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Relationship to Food as to the World

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Food—consuming it, restricting it, hating it, loving it—what does it mean? What is the "food obsession" about for people who suffer from an eating disorder? Their relationship to food can be viewed as a metaphor for how they connect to the world. Linguists have long maintained that one constructs one's world through organizing thought in language. Thus the language in which one frames one's therapeutic interpretations has tremendous importance. The metaphor chosen to connect experiences that the patient knows with experiences that are effectively cut off, unknown to the patient, must be meaningful.

As a therapist, in order to understand my patients, I must immerse myself in the food connection. I must try to grasp the meaning of my patient's fear through food imagery. For example, patients often say that they are afraid of many foods. Labels, they tell

me, are inaccurate. Calories and fat content are falsely reported. These patients weigh and measure foods—read and reread labels. Many foods are considered bad no matter what the quantity. These patients do not trust food. It is as though they must be wary at every turn. How, then, can they be expected to enter the process of psychotherapy where they are asked to "swallow" what the doctor says, which is difficult for them. They are very discriminating about what they "take in." Their measuring and weighing of it is how they keep everything on their terms. Anorexics feel that their bodies react to food differently than the bodies of others. They are convinced that if they eat like other people they will "blow up"—be fat. It is the same with the intimacy of therapy. "If I take in what you say, something terrible, over which I have no control, may happen."

Patients who have a binge-purge pattern do not, for the most part, discriminate about what they eat. When they feel hungry, they take in as much as they can. They consume large quantities of food quickly to fill up—to feel okay. Then suddenly, after the frenzy subsides, it is too much. They cannot bear the thought of keeping what they have eaten, so they get rid of it. By doing so, they deny the whole activity. Now it doesn't count. It didn't happen. Whatever they were feeling has gone away. It is flushed down the toilet with the vomit. These patients often appear enthusiastic in their response to the therapist. They seem open and connect quickly. As soon as they cannot tolerate what is being "fed" to them, they reject everything. All the therapist has offered is rejected when anything is unacceptable or too much to contain. It is as though the therapist and patient never discussed certain issues. Such patients say, "I know we talked about it, but as soon as I drove away from your office I forgot the whole thing."

Directly attacking a patient's eating symptoms is often ineffective. Pathological eating behaviors are frequently split off from other more acceptable aspects of the personality structure. Patients with these problems rarely come into treatment voluntarily for the express purpose of changing eating patterns. As a therapist, I want to facilitate the patient's exploration of dynamics. Getting stuck on the literal facts surrounding food may thwart this exploration. Using an eating metaphor, as a working hypothesis, is a way to stay close to the patient and help her gain insight into her destructive behav-

iors—somehow to integrate the fragmented behaviors that keep her life so tortured.

How can I be helpful to these patients? How can patients understand themselves? Each person's story must be told and retold. Patient and therapist must listen to each part of every story over and over again until the meanings are unmistakable—until the underlying fears are evident and patients are free to live more directly using their own feelings and significant relationships to negotiate conflicts.

The vignettes that follow are a small part of the life stories that patients are trying to understand.

Theresa

Theresa, a young woman in her mid-twenties, entered the office in a terrible mood. She was having great difficulty choosing between two men she found attractive, one man with whom she has had a long-term relationship, and a new man who had entered her life. She wanted to be with the new man without jeopardizing her other relationship. She blurted out, "It is unfair! Why can't I have both? Who makes these rules?" Theresa was bulimic. She binged and purged off and on. She refused to work with a nutritionist. "I can't eat like other people. If I want to go out and consume huge amounts of bread and spaghetti—I will!" Theresa defied everyone. Following the rules was for ordinary people, wimps, people whose lives were like a B movie. Regarding relationships, she was amazed that people don't just do what they want—date two men at once if it meets their needs. She asked: "Doesn't everyone eat what they want and then do something about it or gain weight?"

When Theresa first came into treatment she was bingeing and purging at least once daily and frequently two or three times a day. She was emaciated and exhausted. She felt driven all the time either to take in food or get rid of it. Some of her bingeing was blatant, and she didn't care who saw her eat huge amounts. At other times she would hide her destructive behaviors. Theresa was always tense and frequently angry. It was as though the fight she was having with food extended to everyone. We talked frequently about how she consumed people almost indiscriminately. She would take in every-

thing she wanted just like food and when she was too full, nauseated, she would throw it up. She defended this as though she had no alternative. "It's the pressure." She would take little responsibility. "It's the food that's around." "If my parents hadn't overindulged me as a child, if they had helped me with limits, I wouldn't have these problems today."

Theresa used her parents, straining the limits of their indulgence and then treating them with disdain. "Why are they so stupid? Don't they know this isn't good for me?" The same theme was reflected in Theresa's relationships with men. She had wanted them to be there for her "on demand," go where she wanted, do what she wanted. She refused to go out of her way for her mother and father, such as to attend any required family functions with them, and yet she had been enraged at them for allowing her to run the show.

Theresa designed her own world, manipulating everyone as though they were props on a stage; when she was all finished, just as when she had binged and purged, she would feel disgusting, empty, and alone. Theresa's task was to connect to others in a way that respected their individuality and needs as well as her own. It was the same with the food—her use of it had to become respectful and suited to what was appropriate for Theresa.

When confronted about her disturbed eating patterns, Theresa was unable to gain insight. She felt that her hunger and the need to purge were unique and that no one, surely not the therapist, could understand them. However, when Theresa's interpersonal style was explored, she found it difficult to close the therapist out. Her behavior, vis-à-vis her family and men, could not be as easily split off from her self-concept as was her binge/purge cycle. So this was where the therapist entered. We established how it appeared that she used those close to her, like objects for her own pleasure, but she was never satisfied. When she did not respect others and ordered her own needs, she found no true satisfaction. Theresa acted out her "me first" theme in the transference. Her style was incredibly provocative. Whenever I would set a limit for her, or push her in anyway, she would devalue me. These attacks were primitive. I had to stand firm and tell her that she could "get rid" of what I said if she wanted to but that I wasn't going to go away. My recommendations had value and should not be dismissed. More than once during

treatment, Theresa wanted to see another therapist. This would be someone working with her family, for example, or someone treating her during a hospitalization. She would schedule a consultation but, like so many of her binges, these initial infatuations or relational binges would turn sour when these therapists challenged Theresa's actions or said she would have to terminate with me appropriately. Seeing these interpersonal behaviors as metaphorically connected to bingeing and purging led to some powerful integrated insights for Theresa. She was able to stay in treatment and work through many of her issues.

Mary

Mary is a quiet, conforming twenty-four year old, who does everything well. She is hard-working and an extreme perfectionist. At work, Mary does a marvelous job. She is conscientious and competent. She overcommits herself and always must do the most work.

Yet she feels a strange uneasiness. If someone else stays late, she must stay later. "It's as if I must do more or I won't be accepted. I can never relax because I may be criticized."

Mary came to therapy five years ago very underweight, frightened, and unable to make decisions. Initially she was rigid, angry, and frightened. She had gained few social skills in high school and was trapped by her need to please family members, especially her mother. Mary was unable to make a purchase without her mother's approval. Very gradually she began to find herself, to have opinions of her own. It was only then that she could relax her incredible food restriction. She began to understand that she could have an opinion of her own without jeopardizing her relationship with her mother. Before the age of twenty, Mary never expressed an opinion contrary to that of her parents. Her only defiance was acted out in a refusal to eat food. She was hospitalized twice for low weight, each time steadfastly refusing psychiatric hospitalization. She has since gone to college and graduate school, moved away from her parents, and taken a job.

At one point late in her treatment, Mary came to our session upset about a skiing experience with her long-standing boyfriend. She had had trouble mastering the beginning elements of downhill.

She fell, was unable to stop herself, and so on. She became so distressed by her apparent lack of skill that she could hardly eat anything for lunch at the lodge. She mistakenly assumed that her poor performance was a result of being overweight and in poor physical condition. (She had, by then, actually settled in at about 110 pounds and is 5 feet, 4.5 inches.)

She was so enraged that she had not demonstrated superior skill during her first try at skiing that she retreated to a safe posture—that of food restriction and weight obsession. She thought: "If I am empty, controlling, I feel more comfortable. Starving helps regain a sense of self. Control over food is the ultimate mastery. If I can keep my body at an incredibly low weight, I must be competent. If I am perfect at nothing else, I will be perfect at this. I will be the thinnest." Although Mary had made progress in treatment, she had difficulty letting down her guard in a crowd. What for everyone else was a recreational experience became a test for Mary.

Mary has talked often in treatment about how her food restriction creates a false sense of security, how it really doesn't mean that she's acceptable or okay. It only means that she is thin. Being able to ski would be just that—not an indication that Mary is good or better or acceptable. Mary must search within herself for healthier ways to be reassured. When Mary needs others most (at times of stress), she restricts her intake, thus effectively setting herself apart. Mary's goal in treatment is to work toward a stronger connection with others so she doesn't have to depend on "food rituals" to get her through tough times. The ideal response to her ski experience, Mary knows, would be a social one. A solution that assumed commonality and interdependence among friends or an understanding bond with her boyfriend would have been more adaptive—in the same way eating a warm nourishing lunch would have been an appropriate response to a tiring cold morning on the slopes.

Elizabeth

Elizabeth, a forty-eight-year-old woman, 5 feet, 5 inches, struggling to keep her weight at 110 pounds, stares at the woman in the cafeteria of a large corporation where she is employed. "They all eat

sandwiches, rolls, cake, and so forth, and are not fat! How can this be?" she says to herself. "I know if I eat like that, I will be fat."

Elizabeth remembers, as a child, standing outside the schoolyard and looking in-something terrible would happen to her if she acted "like the other children." Her mother insisted she would be hurt. Her mother told her over and over again that she was incapable of doing anything properly. After the birth of her own two sons, Elizabeth was not permitted to care for them. Her mother fed, bathed, dressed, and cared for them entirely. Elizabeth's husband was "put down" and ignored. He was required to eat his evening meal in a separate room from the family. Contradictions from him would set Elizabeth's mother off, who, in turn, would verbally attack Elizabeth. Elizabeth was sent to work every day and, when she returned home, was to do as her mother said or be threatened with abandonment. Elizabeth never challenged her mother's tyrannical behavior. She feared saying anything that would provoke her mother and cause her to leave. Elizabeth was sure she could not manage alone with her husband and children.

At work, Elizabeth felt like an entirely different person. She worked to please everyone and received recognition for her responsible and perfectionist's exercise of duties. Although the workplace was a safe haven from her mother's fury, Elizabeth needed more control. She began restricting food intake dramatically in her early twenties. She maintained a weight far below what was healthy. She used laxatives to purge herself and feel clean, and practiced rigid food rituals. For example, Elizabeth was unable for many years to eat a sandwich. She had never tasted foods like corn on the cob and watermelon. She reports hearing that these foods were fattening and has therefore completely avoided them. She has been in treatment with me for two and a half years specifically to address the eating disorder. Her earlier treatment focused primarily on her relationship with her mother. She felt more able to work on this problem since her mother's death three and a half years ago.

Now Elizabeth is working on incorporating normal eating patterns into her life, being like others, entering the playground. Elizabeth is reassured in her psychotherapy and nutritional counseling that eating normally will not bring about dire results, that she will not somehow become obese, that, in fact, she is like "other people." Eliza-

beth needs also to ingest the feelings of those around her. She restricted intimate relationships as she did her food. She would not sit down to supper with her family and, after cleaning the kitchen, would quickly put on her night clothes and retreat to her room. She said, "To get away from the food," but effectively it was to get away from everyone in her family. Once she recognized that her food fears and rituals served to keep her from relating to others, she made dramatic strides in overcoming her anorexia. She found, as she began to eat normally, that she was also able to express her true ideas and feelings and that her family and friends did not leave her as she had feared.

Elizabeth's continual task in treatment is to identify and respond to both bodily and emotional needs.

Sarah

Sarah, a restricting bulimic, has fruit and diet soda from 6:00 A.M. until about 4:00 P.M. Then she has crackers and cheese. She "can't believe" she ate that junk. "I have no self-control. My stomach sticks out. I feel gross." She walks for two or three miles even though the temperature outside is about 25 degrees. She returns home and forces herself to eat a baked potato and a few vegetables. She is restless and agitated. Finally, at 12:00 P.M. she goes to sleep. At 3:00 A.M. she awakes, unable to ward off feelings of anxiety. She gets up and begins baking cookies for her nursery school class. She eats small pinches of raw dough and further castigates herself. She rises in the morning tired, tortured, almost unable to go through another day. She calls a friend and offers to take her children to a movie or ice skating. The friend says, "Why don't you come for dinner after taking the kids out?" She refuses, saying that she has paperwork to do.

Sarah, thirty-six years old, has been coming to therapy for three years. Her life began to fall apart after she lost a private-school job with a built-in social life. Sarah has lived her whole life like a college student. She has never changed the address on her driver's license, which was that of her parents' home. She is always "hanging out," available to work on a project or to baby-sit for a friend. Nothing defines her. It is as though she doesn't stand for anything.

Sarah never feeds herself well. She never eats a normal meal and almost completely avoids any situations in which social eating is required. She takes care of others constantly. She buys them gifts and does them favors. She never lets them care for her or nurture her. She is most comfortable with young children who accept her giving to them and require no mature intimacy. They show her simple affection and never question the fact that she is always the giving one. She gravitates toward impersonal, casual gatherings or activities for which it doesn't matter whether she shows up. These kinds of relationships protect Sarah from having to receive favors—metaphorically, to be fed by anyone.

Sarah's eating pattern is chaotic, with the exception of some health-store-type laxative cereals and fruit. She eats nothing that doesn't produce guilt. She often walks around her village looking into the pizza parlor, local restaurant, or yogurt shop yearning to satisfy herself but unable to do so. She fears someone may see her and what would they think? So she walks home drinking a carry-out diet soda, eating the crackers she keeps in the trunk of her car. This empty chaotic eating pattern parallels her relationships. She has many acquaintances. People think of her as a pleasant, responsible person. When she allows herself superficial, social contact, she never shares a meal, literally or symbolically. No one knows the "meat" of her issues with life. She confides her dreams or her fears to no one. She has never felt intimate with anyone. If Sarah does eat a normal meal, she must purge. If on occasion she has a drink and shares her feelings with a friend, she worries excessively that she has said "too much." She often avoids the friend for weeks, undoing, or purging as it were, the intimacy.

She was not close to anyone as a child, with the exception of one sibling whom she felt she had to protect. As Sarah's despair grew, so did her sense of uselessness and her emotional isolation. Thus Sarah's interior life is mirrored in her inability to feed herself appropriately or be fed in a social situation. We talk often about how she feels hollow and lonely but is unable to risk "taking in" a normal meal or persons and holding on to it or them long enough for digestion or connection to occur.

In psychotherapy Sarah looks at what has become of her friendships over the years. If she can be someone's backup to cover a

community event, baby-sit, bake a cake, and so forth—all is well. Once she cannot maintain this hit-or-miss relationship, she backs away. Adult friends share thoughts, share time; they commit something of themselves to each other. Unfortunately this kind of relating is as foreign to Sarah as is the idea of enjoying a complete dinner. So I work literally and metaphorically at helping her to sample better and better appetizers.

Kathryn

Kathryn is beautiful, very bright, and doing well professionally after obtaining a graduate degree. She works out at a gym and has a healthy-looking body. Kathryn has been in treatment for four years for bulimia. Her pattern of interacting parallels her food behavior. When Kathryn meets a young man, within a matter of days, sometimes hours, she finds herself swept up by him. He is seen as "perfect" for her—the kind of person she's been looking for. She is unable to look at differences, potential problems, or interactional patterns. When questioned, she has little insight. Everything is perfect. This relationship is "it." It is going to change her life. Quickly she becomes possessive. She plans her life around him. When she begins to feel closed in, she may speak with an old boyfriend or even have a fling with another man. She lies about her contact or indiscretion. She manipulates situations to hide what is going on and always justifies her behavior, blaming her situation on the way the men treat her. When the relationships become chaotic—which they always do—and finally end, Kathryn paints a picture of the man as a totally insensitive person. It is never she who acted inappropriately.

With food, Kathryn acts similarly. She has had a pattern of bingeing and purging for more than eight years. She refuses to look at her eating patterns. She won't see a nutritionist or keep regular food records. She won't look at her behavior. She insists that forces outside herself cause the eating problems. She avoids taking responsibility for her binges by stealing her binge food. Healthy, acceptable food is bought and paid for—binge food is stuffed into oversized pocketbooks. This behavior is totally inconsistent with the patient's value system, yet she persists because the behavior permits her to

continue irresponsible eating without acknowledging it beforehand. Then she undoes her binge by purging—she doesn't pay, neither in reality nor symbolically, for the binge food.

Kathryn had been going from one short-term work position to another, gaining recognition—everyone loved her—everyone thought she was doing a good job. She made sure she moved around a great deal and that no supervisor was regularly looking over her; she hated being totally accountable. Like an addict, she needed to manipulate her environment so she could slip away to binge and purge when so compelled. She was a master at creating plausible excuses. She knew she was cheating those she served. She knew, regardless of the rave reviews, that her performance was far below her abilities.

Kathryn's bulimia led her to betray her value system in several arenas. Kathryn manipulated the environment so she could be free to binge, but in reality she was a slave to her compulsion—never free—always trapped by her need to create space for destructive behavior. The dance of denial that she does with food is reflected in her professional life and her personal relationships. When someone comments on how beautiful she is and what a great body she has, she feels like a fake because of how she abuses her body. Recognition at work rings a hollow note in Kathryn's conscience. When friends console her about these ex-boyfriends—saying they were "no good" or "screwed up"—Kathryn never looks at the total relationship. In every arena Kathryn ends up with the sensation of one who has just purged. She feels empty, guilty, alone—she has no plan for the next time. She feels her compulsions will override her judgment. She will binge on another man, a vulnerable supervisor, ice cream, and cookies—purge and then feel empty.

These vignettes are only a tiny piece of each patient's life, yet they embody an important element in each person's pain. The eating disorder reflects, in metaphoric terms, the troubled themes of these women's daily existence. The goal of our work is to reduce the need for metaphor, by first becoming immersed in the metaphor and then moving the patient to talk out feelings rather than managing them through ritualized and destructive behaviors.

When we listen carefully to a story or a melody over and over

again, we touch on meanings that are at first glance hidden. So it is with the stories our patients tell. At first we hear only their prose: how they feel, how they act, and how they understand their food obsessions. Later, these stories transform into ever changing poetry with many meanings. Marcel Proust wrote: "The real voyage of discovery consists not in seeking new landscapes but in having new eyes." Recovery is nothing other than a healing voyage of discovery.