Gut Feminism

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Hysteria behaves as though anatomy did not exist or as though it had no knowledge of it.
—Freud, “Some Points” 169

The stomach and the bowel play puppet games with their own walls and contents, instead of digesting and excreting their contents.
—Ferenczi, “Phenomena” 105

In 1893 Sigmund Freud published a paper that compared organic and hysterical paralyses. This paper had been written many years earlier following his sabbatical at the Salpêtière under Jean-Martin Charcot. For reasons that are not entirely clear, the paper was not published for seven years; by then Freud had formed a working alliance with Joseph Breuer and they had published a preliminary communication on the treatment of hysteria. The first three sections of the 1893 paper are primarily neurological in orientation; the fourth and final section must have been written at a later date under the influence of his work with Breuer, and it is this section that contains an important conceptual argument about hysteria and anatomy. The 1893 paper incorporates two kinds of Freudian approach to the body—one neurological, one psychological. More specifically, the paper documents Freud’s transition from one mode of analysis (neurological) to another (psychological). What was the nature of that conceptual transition? And why does it matter to feminists interested in biology?

Hysterical and organic paralyses, Freud argues, present clinically in quite different forms. While hysterical paralyses are notorious for

I was hardly eating anything at all. Rice, bits of fish. I perfected the art of the silent puke: no hack, no gag, just bend over and mentally will the food back up.
—Hornbacher 97
their capacity to mimic organic paralyses, in fact they differ from organic conditions in important ways: for example, hysterical paralyses are excessively intense, and they are more precisely delimited in their effects than organic conditions. That is, one would expect a hysterical paralysis to be more thoroughgoing than an organic paralysis, and it would be more strictly demarcated in the body (e.g., just the hand, the thigh, or a shoulder would be affected; whereas organic paralyses tend to implicate adjacent parts of the body). Furthermore, hysterical paralyses disobey fundamental rules that govern organic afflictions. For example, in hysterical paralysis proximal parts of the body, such as the shoulder or the thigh, may be more paralyzed than distal parts, such as the hand or foot. This never occurs in an organic paralysis.

How is it that hysterical paralyses can closely mimic organic paralyses, yet diverge from them in significant ways? More curiously, how is it that hysterical paralyses are able to accomplish biological transformations beyond the reach of the organic body? To solve this clinical puzzle, Freud enacted a conceptual distinction that would be very influential on feminist theories of embodiment: he detached the hysterical body from the anatomical body. Organic paralyses, he asserts, are the result of an underlying biological lesion; more precisely, they are governed by “the facts of anatomy—the construction of the nervous system and the distribution of its vessels” (“Some Points” 166). Charcot had hypothesized that hysterical paralyses are also the result of a lesion (what he called a dynamic or functional lesion), but Freud disputes this homology. There is no anatomical influence in hysteria; rather,

the lesion in hysterical paralyses must be completely independent of the anatomy of the nervous system, since in its paralyses and other manifestations hysteria behaves as though anatomy did not exist or as though it had no knowledge of it. (169)

That is, hysteria appears ignorant of the anatomy of the body. Hysteria is uninterested in the facts of how muscles, ligaments, nerves, organs, and blood vessels are mapped, how they converge or dissociate, how they connect to distal parts of the body, or how they rely on certain signals or pathways in order to function effectively. Rather, hysteria “takes organs in the ordinary, popular sense of the names they bear: the leg is the leg as far up as its insertion into the hip, the arm is the upper arm as it is visible under the clothing” (169). That is, hysteria is an alteration of the everyday body (especially as it is understood through tactile and perceptual
data); it is an engagement of the body as we know it colloquially—as we imagine, love, or despise it. It is for this reason, Freud argues, that he has never observed—nor will anyone ever observe—a hysterical hemianopsia. Hysteria “has no knowledge of the optic chiasma, and consequently it does not produce hemianopsia” (169).

This early neurological work, in conjunction with psychotherapeutic treatments of neurotic patients, laid the foundation for Freud’s account of conversion hysteria. He claimed that conversion hysteria is the transformation of psychic conflict into somatic symptoms—such as paralysis, pain, numbness, or, most famously in the case of Dora, nervous coughing. The dissociation of somatic symptoms from anatomical constraint is central to this account of conversion—organs, limbs, and nerves are transformed according to a symbolic or cultural logic rather than according to the dictates of anatomy. In the 1895 paper, Freud makes this dissociation explicit; he imagines conversion in terms of ideational mechanisms rather than (and in contradistinction to) biological injury. Asking permission to move from anatomical to ideational ground, Freud argues that,

*the paralysis of the arm consists in the fact that the conception of the arm cannot enter into association with the other ideas constituting the ego of which the subject’s body forms an important part. The lesion would therefore be the abolition of the associative accessibility of the conception of the arm. The arm behaves as though it did not exist for the play of associations.* (170)

The important conceptual point for Freud is that in hysteria the “material substratum” (i.e., cortex) is undamaged, but ideas about the body have undergone some kind of alteration. The idea of the arm, for example, has become associated with a large “quota of affect,” and this prevents it from being involved in any associative links with other ideas or organs. It has become ideationally sequestered (lost to consciousness) under the weight of this quota of affect. The arm is liberated from its paralysis only when this affective burden is removed, and the idea of the arm becomes accessible again to “conscious associations and impulses” (171).

This model of hysteria, and Freud’s emerging preference for psychogenic etiologies over biological ones, has been enormously influential on feminist accounts of embodiment. The idea that psychic or cultural conflicts could become somatic events was one of the central organizing principles of feminist work on the body in the 1980s and 1990s. This
model allowed feminists to think of bodily transformation ideationally and symbolically, without reference to biological constraints. That is, to think about the body as if anatomy did not exist. This essay begins with the conviction that this dissociation of ideation and biology (and the concomitant distaste for explanation via the biological) is deeply problematic. It is not my intent to dispute the power of Freud’s account of hysteria or to imply that all feminist repudiations of biology can be traced to Freud. Most of all, I do not mean my critique to count as a rejection of Freudian methodologies. On the contrary, I begin with Freud precisely because of the importance of his work for thinking biology dynamically. The 1893 paper is a robust critique of Charcot’s notion of hysterical lesion: Freud argues very effectively that such an idea implies a biological correlate of some kind (e.g., a transitory edema or anemia that is not present post mortem) and that this has the effect of rendering hysterical paralyses more like organic paralyses than in fact they are. The introduction of ideational injury in relation to the body allows Freud to think of the clinical specificity of hysterical symptoms (their intensity and circumscription in the body) without having to take refuge in an explanation that refers directly or indirectly to biological damage. In this sense Freud’s critique of Charcot is on target, and it is typical of his fearless appraisal of his professional seniors at this time.

What this approach does not pay attention to, however, is the role played by biology that is not damaged; that is, how the everyday, minute-by-minute, routine action of biological systems (e.g., surges of biochemicals; metabolic activity; synaptic communication; muscular contractions) might be caught up in, and contributing to, hysterical symptomology. Put another way, in discounting an etiology based in biological damage, Freud minimizes the involvement that biology in general might have in the provocation, maintenance, and treatment of conversion symptoms. Or at least many of us have been happy to read him in this way. I am interested in interrogating the intellectual corollaries that his model seems to have engendered for the contemporary feminist scene—that the most compelling analytic registers for thinking about the body are symbolic, cultural, ideational, or social rather than biological, and that political or intellectual alliances with the biological sciences are dangerous and retrograde. It is my concern that we have come to be astute about the body while being ignorant about anatomy and that feminism’s relations to biological data have tended to be skeptical or indifferent rather than speculative, engaged, fascinated, surprised, enthusiastic, amused, or astonished.
Most troublingly, it seems that the very sophistication of feminist accounts of embodiment has been brokered through a repudiation of biological data. Too often, it is only when anatomy or physiology or biochemistry are removed from the analytic scene (or, in what amounts to much the same gesture, these domains are considered to be too reductive to be analytically interesting) that it has been possible to generate a recognizably feminist account of the body. Taking the eating-disordered body as its case in point, this paper argues that biological data are indispensable to feminism’s conceptual and political efficacy. The exclusion of biological data from feminist accounts of eating disorders has narrowed their explanatory power, and has bequeathed to feminism models of embodiment that cannot engage easily with the contemporary life sciences. This paper argues that what anatomy (specifically, the gut) can know, in hysterical and nonhysterical states, is perhaps the most vital lesson to emerge from the eating disorder epidemic. I begin by following one particularly astute response to the classical Freudian theory of conversion: Sándor Ferenczi’s attempts to inaugurate a psychodynamic biology.

**Organic Thought**

I have [... not sacrificed our usual get-together to comfort but rather to renewed work, for which I can’t use comradeship. I also don’t work easily together with you in particular. You grasp things differently and for that reason often put a strain on me.

—Freud to Ferenczi. Ferenczi and Freud, 22 July 1914, Letter 491, 6

I have also known for a long time that I “grasp things differently” from you, and that you can pursue my work plans only with considerable strain [...]. Certainly my reason tells me that *the* manner in which you grasp things is the correct one; still, I can’t prevent my fantasy from going its own way (perhaps astray). The result is a mass of ideas which never become actualized. If I had the courage to simply write down my ideas and observations without regard for your method and direction of work, I would be a productive writer, and, in the end, numerous points of contact between your results and mine would still be the result.

—Ferenczi’s reply. Ferenczi and Freud, 25 July, 1914, Letter 492, 8

The extensive correspondence between Ferenczi and Freud is often painful to read, as Ferenczi (some seventeen years Freud’s junior) reels between adoration of Freud, on the one hand, and on the other, a longing to push psychoanalysis into strange, wild territory and to drive Freud beyond the limits of his tolerance. When Ferenczi did find the courage to write down his ideas in a clinical diary (in 1932, the year before he died), what materialized was an astonishing set of hypotheses, clinical
fragments, experiments in technique, and—at the end—a touching and lucid account of his fundamental difficulties with Freud and Freudianism (Clinical 182). By this point, however, their intellectual and professional alliance had been gravely damaged; the strain Ferenczi was putting on Freud and psychoanalysis was too much for everyone to bear.7

In these later years Ferenczi was troubled by how to treat trauma analytically. He was concerned that the conventional analytic stance of neutrality and abstinence would be ineffective—or worse—when dealing with traumatized patients. The renewed interest in Ferenczi in the contemporary clinical literature has tended to focus on his work with trauma and his innovations with analytic technique (viz., working with transference-countertransference in a more intersubjective way).8 However, there is another important point of comparison between Ferenczi and Freud that has been less widely commented on: Ferenczi remained more interested in biological explanation than did Freud. As Freud was elaborating complex psychological (ideational) explanations for conversion, Ferenczi was becoming fascinated with the biological material itself: Can we explain the mechanism of hysterical conversion in biological terms? What does a hysterical conversion tell us, not only about the psyche but about the character of biological substrate? In the Rat Man case history, Freud comments on the “leap from a mental process to a somatic innervation” that is emblematic of conversion hysteria, but he claims that this leap “can never be fully comprehensible to us” (“Notes” 157). One of Ferenczi’s early ambitions was to make the bodily transformations of conversion more intelligible; his efforts in this regard may prove to be uniquely instructive for feminists looking to situate their accounts of the body somewhere other than on antibiological ground. Here, I sketch out Ferenczi’s thoughts on the character of biology—on what it is that the body comes to know in states of extreme psychological distress and how a synthesis of biology and psychoanalysis (what he eventually calls bioanalysis or depth biology) is necessary to understand the character of not just hysterical states but any biological substratum.

Ferenczi opens an important 1919 paper on hysterical conversion with a citation from Nietzsche: “You have travelled the way from worm to human being and much in you is still worm” (“Phenomena” 89). By introducing a writer that Freud famously claimed never to have read, Ferenczi signals two important provocations to the classical Freudian project: (1) an engagement with psychosis and (2) an interest in the phylogenesis of the human psyche (the worm-like, regressive nature of the
mind). It was differences over the treatment of psychosis and trauma that became such a source of difficulty between the two men in Ferenczi’s last years. These differences were not resolved either personally or analytically; and the schism between classical and more relational or intersubjective techniques still structures the practice of psychoanalysis today. There was a much more collaborative and enthusiastic sharing of ideas about phylogensis between Ferenczi and Freud. Nonetheless, Ferenczi was careful when disclosing his biological inclinations to Freud. In the period prior to 1919 he had professed his interest in biology but always in the context of reassurances that this did not constitute disloyalty to psychoanalysis: “I got lost in biological problems and can’t find my way back to psychology! Fortunately, I know I am on the wrong track, and I hope—after leaving the mostly biological train—to land finally in the secure harbor of psychoanalysis” (Ferenczi and Freud, 2 Feb. 1915, Letter 535, 46). Again, a few months later:

> It proved to be unavoidably necessary for me also to seek biological support for my hypotheses [about coitus]; for that reason I had to read embryological, zoological, and comparative physiological material [. . .] I don’t want to appear before you before I have emerged from biology and once again returned to the viewpoints of ψα. (To calm you, I will say right away that I have always conceived this detour only as a means to an end.) I hope that by the end of the month I will again be completely at home (with ψα) and will be able to listen to your new findings undisturbed by further distractions. (Ferenczi and Freud, undated, Letter 546, 60)

In 1919, Ferenczi is still struggling to strike a balance between his speculations about biology and classical Freudianism. While acknowledging the fundamental Freudian tenet that conversion hysterias are the effect of unconscious wishes represented in the body, he wants the biological mechanism of hysteria to be more fully elucidated. When circumscribing his discussion of conversion to a particular class of bodily disruption, Ferenczi chooses not paralyses but afflictions of the gut. Globus hystericus (lump in the throat), for example, is one of the most common hysterical afflictions of the digestive tract. Ferenczi seems less interested in the interpretation of such a symptom (which he passes over in a perfunctory manner as “unconscious fellatio, cunnilingual, coprophagic phantasies,”
(“Phenomena” 92) and more engaged with the material transformation that occurs in the throat:

\[\text{The patients themselves speak of a lump stuck in their throats, and we have every reason to believe that the corresponding contractions of the circular and longitudinal musculature of the oesophagus produce not only the paraesthesia of a foreign body, but that a kind of foreign body, a lump, really is brought about.} \text{(92)} \]

So, too, with anorexia nervosa, hysterical vomiting, and disruptions of the stomach and bowel. For Ferenczi, these symptoms demand an explanation of the conversion mechanism that is more conversant with gastric, intestinal, or esophageal substance. A special name is required for these events. He called them materializations:

\[\text{From the analysis of a [female] patient which is meeting with complete success, and from similar earlier and present observations, there arose a plan for a work on “hysterical materialization phenomena,” especially in the gastrointestinal tract; an unbroken line from globus hystericus (fantasies of fellatio) over swallowing air (stomach), then to my case, which I mentioned, in which the patient was able at will to conjure up a penis in her vagina and a child in her intestines; finally; a nice case in a man of rectal “materialization” of a penis sticking into it. (All with the aid of tricks with the musculature of the intestine.) (Ferenczi and Freud, 18 Nov. 1917, Letter 714, 246)} \]

Ferenczi quickly concedes that his use of the term “paraesthesia” in relation to hysterical symptoms is unwarranted.\(^{15}\) After all, these are not faulty perceptions or hallucinations on the patient’s behalf; a material transformation really has been effected. The increased capacity in hysteria for the fabrication of lumps in the throat or a child out of the contents of the stomach or a penis out of rectal contents suggests that an aptitude for condensation, displacement, connotation, repetition, or identification cannot be contained to the ideational realm (dreams, parapraxes, and so forth); these capacities are also part of the nature of the body’s organs, vessels, and nerve fibers. The aid given by the musculature of the intestines is not that of passive substrate awaiting the animating influence of the unconscious but, rather, that of an interested broker of psychosomatic events.
This vital contribution from the body’s substrate guides Ferenczi to an important reformulation of the metapsychology of hysterical conversion. Materializations are not the effect of a *leap* from the mental to the somatic; rather, they are the product of a *regression* to a protopsychic state. That is, hysteria materializes the protopsychic (ontogenetic and phylogenetic) inclinations native to the body’s substrata. By ontogenetic tendencies he means the desire to return to the womb (to fetal or embryonic conditions) in order to “bring about the reestablishment of the aquatic mode of life in the form of an existence within the moist and nourishing interior of the mother’s body” (*Thalassa* 54). Phylogenetic trends are the desire for all creatures to return to the water (the thalassal trend). Like the trauma of birth, terrestrial species have been traumatized by their expulsion from the water as the prehistoric seas receded. In this sense, ontogenetic and phylogenetic events are coeval:

> [W]hat if the entire intrauterine existence of the higher mammals were only a replica of the type of existence which characterized that aboriginal piscine period, and birth itself nothing but a recapitulation on the part of the individual of the great catastrophe which at the time of the recession of the oceans forced so many animals, and certainly our own animal ancestors, to adapt themselves to a land existence, above all to renounce gill-breathing and provide themselves with organs for respiration of air? (45)

Ferenczi argues that these ontogenetic and phylogenetic inclinations (or motives) are latent in all substance, but they come to the fore most plainly in states of psychopathology. Such primal psychosomatic substrate is graphically illustrated in the 1932 clinical diary:

> Inorganic and organic matter exist in a highly organized energy association, so solidly organized that it is not affected even by strong disruptive stimuli, that is, it no longer registers any impulse to change it. Substances are so self-assured in their strength and solidity that ordinary outside events pass them by without eliciting any intervention or interest. But just as very powerful external forces are capable of exploding even very firmly consolidated substances, and can also cause atoms to explode, whereupon the need or desire for equilibrium naturally arises again, so it appears that in human beings, given
certain conditions, it can happen that the (organic, perhaps also the inorganic) substance recovers its psychic quality, not utilized since primordial times. In other words the capacity to be impelled by motives, that is, the psyche, continues to exist potentially in substances as well. Though under normal conditions it remains inactive, under certain abnormal conditions it can be resurrected. Man is an organism equipped with specific organs for the performance of essential psychic functions (nervous, intellectual activities). In moments of great need, when the psychic system proves to be incapable of an adequate response, or when these specific organs or functions (nervous and psychic) have been violently destroyed, then the primordial psychic powers are aroused, and it will be these forces that will seek to overcome disruption. In such moments, when the psychic system fails, the organism begins to think. (Clinical 5–6)

Ferenczi’s analyses of extreme psychological duress substantiate a theory of the organic body that differs in important ways from Freud’s hysteritized body. In this extract from the Clinical Diary Ferenczi appears to distinguish between two kinds of psychosomatic organization. First, the psyche-soma relation as it exists under normal conditions (“Nervous intellectual activities” and organic matter “so solidly organized that it is not affected even by strong disruptive stimuli”). Pathologies in this organization are treatable according to the dictates of classical Freudian analysis: interpretation of ideational content as though anatomy did not exist. This body is neurotically inclined, symbolically guided, and analyzable. Ferenczi describes a second organization of psyche and soma wherein primordial psychic powers emerge after normal psychic structures have been violently destroyed by trauma (“the organism begins to think”). Here, organic substance is intrinsically, primitively psychic (“impelled by motives”); psychological organization has regressed to a state where (as in the phylogenetic and ontogenetic past) it is not possible to distinguish matter from motive or deliberation. The psychotic disintegration consequent of severe trauma reveals to Ferenczi a bedrock of organic thought; and these extreme states provide him with the key to mechanisms of materialization in classical Freudian hysterias:

*The hysterically reacting body could be described as semifluid, that is to say a substance whose previous rigidity and uniformity have been partially redissolved again into a psychic state,*
capable of adapting. Such “semisubstances” would then have the extraordinarily or wonderfully pleasing quality of being both body and mind simultaneously, that is of expressing wishes, sensations of pleasure-unpleasure, or even complicated thoughts, through changes in their structure or function (the language of organs). (7)

At the end of the 1919 paper on hysterical conversion, Ferenczi notes that the conventional knowledge of human and animal physiology (“even the best and most exhaustive text-books” 103) will not be adequate to the task of making the biology of hysterical materialization legible. These biological knowledges think of organs only in terms of their utility for the preservation of life. Instead, biology must be approached “from the other side” (104); that is, from the direction of psychoanalysis. If biological substrate was studied dynamically, the excessive concern with the utility (rationality) of organs that characterizes traditional biological knowledges could be supplanted with a more intricate account of their capacity for pleasure, for the expression of wishes, and for complicated thought.¹⁶

In his 1924 book *Thalassa*, Ferenczi names this approach bioanalysis or depth biology. *Thalassa* is perhaps Ferenczi’s greatest accomplishment in terms of thinking biology differently, but it has not been widely read. I suspect this is because there are not yet enough conceptual tools available to help readers assess biological hypotheses as something other than wholly reductionist. Mechthild Zeul, for example, is one of the rare Ferenczi commentators who does engage with the work in *Thalassa*; yet, her reading conflates Ferenczi’s bioanalysis with “biological concretism” (219). I am arguing that it is precisely this notion of biological concretism that Ferenczi’s work challenges; his bioanalysis is an attempt to bring depth and dynamism to conventional, two-dimensional (“flat”) biological science so that it is no longer possible to automatically align a biological hypothesis with literal-minded reductionism.

By the 1930s the character of the organic had become largely inconsequential to traditional psychoanalytic models of hysteria: analytic focus fell instead on the ideational contortions that hijack bodily function. The body had become the instrument of the unconscious rather than its symbiotic ally, and relatively little intellectual energy was given over to thinking about the nature of biological substance. More and more, the organic was envisaged according to the flat topology of conventional biological knowledge, even though Freud and others were exploring the
strange vicissitudes of the hysterical body and even though they were taking certain aspects of the body to be central to psychic structure. In this sense, classical psychoanalysis often distinguishes (even if only implicitly) between the bodily and the organic, the former being biological structures under the influence of the psyche, the latter being the biological residue liberated or immune from such influence. The psychosomatic treatments that emerged out of psychoanalysis in the 1920s made this connotation in Freudian metapsychology explicit: the goal of psychosomatic practitioners such as Groddeck, Deutsch, or Alexander was to rid the affected organ (e.g., liver, kidney, stomach) of its entanglement with the psyche. For example, Felix Deutsch (who was a contemporary of Ferenczi and Freud’s personal physician) renders organic questions immaterial to psychoanalytically inflected treatment:

*The recurrence of organic symptoms during analysis is not surprising to the analyst, as he does not regard them as turns for the worse, knowing that the analytic treatment must finally render the organic expression of the conflict superfluous. What is really essential is to loosen psychosomatic ties, to purify the organs from their psychic cathexis, so to speak, and to assure their organic function unaffected by too strong libidinal forces.* ("Psychoanalysis" 53)

Ferenczi understood the organic and the analytic differently. Behind what he calls the facade of conventional biological description there is a biological unconscious. This biological unconscious motivates all organic activity; in certain (usually pathological) circumstances the phylogenetic and ontogenetic capacities that compose the biological unconscious come to “dominate the vital activities with their archaic impulses in the same way as the normal consciousness is inundated by psychological archaisms in the neuroses and psychoses” (*Thalassa* 83). There is no way to purify organs of their psychic cathexis in the same way that there is no way of cleansing conscious cognitive processing of the influence of the unconscious.

For Ferenczi, the study of organic phenomena should connect at some point with a theory of the biological unconscious; while not all biological substrata are hystericized, a primitive kind of psychic action (motivation, deliberation) is nonetheless native to biological substance. In the same way that Freud used hysteria to reveal the neurotic/fantastic nature of the normally functioning psyche, Ferenczi uses an analysis of materialization to reveal the plastic nature of all organic substrate.
so doing, he generates a schema for feminists wanting to think about biological substrate as another scene, rather than as bedrock. There has been a tendency (largely unrecognized) in feminist theory to act out this troublesome distinction between the bodily and the organic. It is not simply that there has been a preference for encountering embodiment via social, representational, or symbolic analysis at the expense of biological data. This, after all, could simply be an effect of disciplinary affiliation, correctable by an increase in the number of feminists writing with an interest in the biological. More problematically, much of the feminist work on embodiment seems to gesture towards a flat organic realm elsewhere as a way of securing a more valuable or dynamic account of the body closer to home. The organic—conceptually dull and politically dangerous—lurks at the periphery of these texts, underwriting the claims about embodiment that are made.\textsuperscript{19} Ferenczi provides one way through this impasse. Under Ferenczi, biology is strange matter, proficient at the kinds of action (regressions, perversions, strangulations, condensations, displacements) usually attributed only to nonbiological systems. Clearly, hysteria comprehends more about the body than just what is given by perceptual and tactile data (which, in effect, limits hysteria’s reach to the surface of the body); hysteria also enacts some knowledge of the biological unconscious—the ontogenetic and phylogenetic impulses that motivate the body’s substrata.\textsuperscript{20} Conversion is an immediate and intimate psychosomatic event. It is not an ideational conflict transported into the bodily realm; it is not the body expressing, representing, or symbolizing a psychic conflict that originates elsewhere. To return to an early formulation of hysteria in the opening paragraphs of this essay: conversion hysteria does not point to what is \textit{beyond} the organic body. On the contrary, it directs us right back into the heart of organic matter; hysteria is one particular mode of biological writing. If this seems to render hysteria prosaic, is this not because we have known biology only in its most inert forms?
Antiperistalsis

Once attention is directed to [the biological unconscious] it will certainly become possible to recognize more definitely in certain anomalies of nutrition—in its pathology, for example—the activation of regressive tendencies which under ordinary circumstances remain hidden. In such a fashion one would perceive behind the symptom of vomiting not only its manifest immediate etiology but also tendencies towards regression to an embryonic and phylogenetic primevality in which peristalsis and antiperistalsis were mediated by the same digestive tube.

—Ferenczi, Thalassa 86

It is by no means clear that Marya Hornbacher’s bulimic accomplishment (“I perfected the art of the silent puke: no hack, no gag, just bend over and mentally will the food back up”) can be attributed solely to ideational capacities (conscious or unconscious). It is not simply Hornbacher’s mental desire that is at work in this episode. By the time she has perfected the art of the silent puke, her bulimia is chronic: she is only fifteen years old, but she has been vomiting since she was nine, and her condition has been complicated by anorexic periods and drug abuse. The capacity to will food back up is commonly developed in bulimia. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) notes this skill as a matter of course (“individuals generally become adept at inducing vomiting and are eventually able to vomit at will” [American Psychiatric Association 590]).

Gerald Russell (who in 1979 first laid out the diagnostic criteria for bulimia nervosa) notes two variations of this skill: patient one, in whom vomiting had become effortless (“I just had to think about it. I don’t have to put my fingers down my throat. I press my stomach and I am sick” [“Diagnostic” 19]); and patient two, who at first induces vomiting by putting her fingers down her throat, but “in later years she simply drank some fluid and leaned over the toilet so that ‘it all came up in one go’” (20). Paul Robinson and Letizia Grossi in a 1986 letter to The Lancet observe that the gag reflex itself may be attenuated in bulimics:

In studies of gastric emptying and oesophageal pressure in patients with bulimia nervosa, we have asked controls and patients to accept a nasogastric or an orogastric tube. In four normal controls (including ourselves) this procedure was unpleasant; it took 10–15 minutes and was accompanied by retching and lacrimation [tears]. One control passed the tube without difficulty. We approached the patients cautiously, warning them to expect these symptoms. To our surprise, six of the
seven bulimic patients had no difficulty swallowing the tubes, doing so in seconds with no sign of distress. In the patients a gag reflex could not be elicited by stimulation of the fauces [back of throat]. One patient who did have a gag reflex on swallowing the tube was a bulimic patient who had not induced vomiting for three years. (221)

To say that these phenomena are attributable to the reconditioning of a reflex action is to beg the Ferenczian question. Is the gag reflex a simple mechanical action distinct from psychic or deliberative impetus? Does its disconnection from higher cortical centers (and so from conscious cognitive processing) render it a nonpsychological event?22 What is conditioning anyway? It seems to me that the gag reflex, this seemingly rudimentary biological action, is a very useful place from which to start thinking about the organic character of disordered eating. Freed from an immediate concern with the ideational and cultural systems that help enact such a symptom, we are able to observe the vicissitudes of organic thought. Russell’s second patient, who uses ingestion (drinking) to provoke vomiting, is not simply perverting the course of normal peristalsis; nor is she simply and in a mechanical way reconditioning a hard-wired (flat) nervous event. Rather, the soft tissue at the back of her throat (as with Robinson and Grossi’s bulimic patients) has become alive to a number of different ontogenetic and phylogenetic possibilities (i.e., to what Ferenczi calls the biological unconscious). Here, standard anatomical texts help orient us to the primal nature of the throat’s substrate. Gray’s Anatomy describes the fauces as “the aperture by which the mouth communicates with the pharynx.” The pharynx connects at the upper end with the mouth, nasal passages, and ears and at its lower end with the esophagus. Moreover, the pharyngeal area is “the embryological source of several important structures in vertebrates. For example, the breathing apparatus (gill pouches of fish and lungs of land animals) arises in this area [. . .]. In humans, the pharynx is particularly important as an instrument of speech.”25 The back of the throat is a local switch point between different organic capacities (ingestion, breathing, vocalizing, hearing, smelling) and different ontogenetic and phylogenetic impulses. Much more than the front of the mouth or even a little lower down into the esophagus itself, the fauces is a site where the communication between organs may readily become manifest.

Ferenczi has sketched out such interorgan communication at another overdetermined biological site. In Thalassa, he hypothesizes
that the anal and urinary organs are intimately intertwined in terms of function:

*The organs participating in urethral functioning are crucially influenced from the anal sphere, the organs of anal functioning from the urethral, so that the bladder acquires a degree of retentiveness from the rectum, the rectum a degree of liberality from the bladder—or scientifically stated, by means of an amphimixis [mingling] of the two eroticisms in which the urethral eroticism receives anal admixtures and the anal eroticism urethral.* (12)

That is, the rectum communicates its retentiveness to the bladder; the bladder communicates its liberality to the rectum. Without such interorgan exchange, the bowel would become hopelessly constipated and the urinary tract incontinent. Amphimixis is not a secondary perversion of flat biological substrate; it is the very means by which these organs are able to function naturally at all. This anal-urethral admixture spills over into the copulative act, such that the genitals (for Ferenczi, at this moment, the penis) acquire their natural function (ejaculation) through amphimixic relations to the bladder and bowel: “[T]he genital would then no longer be the unique and incomparable magic wand which conjures eroticisms from all the organs of the body; on the contrary, genital amphimixis would merely be one particular instance out of the many in which such fusion of eroticisms takes pace” (12).

So, too, at the other end of the digestive tract, various organs of ingestion, expulsion, sensation, and expression are borrowing from one another, but this time under the pressure of pathology. In Russell’s patients, the gagging capacities of the fauces have borrowed from the pharynx and become more like swallowing; and ingestion has become a technique for expulsion rather than digestion. Here, the quality of organic amphimixis is more acute and chaotic than in Ferenczi’s case of the urethra, rectum, and genitals. A more detailed examination of any one case of bulimia would no doubt find a trade in primitive inclinations among the digestive organs and their neighbors and between ontogenetic and phylogenetic registers. The longer bulimia continues, the more manifest and routine this primal organic thought becomes. In chronic bulimia, episodes of binging and vomiting are often no longer directly tied to meaningful, analyzable events in the patient’s internal or external world. Binging and vomiting can become compulsive; and it is for this reason that some commentators want to figure bulimia as an addictive disorder. By the time the
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binging and vomiting of bulimia have become functionally autonomous, bulimia is extremely difficult to treat: the organism itself is beginning to think. Distress, anger, need, depression, comfort, and attachment have become primarily organic, and their capacity to respond to cognitively or ideationally oriented treatments is greatly reduced. My argument is that the bulimic capacities of the throat should draw our attention not just to behavioral intent or cultural transformation or disorder in higher cortical centers or mechanisms of unconscious representation but also to the Ferenczian language of the digestive organs. The vicissitudes of ingestion and vomiting are complex thinking enacted organically: binging and purging are the substrata themselves attempting to question, solve, control, calculate, protect, and destroy.

**Gut Analysis**

One of the ways in which chronic bulimia can be treated is via the administration of antidepressants. Since the 1970s it has been clear that a variety of antidepressant medications (tricyclics, MAOIs and SSRI) can significantly reduce binging and purging in bulimic patients. Over reasonably short periods of time (six to sixteen weeks) double-blind, placebo-controlled clinical trials have demonstrated that binge episodes significantly decrease (although they are usually not entirely eliminated) when subjects are on a course of antidepressant medication: “[T]he mean reduction in binge-eating frequency across studies ranged from 22% to 91% with reductions most often reported in the 50% to 70% range. Abstinence rates at the end of treatment have ranged from 0% to 68%, with a mean of 24%” (Mitchell et al. 298). Harrison Pope and James Hudson’s early review of drug therapy for bulimia assessed the efficacy of a wide variety of thymoleptic (mood stabilizing) medications: for example, lithium carbonate, phenytoin (an anticonvulsant), and even methamphetamine. Early research on most of these drugs was inconclusive; it was the anti-depressants that emerged as the most reliable form of treatment for bulimia.

Nonetheless (and this is the point I would like to exploit), it is unclear why antidepressants are so effective in the treatment of bulimia; there is no agreement in the literature as to how the relationship between mood and binging should be understood. Two main schools of thought about the pharmaceutical connection between bulimia and depression have emerged. First, some researchers (e.g., Pope and Hudson) use the
data to argue that bulimia is, in fact, a mood disorder. That is, bulimia is a
variant of depression, and if depression is treated successfully, the bulimic
symptoms will likewise fade away. The fact that there is a high comorbidity
of depression in bulimia supports this thesis. However, the character of
depression in bulimic patients seems to be of a different quality from that
of typical major depression: the diurnal variations in mood, diminished
libido, irritability, and lack of concentration that constitute depression are
often absent in bulimic patients, even though they may have depressed
affect and be suicidal (Russell, “Bulimia”). Moreover, it is difficult to
diagnose depression in bulimia, as the secondary effects of binging and
purging disrupt or mask the usual biological markers of depression such
as weight gain or loss, decreased energy, and disturbance in gastrointes-
tinal function. A second explanation for the effectiveness of antidepres-
sants in reducing bulimic symptoms is that these pharmaceuticals have a
direct effect on appetite, independent of their antidepressant effects. Data
showing that fluoxetine hydrochloride (Prozac) alleviates binging and
purging, irrespective of whether or not the patients are depressed, support
the hypothesis that these pharmaceuticals are acting directly on satiety
mechanisms in the brain (e.g., Goldstein, Wilson, Ascroft, and Al-Banna;
Leibowitz). For these researchers, bulimia is first and foremost a pathology
of eating, to which depression may or may not become attached.

Despite over twenty years of clinical research on bulimia and
antidepressants, there is no clear biomedical etiology for bulimia: Does
depression trigger bulimia? Or do pathologies in the brain’s satiety mecha-
nisms instigate disregulated eating, provoking severe dieting and eventu-
ally binging and purging—all of which are independent of mood? There
are a number of demarcations that these etiological discussions in the
literature seem to force on the reader: depression *then* binging; satiety
*or* mood; brain *not* gut. It has been my argument, via Ferenczi, that these
Boolean demarcations among organs and between psyche and soma are
intelligible only within a conventional (flat) biological economy. It seems
to me that the lack of a clear path from one cause to one effect, from one
organ to another, or from the psychological realm to the biological and
back again, indicate not a lack of conclusive data but the workings of
the biological unconscious made manifest. Perhaps the lability of eating
and mood—their tendency to align and dissociate under the influence of
certain medications—speaks to an ontological organization that is at odds
with organic rationality. As is so often the case in contemporary biomedical
literatures, there is an overriding concern with clearly demarcating causal
primacy (what causes what?)—as if determination is a singular, delimited event. The limitations of such an approach to biological explanation were evident to Ferenczi:

*This seeing things only in the flat, so to speak, had the result that in the natural sciences one was satisfied, in general, with a conception of vital phenomena limited to a single interpretation of the data. Even psychoanalysis was not so long since committed to the view that it was the prerogative of the psychic sphere alone that its elements, indeed one and the same element, could be inserted simultaneously into several genetically different causal series. Analysis expressed this fact by the concept of overdeterminism of every psychic act, as the direct consequence of the polydimensional character of things psychic. Just as at least three coordinates are necessary in order to define a point in space, so in the same way neither a psychic datum nor, as we indeed believe, a datum in the field of physical science is sufficiently determined by its insertion in either a linear chain of events or in a two-dimensional nexus thereof, unless its relationships to a third dimension [the biological unconscious] are also established. (Ferenczi, Thalassa 84)*

The binging and purging of bulimia, and its alleviation by the administration of antidepressants, is not explainable until, at the very least, a connection has been made to organic thought and to the amphimixic inclinations of the substrata involved—that is, until a more plastic model of digestion, respiration, antiperistalsis, neurotransmission, and mood has been established. Rather than seeing a lack of pattern in the clinical data, I see support for Ferenczi’s thesis of a protopsychic substrate that is capable of differentiated, fantastic action (a lump in the throat, a child in the stomach, a penis in the rectum). The gut is sometimes angry, sometimes depressed, sometimes acutely self-destructive; under the stress of severe dieting, these inclinations come to dominate the gut’s responsivity to the world. At these moments any radical distinction between stomach and mood, between vomiting and rage is artificial. Here, a clear indication of what is meant by radical (pertaining to the root: foundational, essential, originary, primary) is important. I am not arguing that organs are indistinguishable from one another, or that psyche and soma are the same thing. Rather, I am claiming that there is no a priori, fundamental demarcation between these entities. For this reason the routine critical
response that bulimic etiology can be attributed to an interaction (mind plus body) is inadequate for the argument I wish to make here. The logic of interaction, addition, or supplementarity presumes that the entities at stake are already, radically detached. I am arguing that antidepressants alleviate bulimia because there is no radical (originary) distinction between biology and mood. Mood is not added onto the gut, secondarily, disrupting its proper function; rather, temper, like digestion, is one of the events to which enteric substrata are naturally (originally) inclined. Manfred Fichter and Karl Pirke allude to such a radically psychosomatic structure when they conclude a discussion of endocrine dysfunction in bulimia nervosa by suggesting that, in addition to thinking of disruptions to eating as symptoms of depression, it may also be useful to think of depression as a kind of nutritional disorder.

The clinical data indicate extensive traffic among the body’s organs and between the gut and mood in ways that are not delimitable to the flat logic of traditional biological science. For example, fluoxetine hydrochloride does not just act centrally (on, say, the serotonin pathways in the hypothalamus, which are thought to administer eating) and cognitively (to reorient infelicitous thinking); it also acts peripherally, on the gut itself. Most of the body’s serotonin (about ninety-five percent) is to be found in the complex neural networks that innervate the gut. While it is not usually discussed in the psychiatric literature, the gut itself (the stomach and attendant viscera, and their specific modes of organic deliberation) is being soothed (or in some cases agitated) by serotonergic treatments. That is, antidepressants do not have effects on mood simply by influencing the brain; they also directly enliven the viscera—in the case of bulimia, calming distress that is more enteric than cerebral in character. The responsivity of bulimia to antidepressants is one key piece of data that illuminates psychic action in the gut—its fantastic capacity to digest and ruminate.

The efficacy of antidepressant medications in the treatment of bulimia can best be explained in a conceptual field where the relations between head and gut; between thinking and eating; among serotonin, appetite, and mood; among disgust and antiperistalsis and the esophagus; among anger and hunger and loneliness and the stomach are more than juxtapositions or utilitarian relations of otherwise disjunct realms. Feminist theory is very well positioned to generate just these kinds of conceptual models—if only it could be in a more open and generative relation to biological data, if only it could allow a less antagonistic, a more
amphimixic relation between itself and the life sciences. In alliance with the biological sciences, feminism could build conceptual schemata about the body that are astute both politically and biologically—schemata in which it is possible to imagine that in cases of severe and chronic bulimia, the capacity for organic thought saturates the more familiar ideational, cognitive, unconscious, and cerebral mechanisms. I have provisionally called this method gut feminism—a feminism that is able to think innovatively and organically at the same time.

This essay was written while I was a member of the School of Social Science at the Institute for Advanced Study, Princeton. It is a further and final expression of an argument made at greater length in Psychosomatic: Feminism and the Neurological Body. I am very grateful for feedback on this essay from Susan Best, Penelope Deutscher, Vicki Kirby, Joan Scott, Gillian Straker, and Elizabeth Weed.

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Notes

1 Hemianopsia is blindness in half the visual field (not blindness in the right or left eye, but blindness in the right or left side of each, or either, eye). It is a condition usually caused by a lesion to the optic nerves that carry information from each retina to the brain. The optic nerves partially cross over at the base of the brain (the optic chiasma) so that the nerves from the inner half of each retina (nearest the nose) cross to the opposite side of the brain. Consequently, objects in the right side of the visual field are projected to the left side of the brain; objects in the left side of visual the field are projected to the right side of the brain. Lesions to the optic nerves therefore cause blindness in only half the visual field. Hemianopsia can also be caused by cortical lesions; but Freud’s argument is the same in either case: 

\[ \text{What is in question in hysterical paralysis} \ldots \text{is the everyday, popular conception of the organs and of the body in general. That conception is not founded on a deep knowledge of neuroanatomy but on our tactile and above all our visual perceptions. If it is what determines the characteristics of hysterical paralysis, the latter must naturally show itself ignorant and independent of any notion of the anatomy of the nervous system. (\textit{Some Points} 170).} \]

Hysteria has no knowledge of the optic nerves or the cortex, so it cannot produce a simulation of damage to these areas. Hysteria can only affect the everyday experience of vision (which is of an integrated, right-side-up visual field)—producing total blindness in both or either eye.

2 Conversion hysteria can be compared to anxiety hysteria (phobia), where “the libido which has been liberated from the pathogenic material by repression is not converted (that is, diverted from the mental sphere
While insisting in the Dora case that hysterical symptoms require “the participation of both sides” (i.e., the somatic and the psychic), Freud affirms his own preference for psychological explanation: “For therapeutic purposes the most important determinants are those given by the fortuitous psychological material” (“Fragment” 41).

See Wilson, *Psychosomatic*.

See, for example, *On Aphasia*, Freud’s critique of Wernicke’s influential theory of cortical localization.

See Stengers; Wilson, “Scientific.”

Perhaps the most distressing consequence of the breakdown in the Freud/Ferenczi relationship was the damage done to Ferenczi’s reputation in the English-speaking world after his death (Bonomi). In his biography of Freud, Ernest Jones claimed that while Ferenczi was the “most brilliant” member of Freud’s inner circle, the one who was “closest to Freud,” and a “gifted analyst” (Jones 2, 157), he was nonetheless mentally unsound: “[T]oward the end of his life, [Ferenczi] developed psychotic manifestations that revealed themselves in, among other ways, a turning away from Freud and his doctrines. The seeds of a destructive psychosis, invisible for so long, at last germinated” (Jones 5, 45). Jones misrepresented the relationship between Ferenczi and Freud at a time when there was no public access either to Ferenczi’s clinical diary or to the Freud/Ferenczi correspondence. He conflated Ferenczi’s disappointment and anger at Freud with psychosis, and he took the psychological symptoms (such as paranoia) caused by neurological degeneration in the weeks before Ferenczi’s death to be indicative of a latent, longstanding mental instability. Immediately following Ferenczi’s death, Jones withdrew from publication (with Freud’s approval) Ferenczi’s famous last paper read at the 1952 Wiesbaden International Psychoanalytic Congress (“Confusion of Tongues between Adults and Child”), and he attempted to obstruct the later publication in English of Ferenczi’s work (Jones and Freud 720–22; Balint). In the wake of this damage to Ferenczi’s reputation, the clinical diary was not published in English until 1988, and the letters were eventually published in English in 1992–2000 (Dupont).

See Aron and Harris; Haynal; Stanton; and special issues on Ferenczi of *Contemporary Psychoanalysis* 24 (1988); *Psychoanalytic Inquiry* 17.4 (1997); *International Forum of Psychoanalysis* 7.4 (1998); *The American Journal of Psychoanalysis* 59.4 (1999); *Group* 23.3–4 (1999); *Journal of Analytical Psychology* 48.4 (2003). These days Ferenczi is variously cited as an important originator of ideas and techniques that lead to object relations (Klein was first analyzed by Ferenczi), self psychology, and the contemporary interpersonal and relational psychoanalytic schools (via Clara Thompson and Michael Balint, both Ferenczi analysands). Unfortunately, there has been much less interest in Ferenczi in the nonclinical scholarly literature that draws on psychoanalytic theory (for a notable exception see Thurschwell).

In the preceding years (1916–1918) Freud and Ferenczi had discussed writing a book together about Lamarck: “The idea is to put Lamarck entirely on our ground and to show that his ‘need,’ which
creates and transforms organs, is nothing but the power of *Ucs*. ideas over one’s own body, of which we see the remnants in hysteria” (Abraham and Freud, 11 Nov. 1917, Letter 525F, 361). This joint project never eventuated, but traces of this interest can be found in the later work of both men. Ferenczi’s account of the regressive trend to earlier ontogenetic and phylogenetic states is explicitly Lamarckian in its sympathies (*Thalassa* 50). Freud, eschewing all biological theory and data to the contrary, remained attached to the doctrine of acquired characteristics until the end of his life (“My position, no doubt, is made more difficult by the present attitude of biological science, which refuses to hear of the inheritance of acquired characteristics by succeeding generations. I must, however, in all modesty confess that nevertheless I cannot do without this factor in biological evolution” Freud, *Moses* 100). His Lamarckianism is most explicit in the posthumously published metapsychology paper, “A Phylogenetic Fantasy.” Freud’s interest in Lamarck has been an embarrassment for many orthodox commentators (Sulloway; Jones 3) but a point of interest to some sophisticated readers of psychoanalysis (Thurschwell). Along with his interest in the occult (another shared enthusiasm with Ferenczi), Freud’s Lamarckianism sits awkwardly with attempts to clarify what is (or should be) at the heart of classical Freudianism. On the other hand, Ferenczi’s Lamarckianism seems more congruent with his intellectual ambitions and innovative clinical practice (Thurschwell). Clearly, there was a divergence of intellectual preferences even in this shared project, and this may be one reason why the work on Lamarck was never written.

10 ψα is the Greek shorthand (psa) used by Freud and others to refer to “psychoanalysis.”

11 “I believe that in spite of all our satisfaction with what has been achieved [in the metapsychology of hysteria], it is more to the purpose to indicate the lacunae in our knowledge of these matters. The ‘mysterious leap from the mental to the bodily’ (Freud), for instance, in the symptoms of conversion hysteria is still a problem” (“Phenomena” 90).

12 Similarly, in 1923 Ferenczi writes to the *Internationale Zeitschrift für Psychoanalyse* repeating the following clinical anecdote from Bernheim’s *Hypnotisme, suggestion, psychothérapie*: “When I [Bernheim] was a pupil of M. Sédillot, that eminent master was called on to examine a patient who would not swallow any solid food. He felt in the upper part of the oesophagus, behind the thyroid cartilage, an obstruction at which level the alimentary bolus was retained, not regurgitated. On introducing his finger as deeply as possible across the pharynx, M. Sédillot felt a tumour which he described as a fibrous polypus projecting in the area of the oesophagus. Two distinguished surgeons touched it after him, and ascertained without hesitation the existence of a tumour such as the master described. Oesophagotomy was performed; no malformation existed at this level” (Ferenczi, “Materialization” 105).

13 The *oed* gives the nineteenth-century meaning of paraesthesia as: “Disordered or perverted sensation; a hallucination of any of the senses.” These days the term is reserved for an abnormal burning or prickling sensation that is generally felt in the hands, arms, legs, or feet but may occur in any part of the body.
What is at stake for me in this difference between a Freudian leap and a Ferenczian regression is not the question of whether hysteria is a movement forward (leaping) or a backward (regressing), or whether it is a higher or a lower, complex or primitive psychological state. Rather, I am interested in how the notion of a leap invokes a gap of some sort between the mental and the somatic (a spatial divide between a psychic event and a bodily one that a conversion hysteria somehow, enigmatically, bridges) and, contrariwise, how Ferenczi’s use of regression folds psychic events (from the present, the individual past, and prehistory) into the heart of organic substrate. Without doubt, Ferenczi reinstates the intractable division of psyche and soma elsewhere in his work. For example, even as he leads up to his reformulation of conversion as a regression, he keeps the question of a disjunction between ideation and (motor) substrate alive: “In the phenomenon of materialization [. . .] the unconscious wish, incapable of becoming conscious, does not content itself here with a sensory excitation of the psychic organ of perception, but leaps across to unconscious motility. This signifies a topographical regression to a depth in the psychic apparatus at which states of excitation are no longer disposed of by means of a mental cathexis—even if only hallucinatory—but simply by a motor discharge” (“Phenomena” 97). This complex imbrication of loyalty to Freudianism with experimentation at the limits of psychoanalytic theory and technique structures most of Ferenczi’s work. My goal is not to argue that Ferenczi avoids the conceptual traps to which Freud succumbs, but to map out how these two major psychoanalytic thinkers have struggled with an ontological puzzle that confounds us all. I am especially appreciative of conversations with Vicki Kirby, who has constantly reminded me of this complexity—not just in relation to this essay but over many years. Her work is an important influence on my attempts to finesse the psyche/soma distinction (see Telling and “Culpability”).

The diary follows the analyses of several traumatized patients. For example, Ferenczi introduces his famous case of R. N. (Elizabeth Severn) thus:

"The first shock occurred at the age of one and a half years (a promise by an adult, a close relative, to give her ‘something good,’ instead of which she was drugged and sexually abused). At the onset of semi-consciousness, sudden awareness of something vile, total disillusionment and helplessness. [. . .] Persistence of this state of half-stupor; probably at her most profound depths a wish not to be alive; nevertheless, under the influence of suggestion, a normal schoolchild’s existence prevails: in other words an artificial double life, together with complete repression of her own inclinations and feelings. At the age of five, renewed brutal attack; genitals artificially dilated, insistent suggestion to be compliant with men; stimulating toxicants administered. Now [. . .] sudden recollection of the events in the second year of life, suicide impulse, probably also the sensation of dying, all before the suggested acts were performed. The enormity of suffering, plus helplessness and despair of any outside help, propel her toward death; but as conscious thought is lost, or abandoned, the organizing life instincts awaken, and in place of death allow insanity to intervene. (Clinical 8)"
My ambition is not to take notions of “thought” and “motive” as we commonly understand them (narrowly cognitive, teleological) and simply apply them to the biological domain. Rather, I am hoping to denaturalize our habitual definitions of these terms by associating them with hysterical materialization. The thinking that an organism enacts when its cognitive, rational, symbolizing structures have been destroyed should provide an opportunity to reconsider the nature of thinking in the usual sense. Similarly, embedding motive or deliberation in biological substance is one way of broadening questions of causality beyond narrowly mechanistic definitions of organic influence.

Much is made in contemporary theoretical work about Freud’s notion of the drive (Trieb) as a concept that lies “on the frontier between the mental and the somatic” (“Instincts” 122). Freud’s use of Trieb—along with his other celebrated notion of the bodily ego (“Ego and Id”)—have proved to be useful provocations to conventional understandings of the body. In both cases, it is the body as it is represented to the psyche that interests Freud. Technically, the drive is “the psychical representative of the stimuli originating from within the organism and reaching the mind” (“Instincts” 122, emphasis added); and the ego is “a mental projection of the surface of the body” (“Ego and Id” 26, emphasis added). Freud was much less interested in thinking about the dynamism of the organic, even though the system he inaugurated necessarily brings one to consider the psyche and soma as radically imbricated. Attention to biology was important for making a differential diagnosis (the difference between an organic and inorganic paralysis, for example), but once a bodily symptom was diagnosed psychogenic, Freud’s attention moved to the ideational difficulties that motivated the symptom. To this end, the Ferenczian notion that biology itself could be motivated did not become part of Freud’s conceptualization of the drive. Indeed, the source of a drive entails a rather conventional understanding of biological substrate:

By the source [Quelle] of an instinct is meant the somatic process which occurs in an organ or part of the body and whose stimulus is represented in mental life by an instinct. We do not know whether this process is invariably of a chemical nature or whether it may also correspond to the release of other, e.g. mechanical, forces. The study of the sources of instincts lies outside the scope of psychology. (“Instincts” 123)

Trieb is underwritten by a traditional understanding of the organic as inert matter, disconnected from psychic motivation; and to this end the concept of Trieb cannot do all the critical work in relation to biology that I think now has to be undertaken. Ferenczi’s work has reoriented the reading of biology I would usually undertake in, say, “Instincts and Their Vicissitudes” or “Beyond the Pleasure Principle”; this essay is written under the sway of that Ferenczian influence. It would take more space than I have here to expand on how Ferenczi strains Freud and how numerous, vital points of contact between them still remain.

“I do not believe that we are dealing here with processes that hold good for hysteria only and are otherwise meaningless or generally absent” (“Phenomena” 103).
For example, see Barad and Kirby (Telling) for meticulous and respectful readings of this dynamic in Judith Butler’s early work on the body.

See Kirby, “Culpability,” for an excellent feminist reading of tactility, vision, and the flesh (via Merleau-Ponty) that broadens the question of perception and knowledge to enfold not just the human and the biological but the world in toto.

Bulimia nervosa was isolated as a distinct disorder, separate from anorexia nervosa, in the DSM III (1980). Bulimia is usually diagnosed when three criteria have been met: uncontrolled binging on large amounts of food; compensatory behaviors to rid the body of food (e.g., vomiting, laxative abuse, excessive exercise); excessive concern about body shape and weight. About one third of bulimic patients abuse laxatives or diuretics; the DSM-IV-TR suggests that between eighty and ninety percent of bulimics use vomiting as a compensatory technique. Here, I focus on vomiting, but there are a number of different ways to enact bulimia in the upper digestive tract (e.g., chewing and spitting out food rather than swallowing it; vomiting food back up into the mouth and then swallowing it again [rumination]).

A reflex action is a nervous event that happens independently of conscious control, “[a]n immediate and involuntary reaction to a stimulus without conscious initiation or modification” (Rudin 317). For an extended discussion of the dynamic and contemplative character of the reflex, see Wilson, Psychosomatic (ch. 4).

See Gray’s Anatomy online: <http://www.bartleby.com/107/pages/page1137>.

Binge episodes are usually measured through self-report, and most subjects are also given a battery of psychometric tests that measure depression and the severity of the bulimia. For a representative sample of this extensive literature, see Agras, Dorian, Kirkley, Arnow, and Bachman; Fluoxetine Bulimia Nervosa Research Group; Goldstein, Wilson, Ascroft, and Al-Banna; Goldstein, Wilson, Thompson, Potvin, Rampay, and Fluoxetine Bulimia Nervosa Research Group; Hughes, Wells, Cunningham, and Ilstrup; Mitchell, Fletcher, Hanson, Mussell, Seim, Crosby, and Al-Banna; Pope and Hudson; Pope, Hudson, Jonas, and Yurgelun-Todd. Some of this research, especially in relation to the efficacy of fluoxetine hydrochloride (Prozac), is conducted by researchers employed or funded by Eli Lilly, the manufacturers of Prozac. Prozac is the only SSRI antidepressant approved by the FDA for the treatment of bulimia (although other SSRIs are prescribed off-label for its treatment).

See Wilson, Psychosomatic (ch. 2) for an extended discussion of this datum.
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