

## Eating Disorders and the Concept of Affective Dependence

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### Abstract

In a psychoanalytical approach, we understand eating disorders as a way of dealing with the tension between the inclination towards the object and the need to protect the narcissistic balance. We develop the concept of affective dependency in order to explain the particular difficulties adolescents with eating disorders encounter in reorganizing their object relationships. In an economic perspective, we understand the addiction to the food object as a counter-investment of the narcissistic weakness of this patients and its dynamic counterpart, the defense against the depressive threat.

**Keywords:** Eating disorders; Anorexia nervosa; Bulimia nervosa; Psychodynamic approach; Interpersonal dependency; Affective dependency; Adolescence

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### Summary

#### Eating disorders

Eating disorders such as anorexia and bulimia remain a constant source of interrogation for both psychopathologists and clinicians. We consider that some relevant facts must be taken into consideration, in order to enlighten such behaviours:

1. Why is adolescence the elective time for the onset of these disorders? More precisely, within the span of adolescence two periods are especially vulnerable: Puberty (with hormonal and body changes) and the time around turning eighteen (which concentrate experiences of autonomy from the parents, access into adulthood, and the completion of secondary school)
2. Why these disturbances are so predominant in female population?
3. How can we situate eating disorders within traditional nosology and from a psychodynamic point of view?

In fact, they are "transnosological". Indeed, a large part of the classical nosology can be observed in various degrees and more or less associated amongst people suffering from eating disorders, and yet no single syndrome alone can fully describe the specificity of the disorder. Instead, we come across different traits such as obsessional, hysterical, phobic, autistic ones, but also, depressive, sensitive and impulsive ones. These traits are nevertheless the least specific elements of the disorder and none of them reveal the essence of the psychological economy of

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these adolescents that is the dimension of their "acting-out", the compelling force which drives them to respond to their personal conflicts with a particular behaviour.

These three essentials questions have led us to believe that the fundamental difficulty of these adolescents lies in their personalities and their capacity to deal with conflict. This is confirmed by follow-up studies with anorexic patients that found a less favourable evolution regarding personality that regarding the eating disorder itself [1].

This statement raises in turn a twofold question: are there specific conflicts involved, and what are the distinctive characteristics of these personalities?

In order to answer to these two last questions we must take into account the aforementioned facts that are the role of adolescence in triggering these disorders, and the necessity of using psychological data which transcends traditional psychopathological diagnosis.

An additional fact that seems relevant to be taken into account is the similar paradoxical relationship this patient display towards both food and people:

1. An oscillation between a great eagerness for relationships and a tendency for isolation and withdrawal, with a same intolerance to loneliness and to closeness.
2. A great awareness of others' attitude and opinion, frequently in a hypersensitive manner.
3. Difficulties in regulating relationships and in finding optimal distance with violent changes from idealized attachment to total rupture, vindictiveness, and even outright hostility when faced with a minor deception.
4. An oscillation between an anxiety due to fear of separation and an anxiety due to fear of intrusion.
5. The coexistence of high expectations towards important people along with the ability to be easily influenced, but at the same time a huge capacity for opposition and obstinate refusal to change.
6. An extreme sensitivity to the fact that we manifest interest in them and the outcome of the treatment depends on how deeply the therapist believes in the methods he uses.

As a whole, these characteristics find a common ground in the concept of dependency. Abraham et al. [2] suggested a personality typology based on the development of oral stage and its difficulties. The oral stage lived in satisfaction gives personalities subject to the influence of orality, but driven by optimism and self-realization. On the contrary, the pitfalls can generate a passive character, in the perpetual expectation of a benevolent and protective being in the image of the maternal figure. This type of personality is characterized by a tendency to depression, emotional greed, and intolerance to loneliness and oral addictions, especially eating disorders. Affective dependency is part of the concept of interpersonal dependency, which includes deficits in: the separation process due to insecure attachment, the establishment of a personal identity, the ability to acquire self-esteem and to integrate into an autonomous and independent adult status, with the ability to make personal choices.

All subjects with these personalities share a predisposition for an excessive affective dependency on specific people in the outside world such as parents, brothers and sisters, etc. with a lack of autonomy and some confusion between the self of the subjects and the self of others.

We consider that this affective dependency:

1. Discloses itself at adolescence due to the conflict which is brought about by the access to sexual maturity, and the consecutive sexualisation of relationships. However, this process doesn't start in adolescence. It is rooted in childhood, especially early childhood, in the lack of integration of stable and reliable enough relationships with a maternal figure, and in a poor oedipal organization.
2. Is characterized by the use of significant others as a counter-investment toward portions of inner reality submerged by turbulent affects, dominated by aggressiveness. This counter-investment means that relationships with

significant others is based on idealisation, lack of conflicts, where the child or the adolescent is more concerned with conforming to what he thinks the other desires than with satisfying his own needs and desires. Any important conflict with these people will bring about effects of aggression and destruction that could put the adolescent at risk of losing his self-esteem, viewing himself as "bad", alone and disorganised. But adolescence is inherently full of conflicts such as sexualisation of bonds, exacerbation of envy and jealousy, and the need of separation.

The existence of relationships of affective dependency towards members of the close family accentuates the incestuous aspect of these relationships during adolescence and makes them conflictual. Every relationship that contains proximity and pleasure becomes dangerous, and is experienced as a threat to the subject's autonomy. The subject is at risk of creating an antagonism internally between his affective needs.

Such an antagonism may result in the reversal of these bonds: pleasure and attraction then leads to disgust and rejection. The intense opposition and refusal is therefore at this age the expression of the inversion of an attachment felt as excessive and alienating.

Every behavioural disturbance can be interpreted as self-sabotaging behaviour in the sense they contain a negative dimension which assures the adolescent owes nothing to parental desire. This behaviour becomes his creation, his way of becoming himself and claiming his identity to his parents. The sought out pleasure is often obscured or enjoyed in secret (as in anorexia the pleasure of hunger and its non-satisfaction).

This negative behaviour does indeed reassure the subject about his autonomy, but at the same time deprives him of narcissistic gratification and possible sources of self-esteem. He then becomes more and more internally empty, thus dependent on others, and then driven to reinforce his behaviour in a self-perpetuating vicious circle. At the same time, he is forced to accentuate the rejection of his affective bonds. His behaviour becomes more and more of a void of affect, more and more mechanical, gradually stifling all possibilities of cathexis. The eating attitude has then become a proper addiction, aiming to fight against a depressive threat, but at the cost of a narcissistic impoverishment.

It is indeed their extreme affective dependency on their environment which forces these patients to refuse any change, and desperately hang on to their self-imposed behaviour, as is the case in anorexia, with the non-satisfaction of all desires. Controlling is the only mental activity of these patients who develop a capacity to protect themselves from introjection (which is the psychic counterpart of the refusing behaviour). Instability/rigidity, vulnerability/resistance, submissiveness/stubbornness are the two faces of the same difficulty to assume independence and limits of the self. Along with Green [3], we can put these pairs of opposites under the heading of "control/submissiveness" and "pride/humility", which are the marks of the archaic confusion between the desire, its object and the self.

This counter-introjective activity contains one of the basic

elements of anorexia, and is in fact the mental expression of anorexic behaviour. The result is a limitation of "the psychic game", cut off from its imaginary and affective roots, letting only few fantasies passing through, in order to have more control over them. It is noteworthy that in the therapeutic relationship, these patients do not use the therapist's psychic activity, but also protect themselves from it, especially by acquiring knowledge and trying to keep one step ahead in view of control. In these conditions, the dual relationship may become traumatic by directly threatening the system of defence, and soliciting a cathexis which is highly feared because it is entirely expected.

This affective dependency towards key figures of their family environment, and later family substitutes, manifests itself in different way: during interviews by frequent confusion between family members, with mistakes in the first names, as noticed as well by family therapists, in fantasies, with a failure to recognize the generations (especially female ones). In projective tests we can observe the existence of indistinct corporal zones belonging to two people at the same time. We are facing pathology of the limits. Nevertheless, the subject/object confusion is not complete and does not lead itself (at least in the immediate future) to a direct threat to identity, as observed in psychosis.

In this affective dependency, we can see the failure of the separation-individuation process as described by Mahler et al. [4], this point of view has been developed by many North American authors. We partially adhere to it, but without denying the possible impact of the first process of separation-individuation, we are doubtful of the etiopathogenic importance of an event such precisely located in time.

Numerous authors suggest that narcissistic anxieties lie behind the addictive impasse. We may therefore conceptualise eating disorders as a narcissistic structure erected in order to defend the subject against disruptive anxieties. When this defence is ineffective, severe depressive reactions are observed.

We frequently see a proximity to, but not continuity with, episodes of melancholy: The narcissistic object relationship, the narcissistic object loss, and the ambivalent conflict all exist in these patients, but are not clearly structured. Subjects addicted to eating disorders seem to have an introjection failure rather than an introjection integration, the lack of differentiation is less important, and guilt and self-blame are clinically less obvious. Narcissistic suffering is here probably less archaic and less intense compared with the one we see in psychotic subjects.

The melancholic aspect of anaclitic depression that these subjects present finds an explanation through the loss of the object, but more essentially in the identity function of the object. Ruesch [5] found a link between psychosomatic patients, dependent personality and alexithymia. The psychosomatic conversion would come from repression of the conflicts and more particularly, prohibition of conflict with the object, in order to avoid his loss. Rewards are centered on safety of love brought by the object. The inability to name these emotions, alexithymia, would result from the lack of acquiring a personal identity [6]. Self-identity is built in fusion with object's identity, and generates a break with

effects of the self. Emotional are artificial, acquired by mimicry and dependent on the presence of the object. Emotions come from those experienced by the "object of identity". Without his object, the individual doesn't have a feeling of existence, which is an important contribution to depression [7].

Most frequently, this defense successfully contains breakdowns, with diverse effects from one patient to another, but what is clinically observed is more about despair and defence against depression than a symptomatic depression [8].

This dynamic, this avoidance of despair, linked to a compensatory juxtaposed narcissistic schema, must to be precisely explored in order to assess the developing risks in these behaviours: psychotic breakdowns, abnormal development, conduct disorders, psychopathic tendencies and psychosomatic illnesses.

The use of the concept of affective dependency enables us to understand:

1. The specific impact of adolescence on these patients.
2. The onset of such behavioural disorders within different kinds of personalities. The extent of affective dependency and the restrictions it imposes can vary from one case to another and according to different environmental factors [9]. The "acting-out" reflects this dependency, but leaves room to the possibility of responding to conflicts by the use of alternative neurotic or psychotic methods.
3. The predominance of eating disorders [10] and of other body-centred disorders, such as self-mutilation and suicidal attempts, among women. Indeed, for females, dependency seems to be originally linked to the mother-daughter relationship, although it may be displaced onto others. It is naturally centred on the body, where identification takes place. For the male, the dependency conflict will predominantly take the shape of oppositional behaviour or drug abuse. Among boys, the choice of the body as the place for symptoms suggests an important feminine identification which contrasts with his anatomical reality, and therefore carries a greater threat for his identity.

## Conclusion

In conclusion, the concept of affective dependency enlightens both economic and dynamic points of view about eating disorders [11] in adolescents. Considering externalized behaviors as a counter-investment of an internal reality weakened by the turmoil of the pubertal process can improve our understanding of their dynamic treatment. Finally, the concept of affective dependency involves its corollary, the anxiety of death; the stronger the dependency is, the more unthinkable the separation and its equivalents are source of an unspeakable terror. The other becomes a persecutor, an alienating experience that the adolescent tries to untie. In order to kill this devoured-devouring alien, the adolescent attacks the body identified, in a melancholic way, to the maternal banned from femininity.

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