Shame, binge eating and bioenergetic analysis

by Janet Pinneau

Introduction

As a Marriage and Family Therapist certified in, and practicing, Bioenergetic Analysis, I identify myself as a body-mind and somatic relational psychotherapist. Considering my background as an athlete, my training in Bioenergetic Analysis, my inclusion of the body in the work I do as a psychotherapist, and in the personal growth I continue to pursue as a client, the human body is critical to my foundation. This paper began as a presentation at the Professional Development Workshop (PDW) in Bahia, Brazil in 2018 with the thesis that successful treatment of binge eating disorder and the shame that exacerbates it, must include a somatic relational therapeutic approach that invites the afflicted to improve interpersonal skills and develop a positive relationship with their body and eating. Recovery from eating disorders with this approach eliminates using eating as a method to check out of one's body, and introduces groundedness and "being seen" to enable regulation and soothing. Bioenergetic Analysis as a treatment for binge eating disorder has the potential to provide longterm success by including the body in treatment. I conclude this paper with the description of a technique that I demonstrated at the PDW.

From the time of my presentation on this topic at the October 2018 Bioenergetic PDW I have delved deeper into the field of intuitive eating and body acceptance and understand that as "body psychotherapists," Bioenergetic Analysis, as a field, must evolve to embrace the body "as okay at every size" and overcome the bias of diet culture that many psychotherapists engage in without awareness or intention. The acceptance of every client that enters our offices, without bias towards their bodies is paramount.

Current Problem

Binge eating disorder (BED) is the **most common** eating disorder in the United States (National Eating Disorders Association, NEDA, 2018), and is complicated by the shame that resides in the sufferer. According to the DSM-Vthe essential features of BED include frequent and recurrent

episodes of eating excessive amounts of food (more than what most people would eat in a similar period of time, in similar circumstances), in a limited amount of time, usually less than 2 hours. The excessive food consumption is accompanied by a sense of lack of control, and include: eating until uncomfortably full; eating when not hungry; having a loss of control over quantity; being secretive because of embarrassment about the quantity; and feeling guilt or shame around the eating (DSM-V, 2013). Bingeeating disorder and the shame that accompanies it drives people to hide their disorder so that even their close friends and family don't know that they binge eat. Shame about eating and our bodies begins for many in childhood, and memories of shameful experiences can perpetuate disordered eating behaviors.

Mental Health Solution

Cognitive behavioral therapy (CBT) is considered the treatment of choice for people with BED. Some studies have shown that after 20 sessions 40-50% of subjects were in remission. Unfortunately, follow ups have not supported that recovery continues at that rate after a years time. In a simplified description, cognitive behavioral therapy proposes that dysfunctional thinking is the cause of the disorder, and that the modification of the thought process is the key to treatment. I do support this idea for some diagnoses. However, I suggest that the body is a critical factor involved in disordered eating and the human body as well as the thinking process must be part of the treatment.

In my work in Bioenergetic Analysis I have seen how becoming open to life and love through recognition and acceptance found in a therapeutic relationship is undeniably healing. Such therapy includes the body, all that has shaped the body and all that the body presents in treatment. "Body-oriented psychotherapists are especially well suited to work with eating disordered patients, for they read the body, interpret its signals and help the patient feel her body again to like it, to be kind to it and eventually gain a healthy and realistic body image of herself," (Ventling, 2004).

Alexander Lowen (Bioenergetics,1994) stated, "The primary nature of every human being is to be open to life and love. Being guarded, armored, distrustful and enclosed is second nature in our culture. It is the means we adopt to protect ourselves against being hurt, but when such attitudes become characterological or structured in the personality, they constitute a more severe hurt and create a greater crippling than the one originally suffered." Consider when such attitudes become structured in

the physical body, the armoring becomes the physical layering of increased body mass. Eating becomes soothing and weight becomes protective until it becomes crippling and unforgivable in this fat shaming world. In itself, eating is a relationship. It is an interpersonal relationship between yourself and the taking in of food. Food can bring enjoyment, happiness and positively fuel the body and mind. In parallel, positive relationships with others can bring enjoyment, happiness, and rejuvenation. Therapists can approach the negative relationship some clients have with food as an experience to be repaired. The modeling of certain behaviors around food and how therapists feel about their own bodies can help mend the wounds and develop strength in the body of the client. Most of all, therapists can see the life and love in clients before they see the size of the client. Bioenergetics is a body psychotherapy that can address the shame in the body that is interwoven into the disordered eating. "Shame strikes at the foundations of the embodied self: our grounding, our sense of boundary, our uninhibited breath, our access to a range of emotion and our intention to be present," (Conger, 2001). In using Bioenergetic therapy, I use grounding, boundaries, breath, emotion, and connection to treat the whole client.

Shame

During intakes with my clients on average 66% will include as part of their goals of treatment a desire to get help with controlling eating habits and losing weight. I hear statements such as: "I have an eating disorder; I want to lose weight: I am always on a diet; I can't lose weight; I have an unhealthy diet; I can't stop eating; I am ashamed of my body; I can't do what I want to do." It is not always what brings them to therapy, but it is a part of what they hope to get help with. In my office one day, I gently asked a large client, "What if this is the size you are supposed to be?" Her eyes welled with tears of sadness. "I cannot go places (theater, amusement parks, etc.). I am excluded. I want to be a normal size."

Shame keeps people trapped in their disordered eating behaviors. For example, they may say, "My body isn't okay so I will do what society tells me and go on a diet." When the diet fails, they then feel shame about the failure. Therapists may use the terms overweight or obese with clients without knowing the shame they are creating. Simply stating that someone "looks good" because they have lost 30 pounds, reinforces the shameful idea that they did not look good before. Then when they gain back the weight they are often met with silence or even a disapproving eye and the shame is perpetuated. Complements can be toxic. Inadvertently fueling an

eating disorder. Promoting a certain size. "Oh, you are so thin, you look great." Such a comment can send someone with disordered eating habits directly into thinking, if this is great then losing more will be better. The shame that society places on not being thin is going unchecked, while the "perfect" body that is depicted in magazines and billboards is repeatedly shaming the non-thin world. Society must overcome the deep bias that stigmatizes those living in a large body, (i.e., fat people). The best-known environmental contributor to the development of eating disorders is society's idealization of thinness. This idealization is delivered through shame. Mental health professionals have a moral obligation to assist in stopping the perpetuation of fat shaming.

Mini experiential exercise:

Close your eyes and imagine the most powerful and respected person in your life is standing in front of you.

Now imagine them saying to you "you are fat".

Wait two minutes, and then record how you feel.

Now close your eyes again and imagine them saying, "You have a large body."

Wait two minutes, and then record how you feel.

Compare the two different feelings.

In a group of 25 or so therapists, the discussion following this exercise revealed feelings of sadness, hurt, and shame with the imagery of being told "you are fat." While the words "you have a large body" elicited feelings that were more matter of fact, less hurtful and more acceptable.

Current Statistics (US)

> 1 in 3 adults considered overweight

> 2 in 3 adults overweight or have obesity

> 1 in 3 adults have obesity

~ 1 in 13 adults considered extreme obesity

The above statistics are found at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) website. They are profound and

paint a dire situation. Yet, the terms used are shaming and continue to shame as society jumps on the diet culture bandwagon.

- Overweight is defined as above a weight considered normal or desirable.
- Obesity is defined as being grossly fat or overweight. In the "anti-diet, health at every size, positive body image" world, the word overweight would not be used and instead one would say, "people in larger bodies".
- Body Mass Index (BMI) is used to estimate what is considered overweight and obese. BMI is the tool most commonly used to estimate and screen for overweight and obesity in adults and children. It is a weight-to-height ratio using the following formula.
  For example:
  Wt 150 lbs = 68kg
  HT 5' 6' = 168 cm or 1.68 m
  BMI= 68kg/ (1.67)2 m = 24.2 BMI
  ($150x703/66^2$ = 105450/4356=24.21)

In the medical model the following determinations have been decided (National Institute of Health: National Heart, Lung, and Blood Institute, NIHNHLBI):

- underweight (BMI less than 18.5)
- normal weight (BMI between 18.5 & 24.9)
- overweight (BMI between 25.0 & 29.9)
- obese (BMI 30.0 and above)

$$\textbf{BMI} = \frac{(\text{weight in kilograms})}{\text{height in meters}^2} \qquad \textbf{BMI} = \frac{(\text{weight in pounds x } 703)}{\text{height in inches}^2}$$

- extreme obesity (BMI 40.0+)

The National Eating Disorders Association (NEDA) has concerns about BMI report cards, because BMI screenings, such as the ones done in schools, may be triggering for individuals who are struggling with or vulnerable to eating disorders. The fear is that if an individual is already struggling with an eating disorder, being evaluated in this way may serve as a trigger for continued or worsening disordered behavior.

Health at Every Size (HAES) is a weight-neutral approach that argues the idea that being overweight/obese causes adverse health outcomes. This approach is supported but the Association for Size Diversity & Health (ASDAH) and it rejects the use of weight, size and BMI as proxies for health, and the myth that weight is a choice.

The Health At Every Size® Principles (Bacon, 2018) are:

- Weight Inclusivity: Accept and respect the inherent diversity of body shapes and sizes
- Health Enhancement: Support health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.
- Respectful Care: Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.
- Eating for Well-being: Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.
- Life-Enhancing Movement: Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

In addition to Health At Every Size (HAES), the anti-dietculture promotes the Body Liberation Movement, Fat Activism, IntuitiveEating, Body Positivity, and Joyful Movement. Why diet? The word diet comes, via Latin, from Greek diaita ‘a way of life’. If is food that is consumed by an organism, and also describes the kinds of food that a person, animal, or community habitually eats. American society has hijacked the use of the word to mean eating a restrictive selection of food. The diet industry makes billions of dollars each year. Yet 90% of all diets don’t work. Instead diets make you think about food and cause you to gain weight. “It’s not that people are failing diets; its that diets are failing them.” Dr. Linda Bacon.

The medical field worries that a continued focus on being ‘okay at any size’ may normalize ill-health and prevent people from taking steps to reduce obesity, specifically to diet. Calorie-restricting diets are constantly being reproduced and physicians are continually recommending them to their patients. What is known about diets is that they are part of the

continuing cycle of binge eating, shame, weight gain, shame, and diet again, then repeat the cycle.

Body shaming

The practice of making critical, potentially humiliating comments about a person's body size or weight, often with the intention of motivating the person into changing, is body shaming and is also known as fat shaming. Society (even physicians and other health professionals), have been reported making the following statements: "If they are overweight, it could be good that they feel shame. Won't body shame help them lose weight and make them more healthy? Don't you think shaming people could help combat the obesity epidemic? Aren't you just encouraging people to be unhealthy if you don't say something?" These are not just hurtful statements. These are biased beliefs. Health care providers, even those who specialize in treating obesity, have been found to have negative biases against large people in a number of studies (Teachman& Brownell, 2001).

I suggest it is time for psychotherapists to step to the forefront and examine the part we play in the mental health field and the treatment of disordered eating. As for body psychotherapists, the action is even more imperative. When someone seeks out a body psychotherapist there is an expectation of a higher level of understanding as to how to integrate our mind with our body, no matter the size, shape or appearance. As professionals we seek supervision when countertransference presents itself, likewise, our own biases against large bodies must be considered. In the midst of writing this paper, I received a text from a client that said, "This is why I get anxiety when I have to fly…" She included a link to a news story about a woman who was removed from a plane because she was critically fat shaming the two people seated next to her. The video received over two million views and showed the rude hurtful behavior of a woman seated between two large passengers. My client was sharing her pain with me. I supported her feelings and shared my anguish as genuinely as I could by validating her experience and supporting her worthwhileness. I was left struggling with how to help her accept and love herself exactly as she is now, and that she is loved unconditionally whatever her size. I work to help her feel fully seen ever time she enters my office.

Review of the Recommended Treatment Options:

Treatments of choice covered by insurance include: cognitive behavioral therapy, dialectic behavior therapy, medication, nutritional counseling, group therapy and family therapy.

Cognitive behavioral therapy (CBT) is considered the treatment of choice for people with binge eating disorder. With the support of decades' worth of research, CBT is a time-limited and focused approach that helps a person understand how thinking and negative self-talk and self-image can directly impact eating and negative behaviors. However, studies of eating disorders under CBT treatment have been short, and indeterminate as to whether observed improvements persisted after clients discontinued the treatment. Average CBT outcomes for BED (research) shows 50% good outcome at end of treatment with 60% maintaining this at one year.

Dialectical behavior therapy has also received some attention as being a supportive additional treatment. Clients learn behavioral skills to help tolerate stress, regulate emotions and improve relationships with others, all of which can reduce the desire to binge eat. Perhaps this approach can be used in combination with other approaches.

Though medications are mentioned as part of an over all treatment plan, the long-term effectiveness is unknown and psychotherapeutic approaches have shown to be more effective than medications for BED. The binge-cessation drug Vyvanse is the first FDA-approved medication to treat binge-eating disorder in adults. It is a stimulant also prescribed for attention-deficit hyperactivity disorder and has shown to help some bingers manage eating-related impulsivity. It's not clear how this medicine and some anti-depressants can reduce binge eating, but it may relate to how they affect certain brain chemicals associated with mood. Importantly some physicians recognize that clinicians must not recommend the drug alone. Therapy must be part of the treatment.

Nutritional weight-loss programs are generally monitored under medical supervision. Weight-loss programs that address binge triggers can be especially helpful in combination with CBT.

The support of group counseling and family counseling in combination with other treatments has also shown to have positive impact. Such support has proven to offer beneficial outcomes.

The above treatment options are what insurance companies will sometimes identify as approved techniques, either as stand-alone treatment or in combination with one of the others. Cognitive Behavioral Therapy has the most funding for research and additional research is needed for all other treatments.

Being Seen as Contact

The following is a technique I use with clients to offer connection, relationship, and mindfulness. For a client who is larger or self conscious for another reason, being seen as they are, in a body that they may despise this can be a powerful experience.

In a group this can be completed with partners working together and then trading roles (client/therapist) before sharing their experience.

Steps

1. Instruct the client get as comfortable as possible in their chair. Therapist sits facing the client, but to the side, so that they are closer than knee to knee.
2. The client is instructed to make eye contact as much as is comfortable. If it becomes too much they can look away and then come back when ready.
3. Therapist instructs the client to breath softly, feeling their feet on the floor.
4. Then they ask them to think of a part of their body that they are least comfortable with. To sense that part. To be aware that they are exposed and are being seen.
5. Therapist then breaths with the client, softly and deeply, and gently makes empathic eye contact.
6. After a few minutes the therapist says I see you and I accept you. (Perhaps, you are perfect as you are.)
7. Therapists checks in with the client and asks if they would like any contact, like hand-to-hand, or hand on shoulder, etc. (Some clients begin sobbing and end up being held.) Therapists will provide support in a manner that is safe for the client, and with the clients permission.
8. To close the therapist will help ground the client and explore the experience.

I use the above technique with clients in a session. There first time I conducted this exercise in a group was at the PDW. The impact was powerful as participants shared their experiences and the profound way that they were able to connect with parts of themselves that they identified not only as uncomfortable, but even disgusting. They were seen by another in their dark place and the door was opened for their shame to be released. Shame is debilitating and often makes people believe that they cannot be accepted by anyone. This process can continue to be a powerful experience as they move about in the world with a new experience of being seen

without judgement. With my clients, as they learn to accept themselves as I have accepted them, we begin the steps towards reprocessing their body shame.

What are we treating?

This question continues to arise for me. Are we treating the impact of shame, a disordered eating process, or a body weight issue? Do we help them with weight control, or do we help them to realize that this is the weight they are supposed to live with? Is there an eating problem or a weight problem? Their shame is in the room. What do we choose to allow in the room based on our shame? I do not have these answers yet. One inspiration I have to finding more answers came in the incredible documentary form 2016, *Embrace*. Body Image Activist Taryn Brumfitt posted an unconventional before-and-after photo in 2013 and it was seen by more than 100 million people worldwide and sparked an international media frenzy. The movie follows her crusade as she explores the global issue of body loathing. It is educational and inspiring as it invites people to change the way they feel about themselves and think about their bodies. I encourage mental health professionals to view and consider how clients walk into our offices pushed by societies non-excepting ideal with the belief that they will never be the 'right' size.

Hope for the Future

In 2008, Morgan Lazzaro-Smith published a study of Body Psychotherapy and Eating Disorders. He posed the profound question: Will therapists of any orientation acknowledge, and even incorporate, the beneficial somatic elements into their practices when working with eating disordered clients? He concluded that it makes little sense to attempt recovery without some sort of body-oriented work, and suggests that body psychotherapy offers a unique orientation and set of techniques, which can be particularly suited to treating eating disorders.

How can Bioenergetic Therapy be useful? The body of someone with BED may be viewed as a source of pain and something that needs to be controlled. There may be a sense of mistrust of the body, its urges, its hunger and fullness signals. One may also feel cut off from a sense of nourishment. Bioenergetic Analysis can facilitate deeply honoring the reasons why this body is in the shape it is in. Building a relationship, bioenergetictherapy offers an avenue to shift from opposing and fighting the body to aligning with the body. An opportunity if presented to allow the client to feel more at home in their body, to view their body as a valuable

tool, a resource, and an ally, and to repair the disconnection between mind, body, and emotions. Bioenergetics offers the opportunity to work toward a beneficial and compassionate relationship with the body and the experience of true nourishment through the depth of the therapeutic relationship. This process gives the client the opportunity to repair the young, childhood relationship that might be the catalyst to the disordered eating behavior.

> "All of us in civilized countries have some shame about the body and its animal functions, but few patients talk about their shame. They are too ashamed to talk about their shame and, being sophisticated, they deny it. Most people have some dark secrets they are ashamed to reveal, and sometimes they even hide them from themselves. Fear, envy, disgust, repulsion and attraction, when hidden because of shame, become important barriers to the surrender to love."
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> *Joy: The Surrender to the Body and to Life,* Alexander Lowen.

In conclusion, I am not opposed to nor do I intend to negate benefits shown by other psychological treatments of eating disorders. My intention is to encourage the inclusion of body psychotherapeutic approaches such as Bioenergetics as a treatment option and to encourage longer term research that can verify its efficacy as a treatment that is less prone to relapse. In life threatening disordered eating, any treatment that shows quicker success and moves a patient out of immediate danger must be primary, and in such a situation the long-term resistance to relapse can be addressed after stabilization. In such situations I strongly support the blending of multiple modalities to offer the best success. It is time for research to be expanded to include body psychotherapeutic approaches. The facts are that there remains too little research and running long-term experimental interventions is very difficult.

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