

Hunger Diseases: Eating Disorders, Self Injury and Compulsive Shopping
Santa Barbara Therapy News, February 2006

One of the major psychological commonalities in eating disorders, self injury and compulsive shopping is the underlying psychic hunger. In his book, Hunger Diseases, Raymond Bategay addresses this drive and defines hunger diseases as all those states in which people are driven to consume objects and to consume them in an addictive manner. In my experience, people don't just wake up one day and "have" anorexia, debt, or slashes on their arms. The deprivation that is being acted out has been operating for so very long, perhaps since the early stages of development and attachment.

By looking at these self destructive behaviors from the perspective of hunger diseases offers several treatment strategies. One, at the core of the hunger disease is pain and as a means to self soothe the patient has developed self harm. This is a sad reality, but when understood and given to insight, the patient feels understood and hopeful for change. For example, a client recently began hitting herself. She reports that she has never done this before this last year even though she had previously been in therapy, been hospitalized for suicidal ideation and on psychotropic medication. She has a history of abandonment and sexual abuse. From a hunger disease perspective, her history may have contributed to the incorporation of very negative feelings and emptiness. Her self harm is a means to fill the void she feels when frustrated, overwhelmed and confused. The self harm soothes her hunger for closeness because she cannot tolerate the feelings of hunger or wanting. She feels bad to want so she abuses herself. When in therapy, she seems very sensitive to any rejection or invalidation and may even look for those acts in the therapist as a means to validate her own unworthy feelings about herself. If she feels wanted or validated in therapy, this may both soothe her and increase her anxiety and resistance because she is not accustomed to feeling acceptable. It is important to balance validation and silence in therapy sessions with someone highly sensitive in this nature. The most important thing to do at the outset is to contain the self harming behavior and to develop a trusting, flexible therapeutic relationship with boundaries. Once these are established, the goal of treatment is to address the hunger disease and help the client feel like she can contain her own feelings and control her reactions. By helping her connect what happened to her early in life and with how she acts out toward herself will be very important because she feels so confused by her self harm. Also, as the adult she is, she will feel more able to control her behaviors and react less like a child still reacting to early experiences.

Second, hunger diseases begin at very early stages of life and grow and develop into ingrained behaviors that are resistant to change. Clients typically have been in treatment and feel they failed so they drop out, have been in debt before, paid off their credit cards, and are in debt again, go on diets and then go off of them, and so on and so on. The pattern is one of inspiration, feeling of failure and then hopelessness. Hunger diseases can trace the etiology of self destructive behaviors and explain how it has become addictive

and very important to the client. For instance, a client presents in therapy with severe bulimia. She binges 3-4 times a day and purges with ipecac. She also reports having difficulty with finances and spends money she does not have. She buys a lot of food, clothes and jewelry. She said she has been bulimic since adolescence and no one in her family felt like it was necessary for her to get treatment. She comes to therapy now because she is worried to go on living this way but only has a few months to “get better” before she moves out of state.

This case presents a client who is disturbed by her lifestyle and harried to stop or get rid of her eating disorder. Her focus is on the end result rather than the process by which these behaviors take place on a regular basis. This is important because in order to really “get rid” of her disorder requires in depth psychological work to undue her religious patterns. She also maintains the feeling that her bulimia and spending are not a part of her, instead something that comes and goes. When approaching from a hunger disease the chances for future severe regression is less because the deeper disease will be addressed rather than just the symptom. In this case, resistance is expected because it takes longer to deal with deeper issues than just a symptom. By talking about this early in treatment with the client, she may be able to commit to longer treatment and an interest in herself. The explanation may make sense to her because she has not been able to sort out why she is so violent to herself. Through the short course of therapy, she was able to understand that she had been emotionally neglected much of her life, particularly when she had been self destructive. She had integrated self abuse in accordance with incorporated neglectful feelings toward herself. She had rarely felt worthy of self care and had not developed self regard. This attitude toward herself is also the attitude she adopted toward her disorder and therapy, that she did not need therapy, wanted to get rid of her disorder and it shouldn't take a long time to do all of this. Although she left treatment for a short period of time, she has now returned understanding her fear and resistance while also comprehending the depth of her hunger disease.

These examples just begin to address the complexity of the hunger that lies beneath self destructive tendencies. Understanding the disordered behavior from a hunger disease perspective can lead to a stronger recovery and resistance to resolution. Much of the therapy is balancing these two possible states and working with the client in the middle of them. Working in the process of therapy and acknowledging the therapy relationship throughout treatment can bring about more insight, action for change and empathy.

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