Anorexia Nervosa – Destruction and Creation of Desire

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The two eating disorders, Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are different clinical syndromes but both are characterized by an immense focus on food, body and weight, an endless attempt to combat the body and by a fluctuation between "too much and not enough" on different levels (behavioural, mental and physical) (Lunn & Petersen, 2016).

Considering the theme of this issue, eating disorders have several similarities with addictive disorders – which, however, is not the same as diagnosing them as such. The similarities may seem more obvious for BN with the two key symptoms: binge eating and compensating behavior, e.g. purging, dieting and exercising. Individuals who binge and individuals who abuse alcohol or drugs experience an irresistible craving and experience a loss of control, and they try to hide the problem. In AN, where the person restricts food intake, often to a minimum, it seems as if the individual has an extreme ability to exert control. However, what appears as control is actually a self-destructive desire that can't be resisted. In the following, the focus will be on AN, especially on the function of disorder, and the great impact it has on the surroundings.

The anorexic patient

The anorexic patient is typically a young girl or woman 13-18 years old. She is in the midst of puberty and adolescence – a period of life typically involving turmoil, changing moods and conflicts between generations. She is surrounded by friends and schoolmates who radically change in various ways. They change their interests, bodies, eating habits, and their emotional ties to parents, etc. As adolescents they are struggling to adjust to, accept and become familiar with their newly awakened sexual desire, their changed bodies and the changed social and psychological demands from the outer world.

While change, movement, crisis and expansion in various ways are central in adolescence, AN is characterized by the opposite. The anorectic young woman is not struggling to adjust to the changed biological, psychological and social reality that adolescence announces. On the contrary, if the refusal to eat starts before puberty, she is struggling against these changes in order to maintain a pre-pubertal and pre-sexual body and unchanged relationships to her surroundings. In other words, she tries to stop the movement of time. This is not just a metaphor. Literally speaking, she stops her development physically by reducing her food intake to a minimum, psychologically by isolating herself from her friends of the same age, and concentrating all her energy on food, weight, body, physical exercises and often also on school work. Her life is limited "to a relentless pursuit of thinness" (Bruch, 1973) comparable to the addictive person's relentless craving and pursuit of the substance.

The patient's relation to her illness

It is well known that AN, (and addictive disorders), is a potentially fatal disorder. Among young women, eating disorders are the most dangerous disease, with the highest risk of death (except for suicide). For the anorexic patient, however, it has another meaning. Her condition does not alarm her, not even when she looks like a 'Musselman' [1], and other people are shocked by her appearance. On the contrary, she reacts to the danger she inflicts upon herself as a classic hysteric with "belle indifference", and she values her symptoms positively. While a patient with BN is ashamed by the

symptoms, the anorectic patient is often proud. The symptoms give a feeling of being in control, of being able to accomplish something, of not being trapped and of having freedom and self-determination. “Whatever happens in my life, I always have an exit, I can just lose weight” as a patient said.

Thus, one could say that the patient experiences anorexia as a kind of “life insurance”, as a solution, not a as problem to be dealt with. This is especially evident when treatment is established – a treatment that typically aims at conquering the symptom. Here one can observe the relationship to the symptom from a more dramatic and passionate side. It is not simply a question of the symptom’s positive charge but a matter of life and death. The anorectic patient can cling to her symptoms as a drowning person in distress. All her desire is concentrated on a self-destructive attitude and behavior with the purpose of destroying, repressing and getting rid of desire. Thus, we see an “addiction” in the sense that the destruction of life, of hunger, of change, becomes the only desire in life. To understand this paradoxical way of “surviving” with lethal weapons, we have to understand the function of the disorder.

The function of the symptom

To understand the function of AN, we have to look at both the background of the symptom and the effect of the symptom. Concerning the latter, the impact of the symptom is very strong intra-psychically as well as interpersonally. AN is like a sponge, absorbing all energy and attention from the sick patient and from her surroundings. Seen from the anorectic patient’s point of view, it occupies mind and body and it slows down and stops the development of the body that in many ways reacts as an animal in hibernation with vital functions like heart rhythm/pulse, body temperature, metabolism etc. slowing down. And it changes the mind. To starve does not only result in tiredness and exhaustion in the long run, but it also governs thinking and the ability to concentrate. This is known from hunger in parts of the world with shortages of food, e.g., concentration camps, prisons etc. When starving, it is scarcely possible to do anything else than to think or fantasize about food or trying to divert oneself from the gnawing feeling of hunger. Hunger destroys psychic life, and this may be desirable. (The Norwegian novel *Hunger* by Knut Hamsun is an illustration of this). Seen from this perspective, AN is a special way of tackling or coping with psychological problems. As a former patient expressed it:

Sometimes I miss my anorexia. Life was so perfectly simple. You only had to count calories, reduce food intake and burn calories by running, jumping, and constantly moving. Now I have all these feelings of anger, envy, jealousy and I don’t know how to handle them.

The similarity with the tranquilizing and “deadening” effect of an addictive disorder is striking.

The background to anorexia is more difficult to describe. Girls/women with anorexia look in an astonishing way alike but the paths to anorexia can be very different, and when the persons recover (if they do) very different personalities emerge. This diversity is mirrored in the number of theories about anorexia and different diagnostic classifications of the disorder. Since anorexia entered medical science in the late 1800s, it has nearly travelled between all psychiatric diagnoses (Sours, 1980, Lunn, 1990), including the addictive diseases. This travelling between diagnoses can partly be explained by currents of different periods, partly by the complexity of anorexia that gives rise to, and to some extent validates, different kinds of understanding.

Case examples

The ‘White Twin’ or ‘Miss Sunshine’

This case concerns a young woman in her twenties. She has a shining look, long fair hair, a smiling

face, and is very neatly dressed. She struggles with a mixture of anorectic and bulimic symptoms but in the beginning of our contact she only talks about her incapacity to control her eating. That is her reason for coming. She is the one of a pair of sisters who were separated at the age of ten due to their parents' divorce. She stayed with the mother, her sister with the father who became an alcoholic, and who died a few years ago. She describes herself as her mother's 'sunbeam', and her sister as the black sheep of the family. During the therapy it transpires that she has struggled with AN and a striving for perfection since her parents' divorce. She has, so to speak, walked along a crag, forever frightened of falling down. Her bulimia represents this fall, an inability to sustain her over-controlled way of living and the possibility of resembling her sister. Her anorectic symptoms have helped her to deny this, as well as her bad conscience towards her sister.

The little girl in a woman's body

Another patient in the first beginning of her teens became anorectic following a far too early puberty. In a very concrete way, she stopped her further physical development by refusing to eat. From an immediate impression, her family seemed well-functioning but she felt totally alone with the unwelcome change of her body. She also felt totally neglected and let down by her female relatives, whom she experienced as absent and ignorant to her painful situation. Following the developing AN, she became the master of her life. "I can defeat everything, even biology".

The running girl

This patient is a woman in her thirties looking much younger than her age. She has been in several psychotherapeutic treatments and asks for psychoanalysis. She is living in an unsatisfactory relationship with a man and two children. She is successful in her professional life and very devoted to her work. Inside she is desperate, full of anxiety of being abandoned by her husband, of resembling her mother and not at least of losing a grip of life and falling down into an bottomless void.

She is the only child of two parents who divorced in her early adolescence. She was born very early, and spent her first months of life isolated in an incubator. After the birth, the mother was discharged from the hospital, and developed depression. When the patient came home, the mother was unable to handle the cry of a constantly crying baby. This patient has all her life tried to "hold" herself together by different strategies, by anorexia, by running and by excessive working. She has been struggling with trying to gather herself together, to connect the body to her psyche and to create meaning and a feeling of continuity.

The scared little girl

The last case to be mentioned concerns a young woman with the diagnosis "Chronic Anorexia Nervosa". Since childhood, she has suffered from an unbearable anxiety and terrifying nightmares, but as soon as she began dieting at the age of 12, "the anxiety disappeared like dew under the sun". Through her teenage years, she was hospitalized several times and her life has seriously been in danger. As a young woman she is still struggling to resist the temptation to stop eating as a solution to all problems.

The cases exemplify very different stories and backgrounds for developing AN. However, they have in common the refusal to eat and not to receive anything from the surroundings. In all these cases, refusing to eat and not to receive anything are ways of holding and handling themselves (Winnicott, 1963), a defence aiming at excluding unbearable feelings and desires, and preventing them from arising,whether they are about premature puberty, sexual feelings, unbearable anxiety, aggression and/or self destructive desires. This strategy has convincingly been described as a "no-entry defence" (Williams, 1997).

The impact of Anorexia Nervosa
The anorectic symptoms are not only strong internally with regard to the individual's psychic economy but also externally. Anorexia has an intense impact on the surroundings. This is evident from the enormous interest it attracts both inside and outside the areas of research and treatment but first and foremost from the reactions of those who are in close contact with the anorectic patient. The fact that a young girl, seemingly healthy, stops eating and thereby exposes herself to mortal danger is quite unbearable and elicits very strong reactions and desires in parents, professionals and other key figures.

The impact can be seen in various ways. In families, the parents can alternate between two opposite ways of reacting: over-reacting and under-reacting. They can at some time control their daughter's eating and movements into the slightest details, sometimes leading to regular battles. In such phases, the daughter's "belle indifference" seems to correspond to an over-involvement and emotional desperation on part of the parents. At other periods the parents may "neglect" the daughter's cheating with the food intake and allow things to pass which may seem quite conspicuous from an outsider's point of view.

The treatment system, too, may alternate between opposite reactions: a tendency to focus too much on the symptom, and a tendency to neglect it. These different reactions may split and create highly emotional and passionate conflicts between professionals in hospital settings working with anorectic patients, one subgroup defending the patient and considered "naïve" by another subgroup considered "harsh and insensitive to the wishes and needs of the patient". It is evident that these conflicts are also influenced by characteristics of the persons involved and that they cannot only be explained by the patient's way of behaving. Nevertheless, the anorectic patient has an enormous impact and arouses strong feelings and desires in those involved– sometimes to such a degree that the treatment becomes absurd and it is difficult to keep common sense intact.

Conclusion
Psychoanalysis is not about common sense. However, in the treatment of AN there has to be "a common-sense eye" on the patient's physical condition. It is not enough to work with the inner life of an anorexic patient and the transference-countertransference field between patient and analyst. Due to the strong impact anorexia can exert on the surroundings, including the perception of weight and physical appearance, supervision of the analyst and/or involvement of a third part, e.g. a general practitioner, is an indispensable part of the treatment.

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[1]A slang term used by captives in the Nazi WWII concentration camps to refer to those suffering from a combination of starvation and exhaustion.