

Starve, Binge or Feel, Engage Embodying the Interpersonal/Energetic Processes of Eating Disorders

Narelle McKenzie

Abstract

In this paper, Narelle presents how observing the signs of a client's embodiment and identifying and working with phases of the energetic pulsation of their body can assist in the healing process for clients with eating disorders or eating issues. The concepts of embodiment and pulsation are described with case examples.

Introduction - My Experience in the Area of Eating Disorders.

Last year I was invited to present a two-hour workshop on eating disorders from a body centered perspective to the Anorexia and Bulimia Nervosa Support Group Association of Adelaide, South Australia. Most of the participants in the workshop had an eating disorder, a few participants were either parents or support people and several were therapists. The workshop was both didactic and experiential. I made it clear to the participants that I was not an expert or a specialist in the area of eating Disorders but working with the body had resulted in me thinking a lot about the relationship between eating disorders and body psychotherapy.

In my private practice over the last twenty-five years, I have worked with many clients with eating issues and a few with severe eating disorders. For a few of these clients, this was their presenting problem. For most, issues with eating emerged as therapy progressed and trust in the therapeutic relationship deepened. For a couple, it was never specifically addressed in sessions but these clients reported at the conclusion of therapy that there had been some improvement in this area for them. As a teenager and young adult, I was anorexic. I never sought therapy for this problem.

However, in my late twenties and early thirties, I immersed myself in a number of different therapeutic approaches for personal growth. In none of these did I present my eating disorder as a presenting problem, in most it was never raised, in those where it was, it was never specifically addressed. Nevertheless, when I completed my Radix body centered training, my anorexic behavior stopped. My guess is that some of the basic issues related to this were indirectly addressed in my therapy over the period of three years of required personal work. This has always intrigued me. This paper reflects my current thinking about how body oriented psychotherapies might contribute directly and indirectly to the effective treatment of eating disorders and eating issues.

What is an Eating Disorder?

The most commonly accepted disorders are Anorexia Nervosa and Bulimia. Some approaches also want to include, Compulsive Eating and Overeating as separate categories. All of them involve a preoccupation with control over body weight, eating or food or a combination of these. In a general way, people with anorexia tend to over control the amounts of food that they eat and people with bulimia tend to go out of control and then try and bring back the control.

According to the National Mental Health Body of Australia, (2000) both males and females seem to be afflicted but it seems that at least in term of official statistics more females than males suffer from these issues. 2/100 teenage girls qualify as having anorexia as a disorder. 3/100 seem to be afflicted with Bulimia. However, many more people have unrealistic attitudes about body size and shape, which can contribute to inappropriate eating habits or dieting practices.

What Are the Specific Characteristics of Anorexia and Bulimia?

Anorexia Nervosa

- The individual doesn't maintain a minimally normal body weight. A rough estimate is that the individual weighs less than 85% of the normal weight for their age and height. Or that they have a body mass index equal to or below 17.5 kg/m².
- The person is intensely afraid of gaining weight. This concern often intensifies as the weight loss increases.
- They exhibit a significant disturbance in the perception of body shape or size. Sometimes this can apply to the whole body. Other times, it relates to specific parts like the waist, the thighs, buttocks etc. This results in excessive weighing, obsessive measuring of body parts, and persistently using the mirror to check for perceived areas of 'fat'
- Post menarcheal females are often amenorrheic. In prepubertal females, menarche may be delayed by the illness.
- Self Esteem seems to be very closely associated with body shape and weight. Weight loss is viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control.
- There is a strong element of denial of the problem

The National Mental Health publicity on this disorder adds a few qualifications and additions to this information. (NMH 2000). They maintain that anorexia is characterized by:

- A loss of at least 15 per cent of body weight as a consequence of refusing food, despite extreme hunger.
- A desire to exercise compulsively and obsessively and become preoccupied with preparation of food or making lists of good and bad food, counting calories etc.

The DSM-IV(1994) states that there are two subtypes based on the presence or absence of eating or purging during the episode of anorexia.

The *restricted type* loses weight due to excessive exercise and dieting or fasting. The *binge eating/purging type* purges with laxatives, self-induced vomiting, diuretics, etc. There are of course other possible associated features of anorexia. Such clients can manifest depressive symptoms, irritability, insomnia, and diminished interest in sex. They can demonstrate some obsessive-compulsive symptoms and become quite concerned about eating in public. They may demonstrate inflexible thinking, limited social spontaneity, and overly restricted emotional expression. Those with the binge eating purging type characteristics may also be more inclined to have other impulse control problems like alcohol abuse etc.

Bulimia Nervosa.

What differentiates people with bulimia nervosa from the anorexic with binge eating/purging type is the former usually manages to maintain body weight at or above the minimally normal level.

Binge eating usually refers to eating much more than normal in a specific time period, e.g. 2 hours. And the binge eating usually occurs in secrecy or as inconspicuously as possible. An episode may or may not be planned in advance and is usually but not always characterized by rapid consumption. The binge eating often continues until the person is very uncomfortable or in pain. An episode is accompanied by a sense of lack of control. This may refer to the starting of eating or to the loss of being able to stop. Recurrent use of inappropriate compensatory behaviors, e.g. induction of vomiting, misuse of laxatives, and diuretics is also used to prevent weight gain. Episodes may be followed by a day of dieting or excessive exercise. Self-esteem is closely related to weight and body shape. The binge eating and inappropriate compensatory behaviors occur on average at least twice a week for 3 months. Subtypes are *purging* and *non purging*.

As with anorexia there are associated symptoms. This condition is often related to mood disorders.

What Causes an Eating Disorder?

Much controversy surrounds this question. Forman, (2004) suggests that *certain environmental and personality variables lay the foundation for the development of an eating disorder well before the disturbed eating becomes apparent.*' and that *'Briefly an eating disorder is thought to be caused by a complex interplay of sociocultural, environmental and individual factors. (Thompson 1996) Issues such as the central role of beauty in femininity, the media's emphasis on appearance, physical changes during the lifespan and personality traits such as perfectionism, and anxiety avoidance and the strong need to please, have all been implicated in the development of eating disorders.(Striegel, Moore and Marcus, 1995) '*

This same publication suggests that age is not so significant in that not only teenagers but also middle-aged women develop eating disorders. More recently, there are publications suggesting that such disorders are developing more with boys and men as well.

The particular manifestation of an eating disorder and its recovery will largely be determined by factors such as development and character structure. Nevertheless some factors that appear to be common in the manifestation of most eating disorders are:

- Absent, inadequate or inaccurate mirroring of self. This includes body sensations, affects, physical appearance and distorted perception of body image.
- Difficulty connecting to and expressing emotions. Especially if judged inappropriate by external people or circumstances and inappropriate or inadequate emotional, physical and psychological boundaries.
- Focusing on external rather than internal messages about self.
- An inability to stay with your experiences and learn what these are about.

All of the above factors have social consequences. They are many and varied but often include:

- Difficulties with activities involving food
- Loneliness
- Controlling behavior
- Deceptive behaviors often stimulated by food related activities
- Fear of disapproval if illness becomes known
- Mood swings. Emotional outbursts or depression

How Might Working from a Body Perspective Assist with the Treatment of Eating Disorders?

As with all clients, not all eating disorder clients have had the same personal history. There will be a wide variation in how this issue is manifested in their relationship with their physical body in terms of its structure, and also in terms of the energetic process.

Two theoretical aspects of bodywork that I have found particularly useful in both diagnosing the starting point of work and in developing some long term therapeutic plan of action are the concepts of embodiment, and pulsation.

Embodiment

When I began work as a client of body centered therapy, there was little discussion of clients being embodied. This is a concept that developed more with the emphasis on trauma work. Basically the trauma work emphasized that just because we are walking around in a body, the assumption cannot be made that we are connected to or 'in' our bodies. Many people in fact, do not really inhabit their bodies. This may develop for a variety of reasons, often not directly related to food. For example, the person may have a history of abuse or trauma. To survive, they withdrew consciousness from their physical body and this protected them from experiencing the physical and emotional pain of what was happening

to them. Or as in the case cited below, parents may have had high expectations regarding their child's appearance and when the child realized that she would not fit this requirement and all that this entailed, she chose to disconnect from her body.

Catherine is a professional woman. She is 5'2" and weighs around 120 kgs. She came to see me because her weight was beginning to create medical problems. She was finding it increasingly difficult to walk as the stress of bearing her weight was wearing out her kneecaps. Her doctors had warned her that if she didn't start to lose weight she would end up in a wheel chair. Catherine lives a very active life and didn't want this restriction to her mobility. Nevertheless, she found it impossible to lose any weight.

In one of her very early sessions, I decided to explore the idea of whether she had much sense of inhabiting her body. I had her state out loud what parts of her body she was aware of as she sat in a chair. This was limited to her forehead where she experienced some pressure. I suggested that she touch her arms with her hands to explore if this increased her awareness. She reported that she couldn't feel her hands touching her skin. We experimented with her touching with more pressure and she could finally feel something. She then looked disdainfully at her arms and said 'I feel that they don't belong to me.' I asked her what she meant. She said it was like they were dangling in outer space and had no relationship with her whatsoever. As we worked with this dissociation in later sessions she reported that she didn't want her arms to belong to her. She didn't want to have the body she has. Her mother wanted her to be tall and slim, a ballerina and if she were tall and slim her father would love her. She couldn't have that body so she was not going to accept or inhabit this one.

What had alerted me to the possibility that Catherine was not 'in' her body was the fixed expression in her eyes as she talked to me and the lack of modulation in her speech. Of course there are many other indicators of this. Such as:

- Spacing out in the eyes
- A deadpan face
- Restricted breathing
- Few spontaneous movements
- Lack of tone in the body or a brittle tension
- Coldness in the periphery of the body like the hands, arms, legs and feet
- Very little color in the skin

Most of Catherine's work so far has focused on helping her to slowly 'inhabit' this body and to deal with her anger and dismay that this is the body she has. Even if she loses a lot of weight, she will still be 5'2" and small and probably somewhat round.

The Pulsation Cycle

A client may be 'in' their body, but still have ways of limiting their inner energetic experience of their body or of its energetic expression in the world. In Radix, we refer to this as the client's characteristic pulsatory style.

Radix work, like most neo - Reichian approaches, adopted Reich's (1945/1972) concept of a life force that flows longitudinally through the body. Dr. Charles Kelley, (1975) the founder of Radix work, chose to call this force which unites body, mind and spirit, the radix, meaning in Latin root or source. The flow of the radix has two strokes, the instroke which relates to our inner contact with ourselves and the outstroke, which relates to our contact with the world around us.

In Radix work, practitioners and clients are taught to observe and work with the pulsation or rhythm of the radix in different segments of the body and in the body as a whole in any moment of time. The aim is to enhance the balance between these two strokes of flow so that we can have both deep contact with our inner being, our emotions, dreams, fantasies, visions, and spirit - through the instroke; and have a way of expressing these in the world – via the outstroke.

When the focus is on the instroke, charging can gradually occur. This is experienced as a deepening of excitement or hunger or anger or love. It also results in a tension building in the physical body, in the musculature and in the inner organs. To experience our bodies, we need a certain amount of this tension. It is what enables us to do tasks and to experience the boundaries of our bodies.

Smith (1985) expresses the effect of building a charge in slightly different language:

"A convenient starting point in the contact withdrawal cycle is the person's want. The want may be a need or a preference. Needs are those things necessary for survival.

This includes receptive needs such as certain nutrients, water, air, heat, love, cognitive stimulation, and aesthetic expression. ..."

Ideally, at all times our bodies and parts of our bodies are pulsating freely. Moving from instroke to outstroke in a relaxed and regular way. Neither stroke dominates. Our awareness swings from inner contact and awareness to outer worldly contact and back again. All with a quality of aliveness or vitality.

"When a want arises, a state of physiological arousal follows. This arousal is a state of tension and excitement. The organism has become physiologically mobilized to a state of higher energy. This heightened energy state that results from arousal is differentiated and subjectively experienced as an emotion. Emotion, also termed 'feeling' or 'affect' is subjective experience of the flow of energy in the body. The emotion in turn implies and calls for an action or movement of the flowing energy into the musculoskeletal system. Action is concrete movement of parts of the body or even the whole body. Action implies and calls for interaction with someone or something in the environment. Interaction occurs at the 'contact boundary' between organism and the world. The final stage of the contact episode is satisfaction of the want"

In my observation of clients with eating disorders I have noticed that they often

have quite ritualistic and subtle ways of disturbing this balance. Sometimes the disturbance is in the instroke phase where they limit their awareness of their body or their feelings, sensations, or emotions, by reducing the charge or energy available. At other times, they allow this inner contact to exist and to build but they reduce it by limiting the expression of these desires, impulses, feelings, and emotions, particularly in relationships.

Within both of these cycles of the pulsation, the instroke and the outstroke, there are many subtle unconscious ways to limit the energetic connection. Each requires a different way of working with the client and their relationship with their body. All may effect how an eating disorder is manifested. These will now be presented as phases of the pulsatory cycle.

Phases of the Pulsatory Cycle

- Limiting the Instroke to a very Low Level.

Some clients are able to 'be' in their body. They know where their body starts and where the body of another starts, they can sense their arms and legs without having to touch them or see them etc. However, they don't like connecting to the impulses of their body so they unconsciously limit the instroke of a pulsation to a very low level. This refers to 'taking in' anything, the intake of breath, the intake of food or the intake of touch for example. Sometimes this may mean they feel a *twinge* of anxiety or loneliness or anger or sadness. For some reason the experience or expression of these feelings weren't supported in their development or caused them difficulties so they would rather pretend they are not there. They might also feel a *twinge* of hunger, but for a variety of other reasons they want to convince themselves that they don't need anything so this is something to block out as well. So they starve themselves or they deaden their bodies by overeating. Either way, they find that they disconnect very quickly from any impulse that arises. The charge that is built by taking in is kept very low thus reducing the awareness.

The work for them is to learn to slowly tolerate higher levels of energetic charge in their body without cutting off and dissociating.

Mary was anorexic and in strong denial of this. She was convinced that she had no problem even though she was a walking skeleton. She came to see me at the request of her mother. When she lay on the mat, she found it very difficult to inhale or to take in any touch. She would make eye contact but stare, keeping me or anyone else out. She was intensely afraid of gaining weight. Over time, Mary began to realize that if she breathed in more in sessions, she would start to feel sensations in her body and especially emotion.

Mary and her mother had a very symbiotic relationship. Mary was aware of this but didn't know how to free herself from this without feeling terrified that her mother would abandon her. So she was particularly distressed when she experienced negative emotions towards her mother. By starving herself she reduced the likelihood of connecting to these conflicting emotions and then feeling weak and hungry. The only way she knew how to prevent this was to reduce her instroke on all activities.

When she lapsed and ate or breathed too deeply she had to rush out and compulsively exercise.

• **Leaking the Instroke**

Others clients allow themselves to feel a hunger pang or a flicker of sadness but they don't stay with it very long and in very subtle ways they leak it off so that it can't build. With Eating Disorder clients this may manifest with them eating some food, not necessarily a lot and then frantically exercising like Mary. They then may feel exhausted but not the hunger or the sadness or the desire for contact. Or they may crave attention or touch and as you are giving them this, they find ways to convince themselves with their thinking that you don't mean it or it is not genuine. This then interferes with containing the contact or the food that has been consumed. Their unconscious obsession is to leak off the energetic charge when it starts to build.

To achieve this, the client needs to experience their physical and energetic body as a container. Clients struggling with this aspect of the pulsation cycle often report little sense of where their body ends and another starts. Work here involves teaching them how to contain the charge when it builds and to work with the anxiety that arises when they do. To experience their bodies as a safe container. When you experience your body as a safe container of experience it is also possible to self soothe. To take in what nourishment has been given to you and to use it at a later date to give yourself comfort.

Esplen et al (1999) explored this dynamic with a group of bulimic women finding that their inability to self soothe deeply intensified their sense of aloneness. One might speculate that this led to more over eating.

When Elizabeth ate more food or took time to rest and therefore charge, she felt enormous anxiety. She would connect with her anger and would fear lashing out at her mother. At these times, she would rush out and compulsively exercise to a point of exhaustion.

In contrast, Joan was bulimic. Over many years she had gained a lot of weight. She reported that every time she began to lose weight, she felt more energetically alive and was able to connect to the aliveness of her body especially her strong sexual feelings. This would terrify her and so she would put on weight again. She had no sense of her body as a container for these feelings. At my suggestion she started to wear a tight leotard under her flowing clothes. She reported that this helped her 'feel' her body boundaries and gave her confidence that her sexuality wouldn't leak out inappropriately. She has a sense of where her body began and ended. She felt contained.

• **Resisting Deepening the Instroke**

Some clients have no problem with staying with the impulse and even containing it but they won't let it deepen. They won't let themselves connect with how really angry they feel, how really hungry they are or how very tired. They distract

themselves with some other activity, emotional, behavioral or cognitive. For example a client may eat a cream bun and begin to feel full and even contented at eating something 'forbidden'

Then they begin to berate themselves incessantly or they act out emotionally. Again resisting the inner feeling of satisfaction of the instroke act. With these clients, the challenge is to assist them to deepen the instroke, across all segments of the body and to trust that they can handle the consequences of a deeper connection with themselves.

Anne reported that even when she ate good healthy meals she couldn't eat the meal without spending hours later, counting and recounting the calories she had eaten. She was confused by the fact that rather than help her, this process increased her anxiety levels.

In this instance, Anne could let in the charge from eating food but she restricted it deepening by isolating her charge to one segment of her body, her head. Anxiety is often related to not being grounded in the body. In Radix, we think of our legs, feet, arms, hands, and eyes as the grounding or reality aspects of our functioning. The drawing of most of her energy to her head, ungrounded her legs and feet and the withdrawal into the compulsive calorie counting ungrounded her eyes. She lost contact with reality. It is not surprising that her experience then became one of increased anxiety.

• **Holding Back the Expression of the Outstroke**

Then of course there are others who will let themselves build a deep connection with their inner feelings, sensations, desires but they won't show these to anyone or express them even if alone. They let themselves feel the impulse or want and they let it deepen but the battle is in not succumbing to the problem by expressing the desire.

These are the people who seem very over controlled. They are starving and they know it but they won't eat. It is also probably this category of client that is being referred to by Shipton, (1999) in his consideration of anorexic space. In his paper he proposes the idea that anorexia is a defense against the consuming desire for the object.

Marjorie reported that when she would go out with her close friends, she would be starving but there is no way she would show this. In fact she would actively and consciously hide her desire for food. Whilst her friends would eat a hearty meal or indulge in some 'bad' food she would only drink a strong cup of black coffee. She shared that she viewed this as an example of her extraordinary self-discipline.

Here the work is on the encouraging the outstroke. Helping the client express themselves and learning that nothing bad happens when they do. Or at least that they have the resources to stand up for themselves if necessary. Marjorie's work began when we focused on her resistance to reaching out with her arms to

express her desires.

- **Expressing the Outstroke in Isolation**

Some clients allow themselves to express their needs but only in isolation, not in the presence of others. So for example, they may binge eat, get really angry in their room or sob quietly into their pillow but they won't do this in the company of anyone else.

The closet binger fits this picture, as do many anorexics. Geller, J. et al, (2000) refer to this dynamic in their research with anorexics where they found anorexics to have significantly higher scores on anger repression and silence of self than a control group of normals and a psychiatric group when matched for age and after controlling for depression, self esteem and global assessment of functioning.

Terry had a severe case of anorexia. She refused to eat during the day or would eat minimal amounts of food. She lived in shared housing but was always being evicted by her housemates because at night she would raid their cupboards and eat all their food. Out of guilt she would then vomit it all up. The next morning she would deny having eaten the food. She was a student and couldn't afford to buy replacement food so her housemates would evict her.

The challenge here is to gently encourage the expression of wants and desires in relationship.

- **Blocking the Satisfaction**

In Radix theory, this aspect of the cycle is not overtly discussed or elaborated but it seems an important one, especially for clients with eating issues. Smith(1985), refers to it as an essential aspect of his Energetic Contact / Withdrawal Cycle. The satisfaction occurs when one feels an impulse, contains it within your body, and lets the intensity build to the point of action or expression. After such a profound sense of satisfaction there is a natural let down or withdrawal period. I suspect some over eaters have something happening at this point of the cycle. They can take in the food and they often can show the rest of the world that they like food by eating publicly and expressing their enjoyment about what they are eating but they block letting in the inner satisfaction of what was just eaten. They can't savor it.

Each aspect of this pulsation cycle is significant and interdependent. Clients will move around in terms of which needs focus when. However, as a general rule of thumb, the steps from being embodied to beginning to connect to an impulse, to toleration of it right to letting in the satisfaction are to some extent cumulative and the success of the later aspects of the cycle require the full expression of the others preceding it.

As Smith(1985) expresses,

"If a given step is not allowed to develop in full form, the proceeding steps will be less well formed and the ultimate satisfaction will be diminished or missed completely...As long as these contact/withdrawal cycles emerge and recede smoothly, there is a state of psychobiological health. "

Segmental Pulsation.

Wilhelm Reich (1945/1972) proposed that the body could be divided segments: the ocular, the oral, the thoracic, the diaphragmatic, the abdominal and the pelvic. Each of these segments are functionally discrete from each other in that it is possible for example, to simultaneously experience or express a different emotion in each of these segments.

Apart from disturbances in the overall pulsatory cycle of clients described above, the absence of a pulsatory flow in specific segments of the body may also contribute to some of the specific symptoms associated with Eating Disorders.

The tendency for anorexics to exhibit a significant disturbance in the perception of body shape and size may be a reflection of a blocked ocular segment pulsation. Either the client looks at themselves in the mirror with a fixed gaze of staring or spacing out, which isn't really seeing, or they focus only one aspect of the body, like the waist and fail to see how this relates to the rest of their body.

Conclusion

Radix work is process oriented rather than problem based. Nevertheless observing the signs of embodiment and listening to the story of a client at intake so as to identify their energetic pulsatory style can greatly assist any work with eating disorders. The actual issue with food may never be directly addressed but if the therapist identifies the energetic pulsation associated with how this eating issue is being manifested it is possible that some healing can occur. Becoming familiar with the different stages of the pulsatory cycle can greatly assist therapeutic decisions made about the kind of bodywork you may engage with even if you never directly address the eating issue.

References

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. Washington DC, American Psychiatric Association 1994

Esplen, M., Garfinkel, P., Gallop, R. Relationship between self soothing, aloneness and evocative memory in bulimia nervosa. International Journal of Eating Disorders. Vol 27, Issue 1. pp 96 -100

Forman, M A Descriptive Overview of Middle Aged Women with Eating Disorders in Perspective. A Professional Journal of the Renfrew Centre Foundation. Summer 2004

Geller, J., Cockell, S., Hewitt, P., Goldner, E., Flett, G., Inhibited expression of negative emotions and interpersonal orientation in anorexia nervosa.

International Journal of Eating Disorders. Vol 28. Issue 1 pp 8 -19

Kelley, C. R. (1975) Pulsation, Charge and Discharge Part of the Radix Teacher Training Materials. National Mental Health Publications. 2000.

www.health.gov.au/hsdd/mentalhe

Reich, W. (1945/1972) Character Analysis, Third Enlarged Edition. New York: USA: Touchstone Books.

Shipton, G. Anorexic Space. Journal of Community and Applied Social Psychology. Vol 9, Issue 6, pp 435 - 448

Smith, E. The Body in Psychotherapy Mac Farland and Co 1985 pp 30

Narelle McKenzie is the Director of the Australian Radix Training Centre. She has been in private practice in Adelaide, South Australia for over twenty years. She is a registered psychologist and has a Masters degree in Developmental Psychology. Narelle enjoys combining her body psychotherapy training and experience with more traditional psychotherapy in her work with adults, children, couples and families.

She can be contacted by email at: narellemckenzie@internode.on.net