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The impact of separation-individuation on the development of eating disorders in adolescent females

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THE IMPACT OF SEPARATION-INDIVIDUATION ON THE DEVELOPMENT OF EATING DISORDERS IN ADOLESCENT FEMALES

by

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I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Community Psychology.

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ABSTRACT

One of the first cases of anorexia nervosa was described by Richard Morton in 1689, and was named by Sir William Gull in the late nineteenth century (Bruch, 1979). This syndrome has intrigued the medical and psychological fields for years.

Anorexia has been estimated to occur in approximately .5% of the target population. Anorexia occurs predominately in females between the ages of twelve and thirty. The most noticeable symptom is major weight loss with no organic cause. Bulimia nervosa is an eating disorder that is often categorized as another form of anorexia, nonrestrictive anorexia, due to the similarity of symptoms, etiology, and factors that maintain the illness. The difference between anorexia and bulimia is the way in which the illnesses behaviorally manifest themselves.

Anorexia and bulimia are examples of gender-specific psychopathology. They are eating disorders that occur primarily among women, with the ratio of approximately 10 females to every male (Beattie, 1988). This paper offers a developmental explanation for the vulnerability of women to eating disorders and implications for treatment. There is little consensus among the literature on the

exact cause of eating disorders. Psychoanalytic theorists have begun to focus on the symbiotic-like attachments that eating disordered patients have with their mothers and the incompleteness of the separation-individuation process (Lerner, 1986), as described by Margaret Mahler (1968).

Although the literature is abundant with theoretical links between separation-individuation and eating disorders, the empirical data is sparse. Using the Eating Disorder Inventory (EDI) and the Psychological Separation Inventory (PSI), this study offers empirical evidence of the relationship between the two constructs. Additionally, this paper empirically illustrates a relationship between parental preoccupation with their daughter's weight and the development of eating disorders in adolescent females. Statistical results, as well as treatment implications are discussed.

CHAPTER I

INTRODUCTION

Review of the Literature

> Mr. Duke's daughter, in St. Mary-Axe, in 1684, in the eighteenth year of her age... fell into a total suppression of her Monthly Courses from a multitude of Cares and Passions of her Mind. From which time her Appetite began to abate...She wholly neglected the care of herself for two years, till at last being brought to the last degree of Marasmus...and thereupon subject to frequent Fainting Fits, and apply'd herself to me for advice.
>
> I do not remember that I did ever in all my practice see one, that was conversant with the Living so much wasted...(like a skeleton only clad with skin) (cited in Minuchin, Rosman, & Baker, 1978, p.11).

This case was reported by Dr Richard Morton in 1689. He was describing what is now referred to as anorexia nervosa, so named by Sir William Gull in the late nineteenth century (Bruch, 1978). This syndrome has baffled, troubled and intrigued the medical and psychological fields for years Hsu, 1980).

Epidemiology and Prevalence

Anorexia nervosa has been estimated to occur in approximately 1 per 270,000 individuals in the general population and about 0.5% of the target population with unquestioning evidence that the incidence has been on the uprise over the past twenty years. Anorexia nervosa occurs predominantly in females between the ages of twelve and thirty. She is usually a very high achieving adolescent who requires perfection. Although the occurrence in males is rare, it does exist, and the prevalence is estimated to be somewhere between 4 and 15%. There is no conclusive evidence regarding heredity, but the incidence of the family members of an anorectic having or developing anorexia or a weight phobia is greater than that of the population. Although anorexia occurs across all socioeconomic levels and races, it is most common in white upper and upper-middle class families (Kaplan & Sadock, 1985; Schwartz, Thompson & Johnson, 1985).

The course of anorexia varies immensely. Recovery can be spontaneous and occur without treatment, there may be recovery after various treatments, there may be a course of repeated weight gain and relapses, or there may be continual weight loss and deterioration resulting in death. Research suggests that the mortality rate of anorexia is between 5 and 20%. The most consistent indicator of a promising prognosis is an early age of onset (Geist, 1985; Kaplan & Sadock, 1985;

Macleod, 1981).

Diagnostic Criteria

The symptoms of anorexia vary from source to source and the description has changed over the years, but the prevailing manifestations have remained distinctive (Kaplan & Sadock, 1985; Levenkron, 1982; Orbach, 1985). The most noticeable symptom is major weight loss. Most sources agree on the criterion of a loss of 25% of original body weight. If the patient is younger than eighteen years old, the loss of original body weight and the patient's projected weight gain are combined to meet the 25% criterion. According to most accepted theories, there is no organic cause of this weight loss. The anorectic is likely to begin dieting by restricting her high caloric food intake and this restriction eventually expands to include all foods entirely. The resistance to food intake can take several forms. There may be an overt refusal to eat, excuses such as, "I'm not hungry" or "I already ate", a secret disposal of food, self-induced vomiting, and/or laxative use. In many circumstances the anorectic displays an increased interest in food and insists on preparing the family meals. Her preparations are often elaborate and she tends to overfeed her own family. In addition to weight loss and a preoccupation with food, the anorectic endures several other common symptoms, such as the likelihood of experiencing a discontinuance of her menstrual cycle (amenorrhea). Other symptoms may include:

loss of hair, constipation, lanugo (a downy growth of body hair), lowered blood pressure and pulse rates, hypothermia, and if the anorectic is vomiting, she may have lowered chloride and potassium levels. In contrast to individuals who are unintentionally starving and trying to conserve energy by lowering their activity level, the anorectic is often inappropriately active, even in the face of emaciation. Sir William Gull described this hyperactivity in 1874, "The patient complained of no pain, but was restless and active. This was in fact a striking expression of the nervous state, for it seemed hardly possible that a body so wasted could undergo the exercise which seemed agreeable." (cited in Eckert, 1985 p.8)

The hyperactivity has been neglected in systematic research, perhaps because objective measuring is difficult. Nevertheless, it's presence has been very well documented (Josephson, 1985; Macleod 1981; Romeo, 1986). The anorectic is usually in perpetual motion and exercise becomes an obsession. Many anorectics have always had an interest in physical activity, but they begin to exercise to superhuman extents. Romeo (1986) suggested that the exercising is a combination of voluntary behavior (a conscious effort to burn calories) and involuntary behavior (an unconscious discharge of internal tension).

Perhaps the most disturbing and destructive of all the prevailing features is the anorectic's distorted attitude toward food and weight. There is a denial of illness and

a refusal to recognize nutritional needs. Additionally, she enjoys losing weight, has a desired body image of extreme thinness, and she is terrified of becoming fat. This is compounded with a distorted body image and low self-esteem. (See Appendix A).

Bulimia Nervosa is an eating disorder that is often categorized as another form of anorexia: Nonrestrictive Anorexia Nervosa due to the similarity of body perception, drive for thinness, etiology and factors that maintain the illness. The difference between anorexia and bulimia is the way in which the illness behaviorally manifests itself. While the anorexic literally stops eating, the bulimic repeatedly consumes large amounts of food in short periods of time. Following the overindulgence, the individual engages in either self-induced vomiting, use of laxatives or diuretics or other method of quickly reducing calories. (See Appendix B).

Statement of Purpose

Anorexia and bulimia are prime examples of gender-specific psychopathology. They are eating disorders that occur primarily among women, with the ratio of about 10 females to every male (Beattie, 1988). The purpose of this study is to offer a developmental explanation for the vulnerability of women to eating disorders, resulting in implications for

treatment. There is little consensus among the literature on the exact cause of anorexia nervosa. There are a variety of theories and treatment strategies, but most explanations generally fit within one of three models: the biomedical, the cultural or the psychological (Brumberg, 1988; Emmett, 1985; Garner & Garfinkel, 1985).

The following is an attempt to summarize the existing explanations for the development of eating disorders before suggesting that a developmental disruption in the separation-individuation process is the genesis of this female dominated psychosomatic disorder.

The proponents of the biomedical model explain anorexia by noting damage in the hypothalamus. Even if there was conclusive evidence for hypothalamic damage, the cause of the damage remains unclear. There are three possibilities: the damage may be an aftereffect of the starvation, psychological stress may interfere with hypothalamic functioning (even strict adherents of the organic hypothesis find it difficult to completely separate the theories), or the symptoms of the disorder may be independent expressions of a primary hypothalamic defect of unidentified etiology (Brumberg, 1988).

Similarly, there is a plethora of information suggesting that eating disorders are due to the emphasis that society places on the ideal female body. "Any deviates from the stereotyped thin figure is considered gluttonous and weak"

(Romeo, 1986, p. 19). This perpetuates the desire for thinness because the propensity toward obesity carries negative and moralistic implications. Once again, the seriousness of sociocultural forces should not be underplayed, but if the media and society were solely responsible for eating disorders why would some adolescents develop anorexia and/or bulimia while others don't? It appears that psychological underpinnings are at the root of each of the perspectives. It is likely that theorists become invested in the unique manifestations of anorexia and bulimia because of the nature of the symptoms, failing to concern themselves with the psychodynamic origins. "Anorexia nervosa often takes on a life of its own after the beginning stages of dieting." (Josephson, 1985, p. 86) Consequently, the psychodynamic reasons that are involved in initiating the disorder may be less apparent in maintaining the disorder. The deficiencies in research linking etiology to symptoms need to be improved before meaningful psychotherapy can begin. This study will attempt to shed light on the psychological origins of eating disorders, given the array of disputable theories.

Psychological Model

For the purposes of this study, the psychological model refers to psychoanalytic and family system theories. Anorexia nervosa and bulimia nervosa were recognized very early as psychosomatic syndromes and were credited with helping the

medical profession believe that there may be psychological underpinnings of certain physical disorders (Weiss & English, 1957). Literature on the psychodynamics of eating disorders is often divided into two related groups. The first emphasizes traditional psychoanalytic concepts and the second group emphasizes ego deficits, impaired object relationships and self pathology (Dwyer, Feldman & Mayer, 1967).

Sigmund Freud (1931) hypothesized that the anorectic is an adolescent girl who fears adult womanhood and heterosexuality and he equated eating behavior with sexual pleasure. Adolescents who do not look forward to adult heterosexuality, due to a faulty maternal identification reexperience the needs of the oral phase vis a vis the mother. Eating and sexual pleasure become identical. A refusal to eat represents anxiety about identification with the mother, adult sexuality and in many cases, fantasies of paternal impregnation. The bulimics were thought to be gratifying their impregnation fantasy and then feeling the effects of the resulting guilt and anxiety leading to a compulsion to rid oneself of ingested food. (Brumberg, 1988; Goodsitt, 1985; Josephson, 1985; Minuchin et al., 1978; Schwartz, Thompson & Johnson, 1985).

Hilde Bruch (1973) was psychoanalytically trained and she initially employed psychoanalytic concepts in her understanding and treatment of anorexia nervosa. She later

found that her clinical data did not support the theory that the fear of oral impregnation was the basis for the disorder. Bruch believed the anorectic's symptoms to be based on ineffective early relationships. The anorectic is thought to be unable to meet demands of adulthood because of the parents' inability to read the child's cues correctly. The parents' responses are based on their own needs rather than those of the child. Bruch further observed that the misunderstanding that parents have of their child's development continued well beyond infancy and hindered the development of a self that is so important in adolescence and young adulthood. She felt that many of the features of the disorder could be explained by deficiencies within the patient's self. The self is made up of three things: the person's hierarchy of goals, aims, values and priorities; the person's experiencing aspect of self organization; and the person's self-regulatory structure that maintains self-esteem, cohesiveness and vitalization. Bruch maintains that the anorectic feels excessively influenced and exploited because there is a deficiency in her self-regulatory structure and she is therefore dependent upon external contingencies for her well-being. One with a healthy and complete self-regulatory system feels in control and not easily invaded by external forces (food or people). The absence of this results in feelings of inadequacy, ineffectiveness and lack of control.

The excessive exercise is a drive to overshadow the painful internal conditions. She finds that being anorexic is special and it gives a contrived meaning to her life. By filling her days with exercise, rituals and a focus on food and weight she gives herself a sense of predictability and control. This narrows her world into one that is manageable (Bruch, 1979, 1985; Goodsitt, 1977; Josephson,1985).

Hilda Bruch (1973) focused on the influence that parents have in the development of their child's eating disorder. She viewed the earlier developmental problems in object relations to be critical in developing a healthy sense of self. Unempathic, intrusive or overprotective mothering results in a child with an inadequate ego structure, thus ill-equipped for the tasks of autonomy and self-regulation (Beattie, 1988).

Bruch furthered this hypothesis by expanding her focus from the mother to to the family system. There is disagreement in opinion among the professionals regarding the effects of the family on anorexia nervosa. Laseque described the adverse effects of the family on the anorectic patient as early as 1873. This idea was put on hold and the focus of etiology and treatment was on the individual until fairly recently. Over the passed 40 years, there has been considerable research in child development that in combination with clinical experience has contributed to