The Hungry Feminine and a Patriarchal Gag Order:
Binge Eating in American Women

by
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I certify that I have read this paper and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a product for the degree of Master of Arts in Counseling Psychology.

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Abstract

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This thesis explores the relationships between American women and food, and how those relationships are influenced by a culture that fetishizes food, celebrates consumption, and shames bodies. What is it about food, and the physical consequences of too much of it, especially pertaining to women, that turns away even the most skilled at empathy and understanding? With specific attention to binge eating disorder, this inquiry examines early attachment relationships as they impact addiction, archetypal functions of overconsuming food, the role of the repressed feminine, and cultural governance of the female body in America. The clinical implications of these factors for the treatment of binge eating are presented. Using alchemical hermeneutic and heuristic methodologies, the author builds upon the findings of psychologists and mythologists and presents her personal stories and perspectives as a therapist, therapy client, and woman with binge eating disorder.

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A snapshot of this moment in time captures the truly lovely people that surround me near and far. I am thankful for my Wild Boars, Brayer Garden's wild inhabitants, Pacifica faculty, my therapist, dear friends, and family from coast to coast for lending their support to this meaningful project.

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Dedication

To Marion Woodman, for being a brilliant and tender voice for the unheard outcasts, and for gifting me something I didn't know I was allowed to have.

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Chapter I
Introduction

Area of Interest

This thesis considers the relationships between American women and food, and how those relationships are influenced by a culture that fetishizes food, celebrates consumption, and shames bodies. In addition to the ways in which social body standards impact treatment, my research explores the archetypal hunger of binge eating disorder in women. This focus pertains to images and motifs that are universal to the experience of being human and are inherited as part of the collective layer of the unconscious (Jung, 1954/1959a, p. 5). In addition to exploring those items through a perspective specific to women with binge eating disorder, this thesis increases illumination on elements that are generally unconscious within American culture to discover why the fetishizing of food, celebrating of consumption, and shaming of bodies amount to competing ideologies—and how deeply buried that conflict is in the collective unconscious.

Through the lens of my personal and professional experiences, I have observed that, in discussions of eating disorders, common associations are anorexia and bulimia, often with little inclusion of binge eating disorder. Likewise, binge eating disorder struggles to fit neatly under the umbrella of addiction, where discourse and exposure are also comparatively limited when measured against drugs, alcohol, and behavioral addictions. I loosely hypothesize that the silence around binge eating disorder may speak

to how the competing ideologies of consumption versus body shaming live in the culture's shadow. However, other factors are likely at play, as well.

Guiding Purpose

My interest in this topic began within, where I discovered my own maladaptive relationship with food and became curious about the ways in which that relationship has both served and stunted me throughout my development. With seemingly limited literature and dialogue available, I began wandering alone down the path to unwrapping the function of my binge eating. My path included accepting it as a once-needed survival mechanism, understanding its pure desire to protect me, and realizing how autonomous and powerful the function became. I also realized that this same protective mechanism ultimately outgrew its purpose of protection, becoming a well intentioned but overbearing obstacle.

As I began exploring those notions, it was a natural progression to compare binge eating disorder to other eating disorders and addictions. Later in Chapter I, I discuss the ethical considerations involved with using the term *addiction* as a broader definition of binge eating disorder. In Chapter II, I survey the literature on eating disorders and addictions to break down in detail the ways in which they are both similar and different, and why that matters for the sake of this thesis. For now, on a personal level, drawing these comparisons helps me value what each of those communities of addicts and compulsives share: the life conditions and human emotions that inspire or require a person to seek external substances or behaviors to quell internal pain. Whether it is the high of a drug, the low of alcohol, the dominance of sex, the protective walls of clutter, the approval of technology, the distraction of material consumption, the fulfillment of

food binging, the penance of starvation, or the exorcism of purging, most addictive behaviors are created from the same selection of ingredients: depression, anxiety, fear, shame, loss, abuse, trauma, unhealthy attachments, and an inability to be with oneself in one's own skin (Martin, 1990).

Understanding the universalities of addiction supported my protracted personal challenge of forgiving myself for the unconscious need to seek love and acceptance from food, an experience I share more thoroughly in Chapter III. To continue adding color to the developing image of my defenses, I began growing curious about the ways in which those individual communities of addicts and compulsives are *different*. In the realm of food, how do the functions of binging, purging, and restricting differ, and in a broader realm, how does reliance on food differ from a reliance on drugs or alcohol? Two observations came to light during my personal exploration of these differences.

The first is of temptation and obstacles to abstinence. In America, it is not uncommon to see billboards and commercials of bacon-wrapped, supersized meals or social media "foodies" sharing images of complex meals oozing with creativity and calories. It is my observation that culturally, we as Americans honor the way food comforts us through the bad times and helps us celebrate the good; social events revolve around food, we feel nurtured by home-cooked meals, offerings of food are anticipated signs of care, radiating with feelings of comfort and safety. As a basic need, nourishment is one of the first ways a human being is cared for. Food is not only woven into American culture but is also a primitive survival need, thus adding a layer of complexity to treatment for binge eating disorder. Many recovery programs for substance abuse take an approach of abstinence, but one can imagine that abstaining from food might be a bit

challenging. To illustrate this challenge, I turn to eating disorder specialists Margo Maine and Joey Kelly (2016), who shared a client's experience of the emotional, social, and cultural influences on disordered eating in women. This client shared her struggle with bulimia as it paralleled her husband's recovery from alcoholism:

> But he won't starve if he never goes back to booze. I will starve if I never go back to food. I think of it like this: he can keep his tiger locked up, and choose not to think about it today. I, on the other hand, have to take my tiger out of the cage for a walk three times a day. (As cited in Maine & Kelly, 2016, p. 86)

Recovering from an addiction to food comes with a constant barrage of engagement with hunger, mealtime decisions about what to eat and how much, temptations in plain sight, and battling the unconscious cries for more several times each day. Behavioral scientist Brian Wansink and sociologist Jeffery Sobal (2007) conducted a series of studies through a Cornell University program that, with the help of 139 participants (75% female), examined how many food-related decisions the average person makes on a daily basis. Accounting for snacks, beverages, and meals, the studies showed that the average person makes more than 200 choices each day about food, including when and where to eat, when to start cooking, who to eat with, and when to stop eating. People who struggle with food addiction are not only taking the tiger for a walk three times a day, they are also spending much more time inundated with internal questions about how to prepare for the obligatory cage-opening.

The second insight I had was about body expectations. Although binge eating disorder is not limited to obese individuals or those who are overweight, the disorder is most prevalent among groups who seek treatment primarily to lose weight (Zwaan, 2001). High-functioning food addicts—that is, individuals whose binge eating disorder does not impede on their basic ability to maintain employment, relationships, and daily

function—still experience judgments built into the social values and limitations of American culture, despite their disorder having a limited impact on the way they engage in the logistics of modern life. Jungian analyst Marion Woodman (1980) pointed to shame as one emotional consequence of the possible visibility of binge eating disorder. She wrote, "The fat woman is ashamed to walk around 'with her neurosis hanging out'" (p. 7). American culture imposes expectations on how women are "supposed" to look, and those negative external perceptions more often than not hurt the binger and her recovery. The cultural bylaws on women's looks contribute to my reasoning for focusing solely on women for the sake of this thesis.

According to psychologist Grant Martin (1990), a fundamental component of all eating disorders is deception:

> The person with an eating disorder will go to great lengths to hide his behavior. Secrecy and deception are done to prevent his out-of-control behavior from being known. He will eat in private, binge at night, pretend to eat when he does not, steal food, use laxatives, or throw up when no one else is around. (p. 94)

And yet, despite their best efforts, bingers' weight may expose those secrets against their will, perpetuating a cycle of shame. Other addictions are also subject to social influence; however, understanding the unique experience of a binge eater in a food-obsessed, body-shaming culture is an important consideration in this thesis.

Rationale

This topic warrants exploration due to its increasingly prevalent nature. According to Lynn Grefe (2015), president and CEO of the National Eating Disorders Association, a 2015 national study revealed binge eating disorder to be more prevalent among Americans than bulimia and anorexia combined. Despite binge eating disorder

impacting an estimated 2.8 million adults in the U.S., bulimia and anorexia are included in more discussions (para. 1).

My clinical rationale for sharing these perspectives has been influenced by my experiences as a student, a therapy client, and a woman with binge eating disorder. In a practicum group supervision session, I witnessed the incongruence of a seasoned clinical supervisor speaking with empathy and compassion for a client addicted to heroin, only to then use the word "stupid" to describe a female diabetic client who struggled to break her compulsion of habitually drinking cola. In his book, *Love's Executioner*, psychiatrist Irvin Yalom (2012) spoke of his client Betty, an obese woman who disgusted him in part because she tainted his view of what women are supposed to look like as objects of his desire or amusement. As a client, my therapists have often hesitated to engage in discussion about my personal issues with food and body image, often appearing to pause while searching for language that I will not perceive as offensive. These may be a few minor anecdotes, but through the lens of someone with binge eating disorder, they are examples of a larger picture. What is it about food and the physical consequences of too much of it, especially pertaining to women, that turn away even the most skilled at empathy and understanding?

Whether it is the ignorance about the chemical impacts and addictive qualities of caffeine and sugar, the lack of education concerning acute medical issues that can arise from bingeing, or the expectations within American culture about women and body size, these anecdotes revealed to me that unconscious cultural biases potentially overreach into the field of psychology. Although Woodman (1980,1985) has done well to present her discovery of archetypal patterns connecting binge eaters and food, binge eating disorder

is not given the full range of study it demands. Through an exploration of depth psychological understanding of bingeing, information on body image in American culture, and my personal experiences with depth-based clinical treatments, this thesis aims to expand awareness of the need to include binge eating disorder and an understanding of its cultural and archetypal influences into psychological discussions. I have personally experienced too many instances in which judgment, shaming, and lack of empathy toward binge eaters were the acceptable social norms. Because binge eating disorder is often a disorder that results in physical attributes deemed less valuable in our society, perhaps compassion and empathy are partial remedies, and they should begin in therapy. Compassion and empathy are born through storytelling (Morales, 1998); but unless a client and her tale are approached with respect within a safe, nonjudgmental therapeutic relationship, shame may prevent the expression of story and compassion. This thesis contributes to the deeper cultural and self-awareness therapists need to effectively treat this disorder.

Methodology

This thesis explores the relationships between American women and food, and how those relationships are influenced by a culture that is incongruent in its celebration of food and disapproval of overweight women. The two-part question that guided my research is: What is the archetypal function of binge eating disorder for women, and what influence, if any, do American expectations of the female body exert on that function?

At the conceptualization of this thesis project, I defined its methodology as heuristic: I was personally called to the topic, I have considered my personal experiences as data, and I have attempted to maintain self-objectivity, which is to say I acted as both

the participant and the researcher (Pacifica Graduate Institute, 2014, p. 53). As the thesis project continued, however, it became apparent that the process was also alchemical.

> When the researcher allows himself or herself to let go of the work, he or she is making a space that can be a place for playing with the possibilities of the work, that is, with the aspects of the work of which he or she is ignorant. The researcher willingly surrenders in such moments to the question, "What is this work really about?" In this spirit of play, the researcher engages the unfinished business in the work. From within that question, the potential space of the transference is made into a ritual place of play in which the ego not only temporarily steps aside, but also is temporarily put aside as one becomes more at home in this place. In this ritual place of play, the researcher steps out of his or her ego position in relation to the work and steps with it into an imaginal landscape, which is neither the world of nocturnal dreaming, or the world of focused daytime wakefulness. The transference dialogues, which are modeled on Jung's notion of active imagination, are an invitation to play in this imaginal landscape. (Romanyshyn, 2007, p. 137)

In the spirit of play and allowing the alchemical forces to fill in this puzzle, I introduce visiting images, share my therapy work, and offer my personal reflections throughout. As Romanyshyn (2007) pointed out, it is in the surrendering of ego that one can become enlightened about that which was previously in the dark. This spirit of play, allowance of alchemical movement, and journey into the imagination create the opportunity for truths to be revealed; thus, I include alchemical hermeneutic methodology.

Ethical Considerations

There were many ethical considerations to take into account as I fell into this inquiry. To begin, I held carefully the importance of the term *addiction*, honoring that certain substance addictions alter states of consciousness, foster chemical dependency, and present acute threats to the physical human body that may be present in food addiction to a lesser degree. I sparingly use the term *addict* in relation to food throughout this thesis, and, where I do, I do so with intent. I spend much of the literature review in

Chapter II exploring the ways in which it may be beneficial for clinicians and clients alike to see similarities between substance and behavioral addictions, which I believe can remove various stigmas, feelings of exclusion, and general barriers to a greater understanding of related behaviors.

It must be noted that I am essentially excluding half the population by focusing this exploration on women and their relationships with food. It is important to call attention to this distinction and note that men do, indeed, experience binge eating disorder. As Woodman (1980) discovered through a series of studies, the motivating factors behind the male relationship with binge eating are consistently different than those of women, warranting their own study. The specific demands American culture places on women's bodies provide a clue to our culture's collective shadow; this thesis focuses particularly on what women's challenges reveal about that shadow.

This thesis is comprised of personal observations made through my cultural lens, focusing more on qualitative research in the field of depth psychology rather than on a quantitative study of prevalence and treatment efficacy. Although different cultures' relationships with food and expressions of eating disorders are considered, the primary focus of this thesis rests on the American relationship between food and body. This inevitably excludes other types of populations that experience binge eating disorder, which is not the intent of the author but rather a consequence of page count.

It is imperative that I maintain my own personal boundaries as I nosedive into a topic that has affected me personally for nearly all my life. I must stay engaged in my own personal therapy and balance my academic exploration with self-care to avoid acute triggering of developmental trauma and embodied anxiety. Additionally, it is important

for me to consider the confidentiality of those included as my personal anecdotal evidence, to ensure that their privacy remains intact while still allowing those stories to add new layers of insight to this project. To accomplish this, I have omitted names and other identifying information.

Overview of Thesis

As I continue the study of individual and collective relationships with food and body image, Chapter II offers a survey of literature assessing the published perspectives on eating disorders, addiction, and attachment, and a history of food consumption. This literature includes the observations and expertise of Jungian analysts, mythologists, clinical psychologists, addiction specialists, attachment specialists, and psychotherapists. This review includes possible archetypal expressions through food, the female body in American culture, and what might drive Americans' divided ideologies of food and body.

Chapter III integrates the literature's perspectives, my personal experiences, and suggestions for clinical implementation of depth treatment approaches. This chapter serves as a heuristic inquiry into my personal experiences with binge eating disorder and how prominent ideas in the field both support and challenge my experiences. This chapter includes an account of my therapy work utilizing active imagination techniques to access unconscious motivations of appetite.

Chapter IV discusses the limiting scope of this thesis, that is to say, the perspectives that were excluded for the sake of brevity. Chapter IV also includes additional questions that have arisen as a result of my research. Finally, Chapter IV connects the dots placed throughout the length of the thesis and summarizes the conclusions and clinical implications of this research.

Chapter II
Literature Review

Introduction

To begin shedding light on the present inquiry, this chapter reviews the literature on the perspectives and research established by psychology experts and mythologists. This chapter begins with an exploration of addiction theory, including how early relational attachments and unfulfilling relationships can influence the development of addiction (Flores, 2004; Martin, 1990), and an introduction to depth psychology as it encompasses archetypal structures that govern behavior (Jung, 1950/1959; Woodman, 1980,1985), the ultimate struggle between self and other (Hollis, 1998), and Western culture's misuse of metaphor (Woodman & Dickson, 1996). To add more depth, concepts of individuation are presented (Jung, 1950/1959), specifically touching upon the role of sexuality (Santana, 2017), and what sociological needs motivate the negative public opinion formed about addictions at large (Huxley, 1992). The discovery continues by examining how eating disorders function as addictions, and how they fulfill or defend individuals in relationship (Flores, 2004; Martin, 1990). Perspectives within the field of psychology on how a woman's relationship with food may be affected by body image and cultural expectations of her body are introduced (Woodman, 1980, 1985), as well as broader examination of humanity's relationship with food and body across generations and cultures (Campbell, 1988; Woodman, 1980, 1985). Finally, a psychoanalytic review of Freud's psychosexual stages of development is presented with an overview of how

oral over- or underwhelm in infancy can lead to disordered eating in adulthood (Barker, 2016; Sandler & Dare, 1970).

Addiction, Attachment, and Longing

It is important to begin with an understanding of how binge eating disorder is both different from and similar to other eating disorders, as well as how it compares to other types of addiction. Clinical psychologist Elizabeth Howell and psychology professor Sheldon Itzkowitz (2016) helped make those distinctions:

> The compulsions of bingeing and purging can be thought of as futile attempts to control bodily sensations—which are alternatively chaotic, overwhelming, shut down or numbed. Furthermore, we can also think of bulimia as an ineffective attempt to rid the body of something that is "not-body"; something that was forced onto or into the person's body. (p. 165)

Addiction and attachment theory expert Philip J. Flores (2004) also stated the importance of acknowledging the differences between types and degrees of addiction. Different forms of addictive behavior are attempts to fill differing archetypal needs; however, they all share common ground as a means of coping and a vehicle for escaping situations. Addicts, Flores noted, seek to escape "the uncertainty of human contact," which would require self-management of "the fears and difficulties stirred up with interpersonal relationships" (p. 1). Using attachment theory and self psychology as a lens for exploration, Flores connected all addictive behaviors to one common denominator, a struggle with relational attachment:

> Because of a person's difficulty maintaining emotional closeness with others, certain vulnerable individuals are more likely to substitute a vast array of obsessive-compulsive behaviors (e.g. sex, food, drugs, alcohol, work, gambling, computer games, etc.) that serve as a distraction from the gnawing emptiness and internal discomfort that threatens to overtake them. (p. 7)

Martin (1990) echoed the complexities of the *addict* term and advocated for its broader use in his book *When Good Things Become Addictions*. He said that addictive behavior "does not come in clearly marked gradations from safe to serious" and that regardless of its particular focus, "addiction means you are out of control" (p. 9). Martin addressed a wide range of compulsive behaviors, from viewing porn to eating too much chocolate, stating that the essential chemical, psychological, and social commonalities between all forms of habitual behaviors usher individuals into addiction once they have lost control over whether they start or stop. Addicts cannot stop, regardless of the related fallout:

> One of the key determinants in addiction is persistence. You continue with the behavior in spite of harmful consequences. However wonderful the feeling of the moment, the consequences of compulsive pleasure-seeking are often devastating and defeating. Yet, in spite of the cost, countless men and women have spent much of their lives in relentless pursuit of those transient moments of heavenly delight. (p. 10)

Martin (1990) expanded on the control addictions have over the sufferer, commenting on how, over time, addiction becomes a way of life, triggering unconscious reactions:

> Addiction seldom remains constant. As it changes, it usually takes more and more of a person's energy and resources, to the point that it can become destructive and even fatal. Addiction is a set of experiences that produces changes within the person. The addict, responding to these internal changes, will begin to act out in particular ways. (p. 10)

Martin allowed considerable space for the often-censored human nature in all people. Putting it simply, almost too obviously, he said people seek "things that are rewarding and positive, and we tend to avoid things which are negative and aversive. If it hurts, we try to stop the pain. If it feels good, we want to do it again" (p. 11).

Addiction and attachment. With the commonalities among addictive behaviors established, this review of literature now returns to Flores (2004) to begin to explore some of the psychodynamic patterns that may underlie any sort of addictive behavior and to examine what originally caused the establishment of those patterns. Although, according to Flores, all addictions display different unconscious needs, what the addictions share is that they are born out of relational wounding. Flores noted that the ability to have "intimate, long-lasting, gratifying relationships is established" (p. 7) in the early stages of development, and addictive compulsions may arise as compensation in the wake of a "relational deficiency" (p. 7). These deficiencies can take many forms, such as when a child's physical needs are not met by a caregiver, or in any relationship in which one is unable to trust, connect, or be vulnerable. As a dysfunctional attachment style is cultivated, the ability to feel satisfied from interpersonal relationships diminishes. "Experiences related to early developmental failures leave certain individuals with vulnerabilities that enhance addictive type behaviors and these behaviors are misguided attempts at self-repair" (p. 7).

Jungian analyst James Hollis (1998) also understood the importance of relationship to the developing self, looking beyond the development of relationships in childhood into that of prebirth. He suggested that humans are engaged in "the going home project" (p. 58), or the desire to return to the place where they felt the most powerful connection to the universe—the womb. The desire to return to the womb, he continued, "is deeply programmed in us from our traumatic onsets" (p. 58), the trauma being our expulsion from the womb into the external world. "But, as we see all around us, it remains the chief saboteur of intimate relationship. Thus, we are all caught between

the deeply programmed desire to fuse with the Other and the inner imperative to separate, to individuate" (p. 58).

According to Hollis (1998), every human being has a lived experience of being in the womb and being the universe, despite a lack of conscious memory of such. Hollis acknowledged that the loss of the Other can spark tremendous anxiety, and the inability to return home can cause a person to unsuccessfully seek Eden through relationships. When relationships become unhealthy, Eden is sought through substances and compulsive behaviors. Hollis noted that "all addictions are anxiety management techniques, seeking to lower the distress of disconnection through some actual or symbolic connection" (p. 27).

Hollis (1998) believed that the "lost paradise" that appears in the tribal memory of all peoples, past and present, is what humans seek on a consistent basis in relationships (p. 15). Hollis explained that this elusive place has great power, even though most people today do not have any conscious memory of the experience:

> Sometimes they characterized this catastrophe as a fall from grace, a separation or a disconnection. Sometimes the cause is rumored to be the result of some human transgression, sometimes due to the capriciousness of the gods. No one ever claims to personally remember this blessed place, but the ancestors, the ancient ones, the Anasazi, remembered. They, the storied ones, were there, in the blissful Garden, but we contemporary folk always experience ourselves outside, estranged, adrift. Perhaps this tribal memory is but the neurological hologram of our own birth trauma, a separation from which we never fully recover. (p. 15)

Although humans yearn to return to Eden, there is good news about this traumatic split. Hollis said, "Consciousness is achieved only through the loss of the Other, and the perception that the Other is truly Other" (p. 17). This understanding occurs in the early stages of life when one realizes that there is, in fact, separation between one and one's caregiver; this realization allows the mysterious Self to develop (p. 17). Hollis harkened

back to psychiatrist and psychoanalyst Carl G. Jung, capturing Jung's idea that consciousness comes at a cost: It is a "price paid in blood. Each day takes the child a step further from the memory of the Garden" (p. 17).

Addiction and longing. Hollis's idea of the struggle between returning home and separating in consciousness complemented Jung's (1950/1959) concept of *individuation*, which suggested that a further separation from one's caregiver was needed to find "inner transformation and rebirth into another being. This 'other being' is the other person in ourselves—that larger and greater personality maturing within us, whom we have already met as the inner friend of the soul" (pp. 130-131). Jung said that together with the inner self, a person is actually a pair of selves, "one of whom is mortal and the other immortal, and who, though always together, can never be made completely one" (p. 131). Although Jung deemed the inner self a friend, he remarked that this other being can be viewed as a foe by the fearful and defended ego, which he defined as the center of consciousness:

> The transformation processes [of individuation] strive to approximate [the mortal and immortal] to one another, but our consciousness is aware of resistances, because the other person seems strange and uncanny, and because we cannot get accustomed to the idea that we are not absolute master in our own house. We should prefer to be always "I" and nothing else. But we are confronted with that inner friend or foe, and whether he is our friend or our foe depends on ourselves. (p. 131)

Psychotherapist Edward Santana (2017) expanded upon Jung's concept of individuation by including sexual development as a crucial component:

> Individuation requires a dynamic engagement with what is least accessible, least adapted, and most foreign. What is wholeness without exploration of our erotic imaginings or without venturing into the unexplored areas of the psyche, our animal instincts, and our physical experiences? These elements are essential for individuation and wholeness, and cannot be ignored without risking a one-sided and isolated intellectual individuation safeguarded from certain contents. If we are left only to spiritualize and intellectualize erotic experiences, then we ignore what is primal and powerful within us; individuation becomes reduced to understanding

> and knowledge, rather than an open spirit of engagement that awakens the mind and the flesh. (p. 128)

Philosopher and novelist Aldous Huxley (1992) referred to drugs, alcohol, and other substances as “substitutes for liberation” (p. 125). Moreover, he claimed that in effort to “pass beyond the limits of that island universe, within which every individual finds himself confined” (p. 125), nearly the whole of humanity is craving self-transcendence as a means to intensify consciousness of being “what they have come to regard as ‘themselves’” (p. 125). Noting the desperation to transcend, Huxley added that individuals may also crave “the consciousness of being someone else” (p. 125). Huxley explained that *self-transcendence* is not the same as escaping physical or emotional pain, for even those who have “made an excellent adjustment to life” have the “urge to go beyond themselves” (p. 125). He claimed that one experiences a deep-rooted horror of one’s own selfhood, a passionate yearning to break free from the “repulsive little identity to which the very perfection of their ‘adjustment to life’ has condemned them,” as well as from the “damnation of their every day life” (pp. 125-126). The liberation one seeks is from one’s own “imprisoning ego” (p. 126). Crediting the hallucinogenic or stimulating effects of certain drugs, Huxley warned that these “toxic shortcuts to self-transcendence” could be used as “avenues of escape from the insulated self” and become their own worshipped gods (pp. 129-130).

Although Huxley (1992) focused primarily on the godliness that drugs and sex have become, his following observation on the function of judgment pertains to other acts of overconsumption, as well. He observed that those who seek substitutes for liberation face negative public opinion and financial discouragement, considering the high taxes on alcohol, the prohibition of narcotics, and the criminality of certain sexual acts. Huxley

argued that the "moralists and legislators" (p. 132) who shed a negative opinion on the addict are simply trying to maintain a communal status quo, avoiding the collective decrease in social energy and negative impact on military, economy, and political efficiency that could come from widespread habits of over-indulgence. Put simply, "Against its excesses, societies contrive, in one way or another, to protect themselves" (p. 132).

Universal aspects of addiction. Woodman made the label *addict* even more universal, examining the idea that compulsive external consumption may be a common defense against a fear of death, literal or metaphorical, keeping its inevitability split off from awareness (Dancingintheflames, 2010). In the documentary *Dancing in the Flames*, Woodman commented:

> I think we are acting like addicts. We have all this wonderful life but cannot believe we can lose it—that is too horrible a thought. So the fear is expressed in adding more and more stuff, stealing more and more from the earth, and acting more and more irresponsible. Just irresponsible. And even angry. (Dancingintheflames, 2010, 0:05)

Woodman and Jungian therapist Elinor Dickson (1996) also claimed that current Western civilization does not understand metaphor, and thus, that which should not be literalized often is. Woodman and Dickson expanded on how people may kill the images psyche offers them via dreams by taking them at face value:

> What is the difference between embodying image and concretizing it? To concretize a metaphor is to literalize and kill it. For example, a woman dreams of making love to her neighbor. If she literalizes the metaphor, she may joyously assume the unconscious wants her to have an affair. She is probably wrong. The dream process is a soul journey, in which all parts of the dream are part of the dreamer. The dream is showing the woman a part of her own masculinity with which she needs to unite. (p. 192)

From Woodman and Dickson's (1996) Jungian perspective, the ego, as the center of consciousness, needs a relationship with something greater and ego-transcendent to compensate for its fear of death. This need for that which is other, is concretized to the object of one's addiction. This confuses people to not know what is going on: There is a need for the transcendent,

> except that God doesn't matter anymore, ritual doesn't matter. But the god they didn't find in the church or in the woods or in wherever, they're finding in the bottle. And the union that they don't find in making love, they find through another kind of sexuality. But the union that they yearn for, that total coming together, they can't find. Because they concretized the concept and it kills them. (Dancingintheflames, 2010, 0:54)

Eating Disorders: Gender Dominance and Body Image

Woodman (1980) probed deeper into addictions and analyzed them from a food-specific perspective, exercising a compassionate and thoughtful approach in applying Jungian analysis to explore the ways in which pervasive eating disorders impact women in a male-dominated society. Beginning with that broader scope of gender dominance and body image, Woodman said of *every* woman who has struggled with her mirrored reflection that "the split between her head and her body is destroying her life and she is powerless to break the spell" (p. 9). Woodman suggested that 20th-century women already have a long, tenured history, passed on from generation to generation, of living in a culture oriented to men. In such a climate, women have been kept unconscious of their own feminine principle:

> Now in their attempt to find their own place in a masculine world, they have unknowingly accepted male values—goal-oriented lives, compulsive divineness, and concrete bread which fails to nourish their feminine mystery. Their unconscious femininity rebels and manifests in some somatic form. In this study, the Great Goddess either materializes in the obese or devours the anorexic. Her victim must come to grips with her femininity by dealing with the symptom. Only

> by discovering and loving the goddess lost within her own rejected body can a woman hear her own authentic voice. (pp. 9-10)

Woodman emphasized Western culture's deep roots in the mother archetype, a mythological integration through symptomology, and how views of obesity have evolved over time—a cultural history overviewed later in this chapter.

In her work with women consumed by food and a negative body image, Woodman (1980) observed that a food complex could hold a tyrannical power over an individual, with food becoming the focus for depression, repressed anger, anxiety, and repressed sexuality. She discovered that food "becomes a means of attempting to control one's fate, of expressing defiance of another's control, defiance of the law and social customs, or even defying nature and God" (p. 20). With so many disowned emotions misplaced, a relationship with food becomes stronger and safer than one with people. In these food relationships, unconscious dynamics continue to unfold:

> The system of punishment and reward in relation to feeding the obese body becomes a moral issue. When they feel rejected by others, they tend to compensate their loss by eating; when they are angry with themselves, they punish their bodies by eating; when they are happy, they reward their bodies by not eating. (p. 21)

In short, food becomes the scapegoat for every emotion, and forms the nucleus around which the personality revolves. Woodman (1980) urged an understanding of the intensity of the emotions behind the complexes feeding the need for food.

> Obese women tend to shy away from the topic of food or to understate their emotions in relation to it. Only when they express their overwhelming sense of futility, and describe their suicidal tendencies, is the full impact of their powerlessness in the face of the obsession revealed. (p. 21)

The repressed feminine. Woodman (1985) explained further that the effect a patriarchal system has on its women citizens extends beyond aesthetic judgments.

Women unconsciously give up pieces of their femininity to achieve what society has managed to convince her is worthwhile. Woodman declared, “A woman whose survival is thus tied to the masculine spirit has unconsciously sacrificed her femininity to what she believes is the best in life” (p. 40). Jungian analyst Betty Meador (2004) expanded on the impact of the repressed feminine on modern women, noting,

> I do not have to elaborate for you who also grew up in this culture, so repressive to woman and sexuality, the innate splitting of instinctual urges young women must accomplish in order to survive with any remnant of self-esteem. (p. 182)

Additionally, a young woman’s development requires a severance from masculine power in order to progress (Woodman, 1980). As Woodman observed, “For many women born and reared in a patriarchal culture, initiation into mature womanhood occurs through abandonment, actual or psychological. It is the identity-conferring experiences that frees them from the father” (p. 33). However, “in a society where so many mothers have lost touch with the rhythms of their own natures, it is not surprising that the fear of life is fundamental in so many personalities” (p. 96). As young women may engage in a ritualistic abandonment from father in order to ascend into womanhood, they look to mother, who has been culturally stripped of her feminine nature, thus perpetuating the cultural loss of the feminine. Jungian analyst Sylvia Brinton Perera (1981) added to this notion by describing the ways in which women must compensate for their collective loss of identity to remain socially successful:

> The problem is that we who are badly wounded in our relation to the feminine usually have a fairly successful persona, a good public image. We have grown up as docile, often intellectual, daughters of the patriarchy, with what I call “animus-egos.” We strive to uphold the virtues and aesthetic ideals which the patriarchal superego has presented to us. But we are filled with self-loathing and a deep sense of personal ugliness and failure when we can neither meet nor mitigate the superego’s standards of perfection. (p. 11)

Archetypal dynamics. To understand archetypal dynamics present in binge eating disorder, a grasp of the unconscious is needed first. Jung (1954/1959a), expanding on the work of psychoanalyst Sigmund Freud, defined the *unconscious* as "a gathering place of forgotten and repressed contents" (p. 3). For Jung, the unconscious could be a personal collection of content, but he argued that the personal unconscious was superficial and that it rests upon a deeper layer that is not derived from personal experience but is rather inborn:

> This deeper layer I call the collective unconscious. I have chosen the term "collective" because this part of the unconscious is not individual but universal; in contrast to the personal psyche, it has contents and modes of behaviour that are more or less the same everywhere and in all individuals. It is, in other words, identical in all men and thus constitutes a common psychic substrate of a suprapersonal nature which is present in every one of us. (pp. 3-4)

Through the collective unconscious, human beings experience archetypes as "universal images that have existed since the remotest times" (Jung, 1954/1959a, p. 5). The primitive man finds guidance in understanding these depths of the collective; his unconscious is not interested in objective explanations of the obvious but instead desires to connect all outer sense experiences to inner, psychic events (p. 6).

> It is not enough for the primitive man to see the sun rise and set; this external observation must at the same time be a psychic happening: the sun in its course must represent the fate of a god or hero who, in the last analysis, dwells nowhere except in the soul of man. (Jung, 1954/1959a, p. 6)

Jung (1954/1959a) stated that the "mythologized processes of nature" such as the seasons and moon phases are not allegories but rather "symbolic expressions of the inner, unconscious drama of the psyche which becomes accessible to man's unconscious by way of projection-that is, mirrored in the events of nature" (p. 6). Meador (2004) added:

> Jung called these fundamental structures archetypes and connected them to inborn instincts. Further he described how the archetypes portray themselves in the

> human psyche in the form of powerful imagery and emotion. Simply put, classical Freudian psychoanalysis tends to focus on the personal aspects of the individual psyche, while Jungian analysis, born out of Freudian analysis, includes the effects of fundamental instinctual, archetypal structures along with the individual's personal psychology. (p. 171)

Woodman (1980) uncovered a connection between the deeply rooted mother archetype and disordered eating in her association experiment. Jungian analysts Sibylle Birkhäuser-Oeri and Marie-Louise von Franz (1988) explained that to understand the nature of the mother archetype, "We must begin by thinking a little more about the maternal principle. In its broadest sense it symbolizes an experience of all living beings. No one is created from nothing; everyone has a mother" (pp. 14-15). Thus the mother image

> symbolizes not only the psychological but also the physical foundation of human existence, including the idea of the body as container of the soul. Modern humanity appears to be especially fascinated by the mystery of the close relationship between the unconscious and the body. One symptom of this is the disproportionate emphasis many people place on the instinctual drives. Perhaps it involves an unconscious search for the Earth Mother. (p. 14)

Jung (1954/1959b) listed some qualities associated with the mother archetype:

> maternal solicitude and sympathy; the magic authority of the female; the wisdom and spiritual exaltation that transcend reason; any helpful instinct of impulse; all that is benign, all that cherishes and sustains, that fosters growth and fertility. The place of magic transformation and rebirth, together with the underworld and its inhabitants are presided over by the Mother. On the negative side the mother archetype may connote anything secret, hidden, dark; the abyss, the world of the dead, anything that devours, seduces, and poisons, that is terrifying and inescapable like fate. (p. 82)

Woodman (1982) argued that "the craving to do the forbidden often comes from a lifelong relationship with the negative mother" (p. 30) who is a constant source of judgment. If one haunted by this negative mother wanted to engage in pleasure without subsequent condemnation, one must do it quickly and surreptitiously. Woodman saw that

a woman's binge eating could be the channel through which she is called upon to bring healing to her own life because the negative mother is often experienced as an alien substance; the negative mother "does not belong to her any more than do two pounds of chocolate before she goes to sleep" (p. 23). Bingeing behavior could be the woman's body yelling out for her to differentiate herself from this negative mother so that she can "discover who she is as a mature women" (p. 23).

Food and Body: A Generational Exploration

Mythologist Joseph Campbell (1988) explained that, for primitive hunters and gatherers from the earliest beginnings of human life in the Paleozoic era, the most fundamental question of being human was not “to be, or not to be?” but rather “to eat, or to be eaten?” (p. 47). This is a worthwhile reminder of the collective human relationship with food as inseparable from life. This of course carries on today, although humans have hunted their way to the top of the food chain.

Campbell (1988) described the original experiences of fear and, subsequently, desire, as instincts. He evoked the old creation myth in the *Brihadaranyaka Upanishad* (p. 13) to make a point about connection: In this myth, the desire “was not to eat, however, but to become two, and then to procreate” (p. 47). Campbell continued, explaining that these themes transmit unconsciously from generation to generation and remain in modernity:

> And in this primal constellation of themes—first, of unity, albeit unconscious, then of a consciousness of self-hood and immediate fear of extinction, union with that other—we have a set of “elementary ideas,” to use Adolf Bastian’s felicitous term (p. 9), that has been sounded and inflected, transposed, developed, and sounded again through all the mythologies of mankind throughout the ages. (p. 47)

Later, Campbell (1988) examined the relationship between morality and survival, or rather how the morality of understanding one's connectedness as a human being continues one's survival. Campbell cited philosopher Arthur Schopenhauer's essay "On the Foundation of Morality," in which Schopenhauer asked how people could feel so much empathy and compassion for one another—be so moved by another person in peril—that they could forget their own wellbeing in order to provide rescue. Schopenhauer wondered how self-preservation as the first law of nature could be suspended so spontaneously and even with great consequence to the rescuer (Campbell, 1988). Campbell paraphrased Schopenhauer's discovery: "This expression of the mystery of compassion is an effect of the experience of an antecedent truth of nature, namely, that 'I' and 'that other' are one" (p. 47).

Turning to a cultural and generational evolution of body image, Woodman (1980) described how the Western cultural interpretation of "fatness" has evolved over time and how it continues to vary culturally:

> Fatness once carried happy connotations. People "laughed and grew fat"; the fortunate few "lived off the fat of the land"; the less fortunate many envied "the fat cat." In cultures less affluent than ours, the plump bride is still worth her weight in gold. In China and Japan, the person with the fat belly is respected and admired as being well grounded in himself. In Western society, however, the connotations have reversed. The 200-pounder has "a fat chance in a slim world" and the fat woman is ashamed to walk around "with her neurosis hanging out." (p. 7)

Oral Stage of Development

The function of food, from a Freudian perspective, would include an understanding of the psychosexual stages of development, which begin at the oral stage. According to mental health nurse Sue Barker (2016):

> Freud indicated that each stage needed to be completed at the appropriate maturational moment and that if a child was over- or under-stimulated at any stage, then they may become fixated at that stage and this would limit their adult personality. They may also return to a fixated stage at times of adult stress (regression) or develop an ongoing personality type linked to that stage. (p. 31)

From the ages of 0-2, infants are preoccupied with seeking food and exploring the world, including new objects, with their mouths. Adults regressing back to this phase will engage in activities related to their mouths, which might include smoking, dieting, drinking to excess, or binge eating (p. 31).

Psychoanalysts Joseph Sandler and Christopher Dare (1970) detailed the impacts of these early stages on adults. For example, they posited, adults who had been unsatisfied at the oral stage as children, and who had not integrated the emotional consequences, shared certain recognizable traits: "The orally frustrated or ungratified character has a characteristically pessimistic outlook on life that may be associated with moods of depression, attitudes of withdrawal, passive-receptive attitudes, feelings of insecurity and a constant need of reassurance" (p. 216).

Summary

This chapter provided a review of literature covering early attachment relationships and the ways in which those relationships can wound a person to the point of seeking external substances to quell internal pain and replace unpredictable, fearful human relationships (Flores, 2004; Martin, 1990). Rewinding even earlier, to prebirth experiences, Hollis (1998) shared the notion that humans are unconsciously in a constant attempt to return home to Eden—the womb—and as such, humans are caught between the deep desire to fuse with Other and to individuate, failure of which could result in addiction. Integrating the mother archetype, the feminine repressed by an unconscious

patriarchal gag order, and American culture's loose grasp on metaphor, Woodman (1980, 1985) provided insight into the underlying causes of the symptoms displayed in various eating disorders.

On the basis that the most fundamental question of being human was not "to be, or not to be?" but rather "to eat, or to be eaten?," attention was given to the primal instincts of individual and collective survival and what role those instincts play in the modern-day, unconscious judgment of overconsumption (Campbell, 1988, p. 47). Finally, exploring through a psychoanalytic lens revealed that adults who may not have completed their oral stage of development at the appropriate maturational moment may regress later in life to satisfy those unmet needs (Barker, 2016). As adults, these individuals may be overeating or restricting food, depending on whether their initial oral stage was overwhelming or underwhelming (Sandler & Dare, 1970).

Chapter III integrates the information provided in the literature review and how it both does and does not contribute to my personal narrative and experience. I describe the interventions that can be applied clinically when exploring binge eating disorder with clients. Clinical interventions include the management of myths, imaginal exploration, and somatic work.

Chapter III
Findings and Clinical Applications

Introduction

This thesis considers the relationships between American women and food, and how those relationships are influenced incongruent cultural values. Viewing these relationships—including my own–from the perspective of depth psychology, in this chapter, I share personal findings and therapeutic exercises by way of journal entries, related theory, and an example of work from my personal therapy. Additionally, I explore the clinical approaches to helping clients with distorted eating behaviors, which include 12-step programs, attachment repair, and active imagination.

The First Step

Once I became aware of my own binge eating behavior, my curiosity was activated. Admitting one has lost power to one's vice is the first step in any 12-step recovery program, because it is a challenge to see and accept the newfound awareness of self-deception, of the "absolute humiliation" one experiences upon discovering one's ability to warp one's mind to the end of self-destruction (Alcoholics Anonymous World Services, 2004, p. 21). Removing the mask of individual maladaptive coping mechanisms is difficult, because one must face the painful truth that has been hiding under there all along. Admitting one has a problem is not for the faint of heart, yet it is the necessary beginning to an end without which the maladaptive patterns would continue. Leading

with curiosity prevented me from slipping into the depression I was poised for upon discovering that very self-deception.

Instead of letting my newfound awareness of self-betrayal be the summation of my information about my disorder, I reframed it in a way that did not place me as the culprit. I was not the villain in my own story, nor was the binge eating, and the sooner I was able to hold that, the sooner I could learn and heal. My binge eating was my guardian. It was born to protect me from myriad perceived threats, and for that I am thankful. Like most defenses, however, it grew and grew and grew, and my consciousness of it was nonexistent. This defense became an autonomous, well-intentioned, but troublesome monster that controlled and suppressed me.

Heuristic Exploration

What follows is a heuristic exploration that began as a series of journal entries about what it was like to engage with food in the aftermath of my binge eating disorder diagnosis, and to slowly begin sharing these secrets with close friends. Psyche kept revealing images and memories to me that started to place the pieces of the puzzle into some recognizable scene, and I wrote down what I was discovering.

I add a disclaimer: I do not blame others for my disorder. Some of these journal entries are raw and angry. I have given the anger a voice, because, like all the emotions that rise up in the deep explorations of psyche, it is not to be condemned or disciplined.

The court of public opinion.

> Everyone has something to say about food and weight because it's something everyone deals with. In fact, those people with tense relationships with food are often the least empathic to those with binge eating disorder because they've struggled with food too. "If you just try this or that, you'll be fine." Most people are just fine eating a meal and living their life, but because they have a sweet

> tooth or occasionally eat too many chips in one sitting, they think they have some idea of what someone with binge eating disorder experiences. They don't. But their belief that they do and the judgment that accompanies it is harmful; it lacks empathy, it fuels shame, it encourages isolation.
>
> Author's personal journal, May 2, 2016

Because food is a universally used substance—a substance necessary to health and survival that most people can manage a relatively healthy relationship with—the idea that a person could become "addicted" to food is controversial. Although anorexia and bulimia are acknowledged as psychopathologies, chronic, uncontrollable overeating is frequently condemned as simple gluttony or lack of will power. My clinical supervisor demonstrated this attitude by treating a heroin addict with empathy, but calling a diabetic client "stupid" for compulsively drinking soda. Although one could argue that the health consequences of a diabetic overloading on sugary soda might appear reckless, it is that very consequence that lends itself to the understanding of addiction. Ramifications often accompany compulsive pleasure-seeking, yet any addict will maintain a desperate pursuit of the latter despite the former (Martin, 1990). Provoking the compulsive pleasure-seeking in this case was the chemical makeup of the substance itself; the particular soda this client was addicted to contained sugar and caffeine, both of which are highly addictive and easily obtainable in American culture.

To illustrate the impact of this availability, I pose a few hypothetical scenarios in order to draw attention to an obvious but little discussed fact: Cultural availability of a substance like heroin differs greatly from that of a substance like soda, and that availability may be one of the determining factors in shaping external perceptions. One can reasonably imagine a member of American culture never being offered heroin and not living in an environment in which it is commonly used and accessible. However,

given the pervasive marketing and presence of soda, it is highly unlikely that anyone, my supervisor included, has not either declined offers of soda, enjoyed it within her own limits of control, or developed an addictive relationship with it. Unlike heroin, cans of soda are easily found in vending machines across the country, bottles of soda are often on display at social gatherings, grocery stores have entire aisles dedicated to soda with some impulse opportunities available at the checkout register, and soda is listed on every restaurant menu I have ever seen.

Thus, my supervisor may be experiencing as socially acceptable, prevalent, and safely consumed a drink that is someone else's addictive substance. When that someone else is one's client, one's judgments of their behavior may be steered by countertransference—in this case, seeing in one's client what one does not want to see in one's self. This can act to defend against one's own potential lack of self-control or make one feel better about one's own choices. This raises the question: Has the pervasively marketed social acceptability of drinks and foods—even with research showing them to be physically addictive—created an unconscious assumption among psychology professionals that overeating is less psychologically serious or deserving of less compassionate treatment?

Disembodied.

> As a kid, I would lay awake in bed at night wondering why I was in this body. The *I* that was speaking was not human me. It was not 5-year-old Vanessa, child of my parents, sister to my sister, animal lover, dancing school student, Connect Four champion, Italian-American, Earthling. No, the *I* that was asking had no tangible associations but instead was some ghost-like locus of self that didn't belong to any world in particular. To this version of self—my soul, perhaps—my Vanessa identity and the body that came with it was foreign, uncomfortable, confusing. My soul demanded answers before it could even consider trusting this body enough to make a home of it. The memory of these experiences began haunting me recently as I came to realize those questions never found their

> answers. If my soul was never convinced to give my body a chance, have I been living 30 years completely dissociated from the very human experiences feeling comfortable in one's skin and bones affords them?
>
> Author's personal journal, December 18, 2015

Woodman (1985) said that for many people, "body and psyche were split apart at a very early age" (p. 57). For children who were unwanted or unwelcome in the world because of their gender, "the body/psyche split began *in utero* or at birth, as if the soul had chosen not to enter the body, but instead remained in exile from it" (p. 57). Apart from asking parents some tough questions with answers of which they may not be conscious, one may have no way of knowing if one was unwanted or unwelcome based on gender. However, although Woodman did not expand, one might speculate that disappointment in gender is not the only factor capable of creating a pre- or post-birth environment in which soul would protest embodiment. Regardless of cause, a disembodied soul creates a challenged existence preoccupied with a seeking of other. "Denied a bodily home, such people are possessed by a longing for some home that is not of this earth" (p. 57).

Protection from a culture of the predatory male.

> I'd drive myself mad with judgment toward myself about this fear. Why did I grow up so generally afraid of men, so anxious about being raped for as long as I can remember? Naturally, I blamed myself for being overreactive to such fears—and that is exactly what the patriarchy-driven collective shadow would have me believe. Growing up in New York, specifically, I was immersed in a culture of victim-blaming and sexual assault. Local news became a barrage of stories of women jogging through Central Park or taking the subway and being attacked. The narrative was fear-based but with the blame on the victim. "Why was she in Central Park by herself?" "Why was she on the subway so late at night?" Women were blamed for living their lives and the men who attacked them seemingly just got a pass for doing what they has been "invited" to do. Few things make my skin crawl more than when a strange man tells me I have a beautiful smile, or sizes me up with his eyes. I've had men grab me inappropriately in public, and privately make unwelcomed advances well beyond the point of me explicitly saying "no."

> The collective man has always asserted his supposed entitlement to the female body, and I hold a desperate need to protect myself from physical, verbal or emotional assault from beings deemed more powerful than me. I built a moat around my body to keep predators away from me, and to make me less susceptible to being blamed should a man decide to exert that power.
>
> Author's personal journal, June 28, 2016

Psychological researcher Steffen Bieneck and social psychology professor Barbara Krahé (2011) performed a study that provided one example of perceptions of victim blaming through a contrast between robbery and rape. The study found that perpetrators of robbery were blamed more than perpetrators of rape, whereas victims of rape were blamed more than victims of robbery (p. 1794). Of course women are not the sole victims of sexual assault, and the study did not specify if blame is distributed evenly among genders. This might indicate that male victimhood in cases of sexual assault is commonly deemed a source of blame, as well. However, the U.S. Department of Justice (2000) reported that 82% of reported juvenile assault victims and 90% of reported adult assault victims are female, which may indicate that there is a gender influence on the distribution of victim blaming (p. 4).

On sexuality.

> I don't find sex and sexuality to be interchangeable. Sexuality, to me, represents a freedom from boundaries in order to be seen, touched and altered by some other force, and then to have that altered version of you re-integrate back behind the boundary. Sex is merely one way to accomplish that. Engaging in conversation, collaborating on a piece of art, singing, dancing—these are experiences of sexuality if done with vulnerability. Likewise, sex can be had without sexuality, missing the vulnerability required to create intimacy. A developed sexuality, to me, means being so safe inside the walls of your own body that you're willing to let down the castle gate, venture outside as your genuine self, and trust that whatever happens, you know who you are and how to get home. That is intimacy.
>
> Author's personal journal, November 12, 2016

Santana (2017) explored what Jung never explicitly wrote about sexuality, and yet because sexuality is so universal, Jung's concepts apply. Santana echoed Jung's (1950/1959), sentiments about the need for individuation, with sex as one element crucial to achieving that.

> Individuals live in split ways—a personality for work, a personality for home, and one reserved for those erotic vacations or late night rendezvous online. Integration is rare, and breaking archetypal and cultural expectations can be disastrous for an individual. Here again, this is where sex, the erotic and the pleasures of the body bring the individual into significant conflict with the world. Integrating the erotic amongst the numerous roles one plays in life is challenging and painful work that calls on the whole person to redefine and reclaim oneself. An individual can serve the cultural image of the good spouse or the dutiful parent, but become imprisoned to a stale image and lost in social expectations and boundaries that fail to serve their individuation. (Santana, 2017, p. 129)

Literal repression.

> The act of eating is to shove the hole in your face otherwise used for expression, clog the pipes that carry your words, and push everything downward into the pit of your body for immediate destruction. If that's not a metaphor for repressing emotion, I don't know what is.
>
> Author's personal journal, May 3, 2016

Journaling is one medium that can allow unconscious content to emerge. Any spontaneous creative process can be helpful in the temporary silencing of ego to make way for unconscious material, allowing images representative of repressed content to be expressed. Releasing this buried content in a safe and contained way, through therapy or with support, helps free one from the burden of holding it within, and symbolic repression through binge eating may cease to be needed. For me personally, an important aspect of myself needing to be expressed was my anger:

> Fucking anger! Anger was not something I was allowed to feel. Anger was unproductive. Anger was scary. Anger was something I hadn't earned the right to feel. If someone made me angry, it was because I did something to warrant being treated that way. That was the myth of my life. So whenever natural anger would

> come up, I was unable to project it outward onto the person or experience it truly belonged to. And yet, the thing about anger is that it doesn't just evaporate. It has to go somewhere, so it went inward, making me angry at myself, angry at my bones, my skin, my blood, my breath, my hair, my teeth, manifesting in my soma and psyche until punishment was needed. There's also the afterglow of a binge that allows me to be explicitly mad at myself for something that made sense, something I could quantify. I created something that I could be angry at myself for, because I couldn't understand how else or why I was mad at myself. (Author's personal journal, February 10, 2016)

Howell and Itzkowitz (2016) explained how dissociation from emotional experience could be integrated into the body, causing one to binge food. They noted that bulimic and binge eating behaviors are experienced as "movements and sensations rather than meaningful actions" and that these sensations are "constricted, disorganized and mired in inertia" (p. 164). These patients struggle to feel their own interiors, which "often reflects the degree to which they crave excessive external stimulations, like binge eating, drugs, or drinking" (p. 164).

Clinical Applications

Although there are elements to healing that include repairing the relationships clients have with themselves, there is often a need to repair their old attachment wounds so food does not have to work so hard anymore. As Martin (1990) noted, "Recovery from food addiction means turning away from the self-administered comfort of food and learning instead how to receive nurturance from people" (p. 103). One way healthy attachment can be achieved is through the transference-countertransference relationship that unfolds between therapist and client.

Acknowledgment of past relationships, developmental trauma, and myths that clients unconsciously carry with them is an important task, and a task that therapists can

help with. Referring back to step one of the 12 steps, admitting that something has gone awry is always the starting point. Unfortunately, admitting the problem is not enough.

Awareness must become a constant practice. It is a difficult feat to keep awareness at the surface of one's everyday engagement with the world, but it is imperative that the awareness happens not only on a cognitive level, but also becomes embodied; only a stronger, more embodied narrative can substitute the old myths. As that occurs, other healthy substitutions are required, as well. If a client binges to replace human relationships, simply ceasing bingeing will not be successful, at least not long-term, until the client finds the relationships to replace the food with. This is one reason the anonymous 12-step programs are helpful; they come with community. Be it the direct relationship between the participant and the sponsor, or attending a group meeting where one's vulnerability is safely held, this community meets an important need for addicts. A sense of community is lacking in the lives of many in the American culture, not just in the lives of addicts. Following are some ways to help utilize this awareness clinically.

Twelve steps of Overeaters Anonymous. Overeaters Anonymous (OA) serves anyone facing an issue with food consumption: compulsive overeating, undereating, food addiction, bulimia, anorexia, binge eating or overexercising (Overeaters Anonymous [OA], n.d.). It applies the 12 steps that founded Alcoholics Anonymous and provides sponsors and a community to help all members fulfill their abstinence. For the overeaters, food addicts, and binge eaters, defining abstinence is a little more complex than, say, just cutting drugs or alcohol from their lives altogether. *Abstinence* in OA is defined by each individual by identifying the specific foods (e.g., recreational sugar, pizza, pasta) or food behaviors (e.g., bingeing late at night, eating when not physically hungry) that person is

addicted to. Otherwise the same 12 steps apply. Participants strive to relinquish themselves to a higher power they personally believe in, take a moral inventory, make amends to those impacted by their addiction, and share their spiritual awakening and discoveries with others in the program.

The efficacy of abstinence as an addiction treatment has been questioned (Flores, 2004). Many have rejected the notion that addiction is so simple a concept that behavior modification can solve its problems. Many addiction specialists agree that addiction grows out of psychological and sociological challenges, and not due to the drug itself. Therefore, merely removing the effects of the drug is not enough. Flores (2004) offered the idea of *moderation management* as a substitute to abstinence; this approach can help alcoholic drinkers, for example, learn how to drink without addictive behaviors, and keeps the main focus of treatment on the undercurrent issues (p. 17).

As Howell and Itzkowitz (2016) claimed, addictions are symptoms that are not simply to be gotten rid of. Instead, these symptoms offer clues about the dissociated parts of clients and their relational histories. Clinical understanding of the dissociative states created by way of addictive behaviors is vital to treatment. Modifying behavior without exploring these dissociative states will greatly limit the efficacy of treatment (p. 165).

Myth management. As the unconscious character of the ego is one-sided and defended, having been severed from unconscious content that is threatening or undesirable (Jung, 1921/1971, p. 419), one may unknowingly act in a way that proves one's personal myth to be a fact. By *myth* I mean the beliefs absorbed through one's culture, family, or individual interactions and experiences. An example of this type of mythology might be that a client's father never listened when she spoke, so she

unconsciously started to believe that her opinions and feelings did not matter. The lack of self-worth that emerges from such dynamics goes deep. The client may feel unworthy without knowing why, or perhaps not even realizing that she believes it at all. The unworthiness becomes a part of who she believes herself to be and a lens through which she interprets her world, projecting the self-judgment onto others in the assumption that they see her as she unconsciously sees herself.

Deconstructing these myths, understanding where they come from, and realizing the falsity of them can help repair the image clients have of themselves and support them in taking back their projected self-judgment. Renewal of the feminine is another way to manage the myths that have been absorbed through one's cultural, familial, or individual experiences. Perera (1981) suggested the importance of a rebirth of the repressed feminine individually and collectively:

> The return to the goddess, for renewal in a feminine source-ground and spirit, is a vitally important aspect of modern woman's quest for wholeness. We women who have succeeded in the world are usually "daughters of the father"—that is, well adapted to a masculine-oriented society—and have repudiated our own full feminine instincts and energy patterns, just as the culture has maimed or derogated most of them. We need to return to and redeem what the patriarchy has often seen only as a dangerous threat and called terrible mother, dragon or witch. (p. 7)

Owning emotions. Clients have a broad range of emotion that they may not always feel safe expressing. In addition to struggling with emotional expression, some clients lack a basic understanding of their feelings, and those who seek substances to regulate their emotions are often struggling to do so on their own. Therapists must begin by providing a container in which clients can exist in their feelings. The clinician's role is to reflect back to clients indications of unexpressed emotion and help them identify and verbalize their feelings. Clients will need a safe space to explore the depths of their

emotions in a way they may have never learned to do, and for this a clinician will need empathic attunement, nonjudgmental engagement, clarifying questions to enhance their understanding of the client's experience, and a strong, respectful therapeutic bond in which the clients trust the safety and privacy of their exploration (p. 179).

Personally, anger was an emotion I never felt safe to express, so it turned inward and became a sort of poison eating me away from the inside out. It is the role of the therapist to help clients realize that the healthiest way to manage their feelings is simply to accept them and express them. A therapist's responsibility is to ensure that the client feels safe as repressed content arises by building a strong therapeutic alliance (Flores, 2004). From the safety of that alliance can begin a transferential relationship in which the client projects a primary caregiver role onto the therapist, who then may counter-condition past painful attachments and help a client feel safe, understood, and supported. It is also important for therapists to understand where and when the client needs to pause exploration, allowing them to process this repressed content at their own speed.

Somatic work. Somatic work should be difficult to ignore in all psychotherapy conversations, especially ones that revolve around ingestion of food or other substances, or issues related to body image. Woodman (1985) underscored the importance of somatic integration, because a disconnect from one's body could block emotional energy from becoming conscious. Disembodiment also blocks psyche from expressing emotions, limiting its exposure in dreams and other imaginal work (p. 57).

Social worker and research professor Brené Brown (2015) outlined one of the reasons listening to the connection between soma and psyche is integral to truly knowing:

> Creativity embeds knowledge so that it can become practice. We move what we're learning from our heads to our hearts through our hands. We are born

> makers, and creativity is the ultimate act of integration—it is how we fold our experiences into our being. . . . The Asaro tribe of Indonesia and Papua New Guinea has a beautiful saying: "Knowledge is only a rumor until it lives in the muscle." (p. 7)

Somatic work, then, can include a variety of exercises, from meditative attunement to areas of pain or body sensations, to authentic movement, to being creative with one's hands. Jung (1950/1959) was known for creating mandalas, which not only contain deep symbolic importance but also help unconscious knowledge become integrated into the body through the creative use of hands. The symbols of the mandala are relevant here as well. According to Jung, the mandala can be a form of mother archetype (1954/1959b, p. 81), a protective circle to seek shelter (1950/1959, p. 130), or a symbol of individuation (1954/1959a, p. 35), all of which pertain to the needs of the binge eating woman, who needs to at once heal the repressed feminine through the mother archetype, protect herself from patriarchal threats, and individuate into a whole, separate self. Considering the ways in which disordered eating alters one's relationship with one's body, somatic work must also incorporate the newly discovered language and expression of emotions described above so they do not become embodied in a confused and defensive way. One must slowly discover the safety of own one's feelings and manage emotional identification and regulation. Per Howell and Itzkowitz (2016):

> Patients with eating disorders assume that if they experience their sensations and feelings they will be overwhelmed permanently. When these patients grow accustomed to relying on an eating disordered behavior, which is, in and of itself, part of a dissociated state invoked to make the sensations and feelings go away, they also lose confidence that they can learn to tolerate feelings without engaging in these maladaptive behaviors. The fear of being consumed by these terrible feelings leads them to believe that "not feeling" is the only answer. (p. 164)

Woodman (1985) expressed the importance of doing imaginal work in conjunction with somatic work. That is to say, attuning to the body while quieting the

conscious mind and allowing images to speak can help reconnect a disconnected soma and psyche. This is important because the place from which images typically emerge is through dream, which can be blocked in certain instances. Woodman said, for example, that the "daddy's girl" has hardly, if ever, experienced her "dark side" (p. 57). "Alienated from her body, she does not know the magnificent energy that is blocked from consciousness, so blocked that it rarely manifests in dreams" (p. 57).

Woodman (1985) cautioned that when images do emerge, analysts cannot simply say, "There, you see, there is the severance from your own feelings. There's where your evil witch is separating from you and yourself" (p. 57). A soul that has chosen to cut itself off from a "'filthy' world is not going to recognize a self-murderer in its midst, nor will it acknowledge such demeaning human passions as greed, lust, power, and 'the thousand natural shocks that flesh is heir to'" (p. 57). Woodman continued that body work, which must be handled with patience and love, helps to develop the strength, tenderness, and assurance in one's body that one may not have been able to develop earlier in life. The work can help a suspicious and terrified body begin slowly to trust its own instincts and "discipline [it] into a firm steady base for the maturing psyche" (p. 59).

Active imagination. Although observing and responding to symptoms from a solution-based approach is helpful, any weeds will grow back unless their roots are tended to. Tending to the roots of behaviors goes deeper than just the managing of myths and gaining consciousness of developmental trauma; it calls for a more spiritual relationship with psyche, where psyche is asked to speak without the manipulations of anxiety-ridden conscious cognitive functioning. The imagination is one way to sneak behind the curtain of the socialized mind and see what lies beneath the surface. *Active*

imagination, or “a series of fantasies produced by deliberate concentration” that can be elaborated on “by observing the further fantasy material that adds itself to the fragment in a natural manner” (Jung, 1954/1959a, p. 49), is one particular execution of this theory. In active imagination, images are asked to make themselves known, and cognition functions as only a tool to understand context and communicate images via language. Imaginal work allows an understanding that clients otherwise cannot gain, and often creates characters or meanings that can be used as allies in clients’ attempts to alter behavior (as an example of this technique, see Appendix A for the complete transcript of an active imagination exercise I did in a session with my therapist).

In one of my therapy sessions as a client, I began detailing an experience I had during the week where I had just eaten a meal but still felt hungry. I tended to that feeling of hunger with some somatic consciousness, which is to say I quieted my mind with some meditative breathing and honed my focus in on sensations in my body. I had never explored the path of digestion in this manner before, but I began feeling into my stomach. My stomach felt full, that was not the part of my body that was sending the message to my brain asking for more food. I continued down my belly, placing the tip of my index finger in the top center of my rib cage and moving it down until I could identify the feeling of emptiness that resembled hunger. My finger stopped when it hit the hollowness shouting from behind my belly button—I found it.

I explained this to my therapist and noted that the belly button as an image was obviously related to humans’ original nutritional needs. But I also sensed an emotional component, one that might not entirely make sense. Some part of me, this unspoken hunger, thought that resources were being sent in one direction but was disappointed to

discover that they were not, which generated feedback of emptiness and a request for more food to be sent. Throughout this exercise, my imagination offered three characters that would provide insight into the transfer of energy and preoccupations unfolding within me. The personality of each character represented the uneven power dynamic within my psyche; I found a helpless child, a controlling yet ambivalent bully, and a clumsy but eventually competent superhero. While the exercise began with the bully holding the power, that dynamic shifted as I engaged with my imagination. Asking my anxious ego to step aside so imagery could be revealed left my mind cloudy and my physical state feeling dream-like, which was just the disconnect to my tangible reality I believe I needed. Because confronting the unconscious requires the suspension of ego, my therapist was first responsible for ensuring my ego strength was healthy enough so that a safe departure and return could be achieved.

As this session wrapped up, and I was eventually able to re-orient myself to the room, it became apparent that something had shifted in me. There was a new sense of awareness of what energies were living within me, where my preoccupations were, and what personas I could use to help mobilize new action. These characters that I met were not anyone I had been aware of before, and yet they were projections of my Self. Now, having a relationship with the little boy allowed me to understand his needs, his limitations, and what is required for me to help him. With this new knowledge, I can implement awareness and new action into my daily practice, all through the spirit of play. Now exists a little boy and a superhero who need my help to further explore a side of myself I have not yet met. Active imagination gave voice to an unconscious part of me I could not have accessed through the rational mind and talk therapy alone.

Chapter IV
Summary and Conclusions

Summary

This thesis considered the relationships between American women and food, and how those relationships may be influenced by a culture that fetishizes food, celebrates consumption, and shames bodies. Citing specialists on eating disorders, addiction, attachment theory, and depth psychology, I navigated through my research question with curiosity, clinical rationale, and personal perspectives. Drawing on my own experiences as a therapist, and as a woman with disordered eating patterns, I emphasized storytelling and engaging with the unconscious as means to bringing awareness to the dynamics that can be created between humans and their food.

In Chapter I, I provided my guiding purpose for choosing this research topic, sharing that my interest was born out of a personal discovery of my maladaptive relationship with food. I also shared my insights on the universal themes of addiction that emerged from my research, noting that many compulsive behaviors and compensatory self-object experiences arise from similar life conditions and human emotions, namely depression, trauma, anxiety, neglect, and other states that might cause a person to seek external substances to quell internal pain (Flores, 2004; Martin, 1990). Additionally, in Chapter I, I offered my rationale for studying this topic, which includes its prevalent nature in American culture (Grefe, 2015), as well as the incongruence I have witnessed among seasoned psychology professionals who work in clinical settings and have

struggled to understand and empathize with clients who suffer from food addiction, seeking their substance no matter the physical consequences.

Chapter II explored well documented theories in the field of psychology that pertain to disordered eating and its underlying emotional triggers. These theories included attachment theory (Flores, 2004), addiction theory (Martin, 1990), and depth psychology (Hollis, 1998; Jung, 1950/1959; Woodman, 1980,1982,1985). Literature was also surveyed that addressed the role of gender dominance in body image and eating disorders (Woodman, 1980, 1982, 1985), as well as the multigenerational roots of food and body image as viewed through the lens of humans' primal needs (Campbell, 1988). These topics were chosen to demonstrate the myriad ways in which both food and body are observed, utilized, and judged in American culture, and to highlight the common threads that could lead to a discovery of why such incongruence exists between the way American culture fetishizes food and shames bodies.

In Chapter III, I shared personal experiences that engaged the underlying unconscious forces behind my binge eating behavior. Understanding that my experiences can be both unique and universal, and contrasting personal findings against published literature, I shared clinical applications and treatment options for clients experiencing binge eating. These treatment options include 12-step programs, attachment and relationship repair, the addressing of shame through vulnerability, the identification and management of myths and the stories they have been taught to believe about themselves, psychoeducation, somatic work as a means to access, integrate, and heal unconscious needs, normalization of feeling one's feelings, and supporting self-esteem against a society that body-shames.

Clinical Implications

Although many themes have been presented in this thesis regarding both the underlying causes of binge eating disorder and effective interventions for it, I believe I have connected them together in such a way that they could be observed and used in therapy alongside the clinician's experience and judgment. I believe the examples and interventions I have offered will prove helpful to clinicians seeking these perspectives. This thesis has offered a deeper understanding of binge eating disorder and the impact of cultural body expectations on women, and it is my hope that at the very least, empathy from clinician to client can be gained from this exploration.

This thesis also revealed the importance of clinicians engaging in their own work about their relationship with food and issues of control to prevent culturally influenced countertransference from impeding their work. Therapists unconsciously projecting weakness or other judgments onto clients can negatively impact their relationship, likely reopening rather than healing the original wound. The need for clinicians to stay engaged with their own work is not specific to disordered eating or cultural perceptions of food and body; however, my work on this thesis has highlighted the responsibility of the clinician to ensure unhealthy social norms are not being perpetuated in the therapy room.

Recommendations for Further Research

This topic proved to be rich in material, and more questions arose throughout the process of researching it than I could answer in this particular inquiry. To offer a resounding voice to this abundant subject, I have included more questions aligned with the food and body motif that I have become interested in exploring. I believe these questions might prove worthy additions to this conversation, educating consumers of

food on human biology, the impacts of agriculture and where food comes from, and the influence of the unconscious on eating patterns.

One of the first things I would be interested in doing is making an inquiry about the relationships between men and food in American culture. Having this thesis focus solely on women served its purpose, in that binge eating manifests differently for different genders. I would also want to expand my cultural lens beyond the West to understand the ways in which binge eating disorder does or does not impact populations of other nations. I would like to apply more quantitative research about prevalence and treatment efficacy through a variety of cultural lenses and then use a depth psychology approach to uncover unconscious meaning behind that data. It would be worthwhile to delve into the ways in which agriculture, social standards, socially acceptable stress levels, socioeconomic status, and cultural lineage play a role in those statistics.

What did food mean to our ancestors, and how were those messages passed onto us consciously or unconsciously from generation to generation? My Italian ancestors lived in wartime Italy, when many people were impoverished, and access to food was celebrated and used as comfort. Plentiful plates meant safety—both physical and financial—so when I was a kid growing up in America and my Italian grandmother would keep filling up my dish with pasta and ordering me to “mangia!” or “eat,” she was trying to tell me we had enough, that we would not run out, that everything was okay. Could a relationship with bingeing be born to unconsciously quell the same fears?

I believe further research is also called for to examine how one’s early food memories forms one’s relationship to food. How are childhood mealtimes influential on one’s use or abuse of food—this research needs to delineate the types of emotional states

children take on in order to feel comfortable consuming? For instance, children who spent their mealtimes at the table with family catching up on their days and enjoying each other's company might have developed a different relationship with food than those who ate alone or ate with a fighting family over a tense dinner table. Children who were screamed at regularly for not eating their veggies would likely develop a different relationship with food than children who were encouraged to eat their veggies but never shamed for it. Moreover, what types of clinical interventions might help bring those memories to consciousness so that clients with disordered eating can start to understand their emotional pull to or from food, and why stress eating or isolated eating became habitual.

I would also be curious to explore how table manners in certain cultures might influence one's relationship with food. There are tight restrictions on the way we in American culture are socialized to consume food, for example, not being able to make a mess or not touching food with one's hands. Oftentimes, as children, we are scolded if we violate rules by playing with our food or by not using our utensils properly. If control is a potential driving force of binge eating disorder, what influence might strict table manners have on someone with disordered eating patterns and what expressions were suppressed in that learning process?

Another depth psychological research topic that may provide a wealth of information is about the symbolic boundary of one's body. How might allowing food across that threshold to become a literal part of one's self, while also trying to keep everything and everyone else out, be reflective of trauma or insecure attachment relationships? What are disordered eaters projecting on to their food before they allow it

past the boundary of their bodies and consume it, and what happens to that projected image once it becomes a part of them? How does this differ from nonaddictive eaters?

Conclusion

As a final reflection on this thesis and its alchemical hermeneutic properties, I note that I do feel transformed by the material. By including my voice in the conversation around this disorder, and seeing myself in a way I have long been unable to see myself, I feel as though my understanding of myself has deepened. Throughout the process of writing, I engaged with great work from great minds: Campbell (1988), Jung (1950/1959), Hollis (1998), Martin (1990), Flores (2004), Yalom (2012), Huxley (1992). I was enchanted by their ideas and was pleased to use their words as a means to embolden mine.

I struggled, however, with Woodman (1980, 1982, 1985). Although her material sat in visible places around my apartment, and although I knew her work—unique in its marriage of the unspoken binge eater and the spiritual awakening of depth psychology—would be the biggest influence on mine, I spent the length of this writing experience pushing her books aside, telling myself I would read them later, and leaving parenthetical notes throughout this piece to add in her perspective some other time. Up until the moments I wrote these final thoughts, *repressed feminine* was just a pair of words that filled me with angst and triggered avoidance. “What does that even mean?” I would ask myself, without the intention to actually find out. The question was not an inquiry but rather a means to diminish the power of those words and guard myself against knowledge that some part of me knew I could not yet handle. That part of me knew it would be too difficult, too momentous, to reconcile the collective loss of the feminine in American

culture and the unconscious loss of the feminine in all the individual women (and men) I know, including my mother, including myself. That part of me knew I needed to be prepared to mourn the loss of something I never consciously knew I had the right to have but unconsciously always longed for, and be strong enough to hold how dire the consequence of that loss is—leading to addiction, relational disconnect, a lack of self-worth, and constant fear of rejection.

It was not until the final weeks of writing that I let in Woodman's message of this lost wonder, still somehow recoverable. Now that I have shared her words alongside mine, I feel a sense of maternal loving and acceptance that arises from the feminine so infrequently permitted. Loneliness, feelings of being misunderstood, and pain are now replaced by hope, self-love, forgiveness.

I felt compelled to add this reflection to my thesis, because throughout the process of writing, I was actively soliciting consciousness, asking psyche to engage, digging for meaning in something that shaped my whole life. However, even being open to conscious awakening, I was still unknowingly protecting myself from discovering something I was not ready to discover. One cannot see something, no matter how much one may think one wants to, until one is ready. That is perhaps the largest clinical implication of all, for only now that I am ready to see can it suddenly become mine to conquer.

Appendix A: The Hero Down Under

I arrived at this session after having the realization that I was confusing for hunger a hollowness behind my belly button. In a meditative state sitting across from my therapist, we began to play with images as they appeared in my mind's eye, most notably images from my lower digestive organs. What follows is the transcript of that discussion, which took place August 5, 2016.

> Therapist: Who's down there waiting and who's in charge of sending down the resources?
>
> Me: One of the things I'm noticing is that who's waiting in that empty space behind my belly button is a male figure who looks like one of those stick figure emojis. He feels young—maybe 8, all black, big head, big hands and big feet, wobbly, dancing, no expression on his face—he has eyes and maybe a mouth but it's not expressive. The only way I can understand his desperation is by his movement and body language. He wants to know how he's separate from this, separate from the rest of me. He's in a glass box in this empty space behind my belly button. He can see everything but he is trapped. There's someone further up the road that's directing traffic from a construction detour. This man is intentionally diverting traffic away from the boy. This man is older, 50s, angry yet complacent—just doing what he's supposed to be doing without putting too much autonomous thought or choice into it. He's very overweight and he's wearing an orange vest and using orange flags to move traffic in one way. He won't be easy to connect to, he's unconscious, lacks empathy, doesn't care if you don't like what he's doing, he'll continue to do it. There's a construction blockade with cones and flashing lights. However, he's directing traffic the way it's supposed to move through my digestive system. He's sending it down the right path of stomach to intestines and missing the boy in the glass box. But the way he's doing it, or perhaps because he's doing it at all, it seems intentional, like he's trying to make sure the boy starves.
>
> Therapist: So it sounds like it's going to take someone in special consciousness—a superhero, of sorts—because everything you've described is going the way it's supposed to go. This is an extraordinary exception.

Me: Yeah, the boy doesn’t have the right to ask for anything, really. He’s not where he’s supposed to be.

Therapist: Yeah and we can find out how he got into the box in the first place, but that story may come after we get him out of it.

Me: He doesn’t know how he got there—it was just chaos and he’s so worn down that he couldn’t remember if he tried.

Therapist: Yeah, and he’s 8.

Me: Right.

Therapist: So sit with the whole picture, and maybe even zoom out a little bit. Feel into it a little bit. He’s in there, there’s the overweight, unconscious guy directing traffic. Just conscious enough to do his job—we need those guys. But he’s not going to be the point of change. The kid in the box isn’t either because he’s trapped.

Me: [Laughs] I just saw—and you put superhero in my head—and it’s weird because I can actually see all of my internal organs—and just behind an intestine I saw a head pop out. Like just from the eyes up, someone’s head appeared and I think he’s one of those superheroes that’s not very good at being a superhero. He’s well-intentioned but clumsy. He’s like “did you need something?” (to me). He’s not a go-getter. He’s got a lot of potential but he’s pretty scared.

Therapist: What’s he scared of?

Me: Failing. He doesn’t know how strong he is. He’s afraid of being humiliated. He doesn’t look very strong—untested in his confidence and ability.

Therapist: What is the limit to trying? Who would he fail in front of?

Me: He’s aware that he’s only one of three people involved. The overweight guy directing traffic probably wouldn’t even notice him. The boy in the glass box needs him and is so worn down.

Therapist: So your superhero really is the most powerful person there. You need to convince him of his power and strength and how much you all need him. It can shift his feeling state for you to tell him how much you need him and that he’s your only hope.

Me: [Laughs] He’s my Obi Wan. But I see his own fear of himself, being his own witness to his own failure and I had so much empathy for that that I haven’t tried to encourage him.

Therapist: So you're understanding his fear. But what if you said "I understand AND let's see if you can do it because I really need you"? Is that fair?

Me: Yeah. Okay. I think he's starting to get it. He's negotiating with his doubt but I think he knows he will have to accept that doubt will just have to come with him.

Therapist: Ah, so that's courage.

Me: Yeah. He's still kind of hiding his body.

Therapist: Bodies seem to be up. You have a stick figure, and overweight guy, and someone who's hiding his body.

Me: And what I can see, he's very skinny and tall and lanky, he looks awkward in his little superhero costume. And yet he's still my best bet. He's doing a lot of looking around, waiting for someone else to either save him or be another pair of eyes he'll have to humiliate himself in front of.

Therapist: And you can help him. Let him know what tools he can use or what powers he has. What's he capable of? Crawling on a tank? Using a glass-cutter?

Me: He's snuck his way over to the glass box, taking the covered route so he's not seen or out in the open. But now he's looking the box up and down the way my dad looks at pieces of the house that need to be fixed, examining the corners and angles, not even noticing the child inside of the box. He's just now focused on the task at hand and feigning some sense of confidence. Now the image jumped. I don't know where he got the tool, but he has a glass cutter. He's started to cut the glass in a strange way. He cut a hole near the floor that was too small. The boy would have to crawl and squeeze his way out, it's ridiculous. There was no reason for the hole to be so small and low to the ground. It seems like he just didn't think it through – he was so worried about cutting the hole in the glass that he overlooked the purpose of why he was asked to cut the glass. But to him the kid in there still doesn't exist, so of course he doesn't know why he's cutting the glass.

Therapist: And what's the kid's experience of seeing this man come cut the glass?

Me: Well he's not even really seeing a whole lot anyway. He doesn't have much agency for himself, he's laying down on his stomach so his face is kind of down and he barely sees the superhero anyway.

Therapist: Yeah kind of like an animal in a cage that's given up. They open the gate and it's like I don't even have enough of a concept of freedom to know to walk through that door. Why would I do that?

Me: Yeah. And that the hole is so small becomes another excuse to not leave. An obstacle not worth fighting for even if it was worth fighting for. Because I myself doubt that his head could fit through the hole. The superhero is pleased with himself for cutting the glass, but I need more from him. He's ready to call it a day, he did what he needed to do. He's patting himself on the back yet he missed the whole point.

Therapist: So he needs some help. It sounds like it's not even conceivable that the boy in the glass could talk to the superhero.

Me: I don't actually know if he can talk. I just realized that. I think every bit of communication we've ever had has been through his body language.

Therapist: Right. His body's important.

Me: Yeah. And his body language now is just communicating helplessness. I'm trying to tap into the empathy of my superhero to get his head out of the clouds. I just want him to understand and pick up on the emotional cues of what's happening right in front of him. The kid will need to be coaxed out.

Therapist: And what you can do, if it fits, is have someone else arrive on the scene as an intermediary. Someone who might be bigger, wiser, and stronger, can't cut the glass but can do the next function.

Me: Yes, although my superhero's feelings are very hurt by that idea. Yeah, I kind of don't want to give up on him.

Therapist: Okay, so you're the arrival. It's your relationship to him that enters. So what would not giving up on him mean?

Me: It's almost like I didn't really have a lot of faith in him when he first showed but we had this ping pong back and forth of convincing each other of his own strength and ability so now we're both sold on the idea that he can defy odds and make this happen. We know we need to finish this together. He's just hung up on something which is the same thing he was hung up on when he was hiding. Oh, and he just got really sad. He just realized—it clicked for him. That naïve thought . . . oh shit, the hole needs to be bigger, what did I do? He was so into his own success that now he realizes the context of it and the importance of it. He realizes it's bigger than his insecurity. He's coming back down. He needs to figure out how to act for the project, not for himself. And also less in a pass/fail kind of way but getting into the meat of meaning and what's actually happening here. He's trying to coax out the boy but the boy won't respond. He wants to cut the glass more but now that he's conscious of the boy, he's afraid of hurting him by cutting the glass. He's trying to reach in to get him but it's too tight.

Therapist: Any change in the state of boy having someone be conscious of him?

Me: No. Although I feel like we're losing him more. Which makes it easier for the superhero to cut the glass because it's almost like the fear of him getting up and moving and getting hurt is not an issue. He's not moving, he's not going to get up.

Therapist: So we lose him for sure if we do nothing. So we have to do something even if it has some risk.

Me: Yes and the superhero gets the urgency of it now. And he got a little out of control and made a huge—almost needlessly huge—hole large enough for him to walk into. So now he's in the glass box with him, standing over him awkwardly trying to wake him up. Realizing it's not working, he bends down to pick up the boy and carry him out.

Therapist: So the little boy's getting contact he might never have had before.

Me: Yeah and as soon as he picked up him the boy woke up. He carried him out and I've noted that the superhero had another moment of his own personal victory because he was so easily able to pick up the boy. But the boy's a stick figure so it's not really that much of an accomplishment. So he's still a little ridiculous but he's serious and understands the gravity.

Therapist: And he's a hero, nonetheless.

Me: He's a hero. So he pulled him out and now they're sitting next to each other. The boy looks lost and confused, he's not interested in figuring it out. This is not a celebratory moment for him.

Therapist: So the boy sounds like he needs some orienting to where he was, where he is now and what happens next. He needs the adult to help him make sense of the world.

Me: Yeah I don't know what he's saying to him but the superhero is pointing over at the box (to show him where he was) and then he's pointing up. As if he's telling the boy "you weren't supposed to be here, you need to go up there." And it's very dizzying and overwhelming for the little boy because now he can look up and the perspective is so different from where he's been stuck for so, so long. It's very bright up there, there's a sunshine, compared to what ended up becoming very dark down where he is. And now they're climbing my intestines, like they're scaling a mountain. It was like "eh, what do you say?" Like all of a sudden there's nothing to lose. Superhero's going up first and keeps looking down at the kid to make sure he's making it up okay. And now they've perched, maybe on my gallbladder or something? They're just sitting there, admiring the new view, like

once you've hiked up to the top of a mountain and can suddenly see everything, and it's breathtaking and you never thought you'd get there. But you can see the bigger picture from there, as well. And the little boy, his emotions still aren't entirely known to me because he's limited in how he can express. But he used his body to get up. He did not use his body get out of the box, but he used it to climb. He's got more agency now. And a friend. They're bonding. The superhero's being healed just as much as the little boy is because they understand each other in a way no one ever has understood them before. So it feels like they don't know where to go next, my heart or stomach. They just knew they needed to get out of there. So it's a moment post-escape where you get to just be, and you let the panic of the escape run by you. And also each of them became more important to each other than where they're supposed to be going. It's about acknowledging the distance they've traveled and how much better it feels and looks, now they can figure out a plan since they can see it. And now that the little boy is more engaged in his own rescue they can team up. The superhero isn't alone anymore.

Therapist: He's become enlivened a little bit. So as we start to come back into the room, we'll have to say goodbye to them for now. Let's thank them for visiting and being so brave, and let them know there's more work to be done and that you'll come to see them again soon. What do you notice as you say goodbye?

Me: That I totally do not feel like a human on Earth.

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