



International Connections

By Asaf Rolef Ben-Shahar

Eating Disordered Relationships

Pondering on the eating disordered therapeutic dyad – enactments, ruptures, and repair

As long as mum is unhappy

“I would rather be miserable than give my mum the pleasure of seeing me healthy and happy.”

This horrifying sentence, which Tanya uttered with a mixture of pride and disgust, illustrates this article’s suggestion – that eating disorders should not only be seen as an individual condition but instead also as a systemic - familial disorder.

Tanya’s relationship with her body, with eating, and with food cannot in my mind be separated from her relationship with her mother: a relationship of use and misuse, characterised by role reversal and enmeshed digestion. This is a world where it is unclear who is digesting what and for whom, a world where the girl could not individuate since the mother needed her connected, and where dyadic regulation was harnessed from an early age to manage and monitor the mother’s narcissistic anxiety. The child’s body and the child’s suffering gave the mother meaning – something to worry about, therefore something to exist for, as her own existence was never validated. You suffer, therefore I am.

In this article I suggest that many who suffer from eating disorders think through their bodies by somaticizing and that this early form of somatisation is a result of early disturbances of dyadic regulation with the attachment figure (most commonly the mother). To simplify this claim – the disordered body is the mother-daughter dyad and not the daughter (or identified patient) herself.

Elaborating on this hypothesis and clinically exemplifying it, I suggest that since eating disorders have a dyadic component that takes place in a relational constellation between a person and her or his attachment figure, psychotherapy is a fertile ground for enacting such eating-disordered relationships, enactments which mostly occur somatically. In short: relationships (therapeutic ones included) could manifest disordered-eating patterns.

Speaking in feeling

Psychoanalyst Diane Barth (1998) describes how some clients “speak in feelings” and not in words. These clients are not incapable of articulating their experience in words, if requested or called to do so (by an attachment figure, for example, or a therapist), but it is not their main way of processing some specific emotions. Barth argues that many clients with eating disorders tend to “speak in feelings,” and that this way of speech characterises both normative and pathological processes. The disordered eating is therefore seen by Barth as somatic communication. The feeling-speech is in par with what Wilma Bucci (1998, 2011) refers to as subsymbolic processes: organised, nonverbal, bodily organisations of language that manifest through gestures, tones, postures, muscle tension, and more. While this sounds revolutionary outside body psychotherapy, it is both well-known and frequently conversed with amidst our body psychotherapy community – we speak in bodies to bodies who speak with us.

Such clients may be highly intelligent and well able to communicate their feelings through symbolic means but in so doing something will be lost in translation. In differentiating between organised and chaotic crying, body psychotherapist Liron Lipkies (2012) suggested that, “There are moments where words do not serve us well, and the language of the body is the most appropriate one to use” (p. 53). It was only after my own Jungian analyst was willing to roll his chair towards me and hold my hands in his that therapy could begin for me. I was no longer requested to translate my experiences into a foreign language: his body and mine could speak directly; and he spoke Body with me when the therapeutic material was Body in me, and we spoke English when the therapeutic material was English.

Many bulimic and anorectic clients speak in feelings, and their bodies speak with us directly without linguistic buffering. At the same time, most of these clients are highly attuned to their typically narcissistic and symbiotic mother (Bachar, 2001; Dmochowski, Rolef Ben-Shahar, & Carleton, 2014), or to their therapist. Thus, if they perceive that the therapist needs them to, those clients would provide their therapist with the necessary verbal engagement, all the while compromising a deeper nonverbal engagement. For those clients, “words do not adequately capture or convey emotion or symbolize experience. Actions, rather than words, often speak of an affective world that otherwise remains uncommunicated and unconsolidated” (Brisman, 1998, p. 708).

Instead of focusing on interpretation, Barth (1998) emphasises here-and-now engagement and attention to action. In discussing Barth's attempts to work affectively and nonverbally with these clients, Judith Brisman (1998) writes: “The process is

effective because it allows the therapist to resonate with the embodied experience of other as it emerges in a nonthreatening milieu, it is likely that the empathic mirroring of experience offered at such moments is a critical factor in allowing words to be used symbolically” (p.309).

I have similarly written of this type of communication when discussing the theory of mind (bodymind) in body psychotherapy:

As body psychotherapists, we endeavour to initially speak with somatic processes in their own language, rather than forcing these into symbolic cognitive terminology, since such a transition incurs a loss of a qualitatively meaningful aspect of the conversation, one that belongs in the bodily realm (Rolef Ben-Shahar, 2014, p.88).

So far this is great news for body psychotherapists. We are trained to work nonverbally, the absence of symbolic communication doesn't necessarily induce anxiety in us; we can speak with bodies directly. One of the deserving contributions of body psychotherapy to the larger milieu of therapy concerns clinical work with subsymbolic processes, working with our bodies and speaking with our bodies to the body of the person who is with us.

My teacher, Silke Ziehl (2005), has beautifully written about this skill: “I can touch in such a way that each finger has eyes and ears as I make contact with the other person. When I touch in this manner, I am more likely to be receptive to who the other person is, and what they want, and what they are saying with their body at the moment. From this somatic dialogue, we get to know each other more deeply.”

Indeed, many psychotherapists and psychoanalysts understand today that there is a gap between contemporary

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Liron Lipkies (2012)

analytic thinking and conceptualisation and its translation into action. Contemporary analytic practice is sometimes found wanting in skills and methods when attempting to address affective, somatic and otherwise subsymbolic or unsymbolised processes (Ramberg, 2006; Stern, D. B., 2010; Stern, D. N., 2002, 2004). Body psychotherapy can assist therapists from other fields in acquiring such skills. Below is an illustrated example from a training situation:

Whose digestive system is it anyway

I like to think we have two types of bodies, one that is ours—bounded within our skin— and another within which we share, a body that comes to be fully realised only in connection. When we occupy one (individual body), we yearn for the other (shared body); when we share in a body, we crave our individuation; and when we are able to hold the tension between both, an intersubjective body comes to life. I have spoken of these two bodies extensively (Rolef Ben-

organisation, resulting in “uniquely intertwined, somatopsychic personality organization – one that I call a ‘perseverant’ personality” (p.708).

This is closely related to what I have previously (2014) called the dyadic-body. The attachment system (parent-child) begins as a dyad; a shared sense of belonging and sharing-in-being is, in my opinion, parallel and not hierarchically secondary to the individuated self. It means that you and I (or mother and baby) create and form the *usness*, and that at the same

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Rita is a trainee body psychotherapist. She is also a very experienced Yoga therapist and teacher. Rita sits with Avner, who speaks of his mutual desire for and anxiety of relationships. Rita listens attentively, and they speak. At some stage Avner becomes physically agitated, and as they speak he points at his stomach and chest with distress. Rita, without stopping the verbal exchange, gestures towards her own body, as if asking Avner to clarify something and indeed, he does. Now she knows, and Rita contorts her face, her somatic empathy is visible, and exhales with a sigh. She gestures and Avner lies down. Throughout this conversation, the verbal and nonverbal are concurrent. These are both organised. Avner and Rita speak perfect Hebrew *and* perfect Body.

But when the main spoken language is Body, transference dynamics also speak bodily. And when the client brings patterns of eating disorders, this may challenge the therapeutic relationship and introduce elements of disordered-eating into it.

Shahar, 2013a, 2013b, 2013c, 2014).

In her endeavour to understand the aetiology of eating disorders, psychoanalyst Alitta Kullman (2007) attempted to characterise the theory of mind of bulimic clients. She believed that most bulimic clients resolved to end their symptomatic behaviour daily. They want to cease this behaviour. Time and again, they vow to stop binging and purging, only ‘something happens’ and they lose their resolve, falling into the slippery slope of cyclical binging and purging. Similar to Barth (1998) and Brisman (1998), Kullman proposes that bulimic sufferers tend to think with their bodies and their turning to food is first and foremost to help with this thinking.

Kullman (2007) emphasises the cyclical nature of bulimia, hypothesising that the aetiology of these cycles may be found in the nursing infant sensing lack of psychic contact with his or her feeding attachment figure. This pre-attachment failure is, according to Kullman, at the heart of the bulimic

time this *usness* creates, forms, and shapes us both. Inasmuch as we are bodies, we first share in our bodies, this is the somatic aspect of intersubjectivity. As attachment theory argues (Ainsworth & Bowlby, 1991; Bowlby, 1988; Bretherton, 1992), we require a sufficiently stable attachment figure (or dyadic self) for our individual self to emerge safe and regulated.

When failure to attune occurs during a fragmented or oral developmental stage, the infant might not develop sufficient self-regulatory capacities but instead manifest compensatory regulation strategies (what Winnicott (1960) might call the false self). The body would nonetheless not fully form as separate but continuously dialogue, as we could have seen from Tanya's statement in the beginning of this article, with the other, unfulfilled, half. Seeking to digest feelings, thoughts, and decisions cannot be attained on her or his own.

If these patterns of relating to self and others are indeed primarily somatic, then how do these attachment

organisations manifest in the therapeutic relationship?

The next section will conclude this article with a clinical example, demonstrating the tides of rupture and repair in an eating disordered relationship dynamics. Please read it with kind eyes, this is an exposing piece for me. It took place about six years ago.

Nothing but the truth

Two weeks after commencing therapy with Billie, I accidentally saw her while doing some shopping with my daughter. Without thinking, I picked my daughter up in my hands and ran. I ran and ran and ran and hoped that Billie did not see me. I hoped she did not see me, I really did. I did not stop to think what would have been so horrible if she did. We hid in a toyshop for fifteen minutes. I bought my daughter an overpriced toy she did not need. Ten minutes into our next session Billie mentions this in passing: "I think I saw you on the weekend, in a shop". I shake my head: "I don't think I was there on the weekend." She looks at me with disbelief. I ask myself, *why am I doing this?* but it's too late. "I am pretty sure I saw you," Billie tries again.

Billie is bulimic, trying to understand what's happening to her, hoping to stop these tormenting cycles of binging and purging. Her breath smells acidic, and she is beautiful, clever, and funny. I could have easily fallen in love with her (and two years later I would). I bring us back talking about her eating, and Billie obliges. She goes into the graphic details: frozen bread-crusts, half a cheesecake, frozen chicken wings, a loaf of bread. A loaf of bread, and I feel her dread; frozen chicken wings, and my relief is palpable. I feel much better now, thank you.

I wish to share with you some of what is taking place in my mind while Billy is talking: *ok, this is long*

term work, poor girl. Can I help her? I think I can. Frozen chicken-wings? This is really disgusting! But I don't like this hour very much, it's too late for me. I wouldn't want to see her regularly at this time. Maybe I can check with Billie if she is willing to move to an early morning slot. But we have just started and surely, creating so much instability to begin with is not good for her. I stop thinking when Billie is looking at me. "Are you ok?" she asks.

I am shocked by my lack of presence with Billie and feel shame and fear. I want to tell her that I am usually a better therapist, that I can be empathic and present, and that she deserves more, that she deserves my full attention. However, I find myself nodding and saying, "I'm ok." Yet again, I evade Billie's question by turning the attention back to her, and she is kind enough to have an anxiety attack. I am called to attend. Now she fully has my attention. "What's going on Billie, what's happening?" Billie is crying. "I don't know," she keeps saying. "I don't know."

At home I realise that what was happening was me, and us. It wasn't her that was going on, it was us. I used her pain to manipulate her away from our relationship and away from me and my shitty behaviour. I barely hold back from calling her all week. And then we meet. And I admit seeing her with my daughter and running and hiding, and admit my lack of presence during the session. I apologise for lying. "Why did you do that?" she asks. "Truthfully, I don't know. But I felt shitty enough about it to lie to you." And Billie smiles, "I feel like that all the time."

Billie talks about her mother, and I realise how her description rings true to my feelings since we started working together. I notice how tempting it is for me to blame her for the projective identification. I can actually feel the seduction of using

her, again.

And, of course, Billie was used, and she too, used others, all her life, and her mother was the first but sadly not the last in a long chain of uses and misuses and abuses. It is so easy to use her. It was so easy for me. And I could use her in a way that felt therapeutic and loving, caring and containing.

Two years later Billie debates about a new job offer. "I am not sure I can trust you to listen to me well," she says, "you are so important to me that I would read every facial expression and interpret any comment you may make and it would influence my decision." Her words are like a knife to my heart. "I think you are right there, Billie, you too are important to me, and I would probably have feelings about your decision and you would then notice them. Perhaps you should wait a little before sharing this with me." Billie sighs. "But then I will remain alone with my decision." I nod. "Yes you will, but at least you will have you. And you can share this with me next week." And Billie does, and our binges and purges reduce as hers ease as well, and our lies are admitted quicker as our love unfolds. And our different, individuated bodies ache as they yearn for the symbiotic connection we once knew but we learn something new. We learn how to remain separated while connecting, and how to remain connected when we part.

I hope that we can share some interests and dialogue, and I welcome your feedback, comments, questions and challenges. You can email me at asaf@imt.co.il

Asaf Rolef Ben-Shahar PhD, has been a psychotherapist, writer, and trainer since 1997. As a psychotherapist, he works as a relational body-psychotherapy, integrating trancework and Reichian body-psychotherapy within a relational framework. He enjoys writing and has *Continued on page 108*

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written dozens of professional papers on psychotherapy, body-psychotherapy, hypnosis, and their integration. He is an international board member for *Body-Psychotherapy Publications* and an associate editor for *Body, Dance and Movement in Psychotherapy*. His book, *Touching the Relational Edge: Body Psychotherapy*, was published by Karnac in 2014. His PhD dissertation (*Surrender to Flow*), focused on the moments of surrender in three different fields: relational psychoanalysis, body-psychotherapy and hypnosis, and these three form the axes of his theoretical and clinical curiosity.

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speaks from experience. In this way, it can certainly instill hope in patients who are struggling with their recovery and help to empower them. The book is organized in a way that truly follows the

thought process of a recovering bulimic and intervenes at every step to help instill a solution at the root of the problem (negative thoughts). The exercises provided in the book allow the

patient to take realistic steps towards maintaining their recovery.

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