have which bought about later fantasies that offered self relief in that they acted as sublimations, embellishments and protective structures (FF 2nd May 1897: 239). These acts are that of Pygmalion, the embellishments being the decorations onto his artwork that symbolises and contains so that,

"past, present and future are strung together, as it were, on the thread of the wish that runs through them" (Freud, (1908) SE IX: 147-148).

I think they are not only strung together but they bleed across and into one another, meeting multiple identities and narratives along the route. The trail is the wish and the terrain of the unconscious encompasses all.

## ORPHEUS AND THE UNDERWORLD

What is lost can be found in what is present. All routes lead back to the idealised love object as exemplified by Pygmalion's creation. But his story is itself a textual wish fulfillment of another artist, Orpheus. Orpheus tells the tale of Pygmalion as a way to conjure up the presence of his dead wife Eurydice. In mourning the loss of his beloved, Orpheus is unable to partake in ordinary life, just as Pygmalion was, and he abstains from the company of women, choosing to spend his days alone. A group of women, enraged by his scorn towards them, kill him and throw his dismembered body and his lyre into the river. The Muses find him and give him a proper burial. It is said that his soul returned to Hades and he was reunited with Eurydice. But this was not the first time he had met her in Hades. When Eurydice died, Orpheus mourned her loss with such grief that he was allowed into the Underworld. There, he played his lyre so beautifully that he enchanted the wardens who then consented to her release. They told Orpheus that when escorting Eurydice out of the Underworld he should not glance back to look at her until they are both out. He does not heed their warning and as he turns back to look at her she is lost to him a second time. Why does he turn round? Is it that he is troubled by the unorthodoxy of rewriting fate? Is his turning back an indication of his humanness and of his mortal uncertainty in contrast to godly omnipotence? Could he not trust that she would follow? Will mother's gaze be there should the infant chance it and look away? (Stern: 1985) Perhaps what is represented is a shift from a psychotic ego's attempt at a cure through magic to one in which the idea of permanently possessing the love object is recognised as a doomed cure because

"reality testing has shown that the loved object no longer exists, and it proceeds to demand that all libido shall be withdrawn from its attachments to that object" (Freud, 1917, SE. XIV: 244).

It is “near the margin, near the upper land” that Orpheus turned round. The margins between the Underworld and the Upper World is perhaps the place where time stands still, freeze frames: the blood does not run through yet the body is still alive, as for the amenorrheic. Psychologically too, there is a freeze frame, where the amenorrheic is unable to “go with the flow.” Instead, in this realm we have someone who is neither fully alive nor fully dead: A Myrrha, A Galatea, A Eurydice, An Orpheus, A Pygmalion.

To move between these worlds, one needs bridges, a healthy dose of narcissism and a third space to think. We shall see in the following clinical examples how important these ingredients are to the anorexic on the cusp of puberty, to the female who neatly avoids border crossing at the intersections of sexuality by becoming pregnant and to the secondary amenorrheic who denies herself a passport for an onward analytic journey by remaining in a transference neurosis with hysterical tendencies. It is hoped that the Ovidian themes presented in my analysis of the Pygmalion tale are discerned and brought to life in the following three case studies.

#### CASE STUDY “MARY” - A CLINICAL OVERVIEW

The transitional point between death and life is a middle space where time stands still and yet life goes on. We have seen this in the way that Eurydice inhabits the margins in between the Underworld and the Upper World befriended by death because she and Orpheus cannot trust life. We also saw this in Myrrha’s transformation into a tree. The subject resides in a land of exile, in between two states. The Amenorrheic and the Anorexic are on the threshold between two worlds; in a place between childhood and womanhood where they can stay uninterrupted because time has stopped still, represented by the cessation and continued absence of a menstrual cycle. Perhaps the stopping of time can allow for her to catch up psychically as her formative illusionary precociousness is inadequate scaffolding for the real perils of adolescence. Perhaps she is waiting for the inadequacies of her parents to be modified so that they might hold and contain her more securely? Similarly, as Galatea makes a successful metamorphosis from Pygmalion’s inanimate idealised statue into a real, human

individual, the two of them have their work cut out, both having to move with the times.

Another way in which the secondary amenorrheic displays the capacity to thrive in the margins and cultivate the land is the way in which she, as an infertile woman, can create her offspring through immaculate conceptions. Interestingly, during analysis many patients with secondary amenorrhea start to menstruate again and some become pregnant. It appears when the analyst and patient are in some way in touch with one another, on an equal footing, the treatment suddenly finds itself brought to an end through pregnancy. As a menstruating woman in analysis the patient could have explored issues surrounding female sexuality and what it means to her to be a woman. Becoming pregnant, her menses cease and she can preoccupy herself with the role and demands of motherhood. She can continue to prolong the non-menstrual state for as long as she chooses to breastfeed (lactational amenorrhea).

We will also see how the patient with secondary amenorrhea can appear both present and elusive. In the consulting room she can be experienced as both fully present and at the same time a hundred light years away. As Freud witnessed in his hysterical patients, they were hard to decipher and their hysterical tendencies in front of him belied their agility in moving in the world at large with great style and accomplishment. I ask that the analyst seriously consider in whose best interest it is to bring her across the margins and into the Upper World? Is it that the analyst feels claustrophobic and must come up for breath under the illusion that he is blowing into her the kiss of life, just as Pygmalion did for Galatea? What happens when the analyst finds himself enchanted in her world, questioning his own capacity for separateness? These are powerful and unearthly emotions, only for the brave-hearted. In the analytic encounter, much is entwined and projective identification is a most powerful tool by which the analyst can become enslaved. As analyst, interpreter and reader of her narrative, he can become entangled in between past and future lines of prose. What those wishes are can become enshrined in a transference love or transference neurosis. As Balint describes it, it takes over the analysis and the patient becomes pre-occupied with the motives of her analyst and her expectations of him become unrealistic.

“To condense this situation into one sentence, one might say that the importance of the past is well-nigh lost for the patient; only the analytic present matters” (Balint, 1968: 85).

It is no easy task to extrapolate the unconscious wishes of the patient when she asks for both symbiosis and separateness, when she fills the consulting room with both life and death forces and when she keeps the treatment alive by leaving. Identification, separation and transformation are matters of life and (or) death.

#### “MARY” – A CLINICAL CASE OF TRANSFERENCE NEUROSIS

The analysis of Mary, a patient with long-term secondary amenorrhea, is published here for the first time, with Mary’s consent. Mary’s menses returned during her treatment and by about the fifth year of analysis, she was in the throes of a transference neurosis. Just as Balint and Freud had described in their work on transference neurosis, she focused only on what was going on, or not, between her and her analyst. She found absence in the presence and presence in the absence. There was hardly any narrative other than a discussion of the two of them. She wasn’t interested in any third party displaying pre-oedipal tendencies. She was pre-occupied with knowing the degree to which her analyst found their work important. She would persistently ask how often he thought of her when they were not together. She would rebuke her therapist’s attempts at interpretations that hinted at envy or greed. For her, it was about creative love and everything was resolutely in the here and now.

For Mary’s analyst, central to the work was the idea that as her hysterical symptoms in the consulting room abated, the transference neurosis restarted. The backdrop to this was the fact that her menses had returned and the background of safety of amenorrhea was no longer available to her. In the fifth year of analysis, Mary became paranoid that something was not quite right. She described herself as the mute Galatea and told her analyst that it was his voice alone that created her therapy and that she felt increasingly powerless. She

started to suggest that the treatment was making her ill and she recognised the dangerous degree to which she could not break out of the cycle. Her analyst used the image of the sea-saw to describe how perilous a state of being this felt for each of them and for them as an analytic couple. This perhaps intimated his acknowledgment of the risks and dangers involved in the mechanisms of psychoanalytic technique. She was angry that he appeared to her more and more like Rapunzel, stuck in the tower, resistant to change. And what was the point of having golden, magical hair long enough to reach the ground, if it were never going to be used to cross to the other side of the transference into the real world? Unable to articulate her thoughts and exasperated by the idea that he was not listening, she wrote them down. Intelligent and psychoanalytically adept, she suggested that the piece of paper represented the masturbatory object which he could touch and play with and which he could engage with through reading over and over again. In her own private thoughts she considered the following:

“I want to talk about the intruder. I want space for my free associations and thoughts. When I don’t get it I sense a gap and I alleviate the anxiety by feeding you with the life force. Who is seduced? Who is abandoned? Who is dependent? Who will be castrated? Who will end this therapy?” (pers. comm. 2014)

As testimony to the power of the unconscious and to the uncanny, around this time Mary fell down five stairs. She was in her fifth year of therapy. Fascinatingly, it was in her mother’s fifth month of pregnancy that she “discovered” she was pregnant, with Mary. The falling down the stairs was, for Mary, a concrete act that symbolised the precariousness of the sea-saw her analyst had referred to. Reflecting on this fall a few months later, Mary said that she had miscarried the analysis. She told her analyst that she found her husband insightful when he had described her hysterical crying at the bottom of the stairs as if there had been an intruder in the home. Mary interpreted this as her analyst being the intruder and she suggested that the work was at an impasse because it was becoming more about his narcissism and self-preservation and less about hers. Her analyst suggested that through the reception and the creation of meaning they might begin the process of finding her voice and outlining the parameters of her space. He was in a double bind as he felt the need to sign post a route to each of their

self-efficacy but he felt he could not deny separateness for fear that she would fall or jump off the sea saw into the gap. Would he become Orpheus in leading her out of this transference neurosis? Would he fail or would it be that she would choose not to go with him? What would fate have in store for them?

The analyst is like a mother who needs to be able to intuitively sense where the infant is (Stern, 1985). Just as the balance on the sea-saw needs to be securely maintained, the analyst also, like the mother, can help the patient develop creatively if she feels he is in attunement with her. A premature or quick movement will startle her and cause anxiety. For Mary, when she believed that her analyst had chosen to move away from her in his mind, she withdrew and left with an angry rejection of him. Of course this allowed for her to restart the whole process over again when she returned. The repetition bought with it a rupture, as increasingly she did not know what it was she saw each time she returned to the mirror. The truth was unreliable. With a mirror image that is hypnotic and magnetic in its narcissism, who is Pygmalion, who is Galatea? Who is the subject and object of transference love? In the face of these questions, I have argued that it is essential that the analyst must not rely on self-analysis and he must seek supervision as a way to maintain distance and provide a third space. As Thomas Ogden brilliantly writes

“Human beings have need as deep as hunger and thirst to establish intersubjective constructions (including projective identifications) in order to find an exit from unending, futile wanderings in their own internal object world. It is in part for this reason that consultation with colleagues and supervisors – even [our own] analysts post analysis – is so important in our work” (Ogden, 1999: 105).

Many of these analyses, pervaded by transference neurosis both erotic and eroticized, result in failure. We have the infamous cases of Spielrien and Jung and we have Anna O with Breuer. So I would like here to briefly mention that the ending of treatment for some patients who present with secondary amenorrhea is never truly terminated. Instead, both patient and analyst are left in a state of limbo, a middle space. The air is rife with both human uncertainty and ghostly omnipotence. I am suggesting here and elsewhere in this thesis that both patient

and analyst maintain this state of limbo unconsciously by going into their own narcissistic retreat. It might appear that the discontinuation of treatment provides space and time to remember and to mourn but it also enables them to deny its creation, existence or termination. Fixated at this point they cannot accept the reality of a permanent ending or accept the uncertainties of continuing on. What is being acted out is what the body in a state of secondary amenorrhea does which itself provides a mirror image of the patient's psychic organisation in which life and death, the inanimate and the animate can co-exist infinitely and equally.

#### CASE STUDY "SYLVIA" - A CLINICAL OVERVIEW

To understand the psychological artistry of Amenorrhea, one needs to bear in mind that the Immaculate Conception of Jesus to Mary stands alongside the incestuous rawness of Jocasta and Oedipus. Whilst the body envelops and contains, the unconscious mind is afforded a space roam. One must acknowledge the bodily urges and the tension between the instinct libido and the ego libido. All that is present in the absence at the outset of treatment is steeped in omnipotence but towards the end the patient comes to realise that it is through her vulnerability that she acquires knowledge and power. After all, the sexual instinct is linked to the instinct for knowledge. The analyst must be brave enough to enter into this no man's land and "the analyst must expend libido on his patient" (Freud to Ferenczi 23rd June 1912). At the same time he must respect that this is indeed a land for no man.

As I have previously stated, exile is a form of silencing but paradoxically it is the space that provides the freedom and safety to speak out. My hypothesis is that the body of the secondary amenorrheic must not be viewed as a body that lacks menses but rather as a body with presence; one that can be used to represent the place of exile. Here we can turn to the exile of the Jewish people out of Egyptian slavery. In creatively worshipping the Golden Calf they delayed their entry into the Holy Land for forty years. It is at the age of forty that women are rendered unsuitable to conceive. For women with amenorrhea they neither need to give up Egypt nor accept the Holy Land. As one patient, whose menses had returned, said to her analyst when he announced he was going on a vacation to

“The Promised Land,” “I shall be re-entering exile. I am not ready to die yet” (anon. pers. comm.).

Here we can turn to the observations of Appignanesi and Forrester in their book *Freud's Women* (1992) to illustrate the point of no man's land. They write of Freud's patient Emma Eckstein whom we shall study in the following chapter,

“Emma's longing, her eager collaboration in her analysis, gave Freud much precious material...the wish theory of psychosis and dreams; the transference reconstruction of her early pleasures in menstruation and its prehistory in her battles with her family; fantastic scenes from her inner life, in the no man's land between fantasy and memory, resonating with the sadistic acts and fantasies of a former historical epoch” (Appignanesi & Forrester, 2005: 137).

#### SILVIA – A CLINICAL CASE OF IMMACULATE CONCEPTION

Marie Langer in her book *Motherhood and Sexuality* (2000) recounts the case of Silvia, a patient of Edith Jacobson (Langer, 2000: 164-169). Aged thirty-five, Silvia came for treatment for her depression, which she identified with her infertility. She had been amenorrheic since the age of sixteen and along with hormonal disorders she was physically weak and lacked appetite for food or life. She and her husband adopted a baby but unable to adequately care for him she gave the baby back to the adoption agency. This brought on a severe depression in Silvia. When she entered psychoanalytic treatment, her analyst asked that she be re-examined medically. The gynaecologist advised against any future hormonal treatment and saw no chance in her conceiving. But from the outset of analysis, her body changed, she put on weight, her breasts developed and in the eighth month of her analysis she became pregnant without her menses ever returning.

Silvia was the child of poor Jewish immigrants. Sharing her parent's bedroom she would witness sexual intercourse between them and she believed that it was her mother eating of a part of her father's penis that resulted in pregnancy. Orally fixated, when one of her brothers died young she repressed her relief that his

death meant there was one less mouth to feed. This guilt translated into sadness. In the analysis, it became clear that as a young girl she had envied the penis of her living brother and its associated powers. She decided she would emulate this masculinity and become successful and she planned to go to university. She met a fellow in love with a Christian boy but her perception of her family's judgment of her resulted in her not eating, which also acted as a vehicle to repress and prohibit her passion. She felt she had no choice but to break off her relationship with him and by this point she had stopped menstruating completely. She later married a man who was kind and who looked after her,

“but her old desires of having a penis or a profession – in order to win her mother's love – or of being a mother – in order to conquer her mother through an identification with her – remained alive within her” (Langer, 2000: 167).

Jacobson interpreted Silvia's loss of appetite as self-punishment for oral envy and as a repression of the desire to eat something unorthodox. Her thin, shapeless body was that of a boy's but at the same time she was a woman. She had hated and envied her pregnant mother but when she wanted a child of her own she was afraid that she would be punished for wishing her mother dead.

“The ingenious solution that she found to this anguishing conflict was her amenorrhea, which signified both an escape from her femininity and the realization in phantasy of her wish to become pregnant. Moreover, not to menstruate was to be like a man. Later, during her marriage, more regressive desires emerged and Silvia renounced her pseudo-virility. She then utilized amenorrhea, lack of appetite, and her entire precarious physical state in order to be able to be a little girl, loved by her husband-mother” (Langer, 2000: 167-168).

Eight months into her analysis Silvia became pregnant and she gave birth to a baby girl. She menstruated regularly after that and despite using contraception she soon became pregnant again which she terminated with curettage. Again, she became pregnant and again she had a curettage. Jacobson hypothesised that her infertility transforming into hyper-fertility communicated the extent to which her basic conflicts had not been resolved. Eventually, rather than using

extreme measures of curettage or sterilisation, her body put itself back into an amenorrhic state. I would describe this as an uninterrupted state, unrivalled in its capacity to symbolise presence, absence and all that resides in the middle space with a remarkable capacity for a four-dimensional state of equilibrium. No schizoid sea-saws in this realm! I think what is being presented here is a pull and a push, a rejection and an acknowledgment of the need for boundaries. Artificial, man-made boundaries are on the one hand necessary containers and holders: The laws of paternity, the medics, the analysts, the voices of reason – where would we be without them? On the other hand, they are impositions and interferences in what should be a natural continuum. After all, ‘All boundaries are artificial interruptions to what is naturally continuous’ (Leach, 1976: 34).

Caught up in the bounce between both, we are neither every fully in or out: neither wholly captive nor free: And if we consider what is being communicated in terms of the maternal body, we have here what Bronfen describes as “the maternal body in her traumatizing intimacy” (Bronfen,1988: 24). Bronfen has Montrelay in mind who writes of the

“time when nothing was thinkable: then, the body and the world were confounded in one chaotic intimacy which was too present, too immediate – one continuous expanse of proximity or unbearable plenitude. What was lacking was lack” (Montrelay 1977 cited in Moi 1987: 233).

For Lacan, the lack is not of or for the object but is a lack of being. Its very lack speaks volumes. And this is sometimes a necessary mode of communication and a central psychic pillar in the mind of the anorexic / ammenorrhic patient as we shall see in the following clinical case.

#### CASE STUDY “KIRSTY” A CLINICAL OVERVIEW

There are clinical cases of anorexic female patients (with the associated amenorrhic symptoms) whose family history includes the death of a loved one which the parents have been unable to adequately acknowledge and mourn. The child can represent a re-incarnation of the deceased and her anorexia stops her

from asserting her own identity and individuation because unconsciously she is afraid of betraying her parents by growing up. Adolescence and the acquisition of a new sexual body represents individuation at its most threatening when up till this point the child is entangled in the parental identifications. Analysis provides a separate space and as Henri Rey observed in his clinical work in *Universals of Psychoanalysis in the Treatment of Psychotic and Borderline States* (1994), it is hoped that the patient will glance away from her own image and project her feelings into a separate space that is not inhabited by her parents. Then the patient's wellbeing can improve. Paradoxically, I have found that parents of anorexic children often say they feel that they are forced into the role of the mirror or that they experience their child as their own shadow. It is hoped that family therapy will provide the arena for them to think about their own projections that the child is in receipt of. Parenting workshops help them to see the importance of creating not only distance but also a triangular space where the child can feel safe enough to relinquish her own omnipotence, as she trusts in the vitality and dualism of the parental couple.

#### KIRSTY - A CLINICAL CASE OF MOURNING

Sarah Huline-Dickens, a child and adolescent psychiatrist, presents the clinical case of a fourteen year old anorexic patient, Kirsty, in her paper "Becoming Anorexic: On Loss, Death And Identification and the Emergence of Anorexia Nervosa" (2005). Kirsty came for treatment because she was having seizure-like movements. When Kirsty was four, her mother gave birth to a baby girl who was unwell with seizures and who nearly died. Her mother spent a lot of time nursing this infant. Kirsty's seizure-like symptoms were perhaps a form of communication through identification with the sister as a means to reach out for assistance and care. However, during therapy sessions in which family members attended together, it appeared to Huline-Dickens that the patient in the room was in fact the mother who was inconsolable over her divorce to Kirsty's father and she was also displaying unresolved emotions about the death of her own father. It became clear that Kirsty used her illness as a way to bring the family back together. She was also finding ways to identify with members of the family and in doing so she was searching erratically for her own sense of self. The anorexic

model, with its clearly defined and uncomplicated parameters was a new identity she embraced. It bought simplicity and it bought relief.

When Kirsty came for treatment she would bring with her a laminated photograph of a pop star who looked like her father. She would often hold it close to her body or place it carefully next to her. We can refer to Sontag's *On Photography* (1977), which describes a photograph as

“something directly stencilled off the real, like a footprint or a death mask...not only like its subject, a homage to the subject. It is part of, an extension of that subject; a potent means of acquiring it, or gaining control over it” (Sontag, 1977: 154-155).

As Kirsty became thinner and thinner she would hug herself around the middle as if to provide a layer that would hold her in. At the same time by disappearing through the act of anorexia she could avoid being unconsciously consumed by a dominant, needy mother and a father whose love she craved.

“In weighing Kirsty I was aware of the parental significance of this act, and that for her there must have been feelings about her approval being in the balance. To meet with my approval, she would need to gain weight, but to meet with her own, she would have to have lost weight” (Huline-Dickens, 2005: 320).

Kirsty had dreams about “ghosts and spooks” and at times she was sure she would die.

“It seemed to me that Kirsty was haunted by death, and her struggle to was to find some wholesome identify for herself before being overcome by feelings of grief and guilt about the illnesses and deaths in her parents' past which had not been dealt with” (Huline-Dickens, 2005: 325).

Anorexia and its associated symptoms including secondary amenorrhea allow for time to stand still, like the father in the photograph and like her mother who was unable to accept the losses in her life and move on. Kirsty wanted to maintain a

link with the original external and internal losses. She would be death's nemesis. After several months of treatment Kirsty was able to maintain a weight that both she and the clinic were satisfied with and as a result of her therapy she was able to see herself as a separate person. She started to talk about how others might view her as different and she showed a capacity to self reflect as she stepped away from the mirror.

## CONCLUSION

It is hoped that the study of Ovid's Pygmalion and the associated clinical material will allow us to think more creatively about Secondary Amenorrhea as a state rich in symbolism and meaning and as a bodily representation of a psychic state that is far from lacking. A patient with secondary amenorrhea, similar to the Hysterics of Freud's early work, can be the patient that a male analyst dreams of treating, with the opportunity for him to display his artistry and embellish her treatment with all his pearls of wisdom. (Here I portend to the intellectual analytic discourse that symbolises the unconscious desire for pearls of semen to pass through actual sexual intercourse.) But as with many of the classical myths and with Pygmalion, had Ovid written on, the analyst might reach a middle place with the id, ego and superego chanting like a Greek Chorus of antiquity BE CAREFUL WHAT YOU WISH FOR!

## II

### **A LITTLE GOES A LONG WAY – ELIZA DOOLITTLE’S TRANSFORMATION FROM A PSYCHOANALYTIC PERSPECTIVE**

This part of the chapter focuses on George Bernard Shaw’s play *Pygmalion* (1916) and the process of change undergone by Eliza Doolittle. Its aim is to show how elements in Shaw’s play represent a developed, multi-dimensional way of intra-psychic relating aligned to the depressive position as apposed to the more paranoid schizoid state that we encountered in Ovid’s version. There is much movement in Shaw’s work allowing for much creativity and growth. How Eliza manages change and how she balances all that she acquires with all that she loses demonstrates the precariousness of the process of transformation. Whilst we are all at risk of being exposed to this, it is with particular reference to patients in psychotherapy who present with Secondary Amenorrhea that this paper directs its focus. The reflections on Eliza Doolittle from a psychoanalytic perspective will be followed by a clinical case study and discussion of an amenorrheic patient in treatment.

#### ELIZA – A 20th CENTURY GALATEA

“Galatea never does quite like her Pygmalion: his relation to her is too godlike to be altogether agreeable” (Shaw, [1916] 2003: 119).

It is with these words that George Bernard Shaw ends the 1916 publication of his stage play *Pygmalion*, as an addendum to his contemporary take on the myth. As readers of Shaw’s work, we are invited to explore what it is that the female lead, Eliza Doolittle, wants. This is different to Ovid’s model in which one can become preoccupied with the needs and wants of Pygmalion. And in Shaw’s version there is a transformation that is different from its classical counterpart. Shaw’s one is aligned with independence, emancipation and freedom. It is the process of transformation itself that is as important, if not more so, than he who is the transformer and she who is transformed. Of course in Shaw’s play we have Professor Higgins whose linguistic mastery is to be applauded and we have Eliza

Doolittle who capably absorbs and incorporates all that she is taught. But we do not start off nor do we end up with a Pygmalion and his Galatea. Firstly, Higgins is not the romantic hero, nor lover. He is devoted to his science and to improving the world but he is no Prince Charming nor is Eliza a clone of the classical sultry heroine waiting for true love's kiss.

“In his quest the modern hero does not always want to or need the fulfillment of marriage, and the modern maiden, more independent than her classical counterparts, may ignore the savior whose ideals she does not share. In the mythical retelling, then, Eliza may leave Higgins and marry Freddy, and Higgins, having freed his Andromeda from a living death, can move on to further adventures” (Vesonder, 1977: 43).

Timothy Vesonder has aligned Eliza with the mythical character Andromeda. To this day the crossword puzzle clue will still ask of the reader, “Eliza's mythical counterpart” to which the correct answer would be the seven-lettered Galatea. What is important here is for us to identify the purpose of a myth by which it can transcend a more concrete way of looking at things. All too often we can get bogged down in trying to find the real life persons on which novels and plays are based.<sup>xliii</sup> But it was the causes, struggles, fights, gains and losses in the world at large, in the relations between “men” and in each of our own internal worlds that are the things intriguing to Shaw, rather than the individuals per se. Shaw, with his retelling of the classical myth, is conveying a myriad of messages against a backdrop of uncompromising Victorian values and subjection. The reader is supposed to engage with Shaw's Pygmalion as one would with the mythical protocol that can be “both a supremely significant foundational story and a falsehood” (Bell, 1997: 1).

Just as we suspended belief and accepted in Ovid's story that the Galatean statue did come to life, here in Shaw's play we cast aside the details and “truths” in terms of class and gender divisions and we afford ourselves the chance to become enraptured and curious about the encounter between Higgins and Eliza. We can then see how it is their collaborative work together, supported by the other characters legitimising Eliza's transformation that counts. There is always a

flow of discourse in which people play, negotiate, agree and more often than not disagree with one another. It is precisely this inter-relating that results in a more realistic and viable metamorphosis able to withstand the test of time. Eliza's outward transformation from a common flower seller into a duchess is not at the expense of her very essence, her spirit and her drive. The process is one of incorporation and of self-realisation. In contrast, once the perfect inanimate statue in the Ovidian version transforms and comes to life, the cracks start to appear. The splits between omnipotence and impotence, between perfection and denigration appear too wide. Subject and object are never really anything more than just that. Pygmalion and Galatea are endlessly inextricably linked.

In Shaw's work there is the interplay between attachment and autonomy and an intra-psychic and interpersonal relating between Higgins and Eliza. This perhaps offers itself up as a new working model for Eliza to internalise. Notably, her outward and inward transformation might enable her to be alone in a way that is contrary to what she is used to, aloneness having been thrust upon her. As Anthony Storr writes on this state of mind,

"The capacity to be alone thus becomes linked with self-discovery and self realization; with becoming aware of one's deepest needs, feelings and impulses" (Storr, 1988: 21).

We shall examine later on what it is that Eliza truly needs and desires. For now though, individualisation and separateness in Shaw's play are born out of Eliza's ability to leave Higgins, a choice that Higgins supports. And it is not Eliza marrying her mentor Higgins that will define her womanhood. It is not this that will emancipate her. Galatea, on the other hand is to marry her creator, no question about it. In the end, Galatea's womanhood is to be defined by this and by motherhood. Eliza might outwardly appear a perfect model of beauty and femininity at the end of Shaw's play but her true beauty and her spirit were always from within. She is enchantingly internally blemished. She has a fiery nature, just like Higgins, a rebellious streak and a drive to assert her individuality. Of course, through Higgins skill, Eliza is now more able and equipped to pursue her goals. She recognises how alike the two of them are but it is in her capacity

to leave him that she becomes an independent whole person. It is this that liberates her, transforms her and defines her womanhood.

At the beginning of the play we are introduced to Eliza the flower seller. Had she not been allowed to sell flowers on the street it is likely that she would have been selling her body, as a prostitute. This situation was mirrored in Vienna during Freud's time with a huge trade in prostitution servicing the sexual demands of men whilst nice girls remained chaste until marriage (Mitchell, 1975). Shaw was fighting for a society in which women like Eliza could be freed from this in-situ and Eliza is offered a way out through her tutelage by Higgins. We can contrast her fate with that of Nancy, the prostitute in Charles Dicken's 1837 novel *Oliver Twist*. Nancy, like most women in nineteenth century literature with a colourful sexual past, did not survive. There is no chance for Nancy to emerge triumphant as a non-conforming heroine. Eliza, on the other hand, carries the beacon of hope. Importantly though, Eliza does not trade her common roots for a new middle class milieu. There is no split or trade off. This is very different to the split between the godlike Galatea who is protected to the point of being enslaved by her creator, Pygmalion, and the Protopoetides, the prostitutes, who, enslaved by their situation, must be done away with. So, Shaw's play demonstrates more fully developed ego integration, on the side of whole object rather than part object relating. For me though, the most crucial ingredient to this is the non-repression of Eliza's instinctual life and the fact that she has found in Higgins a sparing partner who can bear and tolerate some of her "hysterical" tendencies and primitive anxieties. They often mirror one another, giving back as good as they get but they are both committed to the process, to the talking cure, which acts as a third other, a framework that contains and metabolises.

#### LANGUAGE – THAT WHICH IS ACQUIRED

Eliza acquires a new language and, in turn, a new narrative of her own. Language is key to the development of her (and Higgins') external and internal journeys in the sense that "Words are given to experience" (Levin, 1991: 158).

And the interpersonal experience is verbally communicated as it is lived. Of course we have to acknowledge that as much as language opens them up to themselves and to each other, it can isolate and cause divisions. Thus, Daniel Stern notes,

“Just as the being-with experiences of intersubjective relatedness require the sense of two subjectivities in alignment – a sharing of inner experience of state – so too, at this new level of verbal relatedness, the infant and mother create a being-with experience using verbal symbols – a sharing of mutually created meanings about personal experience” (Stern, 1985: 172).

If we go further back to the very earliest days of the infant and mother inter-relating we can look to Didier Arizieu (1989) who writes about the child’s acquisition of her own skin ego when there has been a successful psychic internalisation of the common skin of mother and child alongside a good mothering environment. This skin ego is protected by a second skin, that of mother’s. The threat is that the mother will reclaim the second skin and in doing so the infant’s skin ego and thus the question of ownership is never decided. This appears in Shaw’s play when Eliza asks what has happened to the set of clothes she arrived with at Wimpole Street. She asks this when deciding on whether to leave Higgins or not. She insists on knowing if the clothes she has been given by Higgins and Pickering now belong to her. The clothes represent the second skin. As Lacanian psychoanalyst Eugenie Lemoine-Luccioni writes in *La Robe* (1983),

“the garment is always stolen...she parades it and displays the maternal skin and embodies it in front of the man” (Lemoine-Luccioni, 1983: 97).

Through this, the man can unconsciously identify with the woman who possesses it. Eliza shows her strength in that she is able in gesture to borrow the clothes and give them back. But we all know that now they belong to her. We could say that together, Higgins and Eliza work to create a maternal frame with paternal boundaries, an analogy for psychoanalysis.

## CHARACTERISATION AND THE ANALYTIC ENCOUNTER

There have been many wonderful descriptions of the analytic encounter written in many wonderful papers but the one that I think best analogises what Eliza and Higgins have together I have selected from Neville Symington's book, *The Analytic Experience* (1986). In one of the later chapters he emphasises the need to recognise how important the patient is to the analyst and how the analyst needs the patient (Symington, 1986: 329). My suggestion is that Higgins needs Eliza. Symington quotes from John Klauber's paper,

"Patient and analyst need one another. The patient comes to the analyst because of internal conflicts that prevent him from enjoying life, and he begins to use the analyst not only to resolve them, but increasingly as a receptacle for his pent-up feeling. But the analyst also needs the patient in order to crystalize and communicate his own thoughts, including some of his inmost thoughts on intimate human problems which can only grow organically in the context of this relationship. They cannot be shared and experienced in the same immediate way with a colleague, or even with a husband or wife" (Klauber, 1976: 46).

However, we must not be misguided that all is rosy in the Garden of Wimpole Street. We have a strong pull / push relationship between the two and

"The attraction of opposites is held in suspension by the stubborn independence of each and the play ends in tension, not resolution" (Berst, 1995: 200).

Eliza leaving Wimpole Street allows for us to consider a state of non resolution that can then allow for all sorts of possibilities in terms of what is included in the text, what is left out and what is in our own experience of it all. The free associative possibilities are limitless. This is so different to the absolute surface truths offered in Ovid's *Pygmalion*. The fact that Eliza's fate can be viewed as unsettled is testimony to the deep truths that reside in the id. Eliza can be gentrified and made into a duchess but we sense her instinctual life throughout the play and this is the essence, the blood, the life and soul of our affection towards her. The bliss and terror and all that she has to negotiate between the

start and the end of the play she bravely faces. We could look to her as an inspiration to the amenorrhoeic analysand who braves the unknown in pursuit of new reality based truths. We shall look at this in more detail in the clinical review.

There are many immediate metaphorical references in Shaw's play to the analytic encounter. For example, Higgins says to Pickering about Eliza

HIGGINS. *You know Pickering, that woman has the most extraordinary ideas about me. Here I am, a shy, diffident sort of man. I've never been able to feel really grown-up and tremendous like other chaps. And yet she's firmly persuaded that I'm arbitrary overbearing bossing kind of person. I can't account for it (Shaw, [1916] 2003: 40-41).*

We also have in Higgins what psychoanalyst Adam Phillips calls the "free listening analyst" (Phillips, 2002: 31). When Pickering tells Higgins he can't hear a difference between most of the letter sounds Higgins replies

*"[chuckling and going over to the piano to eat sweets] Oh that comes with practice. You hear no difference at first; but you keep on listening, and presently you find they're all as different as A from B" (Shaw, [2016] 2003: 24).*

And from Shaw, we have an Eliza who thinks of Higgins as follows

*"She is immensely interested in him. She has even secret mischievous moments in which she wishes she could get him alone, on a desert island, away from all ties and with nobody else in the world to consider and just drag him off his pedestal and see him make love like any common man" (Shaw, [1916] 2003: 119).*

Shaw wrote this in a sequel to the original play as an angry demonstration to his audience and to his actors who kept insisting that there be a romantic union between Higgins and Eliza at the end of the play. At the 1914 London theatre premiere, Herbert Beerbohm, the actor playing Higgins, threw flowers to Mrs Patrick Campbell, the actress playing Eliza Doolittle. He ignored Shaw's ending

replacing it with his own revision, giving the audiences what they wanted. In the *Collected Letters*, Shaw is clearly a man on a mission:

“Don’t talk to me of romances; I was sent into the world to dance on them with thick boots—to shatter, stab, and murder them” (Shaw, CL 1: 163).

This resistance might have been born out of his refusal to fantasise about the relationship between his mother and her voice coach, whom she followed to Dublin taking her two daughters with her and leaving Shaw behind with his father. Shaw emphasised that his play was designed to be an anti-romantic social satire about class and independence and although he did describe it as a romance, it was meant in the sense that the story was unlikely. In the sequel, a union between Freddy and Eliza is crystallised. Whilst Eliza can have her “private imaginations” (Shaw, [1916] 2003: 119) about Higgins, marrying Freddy symbolises that

*“when it comes to business, to the life that she really leads as distinguished from the life of dreams and fancies, she likes Freddy and she likes the Colonel; and she does not like Higgins and Mr. Doolittle”* (Shaw, [2016] 2003: 119).

This actually serves as a creative outlet for unconscious incestuous impulses without the resultant damage that we witness in Ovid’s *Metamorphosis*. In Arnold Silver’s book *Bernard Shaw the Darker Side* (1982), Silver discusses the issue of incest in Shaw’s play from a Freudian perspective.

“Shaw knew that in longing for the union between Eliza and Higgins we ignore the secret appeal of the Pygmalion legend...For, after all the sculptor would be committing incest in marrying the woman he fathered parthenogenetically. And if the obvious appeal of the Pygmalion story lies in its adolescent fantasizing of the ideal woman, its hidden and concomitant appeal lies in incest, initially between father and daughter but also between son and mother for deep within the male fantasy of the ideal woman are memories of the most fulfilling of ideal women, the mother. Galatea is thus daughter and mother simultaneously, as Pygmalion is father and son” (Silver, 1982: 198-199).

If Eliza is to inherit Higgins' legacy then she has to be the legitimate heir, as "my creation of a Duchess Eliza." Does this play then offer us a successful example of sublimation in terms of a social value being the result of the artistry as described by Freud in "New Introductory Lectures on Psychoanalysis" (1933)? Freud describes

"A certain kind of modification of the aim and a change of object, in which our social valuation is taken into account, is described by us as "sublimation"" (Freud, (1933) SE XXII: 97).

We can link this to Freud's earlier work, "Three Essays on the Theory of Sexuality" (1905d) in which he writes that "sexual curiosity can be diverted ("sublimated") in the direction of art..." (Freud, (1905d) SE 7: 156).

In terms of the eighteen-year-old Eliza, it might very well be that the creative act she partakes in with Professor Higgins is

"an attempt to avoid a desired relationship with an object as well as to satisfy it; a developmental conflict that characterizes adolescence" (Levine, 2009: 10).

Let us bear in mind that Shaw was an adolescent fifteen year old when his mother left him and the family home for London. We might then suggest that the writing of this play was an act of sublimation for Shaw, offering him textual retribution and redemption from his feelings towards his parents. Shaw indeed admits to an Oedipus Complex prior to writing the play and Erik Erikson explains in *Identity: Youth and Crisis* (1968) how Shaw used creativity to help contain an identity crisis and to resist identification with an impotent father, one who was drunk and disorderly. Higgins need not leave the comfort of his consulting room to feel that he has conquered the world and he congratulates himself on having transformed a gutter girl into a duchess. Shaw, through his own literary skill and artistry can manage his own internal battle of omnipotence versus impotence and can become ruler supreme. But we do not have a sanitised play nor do we have something that offers us the illusion of cohesion and reparation. Instead we have mess, guts and gore, visual and verbal. We have ambivalence and uncertainty

and we experience the way in which preconceptions and perceptions are challenged. The play is a vehicle for the expression of the instinctual life in a way that Freud describes in “The Unconscious” (1915b),

“an instinct can never become an object of consciousness – only the idea that represents the instinct can” (Freud, 1915b, SE XIV: 177).

## THE DISCOURSE OF THE OTHER

Lacan wrote that the “unconscious is the discourse of the other” (Lacan, 1966: 16).

The more articulate we become, and the more we master this interlocution, the further away we are from our true selves. So we start at the beginning with Eliza who sounds out letters into a phonograph, over and over again. These sounds represent something raw and instinctual. As she becomes more proficient in the task of learning to talk like a duchess, and as she displays the capacity to replicate and mirror those around her we can see that the addition of language and text to those primitive letters symbolises a unification of the id, ego and superego in the art of socialisation. But, Eliza, in her resistance to the seductive powers of a new order symbolised by her acquisition of language, never renounces those early days and she does not become a slave to the discourse of others. For me, she is a true heroine. In Act II of the play Shaw shows us how determined Eliza’s drive is to be unrepressed. Higgins is testing her out on a trip to his mother’s house. The conversation between Eliza, Mrs Higgins and a visiting friend Mrs Eynsford Hill unravels.

LIZA. *[darkly]* My aunt died of influenza: so they said.

MRS. EYNSFORD HILL. *[clicks her tongue sympathetically.]*

LIZA. *[in the same tragic tone]* But it is my belief they done the old woman in.

MRS. HIGGINS. *[puzzled]* Done her in?

LIZA. *Y-e-e-e-es Lord love you! Why should she die of influenza? She come through diphtheria right enough the year before. I saw her with my own eyes. Fairly blue with it, she was. They all thought she was dead; but*

*my father he kept ladling gin down her throat till she cam to so sudden that she bit the bowl off the spoon.*

MRS. EYNSFORD HILL. *[startled] Dear me!*

LIZA. *[piling up the indictment] What call would a woman with that strength in her have to die of influenza? What become of a new straw hat that should have come to me? Somebody pinched it; and what I say is, them as pinched it done her in.*

MRS. EYNSFORD HILL. *What does doing her in mean?*

HIGGINS. *[hastily] Oh, that's the new small talk. To do a person in means to kill them. (Shaw, [1916] 2003: 60)*

We could say that this unravelling is an example of how Plato anticipated the lawless voice as a catalyst for a chaotic situation that would bring about a breakdown in social bonding. As Dolar describes in his book *A Voice and Nothing More* (Dolar, 2006)

“In order to forestall this truly apocalyptic vision – the end of civilization, a return to chaos initiated by innocuous-looking changes in musical forms – one has to impose a firm regimentation of musical matters. The first rule, the prime antidote for combating the monster, is already known: “The music and the rhythm must follow speech.” (Plato 1978, Republic III, 398d, 400d). For the core of the danger is the voice that sets itself loose from the word, the voice beyond logos, the lawless voice ” (Dolar, 2006: 45).

All parties at Mrs Higgins house survive the ordeal and Eliza and Higgins return to Wimpole Street to continue to refine the model; the model being the transformation and not Eliza. At her next outing, the ambassador’s ball, an arena for music, all the guests believe Eliza to be of middle to upper class status, of royal blood even. So we have a process of change, which Forrester would describe as “speech which transforms the speaker in the very act of saying” (Forrester, 1990: 147).

Obviously we must accept the poststructuralist argument that language is more than a tool to communicate or to pass on information. It is an agent that can create and destroy, and Eliza can never be the same again, nor for that matter can Higgins. But we are not left with an apocalyptic transformation. Eliza has

undeniably changed, grown and matured out of an impoverished state but, wonderfully, her unconscious realm was never going to be taken as a hostage to this new order. Over her dead body! At the end of the play, during a heated and passionate display of emotional attachment the question of “what is to become of her,” comes up but this time a realistic solution, an emotional compromise is formalised in her mind. This is not a stalemate nor does it have the quality of a negative therapeutic reaction, testimony to Higgins commitment to the process even if it means not giving Eliza what she thought she wanted. The process, the transformation, has enabled her to claim

*LIZA. Aha! Now I know how to deal with you. What a fool I was not to think of it before! You can't take away the knowledge you gave me. You said I had a finer ear than you. And I can be civil and kind to people, which is more than you can. Aha! [Purposely dropping her aitches to annoy him] That's done you, Enry Iggins, it az. Now I don't care that [snapping her fingers] for your bullying and your big talk. I'll advertise it in the papers that your duchess is only a flower girl that you taught, and that she'll teach anybody to be a duchess just the same in six months for a thousand guineas. Oh, when I think of myself crawling under your feet and being trampled on and called names, when all the time I had only to lift up my finger to be as good as you, I could just kick myself.*

*HIGGINS. [wondering at her] You damned impudent slut, you! But it's better than sniveling; better than fetching slippers and finding spectacles, isn't it? [Rising] By George, Eliza, I said I'd make a woman of you; and I have. I like you like this.*

*LIZA. Yes. You can turn round and make up to me now that I'm not afraid of you, and can do without you.*

*HIGGINS. Of course I do, you little fool. Five minutes ago you were like a millstone round my neck. Now you are a tower of strength: a consort battleship. You and I and Pickering will be three old bachelors instead of only two men and a silly girl. (Shaw, [1916] 2003: 104-105).*

Some feminists would regard this as a misogynist statement from Higgins. But I read it as something different. The route of the word bachelor comes from the Anglo Norman word bachelor, which linked to escolier, means a young squire in training. They are all students in training, regardless of their gender, when it comes to relating to one another and navigating their way within this new dynamic that they find themselves in. Is this not a new way of revisiting the question of transformation that they tackled earlier with their linguistic

endeavour? And is this not another attempt at something from much earlier; the re-enactment of the first image; that of “coming in by the mouth” where the mother and her infant are trying to attune themselves with “a breast, a mouth, a movement of mouth seizing a breast...revivified” (Laplanche, 1976: 60).

Higgins and Eliza both represent people outside of the institution; non-conformists. On a concrete level, he lacks a father. She lacks a mother. What they offer each other is a new setting that chimes with what Anna Freud and Dorothy Burlingham describe in their 1943 paper “War and Children”

“The ability to love...has to be learned and practiced. Wherever, through the absence of or the interruption of personal ties, this opportunity is missing in childhood, all later relationships will develop weakly, will remain shallow. The opposite of this ability to love is not hate but egoism” (Freud & Burlingham, 1943: 191).

Higgins and Eliza could be described as each possessing their own defensive egoism but they seem able to acknowledge what each of them lacks as much as what each of them brings to the table. As their process symbolises a chink against the institutional dictum of class and gender inequality, central to this is the concept of egalitarianism and entitlement and we know that the door of Wimpole Street, is always open to Eliza and that Eliza’s heart is always open to Higgins.

DO YOU SEE WHAT I SEE?

I believe that Shaw’s play symbolises the Lacanian idea that

“man’s desire finds its meaning in the desire of the other, not so much because the other holds the key to the object desired, as because the first object of desire is to be recognized by the other” (Lacan, 1977 [1959]: 58).

Higgins, like the analyst perhaps, can be a figure to be desired. He is seductive to Eliza. As he offers her chocolates from the bowl to entice her to stay, he takes from the same bowl an apple and munches on it demonstrating that his life force,

if not charged, can be easily replenished. All of Eliza's questions, notably what is to become of her is I believe linked to Freud's understanding of the intrusion of the adult's unconscious fantasies into the psychic world of the child. Higgins might have mastered intellectual and technical erudition but Eliza wants to know what it is he wants from her in the face of his own unconscious and un-mastered fantasies. She wonders why it is he is interested in her and yet she tells him she has noticed that he does not notice her. For Freud, the child's questions are a series of displacements, circling around the one question she cannot ask; "why are you telling me this?" I think this is an important point in terms of the analytic technique that includes the analyst choosing to self disclose or sharing his counter-transference. She wants to know if she is loved and in Lacanian terms following his theory that the phallus is a signifier of the desire of the Other.

"it is in order to be the phallus, that is to say, the signifier of the desire of the Other, that a woman will reject an essential part of femininity, namely, all her attributes in the masquerade. It is for that which she is not that she wishes to be desired as well as loved" (Lacan cited in Salecl, 1998: 25-26).

But this phallus is also a signifier equivalent to the lack in the other. In Stephen Heath's reading of Joan Riviere's "Womanliness as a Masquerade" (1929), Heath points to the phallus as "the supreme signifier of an impossible identity" (Heath cited in Burgin, Donald & Kaplan 1986: 53).

What of Eliza's acquisition of the vagina? Freud writes about the displacement of the symbolised by the symbol and it could be suggested that the use of the slippers and the gloves at the end of two of Shaw's revisions tidies up any symbolic thinking with regards to Eliza acquiring the vagina. When Eliza first settles in to her new home at Wimpole Street, Mrs Pearce, Higgins' housekeeper, gives Liza her first bath wanting to start the process of changing her from a "frowzy slut" into a "clean, respectable girl." Cleanliness is equal to self-esteem:

MRS PEARCE. *You've got to make yourself as clean as the room then you won't be afraid of it.* (Shaw, [1916] 2003: 35).

What a perfect metaphor for the amenorrhoeic body. Mrs Pearce continues,

MRS PEARCE. *Well, don't you want to be clean and sweet and decent, like a lady? You know you can't be a nice girl inside if you're a dirty girl outside (Shaw, [1916] 2003: 36).*

Mrs Pearce proceeds to scrub Eliza with a phallic shaped brush. In this scene, Eliza sees herself naked in the mirror for the first time. Shaw does not give us much description of this scene, which allows our imagination to run wild. One could theorise that Eliza's desire and approach to master the pronunciation of language is an attempt to "get" the phallus but to what extent can her attempt be satisfied? Perhaps when looking in the mirror, she sees, for the first time, Eliza the prostitute and she questions her potential to manipulate, seduce and acquire the phallus, maximising her position as the objectified object. Does she become aware of those coquettish charms that she might possess and employ to redirect her narrative back to the days of the Cinderellas and the Galateas of this world? Earlier in the play when Higgins offers her a chocolate, to entice her to stay, she says

LIZA. *[halting, tempted] How do I know what might be in them? I've heard of girls being drugged by the likes of you (Shaw, [1916] 2003: 33).*

Perhaps in looking at herself in the mirror she realises more fully how she, Higgins and their joint project have the capacity to intoxicate like chocolates. Higgins declares his allegiance by eating half and offering the other half of the chocolate in a "Pledge of good faith" (Shaw, [1916] 2003: 33). Whilst this is a clear play in the erotic transference, we know that a play is all it is. When pressed by Pickering on the matter, Higgins consciously declares,

HIGGINS. *I've taught scores of American millionairesses how to speak English: the best looking women in the world. I'm seasoned. They might as well be blocks of wood. I might as well be a block of wood (Shaw, [1916] 2003: 38).*

No danger of acting out in the erotic transference then! Despite his boasting though, Eliza is afforded much space for her femininity to breathe. Returning to

Eliza in the mirror, I think she is an example of someone who is defended against the Freudian notion of exhibitionism (1905 / 1915), which as Pacteau (1994) describes in her book *Symptom of Beauty*

“originates in the auto-erotic activity of looking at a part of one’s own body – an activity that initially coincident with pleasurable bodily sensations which will later evolve into looking at someone else’s body by a process of comparison...the pleasure afforded by self display arises from the subjects identification with the gaze of the other” (Pacteau, 1994: 148).

Pacteau also refers to Flügel’s book *The Psychology of Clothes* (1930) in which is invoked

“the scene of the child prancing about naked, without any sense of shame, it pleasure sustained and heightened by the adoring gaze of the parents or adults standing by” (Pacteau, 1994: 148).

Eliza has missed out on the vicissitude of the scopophilic drive which oscillates between being looked at and looking at. Freud states that “anyone who is an exhibitionist in his unconscious is at the same time a voyeur” (Freud, (1905) SE. VII: 167).

Taking this a step further, the drive to look facilitates a learned skill to lose. For the daughter who is able to look kindly at herself in the mirror, she is able to acknowledge that she is different from her mother. As Eliza does not have an actual mother, perhaps it is a separation from her internalised mother that will bring about a successful maturation. From this moment on Eliza demonstrates a capacity and a resilience to do this. If there had been an unconscious symbiotic pact from which to leave would be treacherous, her only outlet might have resulted in that of so many young girls who adopt secondary amenorrheic / anorexic means to delay the divergence. We shall consider this in the clinical review.

## DO YOU HEAR WHAT I HEAR?

Whilst looks might kill, this is offset with Eliza's voice preserved in the phonograph and it is Higgins who acts as a paternal presence, watching her, listening to her, studying her and interpreting both as the gazing subject and the gazed at subject. This enables Eliza to hear herself speak.

"Voice and gaze relate to each other as life and death: voice vivifies, whereas gaze mortifies. For that reason, "hearing oneself speak" [s'entendre-parler], as Derrida has demonstrated, is the very kernel, the fundamental matrix, of experiencing oneself as a living being while its counterpart at the level of gaze, "seeing oneself looking" [se voir voyant], unmistakably stands for death: when the gaze qua object is no longer the elusive blind spot in the field of the visible but is included in this field this one meets one's death" (Žižek, 1996: 94).

Shaw's play demonstrates how there need not be a split between voice and gaze, living and dying, omnipotence and impotence as we saw in Ovid's tale. What we have with Shaw is what Žižek offers us to the conundrum;

"metaphysics" stands for the illusion that in the antagonistic relationship between "seeing" and "hearing," it is possible to abolish the discord, the impossibility, that mediates between the two terms (one hears a thing because one cannot see it at all, and vice versa) and to conflate them in a unique experience of "seeing in the mode of hearing" (Žižek, 1996: 95).

This is facilitated in Higgins: As the linguist watching and interpreting, we could say he represents the paternal. Importantly, Eliza does not idealise him. She sees him as another human being, of flesh and blood like her. She in fact gives him a project that ignites his raw instinctual life into the arena of creative sublimation. Surely this is true love? As Lacan describes it, true love is always a love returned.

The Lacanian idea that language interrupts the imaginary relationship between mother and infant might explain why Eliza says to Colonel Pickering as she enters the banquet,

ELIZA. *It is not the first time for me, Colonel. I have done this fifty times – hundreds of times – in my little piggery in Angel Court in my daydreams. I am in a dream now. Promise me not to let Professor Higgins wake me; for if he does I shall forget everything and talk as I used to in Drury Lane* (Shaw, [1916] 2003: 70).

We have Eliza, whose destiny looked likely to involve a life of prostitution now in the circle of a higher culture. Shaw describes Eliza's withstanding of her ordeal,

"she walks like a somnambulist in a desert instead of a debutante in a fashionable crowd" (Shaw [1916] 2003: 71).

I am reminded of the somnambulistic state associated with hysteria (that of Lady Macbeth is an obvious one) and with disassociation. Eliza says she is in a dream but it is not

"Dreaming as a recreation for the brain which by day has to satisfy the stern demands of thought imposed by a higher culture" (Nietzsche, 1878b: 24-27 cited in Hauke, 2000: 151).

It is more of a fugue state, an awakened state that lacks awareness imbued with a ghostly sense of self. This enables her to pass through the salon. People stop talking to look at her and to admire her dress and jewels. At this stage we are closer to Galatea than we might wish to admit but there are very important differences. Eliza is not merely a product of one man's wish fulfilment. Higgins has worked with the raw materials that Eliza presented with and they each played their part in creating their shared vision of the ideal woman. Although at this stage there is this disconnect, Eliza is not mute and she is not an impersonator. In that moment, at the banquet, past, present and future flash before her eyes and she survives it. This play is not solely about Eliza realising her own fantasies; it's about her acquiring a narrative of her own, that which seems a far-reaching

fantasy for Galatea. Eliza's successful transformation is in her autonomy. When she makes a mistake she can correct herself. Akin to those patients who have internalised the analytic function, she now has a choice and it is this that is empowering.

#### AMENORRHEIC DISCUSSION

"I am a good girl, I am" repeats Liza in the first scenes of the play even though Higgins describes her as from "the gutter." This could be used as a representation for the order and control of the good amenorrheic / anorexic girl; no mess, no blood, no odour. Body fluids in the body create life. To expel them would be to expel parts of the self. The waste of the menstrual blood is the expelled link between mother and foetus. Furthermore, what is indicated by the blood is of course the very fact that nature provides menses as part of and target of sexual intercourse. Safer for the amenorrheic to wash her hands of all of this.

When Eliza arrives and agrees to stay with Higgins her clothes are burnt and she is given a set of Japanese clothes. Interestingly it is the Japanese woman who differs the most from her Western counterpart in that she has a positive regard for the menstrual cycle. In Japanese culture menses is not seen as a curse of an uncontrollable syndrome. Additionally when an elder reaches menopause and her menses cease, she becomes a wise and respected woman rather than a redundant, aged civilian. This, noted psychoanalyst Clara M. Thompson, was mirrored in China. Thompson, studying the cultural pressures facing women and the psychological development of women in relation to one another wrote

"A psychiatrist working in China reported to me that she had never seen a menopausal psychosis in a Chinese woman. This she attributed to the fact that in China the older woman has a secure and coveted position" (Thompson cited in Green, (ed.) 1964: 29).

The point here is that it is the cultural attitudes of mankind rather than the biological constitution of women that can determine the extent to which women during any moment of their menstruating / non-menstruating life cycle can

become subjects for taboo. For Shaw, when it comes to women things it can never be as simple as black or white. Eliza is a wonderful vehicle for Shaw. In her Japanese attire she represents a sobriety but she reaches for her old hat that she first came in with; one with three ostrich feathers, orange, sky blue and red.

ELIZA. *"I shall look alright with my hat on"* (Shaw, [1916] 2003: 48.)

This offers her psychic equilibrium, and a defence against fragility now further compounded by the fact that her father has turned up searching for money. Her father liked a drink, as did Shaw's. In this scene I am reminded of the synthesis between the unconscious and conscious landscape of the hysterics that Charcot treated. Elaine Showalter (199: 32) describes how Charcot, at a public session during which he planned to discuss hysterical tremors, bought in three women wearing hats with long feathers each of which trembled in a way that was characteristic of the disease. The slightest movement by the patient was picked up and represented by the shaking feathers. Furthermore, the exact ways in which the feathers shook demarked the particular movement associated with the particular disease in the nervous system.

When Higgins presents Eliza on her first public outing to show how the "common idiot" can be "a consort for a king," his mother, Mrs Higgins warns

MRS HIGGINS. *"She is a triumph of your art and of her dressmaker's but if you suppose for a moment that she doesn't give herself away in every sentence she utters, you must be perfectly cracked about her"* (Shaw [1916] 2003: 64)

I am reminded of the clinician's early warning to parents whose daughters are on the cusp of developing anorexia and the associated amenorrhic symptoms. Parents are warned not to be disillusioned by the idea that all is within a safe perimeter. The discrepancy between reality and illusion with regards to what the adolescent girl sees in the mirror is often reflected at the outset in the attitude of the parents who unconsciously act collusively into the myth, as they are unable to bear witness to the truth.

The truth of Eliza's predicament at the beginning of the play is that her father was narcissistically devoted to himself, her mother was absent from the outset and her psychic impoverishment and the nourishment it acquired was attached to her job as a flower seller. She demonstrates a capacity to thrive at Wimpole Street, despite the burden of what is lacking. Language is the transformative, saving third. It is as Jung explains, the transcendent symbolic third that mediates between the opposites that consciousness cannot reconcile on its own. Creative expression and meaning add to the transcendent function and individuation and a greater psychic wholeness is possible (Jung,(1939) / 1954, para. 780). We can turn to Foucault (1963) for added inspiration:

“Before the imminence of death, language rushes forth, it also starts again, tells of itself...headed toward death, language turns back upon itself; it encounters something like a mirror; and to stop this death which would stop it, it possesses but a single power: that of giving birth to its own image in a play of mirrors that has no limits. From the depths of the mirror where it sets out to arrive anew at the point where it started (at death) but so as finally to escape death, another language can be heard – the image of actual language, but as a minuscule, interior, and virtual model” (Foucault, 1963: 54).

So we have language as a transformative third alongside the thematic conceptual terms voiced by Higgins and the feelings and emotions expressed by Eliza. In other words, Higgins talks the talk and Eliza walks the walk.<sup>xiv</sup> Is Higgins like Freud who perhaps believed that he knew more than Dora did and furthermore, did he think that he knew more than Dora wished to know of herself? As Eliza insightfully tells her mentor

*ELIZA. I'm no preacher. I don't know things like that. I notice that you don't notice me (Shaw, [1916] 2003: 101)*

We can say then that it is only when one acknowledges a lack in oneself and a lack in the other that a healthy engagement can develop in which ambivalence and the love and hate can co-exist.

What follows in this chapter is a case study that aims to highlight the difficulty the secondary amenorrheic patient has in managing any insight and acceptance that the other is lacking. It is a case study that demonstrates how a slight movement in a range and a disturbance in the equilibrium ignite dangerous feelings, which threaten the ego. When the patient, through language, communicates a sense of independence her body communicates the anxiety and they are at odds with each other. With no resolution on the horizon, ambivalence sets in and shores up the discord. In a way it becomes a transitional third. In such instances, ambivalence appears the most desirable and achievable of immediate goals. If it can be tolerated and if not too intrusive it might slowly be worked with and worked through to make way for a more accepting, integrative state where past, present and future can co-exist in the mind of the patient.

#### A CLINICAL CASE OF AMENORRHEA SHOWING PSYCHO-HORMONAL INTERRELATIONSHIPS

The following clinical case study is taken from psychotherapist Ruth Easser's paper "A Case of Amenorrhea Showing Psycho-Hormonal Interrelationships" that she presented to the Association for Psychoanalytic Medicine in April 1954. At this time, Easser's research into Secondary Amenorrhea was part of a more general study of the psychodynamics and psycho-physiological links in patients with long standing amenorrhea. The study, under the direction of Dr George E. Daniels observed twenty-six unselected cases, which had been referred to his Endocrine Clinic. Easser's research was with those patients who were seen for psychotherapy and she investigated the possible relationship between emotional attitudes and hormone levels. Would changes in the patient's "adaptive functioning" influence the hormone levels that would in turn impact on menstruation? This was the key line of enquiry.

Easser presents a patient, a twenty three year old attractive woman, who was amenorrheic from the age of eighteen. Her menarche occurred around the age of thirteen and until the age of eighteen she menstruated regularly. Easser describes the patient's family environment. She was the sixth child in a family of seven of which there were five girls and two boys. The family was very poor.

Her father did not work until the patient was sixteen. He was often mocked by his wife and by the children. The parents would argue a lot. The mother was domineering and would often play the martyr, denying herself food to feed the children. She often displayed hysterical outbursts with threats to leave or commit suicide. When the patient was born, her mother was hospitalised. The patient was told it was because she had scratched her mother's breast causing blood poisoning. Whenever the patient recalls her mother's menses it is always linked to her mother visiting the hospital. She grew up believing that anyone who went to hospital, male or female, could have a baby. When she was about eight years old a boy kissed her and she was so ashamed she wanted to throw herself off the roof. She wanted her genitals to be bandaged, seeing them as a wound. At the age of ten, her seventeen-year-old brother played with her sexually and she kept quiet about it, ashamed. Her older sisters who competed with one another for the title of best mother surrogate looked after her. They were keen to delay the patient's initiation into womanhood so as to prolong their role as caregiver. The patient recalled a family outing to the swimming pool when she proudly announced that like her sisters she couldn't go swimming because she was menstruating. They examined her knickers, laughed at her and made her go into the water. When boys would ask her out on dates, her sisters made fun of her and became hostile. All of her dreams of being in the sisterhood were shattered. Menses went from something to boast about as a newly acquired feminine status that could place her equally alongside her mother and sisters into something dangerous and indeed her last two bleeds she associated with shameful traumas. The first incident was when her female dance teacher told her she was mannish. The second incident involved a married teacher who told her he would leave his wife to marry her. During her last menstrual period they went away for the weekend. They "petted" but they did not have intercourse. Despairing of the whole affair, the patient's menses stopped. Easser writes,

"She reacted to her amenorrhea with mixed feelings. She broke off the affair and confessed to an older sister, experiencing some emotional relief, but at the same time she developed the fear of pregnancy and the fear of defeminisation, both partially induced by the statements of a physician who was consulted. After the artificial induction of menses, the patient refused to continue therapy because

she felt it was not going to help make her normal. For a time she became obsessed with the fear that she was changing sex. She would frequently examine her clitoris and look for evidence of physical change” (Easser, 1964: 429).

The patient was in effect identifying with her martyred, suffering mother and competing with the mother (both real and internalised) signified a death struggle. The idea that she could take a man from another woman entailed a fate that included a fear of retaliation from her sisters. She broke off the affair and gave up her desire to be beautiful and feminine experiencing this as too dangerous a position. To control her menses meant she could control her sexual desires and thus her psychic and physical landscape changed.

During her time in psychotherapy, the patient’s hormone levels were recorded. At the outset her estrogen level was below the normal physiological range corresponding to pre-menarche functioning levels. This low figure stayed throughout most of the treatment with the exception of two occurrences when there was a marked increase, taking the estrogen level to that of a “normal” adult female. The first increase was at eight weeks into the study, at a time when she was able to speak of her hostility towards her sisters and towards a female boss. But with the sense of independence came feelings and expressions of confusion. She had started the treatment anxious that the therapist would make her menstruate and this would mean her sisters would withdraw their protection from her. The patient’s anxiety became heightened and one week she returned to her therapy reporting that she had attacked her husband for being weak and unambitious. She had impending menstrual symptoms such as a tingling sensation in her breasts and abdominal cramping. Her eyes felt weak and she felt her teeth were shifting. She told her therapist that as a child she had been told that childbirth had caused her mother to have no teeth. Easser wrote that this experience for the patient “appeared to be the beginning of a psychotic decompensation” (Easser, 1964: 430).

The therapist strove to stabilise the patient’s emotions and correspondingly, the hormone level returned to the previous low and the menstrual symptoms ceased.

During this time of reflection the patient gained insight into the nature of her fear towards her retaliatory sisters and felt more independent. In the eighteenth week her hormone level rose markedly again. She had nightmares and believed that if she were to become a parent she would mutilate her children. The focus of the work was now on her unmet needs and her competition with her mother with the therapist becoming the surrogate mother.

“The patient’s desire to complete herself as a woman by bearing a child evoked early memories of her oral destructive fantasies towards her own mother, which were then projected onto the fantasied child. The patient’s understanding of the nature of her hostility and of its ramifications enabled her to re-establish her equilibrium” (Easser, 1964: 430).

When the anxiety subsided, her estrogen levels resumed to their low levels. We are told that soon after, the patient left therapy because she had got a summer job in another city and the project had discontinued before her return. Easser uses this case study to confirm

“In the majority of the cases studied in the “amenorrhea project” adaptive decompensation, actual or threatened, did occur with either a return of the menses or an increase in the hormone level” (Easser, 1964: 431).

A hormonal rise in this particular patient occurred when she felt independent and most able to compete with her sisters. But with a glance towards mature femininity, sexuality and maternity came also a mental confusion, emotional stress and a threat to her “ego integration.” Thus, Easser stresses the need for practitioners to think carefully before a patient with secondary amenorrhea embarks on psychotherapy as most will start out with a weak ego and treatment might result in an emotional disruption that threatens its very existence.

#### FURTHER REFLECTIONS

In the patient’s leaving the city, she moves away, sidestepping staying with the difficult conflicting thoughts and feelings that have emerged out of the therapeutic

alliance. She comments on the consultant physician who had put her on a course of treatment to induce artificial menses.

“After the artificial induction of menses, the patient refused to continue therapy because she felt it was not going to make her feel normal. For a time she was obsessed with the fear that she was changing sex” (Easser, 1964: 429).

Could it not be that the patient is also referring to the psychotherapy treatment - one that leaves her feeling destitute, lost and far from her psychic familiar “home?” It was difficult for this patient to whole object relate. The splits were aggressive in that her mother was both a dominant woman who fed her children but at the same time could be captured by anxiety that led to outbursts of threatened suicide. For this patient, her menses represented the extreme opposites of the Life and the Death Forces as embodied in her mother. Her menses were of the model studied by anthropologists in which the rich blood could symbolise the fertile mother whilst also having the power to destroy (Buckley & Gottlieb, 1988). The patient’s sisters in their role of caregivers also demonstrated the split in that their mothering of her smothered her. Alongside this we have the patient’s father who argued violently with the patient’s mother and yet he was experienced as impotent in the eyes of all the other family members. It’s as if whichever way the patient turns, all roads lead to one of infantilisation and destitution. The amenorrheic body, with its absence of menstrual blood carries that legacy, thus freeing the psyche of such a burden. That is why the treatment of secondary amenorrhea should always be thought of in the context of it representing a possible transformation that becomes a question of life and (or) death. The thought of bringing together the internalised omnipotence (and the repressed rage) with the internalised impotence (and the repressed rage!) is hard for the patient to conceptualise as something that represents “normal” viable growth. The secondary amenorrheic is not concerned with growth. Her energies are honed towards mastering the art of survival.

Defended against differentiation, the menstrual lockdown can protect against too much conflict or not enough activity. We might view this as frigidity. Easser tells us that her patient masturbates for the first time when she is a married woman

and intercourse with her husband, although pleasurable, is always first anticipated with terror. Clitoris stimulation by her husband makes her believe she is being injured. We could link this to how Freud in "From the History of an Infantile Neurosis" (1918) describes how the child perceives the primal scene as an act of "aggression by the father in a sadomasochistic relationship" (Freud 1918 in Laplanche and Pontalis, 1998: 335).

This suggests dominance and submission of the female role, a dangerous position to be in. That each child who witnesses the primal scene suffers a form of abuse is a long held belief. The child is ill equipped to make sense of what she sees. And unconsciously she is caught between desire and repulsion and conflicted by the notion that one day she might replace mother and invite her wrath. For Easser's patient this had presented itself in the patient's relationship with her sisters:

"The fear of relation from her sisters became overwhelming when faced with the possibility of taking another man from his wife. At this point she withdrew from the struggle, broke up the affair, ceased to menstruate and withdrew from the dangerous feminine position. She overtly feared but unconsciously desired the defeminized "hermaphroditic" status" (Easser, 1964: 429).

The patient was horrified by the fact that her desirability could cause the man's marriage to break down. As a child she had been told, by her frequently violent father that she was the cause of his marital problems. It's as if she must integrate the non-threatening elements of man and woman into the hermaphroditic status and then make time stand still. The threat of menses must be surmounted. Menses must be repressed and the phase of development must cease.

When I left my first analysis I remember so many times I would look in the mirror and "wish" my face to change into that of a man's. Out of the damage of the analysis, as part of my own healing process, I looked for my masculine, handsome face. That was my desired feminine state, the heroic heroine. Needing to incorporate rather than deny my menses, I thought of myself as a new

revision - of man and of woman with gender becoming an out-dated marker of difference. I am the same me, but wiser. It took my leaving the analysis to realise this.

## CONCLUSION WITH A NOTE ON THE ETHICS OF CARE

It is hoped that these chapters will be an inspiration to the analysand who like Eliza Doolittle, through bravery, might thrive when freed from the “prison of her former existence” (Reynolds, 1994: 212).

We can pick up Easser’s highlighting of the ethics of care in Bernard Shaw’s play. As with Higgins and Pickering who appear at times to play with Eliza with no consideration for her wellbeing we can wonder whether the ethics of care with regards to the treatment of Secondary Amenorrhea is a rationale for the subjection of women. This, we know, was issue in the treatment of hysteria around the time of Freud. But we know that Shaw’s Eliza gives as good as she gets. She is not like Galatea. On the contrary, she will not be muted nor will she be fashioned by mimicry. In fact she shows a depth of insight with regards to her transformation that is unrivalled by many a heroine.

*LIZA. I sold flowers. I didn't sell myself. Now you've made a lady of me I'm not fit to sell anything else. I wish you'd left me where you found me. (Shaw, [1916] 2003: 78)*

Eliza’s outburst and her attacks, both verbal and physical, signpost the fragility of too soon a rebirth. The research by Ruth Easser confirms that those who experience a return of menstrual activity from analytic intervention are prone to suffering breakdowns. I believe the danger lies in the fact that a return of menses is too readily welcomed and celebrated by both patient and analyst: The lost amenorrheic state is too soon renounced and forgotten. This can cause havoc in the patient. It is imperative that the patient return in her analytic discussions to this lost amenorrheic state. She needs to mourn the loss. So-called progression and advancement of one’s psychic homeland cannot exist without thought for the

motherland. Eliza Doolittle had articulated this, realising how much her journey and her transformation had taken her to the place of no return.

*LIZA. You told me, you know, that when a child is brought to a foreign country, it picks up the language in a few weeks, and forgets its own. Well, I am a child in your country. I have forgotten my own language, and can speak nothing but yours.” (Shaw, [1916] 2003: 96)*

The amenorrhoeic patient transformed into a menstruating woman might struggle coming to terms with the fact that things can never be the same again. Working with the secondary amenorrhoeic patient whose menses returns can become very messy. Their original defences soften to make way for the analytic tissues of discourse, symbolic of the very early stages and extremely fragile, open to pain and damage. It is like penetrating the vaginal lining for the first time. In the thinking of the analysis we have the Freudian symbols of the faeces, odour, phallus with the Kleinian breast and with the Lacanian symbols of the voice and the gaze. There is a kinaesthetic feel to it all that can overwhelm the practitioner. Most importantly, the treatment of this patient requires that the analyst not typecast her. She is elusive to all generalisations.

Is she not therefore the Eliza of psychoanalysis?

## CHAPTER SIX

### A BLOODY AFFAIR: THE CASE OF EMMA ECKSTEIN AND FREUD'S IRMA DREAM

#### AN INTRODUCTION BY MEANS OF A SHAVIAN TEXTUAL TRANSITION

MRS. HIGGINS. *You certainly are a pretty pair of babies, playing with your live doll.*

HIGGINS. *Playing! The hardest job I ever tackled: make no mistake about that, mother. But you have no idea how frightfully interesting it is to take a human being and change her into a quite different human being by creating a new speech for her. It's filling up the deepest gulf that separates class from class and soul from soul.*

PICKERING. *Yes: it's enormously interesting. I assure you, Mrs. Higgins, we take Eliza very seriously. Every week – every day almost – there is some new change. We keep records of every stage – dozens of gramophone disks and photographs –*

HIGGINS. *Yes, by George: it's the most absorbing experiment I ever tackled. She regularly fills our lives up: doesn't she, Pick?*

PICKERING. *We're always talking Eliza"*

HIGGINS. *Teaching Eliza*

PICKERING. *Dressing Eliza"*

MRS. HIGGINS. *What!*

HIGGINS. *Inventing new Elizas (Shaw, 1916, Act III lines 179-187)*

Eliza's tuition gives Higgins and Pickering the opportunity to test their theories and try out their techniques, writing follow up notes on their clinical case study. The process of Eliza's transformation from a common flower girl into a woman of refined speech and demeanour proved to the two men that a woman could be cured of phonetic irregularities and saved from linguistic ruin. In a similar vein, we have the treatment of Emma Eckstein by Sigmund Freud and Wilhelm Fliess. Here, we have two male doctors, fond and supportive of each other and of each other's work. In collaboration they test out their theories and apply their techniques on the female patient, Emma. The two men set about curing her from menstrual irregularities and saving her from hysterical ruin. The question of what was to become of Emma Eckstein, post treatment, was an oversight on the part of Freud and Fliess, just as Higgins and Pickering chose to overlook their

consideration of Eliza Doolittle's future, post-transformation. We have in the Eckstein case, as we saw in Ovid and Shaw's *Pygmalion*, a piece of artistry taking shape. It is psychoanalytical in its composition and it is made up of individual wishes and wishes borne out of collaborative work which are seeking expression, repression and / or realisation. Transformation takes place amidst a sea of wider social, cultural, philosophical, scientific and religious change, but all goes horribly wrong in this process and Eckstein is left nearly bleeding to death.

## BACKGROUND

In 1895, a twenty seven year old Emma Eckstein sought help from Sigmund Freud. Eckstein is often described as Freud's first patient in analysis. At the start of her treatment, she presents with abdominal pain and with slight to moderate feelings of depression associated to menstrual discomfort and menstrual irregularity. Freud diagnoses dysmenorrhea and claims it to be symptomatic of a nasal reflex neurosis, linked to masturbation. Freud consults German laryngologist Dr. Wilhelm Fliess who performs a turbinectomy to treat the neurosis. He unknowingly leaves surgical gauze in Eckstein's nose, which results in an infection. Removing the gauze causes her to nearly haemorrhage to death. Freud surmises that her bleeding was of a hysterical nature born out of a sexual longing for him. Whether, upon reading this chapter, the reader agrees with this or not, Eckstein's psychic blood is at times on fire, she is smart, sharp and challenging. But therein lies the weakness. Freud, young and inexperienced, panics under pressure and dismantles the very essence of this woman, disfiguring her face, quite literary, and causing injury on a much deeper level, discarding her, leaving her for half dead, half alive. We shall return to this shortly.

First, the link to amenorrhea. Although Eckstein is diagnosed with dysmenorrhea, not amenorrhea, they can both be understood as instances in which unconscious communications find expression through the body. By unravelling the complexities and mysteries of the Eckstein case and by making links between the troubling body, the tormented and tormenting mind (all mirrored in the troubling, tormented and tormenting treatment!) we can further our thinking and understanding of all women whose menstrual irregularities are symptomatic

of an unsettled psyche seeking relief through the body. In Eckstein's case, the stop starting of her menses communicates schisms across the body-mind-psyche axis. I believe that the feast and famine of her menstrual flow mapped out an internal disparity at having to trust the other who she senses (perhaps even "knows") is untrustworthy. In so many cases where menstrual suppression is a feature, there is an absent other, a confusion of tongues and / or blurred lines which we sometimes see re-enacted in the therapy.

First, a note on the validity of Freud's diagnosis: Although it seems implausible today, the relationship between the nose and the genitals has in fact featured in many different cultural contexts throughout time, including medical history (Mayes, 2005). In Western medicine, the first recorded theory of nasosexual medicine is Hippocratic. Hippocrates writes about the "hodos" or path that links the woman's nose and mouth with her genitals. At each end of the "hodos" is a "stomos" or mouth through which fluids including blood can leak out. Medicine can be administered through these paths, essential in curing many conditions, notably the wandering, displaced uterus that needs to be restored to its natural place. In *Aphorisms V.28* Hippocrates puts the amenorrhic condition down to the wandering womb and suggests the best way to return menses is to return the uterus by enticing it back with sweet scents that are placed at each end of the "hodos." Further along the medical line, it was commonly believed that suppressed menses caused a build up of toxins that if left too long would cause hysterical tendencies. Circa 131AD we find physicians such as Galen applying naso-genital theory to the curing of suppressed menses. Galen recommended sneezing the phlegm out of the nose to expel the corresponding uterine toxins, which would then restore a natural flow of blood around the uterine area. Galen observed that the link between the hysteria to the retention of menses most likely affected widows and those who had to swap a life of sex and childbearing for one of celibacy. One case study was of a "long time" widow whose hysteria was cured by the midwife applying medicine to the genital area "causing orgasm and the release of seed" (Mattern, 2008: 113). Suppressed menses could be fatal especially when the diversion of blood to the upper body failed to find an outlet. Bloodletting was essential in the treatment of suppressed menses. By the time we get to Fliess' work around 1893, nasogenital reflex theory is widely accepted

in the fields of gynaecology and otolaryngology. Fliess was convinced that in terms of nasal and genital problems it worked both ways in that whichever one was faulty, it caused a fault-line in the other. Furthermore, there were two genital spots in the nose that correlated to the genital area. By working on the nose he could cure the damaged “sex” of a woman. Nasal surgery was the operation of the day to cure dysmenorrhea. Interesting that the surgical gauze Fliess accidentally left in Eckstein’s nose blocked the nasal area to such a degree that it caused a build up so immense and overwhelming, it near killed her.

Psychoanalytically speaking, what we have here is not only the suppression of actual blood but also of thought and of mind with Eckstein’s ideas and unconscious phantasy life repressed and overlaid by the ideas and dictums of those around her. That perhaps is the paradox of psychoanalytic practice – it invites the patient to present the feelings whilst at the same time those feelings are repressed, so as not to be acted on. When I consider Freud with Eckstein, the phrase “prick and tease” comes to mind. As Edward Shorter brilliantly writes about the hysterics treated by Freud’s mentor Charcot at the French hospital,

“To many observers it was clear that the Salpêtrière was a carnival of unconscious suggestion and conscious simulation from which had emerged a “hysteria” sui generis that was the product of one man’s desire to classify run amok” (Shorter, 1992: 185).

Similarly we could argue that whilst Freud wanted to discover what was behind the veiled narrative of Eckstein’s hysteria and menstrual erraticism, it is clear he overlaid her version of events with a formulated narrative of his own, supplanting her unconscious with his. It’s as if he cannot tolerate the resistance in the patient and must speed the analysis along so as to reach a satisfying conclusion. His seed must be released especially after all the interest he has shown her. Freud becomes entangled and this whole bloody affair becomes more about him than her just like the absent parent whose narcissism drives them to the forefront of the abandoned child’s mind. He hinders and arrests the development of a healthy analysis just as he wrote about mothers who hinder and arrest their daughter’s sexual activity (SE XIV: 267). What develops is a web of secrecy and lies; part revealing and part hiding with communication and dialogue between the three

main players active and passive, moving and still. In this case, the unconscious runs amok outwitting all of them and Eckstein is left a very sorry, sad and tragic figure. But Freud won't even allow her that. Whilst in reality she is left with ghostly imprints of her former self, he goes on about her witchlike qualities, her potent magical thrust that is ruinous to men. Influenced by sixteenth century commentaries on witchcraft, Freud took from these works the idea that witches were delusional, with even their stories deluding them (Swales, 1982). Their accounts of reality, like Eckstein's, should not be trusted for they often "mistake the hallucinations of their fancy for the truth" (Remy: 1585, 111). And so emerged a new aetiology of hysteria, a condition spun out of the patient's phantasies of seduction (Bernheimer & Kahane, 1985).

Post treatment, Eckstein spends much of her life on bed rest, bereft of life without a companion. Finding it difficult to walk she confines herself to her sofa. Perhaps the sofa represents the analyst's couch, which she will have laid on, now still waiting for her fate to be settled. She reminds me of Myrrha from Ovid's *Metamorphosis* – part alive, part dead, suspended in a middle realm. What a disappointment Freud must have been to Eckstein and yet I think this was too difficult for her to gather up as a well judged statement of fact, just as Myrrha could not accept that the blame and the guilt lay at the feet of her father. In them giving up these men, they redeem them. It's as if they are trapped in a state in between on the one hand the need to release all that is suppressed and on the other the absolute need to contain all that is suppressed. They must be in control. The other is not reliable enough to take charge. The subject can find help for this task through the creation of the amenorrhic state, a symbolic creation of a place in which the psyche finds solace, rests a while, buys time before it must move on. All can be bought to a halt so as not to invite the surge or the splurge of too much outpouring; actual blood, libidinal charge, impulse, thought, deed and so on. In fact, a sudden release of the dam is a danger to the subject as we have seen in the clinical case studies already given. Eckstein's nosebleed was, as Freud admitted, near fatal to her whole being. Similarly, an abrupt overturning of an amenorrhic state transforming back into a menstruating one, can be experienced as that which is unhinged, exposed, naked and open to attack. As Freud would understand it, her(e) in lies the truth.

## IRMA'S DREAM

I would like to begin our examination of the texts on the Eckstein case with a look at a dream that Freud had in 1895, five months after finishing his working with her. The dream inaugurates Freud's methodology of dream interpretation that he presents in his 1900 publication *The Interpretation of Dreams*. Importantly, Freud uses the dream to illustrate his supposition that dreams are wish fulfilments. Erik Erikson writes helpfully that Freud as the dreamer,

“in experimenting with traumatic reality, takes the outer world into the inner one, as the child takes it into his toy world. More deeply regressed and, of course, immobilized, the dreamer makes an autoplasic experiment of an alloplastic problem: his inner world and all the past contained in it becomes a laboratory for “wishful” rearrangements” (Erikson, 1954 cited in Schlein, 1995: 259).

Could we not say that Pygmalion applies the same method with the creation of his ideal statue? His is a wish fulfilled and a problem solved through artistry. Similarly, Higgins uses language and Freud accesses transformative powers through dreams. It is generally agreed that this dream not only has amidst its wake the residues of the bloody mess of the Eckstein episode but that the two clinical cases of Eckstein and Irma are inextricably linked. This chapter supports this view. Here is Freud's dream in full, translated by Joyce Crick (1999):

### *Dream of 23-24 July 1895*

*A large hall – many guests, whom we are receiving. – Among them Irma, whom I take aside at once, as it were to answer her letter and reproach her for not having yet accepted the “solution”. I say to her: If you are still having pain it is really only your own fault. – She replies: If only you knew what pain my throat and stomach and abdomen are giving me. I feel I am choking. – I am startled and look at her. She looks pale and puffy; I think perhaps I have overlooked something organic after all. I take her to the window and examine her throat. At this she shows some reluctance, like women who wear dentures. I think to myself; but she has no need to. Her mouth then opens wide and I discover to the right a big white patch, and elsewhere I see large, greyish-white scabs set on remarkable curled structures clearly modelled on the nostrils. – I quickly call Dr M. over, who*

*repeats the examination and confirms it...Dr M. looks quite different from usual; he is very pale, walks with a limp, and his chin has no beard...My friend Otto is now also standing beside her, and my friend Leopold is percussing her through her bodice saying: She has an attenuation low to the left, also pointing out an infiltrated part of the skin on the left shoulder (which like him I felt, in spite of her dress)...M. says: No doubt about it, it is an infection, but it doesn't matter; dysentery will set in and the poison will be eliminated...We also know directly where the infection originated. Not long before, when she felt unwell, my friend Otto gave her an injection of propyl preparation, propylene...propionic acid...trimethylamine (I see its formula before me printed in bold type) ... Such injections are not to be given so lightly...Probably the syringe was not clean, either (Freud, [1900] 1999: 85).*

Some commentators think that Irma in the dream represents Eckstein whilst others believe her to be the young widow Anna Lichtheim who was the daughter of Freud's religious teacher Samuel Hammerschlag and who later became the godmother to Anna Freud (Masson, 1992). According to Peter Gay, Lichteim was "one of Freud's favourite patients" (Gay, 2006: 83). Both women shared similar features in that they were diagnosed as suffering from hysteria, were without a male companion, they were Jewish and their families were associated with Freud's. We might also consider Irma to represent Freud himself. The throat material certainly links up with the throat and mouth cancer that gripped Freud. It was Fliess who was treating Freud at the time and as we know Fliess was also Eckstein's doctor. So, as Freud witnessed Eckstein's health spiralling along a downward trajectory he understandably became increasingly anxious about the patient / doctor relationship. Paranoia and panic fill both the dream and the treatment of Eckstein. As Schur (1966) observes

"here was a patient being treated by Freud for hysteria who did have an organic, largely "iatrogenic" illness; who had narrowly escaped death because a physician really had committed an error; whose pathology was located in the nasal cavity; whose case had confronted Freud with a number of emergencies requiring him urgently to call in several consultants, all of who had been helpless and confused; Emma's lesions had a foetid odor (propylamyl); Freud had had to look repeatedly into her nose and mouth" (Schur, (1966) cited in Masson, 1992: 214).

Max Schur's quote was intended to be part of a complete edition of Freud's letters to Fliess that Schur was working on with Ernst Young. Schur was the author of "Some Additional "Day Residues" of the Specimen Dream of Psychoanalysis" (1966), and in this paper many of the letters that Freud wrote about Eckstein were published for the first time. They had previously been censored in part by Anna Freud. Schur had acquired the letters from Marie Bonaparte. In an unpublished letter from Anna Freud to Ernest Jones written November 19th 1953, Anna Freud writes,

"Emma Eckstein was an early patient of my father's and there are many letters concerning her in the Fliess correspondence which we left out, since the story would have been incomplete and rather bewildering to the reader" (Masson, 1992: 55).

This letter by Anna was found by Masson in the Jones Archives, London Institute of Psycho-Analysis. For Schur, what also links the Eckstein episode with the Irma dream, is Freud's relinquishing of his seduction theory in favour of the idea that fantasies lie at the heart of neurosis. Why Freud makes this analytic diversion is interesting. Many believe it was to exonerate the incompetent male surgeon in favour of apportioning blame on to the female hysterical patient. In sacrificing Eckstein in order to preserve his alliance with Fliess, Freud ended up with blood on his hands. Similarly, Irma in the dream was to take responsibility for her misfortune. Schur concluded that Irma represented Emma and the dream had been designed as a wish to exculpate Fliess and Freud of Emma's injuries. It was to serve as "a disclaimer that he had not been conscientious" (Schur, 1966 cited in Loewenstein et al: 70).

Freud had to keep alive in his mind the idea that Fliess was a competent and admirable clinician. Furthermore, as the person who listened to Freud and helped him work on his theories, to lose Fliess would send Freud into a state of isolation and perhaps "paranoia" that he later claims he successfully avoided. Frank Hartman takes up the themes of self and co-dependency in his paper, "A Reappraisal of the Emma Episode and the Specimen Dream" (1983). He links the treatment of Eckstein by Freud and Fliess to the early childhood memories that

Freud had of him as a three year old boy and his cousin John, teasing John's younger sister Pauline (Freud's letter 3rd October 1897 in Freud's letters to Fliess, 1897-1902: 219). The two boys were both in love with Pauline and in stealing her flowers, fulfilled their wish to deflower her. Their tormenting treatment of her strengthened and reasserted their male bond. Hartman writes,

"I speculate this is the importance of the Emma episode and the source of Freud's powerful affects. If so, we have understood, for the first time, the importance of the repetition of infantile conflict in the discovery of psychoanalysis" (Hartman, 1983: 559).

Hartman's paper also includes a draft from Freud to Fliess in which Freud speculates on how neurasthenia could be the outcome of either masturbation or "onanismus conjugalis – incomplete copulation in order to prevent conception" (Freud, Draft B Feb 8th 1893: 66-72 cited in Hartman 1983: 578).

In Freud's time it was customary for the husband to abstain from having sex with his wife when she was pregnant. So too, in Jewish law the man was not allowed to masturbate, nor was he allowed to touch his wife during certain times in her menstrual cycle. Freud's wife was observant, coming from a religious, orthodox family. Freud wished to renounce much of the Jewish customs. I am reminded here of the gauze that Fliess accidentally left in Emma's nose, thus causing a build up of blood and an eventual, near fatal hemorrhage. The link to the menstrual tampon is a sensible one along with the symbolism of repressing unclean thoughts. But there is another link that comes to my mind. It is to the piece of cloth that a Jewish woman inserts into her vagina once her menstrual bleed has stopped. For several days before she plans to visit the Mikvah, the gateway to purity, she checks to make sure that there are absolutely no remnants of menstrual blood left over. In the Jewish tradition, the woman then visits the Mikvah and before immersing herself into this pool of rainwater she cleans her outer body. Upon leaving the site, she is available to resume marital, sexual relations with her husband. A bloodied white cloth or piece of gauze represents a woman unavailable for the intimacies of sex and the act of procreation (Siegal, 1985 / 1986). Thus, symbolically, Eckstein was rendered unavailable to either of

the men thereby allowing for their duality to flourish undisturbed. The texts tell us that Freud was hopeful that Fliess's research into the menstrual cycle would offer a way in which coitus could take place without a contraceptive. At the time of the dream, Martha, Freud's wife, had become pregnant again. Anzieu (1975) suggests that Irma's open mouth represents the uterus of the mother and the dream is an expression of Freud's ambivalence about Martha's pregnancy and even with the fantasies of abortion. So too, had she had allowed him to perform an oral sexual act on her, she would not have become pregnant. This is supported by the views of Erikson who wrote that the mouth opened wide represented the

"woman's procreative inside which arouses horror and envy because it can produce new "formations." It is also the investigator's oral cavity, opened to medical inspection" (Erikson 1954 cited in Schlein 1995: 272).

The gynaecological investigation into Irma's mouth runs parallel to the analytic investigation that Freud was making and the mouth might symbolise his entry into the realm of the unconscious, as yet a dark, hollow and unknown place. The foul smelling solution in the dream and the bleeding of Emma might be linked with the trimethylamine, which is an organic compound that produces a strong "fishy" odour and can be linked with bacterial vaginosis. In other words, Eckstein and her menstrual issues were odious. If we consider this further, we can pick up Lotto's hypothesis that Freud was troubled by

"the conflict between misogynistic thoughts and deeds and the guilt this generated as well as a reminder of those shameful parts of himself that he characterised as feminine, the passive castrated Jewish victim" (Lotto, 2001: 1310).

And so here we are led to associations with castration of the Jew, which as we know equates to circumcision of the penis. Healthy Jewish baby boys have this procedure done when they are eight days old as part of a ritual service called the Bris Milah, meaning covenant of circumcision.

“Circumcision is such a basic element of Judaism that the child does not enter into account in his generation unless he is circumcised. Moreover the covenant of circumcision is considered as important as all the mitzvot (commandments) in the Torah together” (Matzner-Bekerman, 1984: 44).

We know that Freud was traumatised when he saw his baby brother Julius’s circumcision. Julius was always an unwell child and he died when eight months old. Freud who was jealous of his younger sibling was left with residues of guilt associated to his wishes that Julius disappear. To relocate the trauma away from circumcision, Freud maneuvered his theory away from hysteria and female castration, for at that time it was common to treat one with the other. The fashionable cure in the 1880s for dysmenorrhea and “menstrual madness” was to remove the patient’s ovaries (Moscussi, 1990). We know that many doctors in the second half of the nineteenth century believed that the way to cure hysteria, epilepsy and catalepsy was by removing the clitoris. Hysteria linked to habitual masturbation of girls was also commonly treated with

“clitoris scarification or amputation” or “cauterization of the labia or of the entrance of the vagina” (Fleischmann, 1878: 49 trans Bonomi, 2015).

According to Charcot, in his “Lectures on the Diseases of the Nervous System” that he delivered at the Salpêtrière in 1877, mental health was affected by the excitation of the vulva and clitoris. If we turn our attention back to Eckstein, here we have a patient who fulfils many doctors’ stereotype of the intellectual, hysterical patient who as they see it “will make the most of her dysmenorrhea as she will of any other gynaecological complaint” (Garrey et al. 1972: 117 cited in Laws, 1990: 169).

Fliess believed that the nose and the female sex organs were related and he set about operating on Emma’s turbinate bone to create a larger opening of one of her sinuses. Many scholars agree that Freud probably went along with Fliess methodology because compared to an ovariectomy, this “must have appeared to Freud as innocuous” (Eissler, 1997: 1303 cited in Bonomi, 2015: 97).

At the time, Freud would have been aware of some tribes amongst which the men would slit a part of their penis to create a bloody discharge reminiscent of the physiological bloodletting of menstruation. Anthropologists recording this ritual bloodletting interpreted it as a way that men rid themselves of bad blood so as to be healthy like their women. Chris Knight (1985) explains why this might be if menstruating women are also seen as polluting and in need of exclusion. Knight writes that the philosophy underlying the male ritual of incising the penis came from the fact that women were seen as powerful in marriage and a husband must think twice before imposing himself upon her. Knight quotes from Hogbin's book (1970) *The Island of Menstruating Men*

"All she has to do by way of retaliation is to touch his food when next she menstruates and thereby inflict him with a fatal illness (Hogbin, 1970: 86 cited in Knight 1985: 681).

Knight continues

"The warriors who "make sure to menstruate before setting out on a "raid", like the canoe-travellers and hunters who act likewise, are cleansing themselves of the contamination which stems from an excess of marital life, performing artificially the spouse-repelling function which women perform with each menstrual flow" (Knight, 1985: 681).

We can here pick up the idea, previously presented, that Freud wanted to turn away from all of this trauma and conflict associated with bloodletting and symbolised by female hysteria, so vividly brought to life by Eckstein, in search of a new theoretical realm in which a male, potent and most definitely wholesome a hero dominates the narrative. Freud turns to The Oedipus story. This shift would also help Freud exorcise some of the ghosts of his past. One such ghostly impression left on Freud was the memory of him bathing in a pool of red bathwater when he was a young boy. It is believed that he was sharing the same water that his menstruating nanny had used (Bonomi, 2013). What impact would this have had on him? According to Daly, a deeply suppressed "hysterical amnesia" would be the long lasting trauma for the male boy confronted by his

mother's menstrual blood (Daly, 1943). Having said this, in contrast to menses being a castrating force, it can be experienced by many as a creative influence. For example, psychoanalyst Groddeck

"believed he derived his insight as a doctor from having bathed with his mother as a child when she was menstruating. He saw "the black, the white, and the red", the pubic hair, the white skin, the red menstruation, and had no fear" (Shuttle & Redgrove, 1978: 259).

Shuttle and Redgrove also cite Jung as more open than Freud to the idea that the menstrual experience could be a transformative and creative one in the minds of men. In *Wise Wounds* (1978), the authors write up one of Jung's dreams from his autobiography *Memories, Dreams and Reflections* (1962). As a young boy of three or four he dreams that he has discovered a rectangular chamber of hewn stone with an arched ceiling laying deep beneath a rectangular stone lined hole in the ground. It was accessed by a stone stairway that he descends in fear.

"From the entrance across the flagstones, runs a red carpet to a low platform, on which is standing a rich gold throne, "a real kind's throne". There is perhaps a red cushion on the seat, but standing on that is something like a tree-trunk, huge, reaching almost to the ceiling, made of flesh with a rounded faceless, hairless head. There is a single eye on the very top of the head, unmovingly gazing upwards...He is paralysed with terror. Then he hears from outside and above his mother's voice calling out: "Yes, just look at him. That is the man-eater!" He awakes sweating with terror, and for many nights after that is afraid to go to sleep" (Jung cited in Shuttle & Redgrove, 1978: 105-108).

For Jung this dream symbolised "the motif of cannibalism" and what he had seen was "a ritual phallus." Shuttle and Redgrove interpret Jung's dream journey as one in the womb where the phallic shape is the cervix of the womb, which during menstruation ejaculates blood like "a red carpet." They also suggest that the man-eater is in fact the woman and her menstrual bleed symbolises the moment when the potential for a baby to survive and grow is no more. Returning to Freud's dreams to further illustrate castration fears of the dreamer, I have

selected a dream, which he presents in his 1900 book *The Interpretation of Dreams*. The dream is as follows,

*“I am going, very incompletely dressed, from an on the ground-floor flat up a flight of stairs to a floor higher up. As I go I just three at a time, pleased that I can climb stairs so nimbly. Suddenly I see a maidservant coming down the steps, that is, towards me. I feel embarrassed, try to hurry, and then that sensation of inhibition appears. I am stuck to the steps and cannot move” (Freud (1900) trans Crick, 1999: 184).*

In his follow up analysis, Freud says that the dream is undoubtedly sexual in its nature. Around this time his dreams were on hysterical impotency and castration fears, mirroring in content and analysis his daily clinical practice. Freud linked the dream to a visit he made to a patient’s home where he was reprimanded by the maid for staining the red carpet with his muddy boots and with his spit, whilst clearing his throat, hurrying up the stairs. I suggest that the spit represents his non-conformity and defilement of Jewish Law. Not only does Freud’s spit, his semen, come into contact with the red, menstruating vaginal pathway, thus breaking the orthodox rules that state a man and woman can only be intimate when she is clean, but his spitting / semen is also an act of defiance against the repression of masturbation as stated in Jewish Law. Masturbation and inhibition and hysteria as we know are all spotted along the same psychic thread. Masturbation was, at that time, thoughts of by many as a poison, and many female infants were “castrated” to cure them of it. At some point, Freud speculated that this had been Eckstein’s fate, as discussed in Masson’s book *the Assault on Truth* (1992). The subject of masturbation became the focus of Eckstein’s own work and she undisputedly regarded “this bad habit as a hateful one” (Eckstein, 1908: 18).

Returning to Freud’s dream and the significance of him clearing his throat whilst running up the stairs, Freud suspects the theme is one of health and vitality which as we know is something he was pre-occupied with and was why he needed to preserve Fliess, his saviour surgeon, in an idealised transference. We could say that Fliess was to serve a purpose of providing Freud with a double image that represented immortality in the same way that Pygmalion had designed his perfect

statue. Jewish people who are superstitious believe that to spit means to be rid of the evil eye. A red ribbon also wards off unwelcome and envious energy of others. The red carpet and the spit can symbolise a ridding of a desire to devour, just as the mother and the midwife traditionally spit to rid themselves of their desire to devour the newborn child. So what is it that Freud wishes to rid himself of / devour? Perhaps his wish, which would invoke the wrath of the Hebrew G-d, is that he give and be in receipt of the most unholy of all acts in the eyes of his religion; a homosexual union through oral sex. He wishes to be in receipt of the semen of another and as the red carpet, he is the circumcised, (bleeding) object laid down for another.

To recap, we have the theories of female hysteria and Freud's associated thoughts on the female body superseded with a new male orientated Oedipal set up dominated by the power of the penis. In Irma's dream, the solitary female patient at the start of the dream, who refuses the solution, is replaced by a group of male doctors, pungent potions and a dirty syringe. If we again consider that Irma represents Freud, we have a man alleviated of his ailments with a cocktail of drugs. It is possible that this dream is also about Freud's love and need of cocaine. We know that in 1884 Freud was enthusing about the curative powers of cocaine and due in part to his influence on his medical colleagues cocaine was prescribed in the treatment of morphine and alcohol addiction and also to alleviate stomach pains and indigestion.

"I have experienced personally how painful symptoms attendant upon large meals – viz, a feeling of pressure and fullness in the stomach, discomfort and a disinclination to work – disappear with eructation [i.e. burping] following small doses of cocaine (0.025-0.05g). Time and again I have brought such relief to my colleagues" (Freud, 1884 in Alexander & Shelton, 2014: 401).

By 1895, the time of the dream, Freud had stopped using the syringe and was instead applying "cocaine paste" into the nose. Four years earlier he had witnessed the death of his friend Fleische-Marxow, addicted to injecting morphine and cocaine. Taken intra-nasally, cocaine can constrict blood flow to the septum causing a perforation to the nose. And so the link with Eckstein here is an

obvious one in that Freud sees her bleeding nose and the nasal damage done by Fliess, supposed expert, and he is anxious about the curative effects of the supposed wonder powder. Perhaps Freud had even suggested to Eckstein that she take cocaine to alleviate her symptoms? He had written about a female patient whose use of the substance had caused “extensive necrosis of the nasal membrane” (Freud, 1900: 144).

Maybe the patient he was referring to was Eckstein? Perhaps Eckstein’s exposure to cocaine aggravated her symptoms. A report in 1997 “Cocaine’s Effects on Neuroendocrine Systems: Clinical and Preclinical Studies” (Melo & Mendelson) concludes that whilst it is difficult to interpret the data because many of the participants in the study are polydrug users (opiates and alcohol misuse might also be associated with menstrual cycle disorders such as amenorrhea and anovulation) it seems likely that cocaine disrupts the endocrine system, reproductive functions and the menstrual cycles in women. Returning to Irma’s dream, it takes place in a large hall in which we can imagine a large, stomach-ingesting banquet might be taking place. The throat, stomach and abdomen pains experienced by Irma in this dream are an indication of Freud’s own throat and stomach pains which are to be cured by the white lines of cocaine. Significantly, on 24th January 1895, a few months before the dream, Freud writes to Fliess from Vienna

“I must hurriedly write to you about something that greatly astonishes me; otherwise I would be truly ungrateful. In the last few days I have felt quite unbelievably well, as though everything had been erased – a feeling which in spite of better times I have not known for ten months. Last time I wrote you, after a good period which immediately succeeded the reaction, that a few viciously bad days had followed during which a cocainization of the left nostril had helped me to an amazing extent. I now continue my report. The next day I kept the nose under cocaine, which one should not really do; that is, I repeatedly painted it to prevent the renewed occurrence of swelling; during this time I discharged what in my experience is a copious amount of thick pus; and since then I have felt wonderful, as though there never had been anything wrong at all” (Freud cited in Masson, 1985: 106).

Freud continues to write to Fliess during this time on two key subjects, Eckstein's health and his own. As he reports Eckstein's demise to the point where a renewed haemorrhage nearly causes her to die, he also informs Fliess of his self-observations in relation to his dependency on cocaine. On 20th April 1895, following an improvement in Eckstein's case, Freud writes

"Today I can write because I have more hope; I pulled myself out of a miserable attack with a cocaine application. I cannot guarantee that I shall not come for a day or two for a cauterization or galvanization, but at the moment that too is not possible." (p.116) By June 12th 1895, Freud writes, "I need a lot of cocaine" (Freud cited in Masson, 1992: 132).

One last note on cocaine: If Eckstein's hysteria was to be associated with masturbatory activity, she could have been cured with a light dusting of cocaine because in those days many people thought that cocaine, when applied topically to a woman's vagina, numbed the area and prevented masturbation (Grinspoon & Bakalar, 1976: 23-24). We would have witnessed a careful medical and analytical "touching" of the patient. What unfolded instead was a dangerous intrusive method of treatment. Perhaps it was Freud and Fliess, mutually gratifying one another with their theories and practices, who needed to cap their own excitation, not Eckstein! Amidst the chaos and confusion, both external and internal in Freud's professional and personal life, the dream of Irma offers Freud a fortress of solitude and a space to reflect and to think whilst maintaining a semblance of being in possession of heroic, supermanesque powers for himself.

#### AN ANALYSIS OF FREUD'S DREAM IN RELATION TO AMENORRHEA

After his own thirteen pages of self-analysis on Irma's Dream Freud writes in italics

*"After the work of interpretation has been completed, the dream reveals itself as a wish fulfilment"* (Freud, [1900] 1999: 97).

Wishes can be bought to life through dreams. In a way, Freud is offering us a solution to the fulfilment of wishes that does not require a concrete acting out, as we saw with Pygmalion's creation of his ivory statue and with Higgins remodelling of a live person. The dream offers Freud a place to access a semblance of meaning and cohesion amidst internal and external dislocation.

“What Freud may have been attempting for the first time with the Irma dream was the systematic application of free association to every single element of the manifest dream, after which he connected these associations until a meaningful trend emerged” (Schur, 1966 cited in Loewenstein et al. 1966: 48).

I shall be continuing to offer my own analysis and interpretation of these events, through my own associations with the text. My associations to this Freudian episode are informed both on a conscious and unconscious level by my research, associations and subjectivity to Amenorrhoea. Some might read my analysis of this Eckstein case as rather phallogentric, in some way aligning myself with psychoanalytic theories that have been designed by men for men. I would argue that however these theories came about they exist in the psychoanalytic realm for us to work with if we so choose. Thoughts, ideas and concepts should not be pummelled by segregation or division because some agencies have their own political or activist agendas. As I said to the two female examiners at my MPhil viva, (me feeling slightly aggrieved and defensive by the suggestion of disloyalty to the women's movement), I was not there to cheerlead feminism. I happen to like the works of Freud and the early thinkers (men and women) and I think it is important that we revisit them. Just as Jewish Modern Orthodoxy, Progressive and Liberal Judaism thrive in their ability to engage in dialogue with one another and as they skilfully integrate traditional values with modern ones (with increasing membership numbers made up of women), so too with Psychoanalysis. I think the way forward is to carefully and appropriately assimilate the old with the new. Importantly for this thesis, I think that our engagement with secondary amenorrhoea is best placed in this setting. It is in this light that we can truly understand the origins of amenorrhoea, its purpose, its meaning and its matter. I hope I have given it a voice that does it justice and that I hope I have created a space in which continued dialogue can ensue.

Back to my associations then with one of Freud's earliest of speaking tools, free association. Lacan writes helpfully on how best we can think of it in our clinical work. Lacan writes

"You must start from the text, start by treating it, as Freud does and as he recommends, as Holy Writ. The author, the scribe, is only a pen-pusher, and he comes second. The commentaries on the Scriptures were irremediably lost the day when people wanted to get at the psychology of Jeremiah, of Isaiah, of even Jesus Christ." (Similarly, when it comes to our patients, please give more attention to the text than to the psychology of the author – the entire orientation of my teaching is that" (Lacan 1954-1955 cited in Miller, 1991: 153).

Psychoanalytic orienteering through free association will inevitably lead to uncharted territory, fraught and erratic. I would suggest too that it is not for the faint hearted. Indeed Freud actually became faint on occasion with Emma, probably because his theoretical wanderings with Fliess were ill mapped out causing all parties extreme physical and mental distress. Upon seeing Emma's nose haemorrhaging, Freud felt faint and he wrote afterwards that it was not the sight of her actual blood that overwhelmed him but the "storm of emotion" (Freud, 1925, SE XIX: 252). We can see in his letters to Fliess that Freud, flooded by thoughts and ideas based on multiple identities and narratives, was metaphorically wandering through the woods of his own self-analysis whilst culling old theories and planting the seeds for new ones. In the early to mid 1890s Freud was reassessing his formulations on hysteria that he had worked on with Joseph Breuer, he was developing a theory of psychic fantasy life and infantile sexuality, he was formulating the beginnings of the Oedipus Complex and in the analytic encounter he was discovering the transference. Within the seas of change, "the storm of emotion," Fliess was proving to be an unreliable compass but one Freud was having great difficulty giving up. Indeed, it was Emma Eckstein who grounded Freud amidst the fragility of the whole disastrous episode. When he returned to the consulting room, having recovered from feeling sick at the sight of her blood, she declared, "so this is the strong sex" (Freud letter to Fliess 8th March 1895).

With regards to amenorrhea, I am led to an arena where issues of sexuality are at play. In a letter to Ferenczi dated 6th October 1910, Freud writes that he has overcome a homosexual tendency towards Fliess.

“A part of homosexual cathexis has been withdrawn and made use of to enlarge my own ego. I have succeeded where the paranoid fails” (Jones, 1955: 83).

Just as Freud was examining his own homosexual tendencies through his unshakable positive transference towards Fliess (as he did with Jung in front of whom he fainted in Munich admitting homosexual feelings to be at the root of this turn) we have issues of bisexuality in the amenorrheic whose body shares imprints of both male and female. Indeed, in long-term cases, put simply, “One may expect to find a neurotic conflict related to feminine identity as the cause” (Schoenfeld et al. 1990: 393).

On the outside she looks like a woman but as she does not menstruate, issues of conception and pregnancy are off site. Perhaps she can fulfil the unconscious homoerotic phantasies of the man as his penis is not being desired by the woman solely as a means to procreate? There are no feelings of guilt associated with the loss of sperm since it was always going to die anyhow. Sex then is a no strings attached affair. Symbolically, there are no psychic chords of attachment and thus, no risk of a painful separation. In terms of treating the secondary amenorrheic, anorexic patient, who in the clinician’s eyes clearly needs help, often in the patient’s mind she is totally self sufficient. This state of mind Janine Chasseguet - Smirgel (2005) calls “autarkic” which refers to a political system that puts the emphasis on self-sufficiency whilst highly restricting any contact with neighbours.

I am reminded of the very first dream a patient with secondary amenorrhea brought to her analyst. She had not had a menstrual bleed for at least ten years but this was not the reason she had come for “treatment.” She dreamt that she was watching her husband caressing and fondling the body of a blonde, Barbie Doll woman who she described as being totally opposite to her in every single

way. She said she watched in a voyeuristic manner, a position “once removed.” The man and woman in the dream were in the classical pose of the statue and onlooker often represented in art and sculpture that we came across in our earlier Ovidian review. The blonde woman was looking down on the man (anon. pers. comm).

Issues of desirability and excitement alongside fear and timidity in this early sexual orienteering can be interpreted as a mirroring of the wishes and concerns of the patient in the early stages of the analysis along with issues of gender and equality between the female patient and male analyst being signposted. Sex in the set up of this dream also served as a screen to avoid more painful analytic intercourse surrounding issues of identification, individuation, separation and loss. What would it mean to penetrate this patient or at the very least to become a close neighbour within her “autarkic” set up? A child and his doll is a bond unlike any other. An evolutionary process would certainly mean a more complex affair.

My second association to the Freudian text leads me to oral sex which I suggest links to the dirty syringe in Freud’s dream. For me, Irma represents Freud and his wish in part is that he be in receipt of the penis in a pleasurable but guilt-ridden act of oral sex. Freud had the dream whilst his wife was pregnant; a conception that Freud openly bemoaned. Oral sex would dispose of the possibility of pro-creation. We know that discussions on the subject of oral sex came up during Freud’s analysis of Dora in 1900. When Dora discusses the love affair between her father and Frau K, Dora declares that her father is impotent and Frau K must be sexually gratifying him orally. As Freudman writes, in his chapter “The Cigar”

“This is Freud’s eureka moment. When Dora has a coughing fit, she is acting out a sexual fantasy. Dora is imagining that it is she, not Frau K., who is giving “sexual gratification per os” (orally) to her father. This conclusion, Freud harrumphs, is “inevitable.” Later, feminist analysts would raise the opposite possibility: that Dora’s father was giving “sexual gratification per os” to Frau K., something that does not seem to have crossed Freud’s phallogentric mind at all.

Rather Freud is convinced that Dora's hatred for Frau K. is the hatred of a "jealous wife." Dora's cough and persistent hoarseness is a "hysterical conversion," symptoms of her repressed Oedipal desire to be penetrated by her father's penis. If not vaginally, orally. (Friedman, 2001: 179).

Dora begged to differ. In Freud's analytic excitement, failing to listen carefully to his patient, he was to be cast aside by his analysand. Dora cut the analytic cord and left. With the act of the analytic union only half-baked, partly consummated, Freud has no choice but to finish the job off himself! With a sort of masturbatory vigour and determination, Freud writes prolifically about the case and it becomes one of his most famous and widely read. If we return to the amenorrhic patient, oral sex means she can appear intimate whilst playing the part of both virgin and whore, just as we saw with Galatea and Pygmalion. She does not have to conform to all that is embodied by menstrual blood, which as Deutsch describes it, and as we saw in our analysis of Galatea, represents "the double function of the female as a sexual creature and a servant of the species" (Deutsch, 1945, Vol II: 456).

Unlike other women who have to wait for the menopause to sever their links with their "service of the species," the amenorrhic has no ties. Again, we have the theme of no ties, no losses. In the consulting room she can be intimate with her analyst by means of an oral engagement but will they ever achieve true analytic intimacy? I think not as this would be too dangerous especially if it were in its beauty to precede an ugly ending.

My third association to Freud's text is linked to the Oedipal triangle. Unable and defended against realising his wish in reality, Freud then creates a textual wish fulfilment through the narrative of the Oedipus Complex as a way to acquire the penis. Freud theorised that

"The wish with which the girl turns to her father is no doubt originally the wish for the penis which her mother has refused her and which she expects from her father. The feminine situation is only established, however, if the wish for a penis

is replaced by a wish for a baby, in accordance with an ancient symbolic equivalent” (Freud, 1933: 138).

As a mother acquires the penis through the birth of a son, Freud gives birth to this psychoanalytic offspring; a narrative about a boy, the phallus and the subsequent victimisation and turn around victory of this hero. Concurrently, at this time of treating Emma Eckstein he renounces his seduction theory and as Martha Noel Evans describes

“at the center of the seduction theory is a young girl seduced by the father; at the center of the Oedipus Complex there is a young boy constructing erotic fantasies about his mother. In the new substitute theoretical formulation, then, the little boy takes the place of the victimized girl” (Evans cited in Hunter, 1989: 80).

All eyes are on the male victim. In Irma’s dream all eyes appear to be on Irma but the reader’s attention is turned to the many male doctors in the dream: Doctors, who like Fliess and Freud, must be exonerated. With regards to the misfortunes of the female patient, she, Eckstein, has only herself to blame. If Freud renders the “feminine” and his identification with her as impotent then he can alleviate his own fears of castration. For the secondary amenorrhic and anorexic, the significance of the myth whose themes of incest, intrusion and conflict circle around the parental couple is often accompanied with a view that the mother is superior and the father is weakened in his awe of her. Marilyn Lawrence (2008) discusses in her book *The Anorexic Mind*,

“the way in which anorexic patients in particular appear to fear being intruded upon in much the same way as patients who have been abused. I suggest that this fear of intrusion is linked with a very intrusive object in the mind of the patient. I further suggest that this intrusive part is linked with the patient’s own intrusiveness, particularly with regard to the relationship between the parents” (Lawrence, 2008: 27).

To illustrate the poignancy and delicacy of this inter-relating I would like to share a vignette given to me by a friend whose daughter was being treated in the Child

and Adolescent Mental Health Services. A thirteen-year-old girl, “Belinda” was referred to the specialist eating disorders unit in an NHS hospital. She was rapidly losing weight by defiantly not eating, insisting that the only road to happiness was by being thin. She had her first menstrual cycle around this time but no more followed as the weight fell off. Through a “muddled” mode of survival strategies by the girl, her parents and by continued support from the clinic, she was saved from the clutches of anorexia. Her parents acknowledged that their own marital disharmony was too much for their daughter to bear and the eating disorder served as a container. Belinda was trying to rescue them all by means of a diversion. With all parties occupied in managing the disease, friction was disseminated. The mother recalled how one afternoon she was sitting on her bed and her daughter came in wearing her wedding dress and veil. Belinda asked her mother if she looked pretty. Belinda felt good in the dress, not least because she could fit into it. Her mother told her she looked beautiful. In fact, she looked like a dolly. It was as if she had appeared like a mythical apparition; “part ghost, part human whose guts had not been totally ripped out.” When the doorbell rang, Belinda raced downstairs to open the door to her father. He tried not to show surprise and he embraced his daughter telling her she looked beautiful. The three of them congregated in the parents’ bedroom and then Belinda went off to her room to take the dress and veil off. Belinda needed to internalise the parental couple as a creative one and not a destructive one. The concept of the intruder was prevalent in Belinda’s mind and had to be eradicated rather than re-evaluated and re-integrated. Burdened by this she needed to be seen in the eyes of her parents as just a child, playing at being a grown up. Belinda’s mother said that not even Freud could have thought up this scene. It is a scene she says that will both haunt and inspire her (interview 2016).

White, whether it be the wedding dress or the “large white patch,” dentures or spit referred to in Freud’s dreams, is an important symbol for it can represent an objectless world, perfect, pure, and uncontaminated in quarantine. The white wedding dress that Miss Havisham never takes off in Dickens’ novel, *Great Expectations* (1861), represents the internal world of a woman for whom all life is annihilated, wiped out. Marilyn Lawrence describes the anorexic patient who talks of a “white-out” as

“a state of mind where the couple no longer exists. It is very significant that the state is white. It is felt by the anorexic to be “pure”, “clean”, and hence good. The murderous destructiveness that has been employed in order to bring about this state of affairs is entirely denied” (Lawrence, 2008: 45).

Belinda’s mother recalls discussing with her daughter how the wedding dress was grubby and grey, having been in a box for over twenty years. They discussed how it had potential, how a new underskirt could be made and things could be tidied up whilst the essence of the dress would be kept the same. The mother was aware that she was talking about Belinda’s internal world and this conversation did mark the beginning of Belinda turning her back on the temptations of the fruits of anorexia. We can link this to the moment when Emma Eckstein, during Freud’s treatment of her, turns white, her eyes bulging, appearing as if she were about to die. The white gauze too, that had up to this point intruded upon her nasal cavity to such an extent that it swamped the area, was a deathly symbol of annihilation. Only through bleeding is Emma released of the tension and signs of life emerge, but the flow is so full of energy that it needs to be reigned in so as not to kill her. Equilibrium is the only life-saver.

In Jewish tradition, the groom wears white at his wedding day. I think Freud chose companionship and till death do us part with Fliess over Eckstein. The syringe at the end of the dream might have been unclean but it represented a fate as yet unsettled in that the bacteria or germs might in fact be of a curative nature rather than a deadly one. Freud chose this phallic object over the female symbols of the mouth and white patches, which to him were already doomed. Perhaps too, we could say that what has annihilating qualities, if allowed to blanket over like white snow on our minds, is the wish itself. It can be fatal if it obscures and dominates over the thought that we associate with life and creation. It is interesting that on September 21, 1897, Freud writes to Fliess, announcing that he no longer believes in his theory of hysteria and neurosis, formatively built on the idea that seductions and traumas in childhood had actually taken place. It’s as if he is saying he must be guided by thinking these theories through and not by wishing them through. He ends the letter with

“A little story from my collection occurs to me: Rebecca, take off our gown, you are no longer a Kalle [bride]” (cited in Masson 1985: 108-110).

To spend a lifetime taking off the gown would allow Rebecca to hold onto her former status without relinquishing it fully: The virgin bride. At the same time the future and all that it signifies is not fully out of reach, let's say the sexual creature, perhaps even the prostitute. Rebecca is in that moment, a bride and not a bride but neither one nor the other. I think Rebecca represents the Secondary amenorrheic, who reigns in such a place.

#### ANALYTIC RELATING IN ECKSTEIN'S CASE

Let us return to Freud's work with Emma Eckstein, his jilted analytic bride and look more closely at the approach he and Fliess took in their treatment of her. When Freud referred Eckstein to Fliess, the ear, nose and throat surgeon, Fliess was working on a theory of periodicity to show how the rhythms in men and women affected their psychology. Furthermore,

“The pathology of menstruation finds its reflection in birth: the same mechanisms and the same conditions that hold true for nasal dysmenorrhea also control the pains of contraction” (Fliess, 1897).

Disturbances in the nose were linked to a faulty reproductive system and

“on the basis of the purported nasogenital link, Fliess went on to insist that Freud's category of the actual neurosis was frequently associated by virtue of its endogenous sexual origins, with the complicating systems of a nasal reflex neurosis. In clinical proof of all this, Fliess cited, amongst other evidence, the phenomenon of visible swelling by the turbinate bone during menstruation, the occurrence of vicarious nose-bleeding during menstruation and pregnancy, and the fact that cocaine applications to the nose were capable of inducing accidental abortions” (Sulloway, 1992: 140).

On March 4th, 1895, Freud writes to Fliess telling him that Emma has suffered a “massive haemorrhage” and he describes Emma’s condition as “still unsatisfactory.” On March 8th he writes again, this time reporting a near-fatal incident. Freud describes how he watched a colleague, Rosanes, cleaning the area around Emma’s bleeding nose. Rosanes

“removed some sticky blood clots, and suddenly pulled at something like a thread, kept on pulling. Before either of us had time to think, at least half a meter of gauze had been removed from the cavity. The next moment came a flood of blood. The patient turned white, her eyes bulged, and she had no pulse. Immediately thereafter, however, he again packed the cavity with fresh iodoform gauze and the hemorrhage stopped. It lasted about half a minute, but this was enough to make the poor creature, whom by then we had lying flat, unrecognizable” (cited in Masson, 1985: 116-17).

When you read through Freud’s letters to Fliess it is remarkable to see how he shifts the place of blame from the two of them and eventually arrives at the conclusion that it is the witchlike Emma who is to blame for her misfortune. Once a victim of injustice, not at all abnormal (Freud to Fliess, March 8th, 1895), Freud claims a year later that Eckstein is both delusional, recreating past traumas in present fictitious form, and she is dangerous. Freud insists, “She has always been a bleeder.”<sup>xlv</sup>

Freud then concludes that Emma’s bleeding was an expression of wishes and thus “she is the agent of her own pathology” (Freud to Fliess March 4th 1896).

In her chapter “Freud, Fliess and Emma Eckstein” (1990), poet and literary critic Madelon Sprengnether coherently organises the facts of this episode to show that Freud needed to exonerate Fliess of responsibility because it affirmed his renewed faith in Fliess’ capacity as a surgeon. After all, Fliess was as much Freud’s surgeon as he was Eckstein’s. Also, by suggesting that Emma’s bleeding was hysterically motivated, Sprengnether describes how

“The latent contradiction in this position gives rise in turn to a thesis concerning infantile eroticism, which has the double advantage of emphasising the boy’s active desire for his mother and further absolving adult male figures of blame. Maternal aggression, named but not explored in the concept of parental seduction, ceases to have meaning in the new Oedipal theory and slips to the margins of consideration. Eckstein’s bleeding, deprived of its traumatic effect, is later reintegrated into the Oedipal paradigm through the concept of female castration, from which its author can safely dissociate himself by virtue of his aggressive masculinity” (Sprengnether, 1990: 37).

Sprengnether stresses the castration fear but very usefully also suggests that in seeing Emma nearly bleeding to death, Freud feared an identification with the victim of a sexual violation as analogous to being a woman, a subordinate. She goes on to refer to Koestenbaum’s interpretation of Freud’s reaction to Emma’s bleeding in terms of an anxiety about anal penetration.

“Blood results from male medical force: such blood would flow from Freud if Fliess fully influenced him, if their congress took place not merely in Freud’s “lubricated temporal lobe” but in his anus. Male menstruation, in this context, seems a figure for the distressing anal bleeding that would have been the likely consequence of their intercourse – if we postulate the existence of a symbolic anal hymen, broken upon first penetration” (Koestenbaum 1988: cited in Sprengnether 1990: 31).

In support of this we have Faergman who writes that “the chief organ of expression of the [male] fantasy of menstruation is usually the rectum” (Faergeman, 1955: 16).

So we have a Freud who is ambivalent about so many things; about his thoughts on the treatment of Emma, about his male identity and his identifying with her, about his feelings towards Fliess, a man who is clearly incompetent but from whom Freud is not ready to relinquish that positive transference. At the same time he relinquishes his seduction theory that supports the patient’s version of traumatic events as being real. Thus he turns away from Emma’s narrative and

pursues his own line of enquiry that leads him to a place of uncertainty in that a patient's version of reality is always informed by the existence of a reality whose origins are from psychic fantasy life. I think there is something else at play here, which writers seem to have overlooked. It seems to me that the commentators act in and collude with Freud's developing phallo-centricity because they all seem to focus primarily on the male players of this episode. What about the one women, Emma Eckstein herself? I propose that she, along with all of the other hysterical patients that Freud was treating at the time, was highly seductive to him. As Jones writes, Freud

“found the psychology of women more enigmatic than that of men....Freud was interested in another type of woman, of a more intellectual and perhaps masculine cast. Such women several times played a part in his life, accessory to his men friends though of a finer calibre, but they had no erotic attraction for him. Minna Bernays, then in chronological order: Emma Eckstein, Loe Kann, Lou Andreas-Salome, Joan Riviere, Marie Bonaparte” (Jones: 469 cited in Masson, 1992: 241).

In turn I think Freud became seductive to Emma. As he wondered whether her story of the shopkeeper accosting her was true or not, the tension between what was real and what was illusionary between the two of them could not be repressed forever. What is genuine and what is transference and where they bleed into one another is one of the key themes of psychoanalytic practice. As Freud himself acknowledged

“The certain insight that there are no indications of reality in the unconscious, so that one cannot distinguish between truth and fiction” (Letter to Fliess 21st Sept 1897 cited in Masson, 1985: 264).

In hysteria we have a synthesis between the conscious and the unconscious worlds. Working with all these highly intelligent creative hysterical women, in isolation, must have been very hard for the young Freud with all that was presented both consciously and unconsciously in the minds of both patient and analyst. As Irigaray writes

“It would be apparently too risky to admit that the father might be a seducer, and even that he might want to have a daughter in order to seduce. Or that he might want to become an analyst in order - by means of hypnosis, suggestion, transfer and interpretations that deal with the sexual economy and with forbidden, proscribed sexual representations – to achieve a lasting seduction of the hysterical woman” (Irigaray’s italics, [1974] cited in Gill, 1985: 38).

The hysterical Emma Eckstein is regarded as Freud’s first patient in a “training analysis.” This is significant as here we have Freud the creator with his creation just as we saw with the Pygmalion tale and all those issues of incest and seduction and the continuation of the dynastical line. Furthermore, we also have Freud enamoured by the life force of such women. Masson quotes from a 1952 interview that Emma’s nephew Albert Hirst gave to Dr. Eissler:

“I think it was of importance to him [Freud] in his practice that he had this great success, this well-known girl, this girl of a well-known family. Now she was a very beautiful woman and after he had this great success, she for several years led a perfectly normal life” (Masson, 1992: 255-256).

However, after about fourteen years, Eckstein suffers a relapse, which Hirst speculates was caused by a Viennese architect, whom she loved, marrying another woman. Freud writes that “she proved inaccessible to a further attempt at analysis” and according to Hirst there was a conflict between Freud and Eckstein. Could we say that proving herself to be fragile, dependent and thus not a desirable double image for his own defence against the “harbinger of death” Freud turns his back on Eckstein?

Hirst describes in his interview to Dr. Eissler,

“Dr. Dora T., a friend of the family, a woman physician, came to see Emma as a friendly visitor. She claimed suddenly to have discovered an abscess near Emma’s naval and drained it. Dora claimed that she had found the source of Emma’s illness and had cured it. She thus confirmed Emma in her rejection of

Freud's diagnosis of a recurrence of her old neurosis. When I told that to Freud the next day he was furious. He took Dora's "diagnosis" as a fake. That to him was a matter of course. He called it a highly unprofessional interference with a patient under another doctor's care. He immediately withdrew from the case saying: "That is Emma's end. Now she will never get well." He was right. Emma was up and about for a short time, but soon returned to her couch on which she had lived so long. She survived, as a hopeless invalid, for another ten years. It may be unjust to him, but I had the impression, or let me say, the suspicion, justified by noting I can adduce, that Freud was not unhappy to be rid of a burdensome charity case."

Interestingly, Freud is furious by Dr. Dora Teleky's medical involvement. This is in stark contrast to his advocacy of Fliess' reckless surgery on this same patient. His anger towards both Teleky and Eckstein is palpable. He projects his own incompetence and intrusiveness onto them. Whilst Freud gives himself permission to forge analytic alliances with whomever he wants, whenever he wants, it appears that his subjects are to remain loyal to him at all costs. When Emma chooses to explore outside of the Freudian parameters, having been left by him in a desperate state anyhow, she is cast as disloyal, just as Dora, Jung and Ferenczi were. To survive the aftermath of a Freudian experience was difficult; too difficult for Emma whom I believe always hoped that Freud would one day come back for her. He never did.

As early as 1899 Eckstein had written a paper entitled "An Important Question of Education" and in it she states

"a child knows shame only slightly, or not at all, knows no sexual feelings of any kind, and so can only guess that there are other reasons, besides the desire to have children, that would fuel the desire to have sexual intercourse." She ends the essay saying that adults "mate when they like each other, in fact, love each other so much that each of them wishes that their child will look like their partner" (Eckstein, 1899-1900: 666-669).

Jeffrey Masson in his thorough account of the transcripts on Emma Eckstein links the above ideas to the wording in the minutes from a meeting of the Vienna Psychoanalytic Society on May 12th 1909 in which Freud is quoted as saying of children:

“Enlightenment should above all make it clear to them that this is a matter of acts of tenderness, that their parents love each other very much” (Masson, 1992: 244).

It feels to me as if Freud the analyst and Eckstein the analysand were like a couple whose relationship was in grave danger and whose union was not one of the harmony and love of enlightenment. They parted and the project was aborted, symbolised by her severe bleeding. It is as if she sacrificed her own desire and longing for him to fulfil his. He was a young analyst at the beginning of his career and she was his first real analysand. She displayed a parental love towards him, something that he, her analyst, was unable to offer her. It is clear to see how Freud is unable to contain Emma’s trauma. Instead, he introjects it, a burden upon his own process, thus proving himself to be increasingly ineffective and impotent. The motivation behind the introjection might actually have been caused by a rivalry Freud the man felt for Eckstein, the woman. In the face of all of this, to identify with an incompetent Fliess would be catastrophic and thus he must adopt the phallic position no matter what the consequences. Both men must be upright, no matter what! In the end she was to blame, according to Freud in a letter to Fliess of 26th April 1895,

“with regards to Emma, I shall prove to you that you were right; her haemorrhages were hysterical, bought on by longing probably at the “sexual period” (Freud, 1895).

Freud then writes in May 1896,

“so far as I know she bled out of longing. She has always been a bleeder, when cutting herself and in similar circumstances; as a child she suffered from severe nosebleeds; during the years when she was not yet menstruating, she had

headaches which were interpreted to her as malingering and which in truth had been generated by suggestion...in the sanatorium, she became restless during the night because of an unconscious wish to entice me to go there..." (Freud, 1896).

## CONCLUDING COMMENTARY

In the face of a hysterical woman, erratic and erotic, I think the acquisition of the phallus, provides Freud with a sense of stability and potency. Shirley Nelson Garner (1989) interprets Freud's liking of Fliess as both homoerotic and homophobic, which I think further reflected and intensified his ambivalence to the manner in which he treated his female hysteric patients many of whom were family friends. I would suggest that Emma Eckstein was indeed the stronger sex and her eventual bleeding created a release of psychic tension and enabled a progression towards recovery. And it is Fliess who in contrast represents the coward who can do no more than simply repress psychic flow and discharge by "unknowingly" leaving the tampon-like gauze in Emma's nose. This blocks the symbolic flow of unconscious, transference and counter-transference communication. But the dam was not well thought through, not sufficiently analysed, made of the wrong material and thus buckles and breaks with disastrous consequences. A middle space, a temporary place of respite is provided by Rosanes who freezes the area. Emma bleeds, just as the woman in losing a foetus from the womb bleeds and thus she exonerates Freud and Fliess of all future responsibility. This is a miscarriage....A miscarriage of justice!

Perhaps Emma aborted the project because she felt the parental couple did not love each other enough to sustain the child; the parental couple being herself and Freud or Freud and Fliess and the child being her psychic health. How Freud contains his own tension, anxiety and stress is via a dream: one of wish fulfilment in which the struggle between men and women, vagina versus penis is momentarily contained to provide the space for some relief and release with no accompanying creative, unwanted procreational burden. It is the best form of contraception. The dream is one of many things including oral sex whilst at the same time provides a space for further re-presentation of the Emma episode.

Furthermore I think we also have Freud's deliberations of the circumcised (Fliess) and uncircumcised (Jung) penis. Twelve years later, after the dream, in 1908, Abraham writes to Freud

"I should like to know whether the interpretation of the paradigm dream in the Interpretation of Dreams is incomplete on purpose (Irma's injection"). I think the trimethylamin leads to the most important part, to sexual allusions, that become more distinct in the last lines" (Abraham and Freud [1908] in Falzeder, 2002 [1965]: 19).

Freud replies that in the paradigm dream

"Sexual megalomania is hidden behind it, the three women Mathilde, Sophie and Anna are the three godmothers of my daughters, and I have them all! There would be one simple therapy for widowhood, of course. All sorts of intimate things, naturally" (Abraham and Freud [1908] in Falzeder, 2002 [1965]: 21).

Here we have a further shift away from hysteria and circumcision and their associated traumas towards the realms of incest. This is enhanced by the Oedipus myth, which becomes emblematic of Freud's future psychoanalytic workmanship. We have here a man who is holding his theories at the border crossing, able to look back and reflect on the origins of his psychoanalytic thinking whilst looking forwards towards a continuing evolutionary journey. As Wax states in "Who are the *Irmas* and what are the narratives?" (1996)

"What is peculiarly startling is not the revelation that Freud might have had erotic desires toward his patients, as well as toward women other than his spouse, and that these desires surfaced within a dream, but that he should here have recognized a dual level of meaning of the dream, while elsewhere contending that in interpreting a dream the analyst sought a single motivating wish" (Wax, 1999: 78).

The dual level is an apt metaphor for secondary amenorrhea, which as we saw in our Ovidian review represents that which is neither wholly dead nor wholly alive. The conscious and unconscious reside in synthesis with one another, as they do for hysterical women such as Emma Eckstein. Her bodily state is symbolic of a psyche that is at the border crossing, able to view childhood of formative years whilst looking towards a future of womanhood. Perhaps here at the crossing she can embrace adulthood and even motherhood whilst bypassing issues concerning womanhood. An absence of menses means no loss of blood, no trace of damage nor reminder of psychological trauma. Allegorically; no castration, no foreskin, no split off part to mourn and bury. No wound, no robbery, no intrusion. No victim, no perpetrator. Her non menstruating body is the furthest away from the horrific mess that Freud discovered when he looked down into Irma's mouth which for Erikson represented "woman's procreative inside (Erikson 1954: 45).

At that moment of discovering "the flesh one never sees" (Lacan 1954-1955: 154), Freud is silenced:

"This moment of extimacy (rendering what is profoundly intimate in an external representation), produces identification with anxiety, a revelation of human mutability and decay: "You are this, which is the farthest away from you, which is the most formless"" (Bronfen, 1998: 73; Lacan 1978: 186).

Secondary amenorrhea is thus also a design that cleverly contravenes

"the prototype of what Lacan named the "real" i.e., what escapes both the imaginary and the symbolic registers of meaning" (Bonomi, 2015: 90).

I think secondary amenorrhea and hysteria as exemplified by Emma Eckstein represent the place between the concrete and the symbolic. In a transcendental state, above and beyond memory, reality and fantasy, these women can prove that transference, notably transference love is indeed "genuine" and "real" in that it is both concrete, symbolic and all that is in between. They are powerful in their vulnerability in that they rise above the anxieties of mortal men and fear not death. Freud's analysis of Eckstein's case represents the way in which he was

holding in the balance his original seduction theory whilst developing his ideas on phantasies as the source of neurosis. I am highlighting here that again we are observing the evolution of a realm, a middle space as part of an axis where several states can co-exist inter-dependently. Thus, I would disagree with Masson (1994), Rush (1977) and others who have been firm in their interpretation that Freud renounced the seduction theory and entirely denied his patient's the truth of their memories and recollections in favour of sexual desires and unconscious phantasies in childhood. As Lynne Segal writes

“Surveying all of Freud's writing when researching their dictionary of psychoanalysis, Laplanche and Pontalis (1988: 404-8) notice that even with his evolving framework of autonomous infantile sexuality, Freud “continued to assert the existence, prevalence and pathogenic forces of scenes of seduction actually experienced by children.”... Despite Freud's own conceptual uncertainties as he felt he must choose between trauma and desire, many other analysts would later suggest that there is no essential contradiction between attributing adult symptoms to a destructive mix of the two- “real” and fantasized events. Indeed, Laplanche (1989) has argued compellingly that all material experiences are immediately invested with, and continuously worked and re-worked through, psychic fantasy” (Segal, 1996: 293).

We have seen in earlier chapters of this thesis case studies of amenorrhoeic women in analysis who have struggled to distinguish between the illusionary and the real, never quite managing to find a middle space. Like Eckstein and Freud who are linked together through the themes of loyalty and betrayal, the analysand with secondary amenorrhoea might wish to be the doll, the transitional object for her analyst. This might find a resolution to the “either / or” paradigm. Pygmalion, Higgins and Freud all blow the kiss of life into their subjects and thus wishes are transformed from conceptual, hypothetical ideas into a new reality realm that resides somewhere between the concrete and the symbolic. The life force of Galatea reconfirms that of Pygmalion, as Eliza's does for Higgins and Eckstein's does for Freud. These women embody the desires of their male “creators” and each of these men are in turn reinvented with a new lease of life through the mutuality of the project. The women are the heroes who wake these men up with

the kiss of life from their sleepy slumber. With the gaining of an identity for each of these women, there comes a process of alienation. This is what is most hazardous in the treatment of the amenorrheic patients for whom transformation, identification and separation are treacherous concepts. The male analyst must not act in to the amenorrheic defence against differentiation; and difference must not be disavowed through the integration of the female patient as phallic into this male analyst's narcissistic system.

Freud's understanding of narcissistic love for another as being perceived as subjectively part of the self, meant Narcissus's reflection would disappear if he were to leave the pool. The female patient must not become incorporated into the analyst's own narcissistic defensive structure otherwise what will become of her? An Echo or a Galatea who shows herself capable of malleability in the face of her imagined lover-creator? She will be too afraid to separate in case she loses his perceived adoration. The symbiosis and its parameters lack clarity. I believe the only way out is when the patient finds her voice (unlike Galatea who does not speak. She does not even have a name in the original text.) Interestingly, when Eckstein spoke of who she thought was the stronger sex, Freud recoiled and recreated his dolly into a Frankenstein. Freud reconfigures his reflections of his treatment of Eckstein in a way that suggests that she, like a witch who wanted the devil, was like a child who wished to be possessed by the father. Thus, his version of the episode stated that he and Fliess were not to blame; they were mere puppets in her internal theatre of fantasy. But I would say that as Eckstein's nose bled, his, like Pinocchio's, grew.

Working with the patient whose menses return during analysis can become tricky. As if like a doll to her analyst it is often here that the strings of puppetry get cut. The analyst must trust in and work towards something much deeper than the infatuation or indifference of common souls that the transference will employ defensively as decoys. He must not act in and have it so that she becomes his living doll. He must remember that it is he who must be used as the transitional object and must make himself available to her for as long as it takes. As we saw with Pygmalion and Galatea, Higgins and Eliza, Freud and Eckstein, the ties are

formed in such a way that they can never be truly severed. The treatment is never truly terminated.

## **CONCLUSION**

### **VIEWING A FEMALE CONDITION THROUGH A PSYCHOANALYTIC (MALE?) LENS**

My investigations into why women of menstruating age stop bleeding took me to all parts of the research globe - medical, anthropological, historical, literary, psychoanalytic etc. and yet all roads seemed to lead back to the same place - one where the paternal, the patriarchal, the third, the father (however you want to call it), are central to the narratives of many of these women. I came across the most concrete of "evidence" that showed how absent, abusive, intrusive, neglectful, inappropriate male behaviour featured in the traumatic pasts of some women who went on to develop amenorrhea. The cessation of menses acted as a disassociative state, containing a host of feelings and emotions that were repressed and securely embedded in this bodily vacuum. For others its design was a safe house in a wider context of defeminisation. As written about in the earlier chapters of this thesis, amenorrhea is a far cry from a no thing. Sometimes it signifies transcendence, wonder and other worldliness and other times it represented sorcery, obscurity, strangeness and otherness. It can represent persecution and resistance. It can be a silent protest or a cry for help.

I have tried to present all of the associative narratives together in a coherent way. As my research progressed and took shape it seemed to me that it was not a clear-cut case of amenorrhea representing that which was lacking, passive or negative. Far from it: Indeed, the cessation of menses is courted by women who, rather than running away from the phallogentric model, run towards it coveting the magic wand, the broomstick, the phallic symbol as part of a wider ideology on womanhood. It represents for them a symbol of potency. "I want what you have but I shall make it my own" is the concept. But what happens when menses returns? And what of my own unconscious? Has it penetrated my research so as to create an amenorrheic script that works for me? These were the questions that so too needed addressing.

I had set out with the belief that harking back to the Golden Age of psychoanalysis we could show how forward thinking the amenorrheic woman is. Classical psychoanalytic formulae incorporate the role of the father as being instrumental in separation-individuation (Abelin, 1971). In the beginning with Freudian psychoanalysis there is the unisex tale of the little girl who, in discovering that she does not have a penis, turns away from her deficient mother and advances towards her father. He has the very thing she wants and the very thing she envies in the masculine. Coming to terms with this lack dominates her journey into the feminine, her psyche having to manage the narcissistic wound of such a castration.

“At this juncture, the girl has attained heterosexuality, but she has yet to attain femininity proper. Until her penis envy is sublimated in the wish to have her father’s child, until she embraces the reproductive consequences of vaginal sexuality, an excess of pre-Oedipal masculinity remains (Freud, 1966: 592). Ultimately, a woman can obtain feminine gratification only by having a baby to replace the penis she is missing (Freud, 1966: 592; 1990: 312)...Thus, remarks Freud, the vestiges of penis envy never entirely disappear from women’s psychic economy (Freud 1966: 592-593). Women’s “enigmatic” bisexuality is never decisively overcome (Freud, 1966: 595; also see Young-Bruehl, 1990: 12-41)” (Meyers, 1994: 67).

In her failed attempts to become pregnant, when fertilisation has not taken place, the woman is faced with the psychological trauma that comes with each failure to have a child. In each attempt to compensate for the original narcissistic wound, she is in turn castrated - Menstruation is castration. Amenorrhea ingeniously overrides nature’s pain in its ushering in the cessation of menses. And in “knowing” that man fears menstruation, as a symbol of castration, the amenorrheic woman aligns herself with the brotherhood, more so than with her procreating sisterhood. Man need not fear her. But she is more than his inferior double. After all the cessation of menses could be seen as the castration of menses, by her own hand. She comes into being, she is her own woman, however the twists and turns of her journey might have played out, through the incorporation of the paternal. The reasons for this have been accounted for in the

previous chapters, many of them have themes of trauma, neglect, loss etc. threading through them. Amenorrhea surmounts these dreads and threats. Many of these women “know” that the acquisition of the phallus in some sense is paramount to their continued living. That she desires this is a complex matter. I find it helpful to think about the issue of desire in terms of the way it threads through the narratives on hysteria, of which the cessation of menses has been a notable feature. Useful in all of this is Lacan’s

“locating the question at the level of desire.” (Lacan, 1969: 129).

In “The Engagement Between Psychoanalysis and Feminism” (1997) Muriel Dimen describes how a women’s desire embodies multiplicity of contradictory states and meanings,

“present here and absent there, flaring here, doused there, flickering still elsewhere, its ambiguity, difficulty, and elusiveness the alternate truth of all, of anyone’s desire” (Dimen, 1997: 543).

I am reminded of the flitting and flirting, the teasing and the game of catch me if you can of the hysteric. What though is behind all of this? I think it’s a game of catch me if you can, I’ll tell you where I am hiding, don’t take too long to find me. The analyst is required to seek. The father has assigned him this task. In the analytic arena of seduction and reciprocity hysteria represents the castrating subject whose heart beats desire. She is a

“never ending beginning...She never wants to recover herself in an opening, which, when repeated, surfaces like a gaping hole, a cry or a howl” (Webster, 2015).

In *Bonds of Love* (1988), Jessica Benjamin writes of “the desire for recognition, which is an essential component of differentiation and autonomy” (1988: 126).

Benjamin argues that a woman does not need the desire of a man to feel fulfilled and she can be the subject of her own desire. But I would ask, which woman

truthfully chooses to be self-taught in all of this? As Eliza Doolittle explains to Higgins towards the end of *Pygmalion*, “Every girl has a right to be loved” (Shaw, 1916: 103). Surely, every child in this world is entitled to be loved?

For Freud and his contemporaries the analyses of such women who appeared to desire the desire of the other were overwhelming. The first of Freud and his mentor Breuer’s hysterics was Anna O (Bertha Pappenheim) whose symptoms advanced shortly after her father’s untimely death. She was termed as having a “double conscience” which was a split between a “normal” and a “hallucinatory” ontological state. She imagined herself to be pregnant with Breuer’s child. In a way this represented her complete impotence of prediction and her outright omnipotence of thought. Many would come to use Anna O’s case as a model of creative expression demonstrating a form of resistance to patriarchal repression. Juliet Mitchell often refers to the creative potential in hysteria and Jessica Benjamin explains that

“Not surprisingly, hysteria was among the first issues explored by feminist criticism, and the idea of the hysteric as an antecedent form of woman’s protest against the constraints of the patriarchal family” (Benjamin, 2013: 3).

I wonder to what extent this presentation of hysteria as a protest against the laws of the Father, social and symbolic, masks more than it reveals. What is it that is too hard to bear witness to? The distress, the madness, the insanity that Anna O displayed? That she imagined she could only recover if Breuer did what she asked of him is sometimes too simple a concept for some to grasp. When needs are not met and psychic conflict is unresolved, aggravated in the therapy even, the patient is, as Nanette Leroux, declared, “done for.” All the praise heaped on the patient for her capacity to sublimate and all the applause for an analysis that perpetuates psychoanalytic theory pails into insignificance if we think of the tragedy that is Anna O. Her wished for longing in fantasy, not being met in reality, left her suspended in a middle realm, part alive, part dead: Another real life Myrrha. Each appearance and disappearance of Breuer left a scar, a fault line in the topography of the patient’s mind. In these instances the analyst is caught between a rock and a hard place and as we know in Anna O’s case, Breuer fled. I

think we need to talk more truthfully about the reality of such cases and the fallout that comes from a failed analysis.

Understanding hysteria to the order of the unconscious was extremely valuable to Freud especially as the disordered bodily symptoms could not be explained for in a physiological sense. So too with the many cases of amenorrhea for which organic explanations must give way to psychological ones we have turned to the unconscious for help. But in Freud's early engagement with his patients so much of the material was left uninterpreted? I think it fell into a gap (which is probably where the more truthful aspects of the unconscious reside, as Freud said, with those slips and tics etc.). If the symptoms of hysteria flutter between the psychological and the organic, amenorrhea is at the point of intersection. It fills the gaps. Its presence is that of a black hole that fills the black hole.

What is it that is lacking? It seems to me that what is lacking is affirmation and recognition that every young girl is entitled to – what they did not get first time round from their “real” father. What does a young girl do when she can't say for sure what their father is thinking or feeling? With no demonstration of a taking up followed by a renunciation of longing, love etc. between father and daughter in neither word nor action there is no settling in “period.” As Andrew Samuels describes it, what is lacking is the place in which the girl can affirm her own “erotic viability” (Samuels, 2016: 82) and make it her own. There is no “erotic playback” (Samuels, 2016: 82). I believe that this vacuum, this non-communicative realm is one in which amenorrhea will occupy. With no experience of the stabilising other there is a hole in the symbolic. Amenorrhea is the lack of the lack.

How does she fill this lack in her every-day life in our modern world? She can cleverly take herself out of the shadows of the mothering imagos of “normal” menstruating women and forge a new system for herself and become a mother in unconventional ways. With the revolutionary system of IVF one can go it alone. But this is not the whole story. Repeated IVF can be an archetypal representation of a mourning ritual that fills an empty space. What is being renegotiated is the original maternal object and in many instances what is being

sought after is the actual absent father and together the creation of an intrapsychic couple is conceptualised as that which can fill an empty space (Barone-Chapman, 2007). How else can she acquire what she needs and incorporate it into her world? She might take a career in a male dominated profession or she might embrace a cultural or religious system that advocates traditional patriarchal views. She might turn into a carer, a parental figure, and notably in the cases of looking after a sick father she makes an attempt at self and other reparation. She might clearly display a “lack” in the father in the way that she identifies herself in relation to gender or she might contravene the ideas of feminine sexuality as defined by man (but as harried by women) by creating her own ideological framework in which the sanitised, defeminised body rejects an antiquated order. Whichever method chosen, there is in all of them an attempt at reincorporating the shadowy imprints of pain, trauma, loss in a way that the ghosts from the past no longer threaten continued living. She survives, even if she has to play dead.

And amenorrhea, as we have seen in the examples given throughout this thesis, has often come to represent that which is dead. And in this still life, something new can emerge. Man is afraid of death. He hunts it down. Amenorrhea can hold both the subject’s sexual and aggressive drives. She need not project it onto the other like man does. Her unconscious reveals itself through the bodily state of amenorrhea (and if need be anorexia) to be unafraid of death. In fact, death becomes her. People understandably react. They think something needs fixing. Fertility must be sought, anorexics must be fed, menses must resume, the hysteric must be rewired. Both men and women make up the cavalry that’s come to save her. But does she want saving? What do these women want?

Freud asked this question in a letter to Marie Bonaparte in 1925, puzzled by woman’s resistance to patriarchy. His investigative approach has ignited ceaseless furious debate with many feminists seeking to destroy the patriarchal gunpowder plots that they feel are so dangerous in the hands of trigger-happy men. Whilst Juliet Mitchell explains that

“psychoanalysis is not a recommendation *for* a patriarchal society, but an analysis *of* one” (Mitchell, 1973: xiii),

many of her feminist compatriots are less generous to Freud. Betty Friedan (1974), Luce Irigaray (1985), Nancy Chodorow (1978), Simone de Beauvoir (1949) and Kate Millett (1969) amongst others, have argued that Freudian psychoanalysis cements patriarchal ideology, constructing feminine sexuality and feminine psychology as passive, disavowing the active and aggressive life and death components in the feminine when it comes to matters of procreation, pregnancy and childbirth. This in turn makes a taboo of ambivalence in the feminine, notably maternal ambivalence. De Beauvoir argues against the position that a woman lacking autonomy and choice is at the mercy of masculine subjectivity (Beauvoir, [1949] 1989). Irigaray exposes the erasure of the mother-daughter relationships and the maternal lineages formed along the life cycle of a woman (Irigaray, [1974] 1985a).

I don't disagree with any of this. Patriarchy does enslave women and many of Freud's ideas, notably that there is only one masculine libido with no feminine one with "its own original nature" (Beauvoir, 1989: 39) is totally out dated. However, when it comes to thinking about the amenorrheic woman whose agency is entangled up with the principles of love and with the masculine ideal, Freudian early concepts on women, particularly in relation to the penis are very helpful and relevant in our deciphering the meaning behind the amenorrheic narrative. What I have come to term "chase the penis" is concretely and symbolically part of the narrative in some cases - in which case it must be allowed for rather than rejected as subordinate, rudimentary thinking devoid of modern philosophical finesse. Does a girl want the penis? Yes, maybe she does. Is that ok? Yes, absolutely it is! Motivated to remain a child, I can own up to playing my own version of "It" at the age of seven or eight. In the playground around the back of the synagogue, whilst the elders were inside praying, I would play "chase the penis." The way I would try to tag the boys and catch them was to touch their trousers in the "private parts." I can remember the perplexed expressions on some of the boys' faces, particularly a pubertal Persian boy, a few years older and significantly taller than me. I didn't see the need for privacy. I was young, innocent, curious and happy for all of that. This was in no way a clash of the genders.

I turn to Karl Abraham's early paper *Manifestations of the Female Castration Complex* (1920) in which he presents his evidence to support the view that women's repressed wishes are that they be male. He includes a beautiful vignette of a two-year old girl for whom turning into her mother and her sisters, with their long hair and tall stature is fully acceptable but for whom the idea that there will be no penis for her is much trickier to deal with. Abraham writes,

"One day as her parents were taking coffee at table, she went to a box of cigars that stood on a low cabinet near by, opened it, and took out a cigar and brought it to her father. Then she went back and brought one for her mother. Then she took a third cigar and held it in front of the lower part of her body. Her mother put the three cigars back in the box. The child waited a little while and then played the same game over again" (Abraham, 1920 cited in Strouse, 1974: 111-112).

Abraham goes on to write

"The fact of the repetition of this game excluded its being due to chance. Its meaning is clear: the child endowed her mother with a male organ like her father's. She represented the possession of the organ not as a privilege of men but of adults in general, and then she could expect to get one herself in the future. A cigar was not only a suitable symbol for her wish on account of its form. She had of course long noticed that only her father smoked cigars and not her mother. Her impulse to put man and woman on an equality is palpably expressed in presenting a cigar to her mother as well." (Abraham, 1920 cited in Strouse, 1974: 111-112).

In more modern terms, we can say that we are not talking about the actual anatomical differences per se but rather the symbolism of the distinction, how this symbolism develops in the child's mind and how this impacts on her development and her personality. Amenorrhea can often be located at the point of a schism in this process often around the time of puberty.

Freud wrote that part of the young girl's pubertal conflict entailed her attempts to keep her boyish nature which she had up until that point already possessed (SE

XIV: 88-90). With Freud in mind, in the role of researcher, I asked my teenage daughters what they thought about penis envy. They are two teenagers of these times, cut out of the same amenorrheic cloth but themselves having menstruated regularly. Evie replied

“I don’t envy them having a penis but it seems more straight forward to me. Vaginas are so complicated. If you just look at them, the actual “thing” itself is such a complicated thing, it can make girls feel self-conscious about it. I guess it’s easier being a man, the glass ceiling and all of that” (pers. comm. 2017)

I asked her sister, Sarah, the same question.

“Boys don’t have vaginas and girls do. No one loses out. I have never wanted a penis. Penis and vagina, man and woman - they need one another” (pers. comm. 2017).

There are echoes of this in Naomi Wolf’s 2012 biography *Vagina*

“An essential paradox of the female condition is that for women to really be free, we have to understand the ways in which nature designed us to be attached to and dependent upon love, connection, intimacy, and the right kind of Eros in the hands of the right kind of man or woman. I believe we should respect the potential for “enslavement” to sexual love in women; to our place with Eros and love. Because only by making room for it, rather than suppressing or mocking it, can we strive to understand it. When a woman is engaged in this struggle with love and need, she is not “subject” to the person in question; she is actually engaged in a struggle with herself, to find a way to reclaim her autonomy, while somehow not cutting herself off from the part of herself that was awakened by the beloved in the longing for connection. A woman struggling with attachment and loss of self is engaged in a struggle for the self as demanding and rigorous as that of any man on any quest narrative. Of course the biological responses I am talking about here have long been identified in psychoanalysis and in literature; only recently has science added new dimensions to and explanations of these

mind states elucidated by poets, novelists and students of the psyche” (Wolf, 2012: 96-97).

As women we don't need to be on the attack nor do we need to play the role of “the everlastingly wounded one” (Michelet, 1858 cited in Bonaparte 1934). Amenorrhea transcends all of this, as the analyses have shown, with the parthenogenetic phantasy that they can be male and female, mother and father, producing the child alone. Amenorrhea is a woman's attempt to take the masculine and the feminine position. If hysterics idealise the parents as asexual beings (Bollas, 2000: 38) then amenorrhea embodies the ultimate asexual being. I don't think it is submissive of her to seek her autonomy and freedom through her incorporating the father into this image. I think she creatively unites the masculine / feminine pair in a way that allows for her own individuality to emerge out of the process of individuation. She doesn't do it like other women, her needs are different and her strategy allows for her coming into being, despite the obstacles she must negotiate along the way. If the real father was lacking, she has found its representation and incorporated it into her own self with it becoming her own symbol of virility. She is neither wholly passive nor deterministically active, neither submissive nor hostile, neither totally exclusive nor inclusive, inside / outside. She is ahead of her time and whereas the “social processing of biological givens” (Kovel, 1974: 139) is changing, the amenorrheic image has reassuringly been consistent as a powerful tour de force. But this thesis has attempted to not stereotype her as solely aligned to the scripts of Medusa, Lady Macbeth and transcendental beings alone. She can be young, naïve, ripe, curious and vulnerable just like the hysteric who Bollas describes as

“impishly undermining the ostensible effect of the biological maturation of the self” (Bollas, 2000: 162).

If a motivation of some amenorrheics, like the hysteric is to remain in a place that avoids maturation and development, standing and waiting and deliberating and then standing and waiting and deliberating some more, then the more it persists the more one has time to craft this dissociative space and then fill it with an

“imaginary figure of desire which can serve as a play object for both” (Bollas, 2000: 55).

In one of my last analytic sessions I recall telling my analyst that in a dream I was at the altar waiting for him to appear and walk down the aisle. Only afterwards did I realise that I had repositioned the genders. Whose story was this? Whose analysis was this? I had changed the Law and now the Law of the “Other” was my Law. But where was he? Good job I left or I would still be standing at that bloody altar, waiting! As I had described in the earlier chapter on metamorphosis in Shaw’s *Pygmalion*, the months after leaving I would often look in the mirror and when I saw my face it appeared to be transforming into a man’s. I was somehow reclaiming and reincorporating the animus back into myself. I was starting over again, and my realignment depended on the masculine – I was to be not the victim of my analysis but the hero, all be it fallen. My days of analysis were over. My amenorrheic years had gone as my menses had returned.

As has been stated, when menses returns for the amenorrheic patient it can often lead to a breakdown in herself and in the treatment. The grip goes. Freud wrote to Ferenczi on the importance of the analyst’s neutrality and on abstinence.

“I have already let it be understood that the analytic technique requires of the physician that he should deny to the patient who is craving for love the satisfaction she demands...the patient’s need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and make changes, and that we must beware of appeasing those forces by means of surrogates” (Freud 1915a [1914]: 165).

Often is the case that the analyst finds this too hard to tolerate, Ferenczi for sure. A heightened and intolerable shared sense of frustration is illustrated in Freud’s early work on hysteria, which uncovered a most enigmatic relationship with both the internalised paternal figure and the externally wished for father. One way this played out is described by Fink:

“In addressing the master, the hysteric demands that he or she produce knowledge, and then goes on to disprove his or her theories” (Fink 1995: 134).

Similarly, “The paradox of the hysteric’s desire is that she wants to have a master, the Other, that she herself can control” (Salecl, 1996: 186).

Analyst and patient can get stuck on a loop of analytic enquiry with the essence of the relationship being like one of cat and mouse. This can only continue if they have one another. As Salecl says,

“The hysteric always deals with the question: “What will happen to him if he loses me?” (Salecl: 1996: 186)

In all of this madness and mayhem, the amenorrhea signifies the lighthouse steadfast in the seas of change. Patriarchal, phallic symbols matter. In creating a patriarchal social order of their own, patient and analyst appear to be in a relationship but paradoxically this is only achieved through sacrificing relationship. As Carol Gilligan reads it, the woman searches for the status quo and in doing so overrides conflict by developing hysteria. She becomes anomalous and autonomous, a non conformist (her lack of menses a present symbol in all of this) yet she is firmly ensconced in the patriarchal establishment.

Many of Freud’s female hysterical patients had been sent by their fathers for treatment. In trying to dissipate the patriarchal mess that these patients had arrived at Freud’s door with, he overlaid their treatment with another patriarchal system of his own where his male-centric interpretations mounted their free associations. Irigaray suggests that in describing feminine sexuality, Freud overlooked the fact that each of these women had their own “specificity” (Irigaray, 1985: 69). As we know in psychoanalysis, the words of a patient are determined not just by her own motivations but by what is created and formed between patient and analyst in their “microsociety” (Modell, 1997: 47). Whilst the transference is both

“a repeatable occurrence and a unique happening...(it) is also a uniquely new creation that reflects the patient’s response to the personality and technique of the analyst” (Modell, 1997: 48).

This is important as the unconscious pull from the patient for control, resolve, order, fight etc. (all those manly virtues) can knock the analyst off his perch. What resulted in Freud’s case was that

“The stubborn, independent, unsuggestible hysterics, who resisted Freud and were his teachers will give way to “Freud’s women” (Gilligan, 1997: 156).

This thesis has located amenorrhea at the point where things ordinarily give way, at the point of transformation. The amenorrheic form is like the chrysalis that represents the link to the past, present and the future. In the past, something has gone wrong and rather than it being verbalised it has been somatised, freeze framed and drawn onto / into the body. Analysis can be the place for thawing out and it can enable the successful transformative process contained within its own chrysalis. The setting is vital. But the patient must not be pinned down, studied like a dead butterfly, enamoured by its collector. Beyond the symptoms presented, beyond the images drawn, the stories bound, the dreams told and the conversations had, there are the feelings that the analyst must seek to catch, born on the wings of those “butterfly thoughts” (Milner, 1950).

All that is beyond the spoken word - the cry, the call and all that can be transmitted without words resides in the stillness and the peace that is signified by amenorrhea, the silent witness. At yet at the same time, it is hoped that having digested all of the words written in this thesis, the reader, when thinking of amenorrhea, need not reach for a single one.

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## CHAPTER NOTES

<sup>i</sup> This does not refer to patients who have irregular or sparse bleeding, referred to as primary ligo-amenorrhea.

<sup>ii</sup> The research on the physio-pathological process that can result in amenorrhea as being a “symptom,” is comprehensively referred to in Björo’s paper.

<sup>iii</sup> It is reported that Jewish women stay longer in abusive relationships than the national average. According to the charity Jewish Women’s Aid, there was a rise in the number of people seeking help and refuge in 2017 not necessarily because the number of incidences had risen but because more women were reporting cases of domestic abuse. Many Muslim women who want to report physical or emotional violence are often, still, dissuaded by their mothers.

<sup>iv</sup> That amenorrhea is a “serious condition” and can be caused by a cold shower or bath is, according to Traditional Chinese Medicine (2014) because “menstruation is flowing under warm conditions; the cold temperature will stop the flow and coagulate the menstruation” (Xutian, Tai & Yuan, 2014: 918).

<sup>v</sup> Women are encouraged to speak of their ambivalence towards the role and responsibilities of motherhood. The “suffering of ambivalence” that mothers experience is realistically and truthfully presented in Adrienne Rich’s *Of Woman Born* (1977: 21-22)

<sup>vi</sup> See Gilman, King, Porter, Rousseau & Showalter (1993) *Hysteria Beyond Freud*. In “the body and the mind, the doctor and the patient: negotiating hysteria” Porter asks

“So what of hysteria? Are historians to think of hysteria as a true disease, whose rise and fall can, in principle, be plotted down the centuries, so long as we exercise vigilance against anachronistic translation or archaic concepts? Or is it a veritable joker in the taxonomic pack, a promiscuous diagnostic fly-by-night, never faithfully wedded to an authentic malady – or worse, a whole spurious entity, a fancy free disease name, like Prester John, independent of any corresponding disease-thing, a cover up for medical ignorance? Or, worse still, may hysteria truly have been the doctors’ Waterloo: a real disorder, but, as Alan Krohn hints, one so “elusive” as to have slipped our nosological nets” (1993: 226) See also Didi-Huberman (2014) *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière* and see too, Micale (1989) “Hysteria and its Histiography: A Review of Past and Present Writings (1)”

<sup>vii</sup> In “Cullen – A Cautionary Tale” (2015), Sean Dyde warns the reader not to fall into the trap of thinking that Cullen was the father of neurosis just because he coined the term. Cullen’s work was on hypochondriasis to which he referred to hysteria. It was a disorder “that affected some of the most important powers in the body. In other words, it was not a distinct nervousness which made hypochondriasis unique, but its combined effects on the vital and intellectual functions” (Dyde, 2015: 230)

<sup>viii</sup> Ernest Charles Lasègue (1816-1883) introduced the concept of hysterical anorexia in 1873, which emerged as a mental disorder in its own right after Charcot’s death. Lasègue emphasised the need to factor in societal and cultural aspects of the times when formulating the pathology behind the disorder.

<sup>ix</sup> In a 2003 clinical study of twelve women presenting with functional hypothalamic amenorrhea (FHA) each was given a single session of hypnotherapy and observed for twelve weeks afterwards. Within that time, nine

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out of the twelve patients menstruated. All reported an increased feeling of wellbeing and self-confidence (Tschuggel & Berga, 2003: 982). The authors of the study report that hypnosis is a therapy that improves the subject's psychological equilibrium and "reverses the physiological effects of stress within an acceptable period of time." Hypnosis in these instances sets about to reduce stress, reset the homeostasis and the body's equilibrium enabling the body to self-correct. Similarly with cognitive behavioural therapy that attributes functional hypothalamic amenorrhea to metabolic and psychogenic stresses, success rates in correcting neuroendocrine aberrations and reversing anovulation are good. Addressing "problematic behaviours and attitudes" a study in 2006 set about to substantiate the role of CBT in the treatment of FHA and to highlight CBT as an alternative to commonly prescribed corrective sex hormone therapy. "Health truly depends upon developing healthy attitudes and healthy behaviors. Misattributions, negative images of self and others, unrealistic expectations, and emotional disharmony can cause neuroendocrine havoc" (Berga & Loucks, 2006: 124). In an earlier study, a group of women were offered sixteen sessions with a therapist, physician or nutritionist over a twenty week period. 88% of those who underwent CBT had evidence of ovulation compared to 25% of those who were observed with no intervention (Berga et al. 2003).

<sup>x</sup> See Haule (1986) "Pierre Janet And Dissociation: The First Transference Theory and Its Origins In Hypnosis" and Van der Kolk (2015) *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*.

<sup>xi</sup> Freud's view of hysterical conversion was of psychological conflict that was too unbearable to bring to the surface of conscious thought and was repressed in the unconscious and "converted" into physical symptoms such as recurring movements, tics etc. The dissociation and the conversion were unified by the hysteria. What they shared was what Breuer termed "double conscience." The hysterical conversion "makes the body into a language, the symptoms tell an unconscious story, and all mental activity finds its source in the erotic libido" (Aisenstein, 2006: 668).

<sup>xii</sup> Aisenstein closely observed the work in Paris by analysts such as Pierre Marty and Martin M'Uzan working on psychosomatic phenomena. McDougall incorporated the Paris School's theories into the more general practice of psychoanalysis, greatly influenced by the works of Winnicott, Bion and Klein and their focus on the earliest phases of life.

<sup>xiii</sup> Pituitary adenomas are benign tumors that arise from cells in the pituitary gland (considered to be the master hormone gland that regulates the body's hormones). Over-production of hormones by the pituitary tumor cells results in "functional" adenoma. These include Prolactinoma, the over-production of prolactin and Acromegaly, an excess of growth hormone. Prolactinoma causes loss of menses in women. Symptoms in men include lower testosterone levels leading to diminished sexual interest (UCLA Health Pituitary Tumor Program: [www.pituitary.ucla.edu](http://www.pituitary.ucla.edu)).

<sup>xiv</sup> See Aruffo (1971) "Lactation as a Denial of Separation", in *Psychoanalytic Quarterly* 40(1): 100-122 for case reports and analysis of psychogenic factors in women with Galactorrhea (milk secretion at times other than post partum), some also presenting with pseudocyesis.

<sup>xv</sup> Walsh writes that a change in environment, diet and overall general health can impact the menstrual cycle but his emphasis is on fright, dread and shock

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commonly disturbing it. “No feature of menstrual difficulty shows so clearly the influence of the mind over bodily function, and especially over those genital functions that are supposed to be involuntary and spontaneous, as amenorrhoea. Almost any kind of mental trouble may produce a cessation of the menstrual functions” (Walsh, 1912: 437).

<sup>xvi</sup> “Psychological weeping” is discussed in *Trauma, Growth and Personality* (Greenacre, 1953). For a detailed study of Karl Abraham see van Shoonherten trans Walker (2016) *Life and Work, a Biography*.

<sup>xvii</sup> Stress during childhood tends to bring down the age of menarche and a 2017 study, the largest of its kind, involving 51, 540 menopausal women from the UK, Scandinavia, Australia and Japan found that it could also influence the age of menopause. The study (Mishra et al.) reported that women who began menstruating before the age of twelve were 31% more likely to have an early menopause (between the ages of forty and forty-four).

<sup>xviii</sup> In a pioneering study of delinquent girls, Dr Gisela Konopka wrote “While these girls also strive for independence, their need to dependence is usually great – and almost completely overlooked and unfulfilled. The need for support seems to exist in all adolescent girls (Konopka, 1966: 40-41).

<sup>xix</sup> Bollas describes the psychoneurotic illness as an expression of the self’s erotic life (Bollas, 2000: 148) and like Menninger writes that the girl is motivated to avoid the realms of the maturational process (Bollas, 2000: 174).

<sup>xx</sup> Psychoanalytic thinking has advanced in that many now push for a greater recognition of the relationship between the mother and her daughter with the aim that the woman reclaims her body and her own unconscious from the phallogocentric frames of discourse analysis: See Irigaray (1977) and Mitchell (1974).

<sup>xxi</sup> In *Helene Deutsche: Psychoanalysis of the Sexual Functions of Women* (1991) editor Paul Roazan includes on the psychology of puberty: “With the giving up of the clitoris as an organ of excitation and with the appearance of menstruation one might say that a real castration has taken place, in the sense of the loss of a pleasurable organ that has functioned as a surrogate penis” (Roazan 1991: 38).

<sup>xxii</sup> Estradiol levels are lower in depressed women than in euthymic women likely from the hpa function. In a three year study of women aged 36-45, those with a history of depression had a higher rate of peri-menopause compared with non-depressed women. This suggests that depression might impact on a woman’s ovarian function causing it to cease in her 30s or 40s (Harlow et al, 2003).

Natural menopause begins on average at the age of 51.

<sup>xxiii</sup> Meenatnigeria.com feb 11<sup>th</sup> 2017 & IndiaToday.com Jan 11<sup>th</sup> 2017.

<sup>xxiv</sup> In *Menstruation I* (1979) Elwes, dressed in white, sat on a round sheet, drawing and writing whilst her menses bled.

<sup>xxv</sup> We can consider some of the nude works by artist Lucian Freud in which the portrayal of women is about the body being scrutinised rather than idealised. The figure paintings are there as an accurate representation of what the artist sees before him. As he argued, they are “truthfulness as revealing and intrusive, rather than rhyming and soothing” (*Lucian Freud Paintings and Etchings* exhibition catalogue Abbot Hall Art Gallery Kendal, 1966 quoted on [www.tate.org.uk](http://www.tate.org.uk)). *Standing by the Rags* (1988-1989) is a large oil painting of a nude woman on a heap of white rags. The rags are painted in as much detail as the woman is. Freud would use the cloth to wipe his brushes making his

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presence in the picture known. Jeremy Lewison suggests that the smeared paint on the sheets represented blood and other bodily secretions.

<sup>xxvi</sup> The missionary position (in which the couple lie face to face with the male on top – Random House Dictionary, 2017), is believed to have got its name from when Christian missionaries were encouraging indigenous peoples to have sex in this way rather than their preferred way which was “from behind.” Another story goes that the natives would peek into the tents of the missionaries and watch them having intercourse in the missionary position.

<sup>xxvii</sup> In *On Virgins VIII. 466-470 Littré G*, Hippocrates describes how blood from the womb, when it is not released through “the mouth of the egress” is redirected to the heart and the lungs. As a result, the heart becomes sluggish and numb which eventually results in insanity.

<sup>xxviii</sup> On the cult of Joan used by Le Front National see Davies (1999) *The National Front in France: Ideology, Discourse and Power*.

<sup>xxix</sup> Lawyer Sir Edmund Plowden (1518-1585) wrote about the king’s two bodies: one signifies his physical body and the other is an abstract concept of the king and his relationship with his subjects. See Kantorowicz (1957) *The King’s Two Bodies: A Study in Medieval Political Theology*.

<sup>xxx</sup> Fairbairn (1952) *Psychoanalytic Studies of the Personality*. See too Grodstein & Rinsley (eds) (1994) *Fairbairn and the Origins of Object Relations*

<sup>xxxi</sup> Sleep and sleep disturbances have long been linked with a person’s general health and wellbeing. In the context of a woman’s menstrual cycle, fertility and pregnancy, sleep is known to influence several hormone patterns. See Kloss et al. (2015) “Sleep, sleep disturbance and fertility in women” and Mehta et al. (2010) “A Case of Resolution of Amenorrhea after CPAP Therapy for Obstructive Sleep Apnea” and Lee et al. (2014) “Is Sleep-Disordered Breathing Associated With Miscarriages? An Emerging Hypothesis.”

<sup>xxxii</sup> Coleridge (1772-1834) with his friend William Wordsworth (1770-1850) was a founder of the Romantic Movement in England. See Coleridge, H. (ed) (1835) *Specimens of the Table Talk of The late Samuel Taylor Coleridge In Two Volumes*.

<sup>xxxiii</sup> It is widely thought that Woolf suffered from bipolar disorder or a borderline personality disorder of which chronic suicidality is a recognised state. Her husband, Leonard, kept a record of her menstrual activity for ten years after a suicide attempt. As Panken writes in *Virginia Woolf and the “Lust of Creation”: A Psychoanalytic Exploration* (1987) “Closely scrutinizing Virginia’s menstruation pattern, Leonard kept records, noting she had no periods from August to November 1913, when her weight was at its lowest. During this time, she was acutely disturbed, and had four nurses in attendance. The inner struggle with Leonard over the issue of having children was at its height at the time she was starving herself and not menstruating” (Panken, 1987: 69). It makes sense that Woolf would think of seeking unity of mind and fulfilment from an androgynous state rather than from motherhood. On this see Mukiri (2014) “Woolf’s Vision of Androgyny.” Woolf’s conflict is appeased by her creativity and through the artistry of sublimation. Woolf’s work predates that of Carl Jung and his theory on the anima (the female within the male) and the animus (the male within the female). Jung wrote “The animus is the deposit, as it were, of all woman’s ancestral experiences of man – and not only that, he is also a creative and procreative being, not in the sense of masculine creativity, but in the sense that

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he brings forth something we might call...the spermatic world” (Jung, *Anima and Animus, Collected Works* 7, par.336).

<sup>xxxiv</sup> Modern studies on amenorrhea in the workplace show that “after adjustment for relevant non occupational variables, irregular cycles were significantly related to schedule variability and cold exposure” (Messing et al. 1992). At the time of writing the report, the food and agriculture industry employed 14.6% of the female industrial workforce in France. The study “Menstrual-cycle characteristics and work conditions of workers in poultry slaughterhouses and canneries” involved giving an examination and a questionnaire to 726 workers with menstrual periods from 17 poultry slaughter houses at six canning factories. Of the notes “Other parameters such as repetitive work, standing posture, lifting weights, job satisfaction, and hours of domestic work were not associated with cycle anomalies. Cycle anomalies may be a useful indicator of occupational effects on female reproduction, analogous to the use of sperm parameters to warn of effects of male workers.”

A study “Characteristics of Menstrual Cycle in Shift Workers” (Attarchi et al. 2013) showed that menstrual irregularities are higher in shift workers than day workers. In their study of 406 female workers in pharmaceutical packaging units in Tehran, the data suggested that shift work disrupts sleep patterns, raises the prolactin level and with a resulting in-balance in the hormones sends the menstrual cycle off course. Attarchi also noted that environmental stress and psychological stress could activate agents in the endocrine profile again causing disruption to menstrual functioning. Other studies show how menstrual function is altered by workers’ exposure to toxicants such as lead, tobacco, pesticides and other chemicals (Goldman et al. 2009).

<sup>xxxv</sup> In 2016 China recorded 9.8 million deaths and it grew by 8.1 million people. It looks likely that the maximum of two children might not be enough to match the desired increase in the birth rate. Zhang Yi, a social development expert of a government think tank, the Chinese Academy of Social Sciences, says that the government may need to “consider fully relaxing birth policy” (quoted in “Drop laws on family size or face catastrophe, Beijing told” (The Times Newspaper, Jan 23<sup>rd</sup> 2017). Currently having a third child risks punishment, fines, forced abortions, house repossession. And only women who are married and of child bearing age are eligible to have a second child legally.

<sup>xxxvi</sup> In February 2017 Norma McCorvey died, her obituary featuring in many of the Western press. She had been the client “Jane Roe” in the famous *Roe v Wade* case that led to the establishment of the abortion law in America. Following years of legal wrangling over the case, in 1973 the US Supreme Court eventually ruled that women had the right to abortion “free of interference by the state.” The decision was nearly overturned during Ronald Reagan’s presidency and when George W Bush become president one of his first acts was to stop US money to countries that allowed for abortions. Donald Trump’s executive order stopped government funding to organisations that promoted or performed abortions as part of their family planning care.

<sup>xxxvii</sup> Menstrual activism is broad ranging. In 2015 Kiran Gandhi ran the London Marathon whilst menstruating, not wearing any sanitary wear. Tennis player Heather Watson said after losing her game in the 2015 Australian Open that she was off her game because of “girl things.” Great Britain’s women’s hockey team emailed their coach with their period dates so that he could timetable trainings

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with this in mind. The companies that make products and services designed to “manage” menstruation commission lots of the research. Most indicate that menstruation does impact on performance. So, whilst there is a new focus in medical and behavioural science research on “what can be done for women rather than what is wrong with women” (Golub, 1992: xiii) there is still an element of control being exerted upon women.

The concept of “menstrual leave” trails in the West behind countries such as South Korea, Taiwan, Indonesia, Zambia and Japan. Nike is the only global company that officially recognizes it, having introduced a menstrual policy in 2007. Of the European countries, Italy looks likely to introduce it but it is not popular with many women who feel it might be a basis for bias. This, they say, would make it even more difficult for women to find work, undermining activism for equality already done by women wanting to be seen as equal to men.

<sup>xxxviii</sup> It is from Aristophanes’ satire *Thesmophoriazousae* (411 B.C.) that we glean much of the cult status. Archaeologists have located Thesmophorion sanctuaries or epigraphic evidence in over fifty sites in Greece and its surrounding areas with some dating back to the second millennium B.C. In Aristotle’s *On the Generation of Animals* (350 B.C.) it is semen from the active man that creates form and fetus whilst the body of the passive woman contains it. Aristotle referred to menstrual blood as a nourishing “nutritive soul” for the fetus but it was of its own an overflow and the visible sign of a woman’s inferiority. A man’s semen was by contrast the perfect specimen.

<sup>xxxix</sup> In religious practice there are lots of rules around menstruation. Vossleman describes the stringent cleansing and abstinence rules for menstruating Orthodox Jewish women but she does so with the Talmudic interpretative verse: “As yeast is good for dough, so is menstruation good for women” (Vosselman, 1935: 121). In the Jewish Karaite tradition, if a menstruating woman moves towards and looks at a lactating woman it is believed that the mother’s milk will stop flowing. To cancel this out, the lactating woman urinates over the urine of the menstruating woman. Urine has no link to reproduction and is not a symbol of power or strength (Tsoffar, 2004).

<sup>xl</sup> In “Some Thoughts About The Artist and His Art” (2014) Lesley Caldwell considers McDougall’s work and the role of analyst as artist in the consulting room. Caldwell writes “From her work in the consulting room McDougall grounds her account of the creative process and its challenge in an explicitly Freudian approach that emphasizes the primacy of the body and its drives and affects as the symbolic foundation of thought and of creativity” (Caldwell, 2014: 93).

<sup>xli</sup> Research from 2014 shows menstrual cycles on average last for twenty- eight days similar to the length of each lunar cycle. In one study, 39 000 women recorded their menstrual patterns on an “app.” The data was presented at the American Society for Reproductive Medicine’s annual meeting in 2014. 56% of women began their periods around the new moon with ovulation coinciding with the full moon. Dr. Philip Chenette of the Pacific Fertility Centre in San Francisco explained “It probably goes back to evolution and the fact that we use to live outside and were exposed to lunar cycles which related to harvest and times of plenty and reproduction was timed to natural rhythms (“Women are in tune with the moon”, The Daily Telegraph Newspaper 25<sup>th</sup> October 2014, page 18).

<sup>xlii</sup> This is discussed in Frankel’s *Ovid – A Poet Between Two Worlds* (1945) and in Hardie’s *Ovid’s Poetics of Illusion* (2002).

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<sup>xliii</sup> For the curious amongst us – some have said that Shaw based Higgins on the eighteenth century poet Thomas Day. Day was an eccentric activist and philanthropist. In search of the perfect wife and inspired by the writings of Rousseau, Day chose two orphans from the Foundling Hospital to transform them into women fit for marriage. Their attributes were to be education, beauty and virginity. However, the “experiment” didn’t go according to plan and both girls failed to meet Day’s expectations.

<sup>xliiv</sup> That the middle to upper classes talk thematically about personal details whereas those from working class backgrounds walk the walk and talk and talk is reflected in Goldsmith University lecturer Pia Pichler’s study into discursive practices amongst three different teenage girls, aged between fifteen and seventeen. In *Talking Young Femininities* (2009) Pichler observes that amongst the working class girls it was the white English / Irish East End girls who self disclosed on sex related topics such as “the first time” and contraception. The middle to upper class group from a private school in London’s West End talked sparsely about sex in a way that Pichler describes as “knowing but not doing.” They present themselves “as being fully informed and uninhibited about sex, without engaging in any personal self disclosure” (Pichler, 2009: 2). This group is the only one “to talk explicitly about social class (p.2). The study explores the links between ethnicity, gender and social class as represented in language and discourse. The third group was made up of British Bangladeshi girls from the same state school in the East End. “Here the sex talk is marked by the girls switching between playful teasing or boasting and more serious talk, with the former allowing the girls to present themselves as sexually experienced “bad girls” and the latter as sexually inexperienced “good girls” (p.2). In this way they straddle between negotiating their femininity from both British and Muslim Bangladeshi viewpoints.

Walkerdine, Lucey and Melody’s *Growing up Girl: Psycho-Social Explorations of Gender and Class* (2001) studies the role of women in social change. Class was always used to regulate society but the working class “became the repository of fantasies of Otherness and promises of transformation, which for so long failed to be delivered, until the disappointment bred destruction and the cry that there was no longer any “real” working class” (2001: 12).

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## APPENDIX

### Pygmalion – Book X lines 243-297 of Ovid's Metamorphosis

Pygmalion had seen these women spend  
Their days in wickedness, and horrified  
At all the countless vices nature gives  
To womankind lived celibate and long  
Lacked the companionship of married love.  
Meanwhile he carved his sow-white ivory  
With marvelous triumphant artistry  
And gave it perfect shape, more beautiful  
Than ever woman born. His masterwork  
Fired him with love. It seemed to be alive,  
Its face to be a real girl's, a girl  
Who wished to move – but modesty forbade.  
Such art his art concealed. In admiration  
His heart desired the body he had formed.  
With many a touch he tries it – is it flesh  
Or ivory? Not ivory still, he's sure!  
Kisses he gives and thinks they are returned;  
He speaks to it, caresses it, believes  
The firm new flesh beneath his fingers yields,  
And fears the limbs may darken with a bruise.  
And now fond words he whispers, now brings gifts  
That girls delight in – shells and polished stones,  
And little birds and flowers of very hue,  
Lilies and coloured balls and beads of amber,  
The tear-drops of the daughters of the Sun.  
He decks her limbs with robes and on her fingers  
Sets splendid rings, a necklace round her neck,  
Pearls in her ears, a pendant on her breast;  
Lovely she looked, yet unadorned she seemed  
In nakedness no whit less beautiful.

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He laid her on a couch of purple silk,  
Called her his darling, cushioned her head,  
As if she relished it, on softest down.  
Venus' day came, the holiest festival  
All Cyprus celebrates; incense rose high  
And heifers, with their wide horns gilded, fell  
Beneath the blade that struck their snowy necks.  
Pygmalion, his offering given, prayed  
Before the alter, half afraid, "Vouchsafe,  
O Gods, if all things you can grant, my bride  
Shall be" – he dared not say my ivory girl –  
"The living likeness of my ivory girl."  
And golden Venus (for her presence graced  
Her feast) knew well the purpose of his prayer;  
And, as an omen of her favouring power,  
Thrice did the flame burn bright and leap up high.  
And he went home, home to his heart's delight,  
And kissed her as she lay, as she seemed warm;  
Again he kissed her and with marveling touch  
Caressed her breast; beneath his touch the flesh  
Grew soft, its ivory harness vanishing,  
And yielded to his hands, as in the sun  
Wax of Hymettus softens and is shaped  
By practicing fingers into many forms,  
And usefulness acquires by being used.  
His heart was torn with wonder and misgiving,  
Delight and terror that it was not true!  
Again and yet again he tried his hopes –  
She was alive! The pulse beat in her veins!  
And then indeed in words that overflowed  
He poured his thanks to Venus, and at last  
His lips pressed real lips, and she, his girl,  
Felt every kiss, and blushed, and shyly raised

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Her eyes to his and saw that world around him.  
The goddess graced the union she had made,  
And when nine times the crescent moon had filled  
Her sliver orb, and infant girl was born,  
Paphos, for whom the island takes its name (trans. Melville, 1986).

### **Ovid's Amores 1.5**

Scorching hot, and the day had drifted past noon;  
I spread out on my bed to rest.  
Some slats of the windows were open, some shut,  
the light as if in a forest  
or like the sinking sun's cool glow at dusk  
or when night wanes, but dawn's not come.  
It was the sort of light that nervous girls love,  
their shyness hoping for shadows.  
And oh – in slips Corinna, her thick dress unsashed,  
hair rivering down her pale neck,  
just as lovely Sameramis would steal into a bedroom,  
they say, or Lais, so loved by men.  
I pulled at her dress, so scant its loss barely showed,  
but still she struggled to keep it.  
Though she struggled a bit, she did not want to win:  
undone by herself, she gave in.  
When she stood before me, her dress on the floor,  
her body did not have a flaw.  
Such shoulders I saw and touched – oh, such arms.  
The form of her breast firm in my palm,  
and below that firm fullness a belly so smooth –  
her long shapely sides, her young thighs!  
Why list one by one? I saw nothing not splendid  
and clasped her close to me bare.  
Who can't guess the rest? And then we lay languid.  
Oh, for more middays just so (trans. Alison, 2014).

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