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Shame, the Affective Side of Secrets: Commentary on Barth's Hidden Eating Disorders

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Abstract This paper expands on the ideas presented by Barth's article on hidden eating disorders. The topic of eating disorders continues to be an important focus of clinical work. Applying constructs related to the experience of shame, I explore the way that feelings of shame may impact an exploration of eating disorders by the patient and clinician.

Keywords Secrets · Attachment · Eating disorders

Over 20 years ago, I worked with a young woman who came to therapy after being discharged from a drug rehabilitation program. She described a childhood in which her mother was critical, abandoning and unloving. Intermittently, she would miss sessions. It took me some time to realize that she would experience some comment I made, or question I asked, as critical of her. As I understood this, we learned how to talk about what was happening. After about a year, this same woman began to tell me, for the first time, about the way that her grandfather sexually abused her. I was struck, at that time, by how long it took for her to feel able to tell me about her experience.

In another situation, a woman came to see me because of an eating disorder. As often happens with patients who come with a presenting complaint of an eating disorder, after an initial session during which she talked about her binging, little was said about her eating problems. The sessions began to focus on her marital relationship or work. Although she came to her sessions regularly, and always had something to talk about, I had the felt sense that something was missing. There was a deadness or emptiness, perhaps with the question, where are we going? This particular patient was African American. Although the difference in our race didn't feel uncomfortable to me, I did wonder if this was something we needed to speak about. I raised the topic by asking her if she had any thoughts or feelings about seeing a therapist who was white. Although this did not evoke an immediate reaction, she did begin to speak to me about a family member who was in prison, and how ashamed she was of this. As she was able to share this shameful secret with someone who responded empathically to her feelings, she was also able to explore, in a more meaningful way, her binging and dissatisfactions with life.

These vignettes demonstrate that what the patient tells us in the first few sessions, may not be all that he or she is struggling with. I agree with Barth (2008). Hidden symptoms do not mean that the therapy is unhelpful. Patients have secrets, hidden parts of themselves that may not emerge in a particular therapy. In my experience, sometimes the patient does not even consciously remember the secret. Furthermore, the literature suggests that after natural terminations, patients who have internalized the experience with their therapists continue to reflect, develop insight and in other ways benefit from the experience (Siebold 2007). It may be because the therapeutic alliance was good that a patient, who didn't reveal the secret in an earlier therapy, seeks further treatment when he or she is ready to share, or to know, a shameful secret.

Secrets could be considered another phenomena of the therapeutic process. As Barth (2008) notes, when the secret is revealed, the therapist may wonder if she or he has done something wrong. With the first patient, who had been sexually abused, I certainly did wonder if I had missed something, and I may have. My inexperience as a therapist

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may have made me clumsy in my comments. Perhaps the critique she experienced from me earlier in the treatment, encouraged her to hide her more painful memories. But I have also come to recognize that the evolution of the therapeutic relationship is different with each patient. Together we create a unique model of relationship that is both old and new for the patient (Schafer 1983). Attachment theorists have suggested some broad categories for these models of relationship, but each therapeutic dyad is unique, as is the mother child dyad (Tronick 2003). Moreover, the therapist role is not to control the development of relationship, but as Barth's detailed description of Alice demonstrates, to allow it to emerge over time.

Before elaborating on the theme of hidden eating disorders, I would like to comment on Barth's points regarding diagnosis, affect and attachment. In her depiction of the complexity of eating disorders, Barth reminds us of the limitations of using a symptom or behavior to assess a patient's struggles. Since the DSM III, assessment and diagnosis have increasingly emphasized behavior or symptoms as a way to determine diagnosis, and guide treatment. As Barth demonstrates, there are many ways in which behavior around food can be elaborated. Anorexia, bulimia and compulsive overeating can emerge singly, or in a variety of combinations. Although particular symptoms can be thought of as reflections of a patient's culture (Littlewood 2002), symptoms such as eating disorders are also strategies to not feel one's feelings (Birksted-Breen 1989). As Barth asserts, along with difficulty tolerating affect, the patient may be struggling with attachment issues related to knowing and accepting oneself and an other. Rather than focusing on the eating behavior, efforts to raise awareness of affects, or to strengthen the patient's capacity for connection (Chiozza 1999) may prove more fruitful than efforts to cognitively explore and contain symptoms.

Barth (2008) describes in detail the therapeutic process with Alice, who is struggling to understand who she is, and why she feels as she does. As a result of this process, Alice shares her secret about eating. Barth asserts that for Alice, the relationship needed to be experienced as secure before Alice could begin sharing her secret eating behavior. Barth's discussion of the need to create a secure attachment is consistent with Bowlby's (1984) application of attachment theory to the therapeutic process. He asserted that it is first necessary to establish a secure base with patients, before dreams and fantasies can be analyzed, or interpretations made. Bowlby's idea of a secure base seems similar to Barth's (2008) depiction of Eagle and Wolitzky ideas about 'creating a safe haven.' Although I agree in part with Bowlby's idea, as I have noted elsewhere (Siebold 1999) it may be difficult to keep these activities separate. Some patients want to hear interpretive comments or reflect on dreams before they trust us and that becomes part of creating a secure base. Usually it depends on the patient. Attachment theory also recognizes that the earliest models or patterns of behavior are largely a component of implicit memory (Cozolino 2006). Often with our patients, part of the initial work is to find ways to establish new patterns of experience that will help them put words to their feeling states and lead to a more secure relational experience. Barth's use of inquiring about the details of the patient's life, seems to me to be an example of one way that the therapist might encourage a new model of interaction, a model that leads to greater connection with another person and greater integration of feelings and experience.

Having said that, there is another aspect of secrets that I would like to discuss, which further illuminates this issue of hidden material emerging in the treatment. Secrets can also be understood as being associated with feelings of shame. As Morrison (1984) notes, shame leads to hiding and hiding leads to shame. In the remainder of this commentary, I would like to elaborate on the evolution of our thinking about shame, and then present a clinical example to illustrate these ideas, and their relation to affect tolerance and secure attachment.

Although Breuer and Freud (1893–1895) identified shame as a significant early affect, its importance in psychoanalytic thought was eclipsed by the emphasis on guilt and conflict (Morrison 1986). Since the 1950s, discussions of shame as a significant affect have emerged in the writing of Lynd (1958), Tompkins (1962–1963) and Lewis (1971). These therapists perceived shame as a core affect and motivational force. Lynd (1958), for example, acknowledged the importance of shame in the development of a sense of self. Tomkins (1962–1963) noted that affects such as shame are illuminators of experience and are an impetus for giving meaning to what happens. Lewis (1971) emphasized shame within the context of treatment. She pointed out that shame was a common experience of the patient early in the treatment. Morrison (2006) has since elaborated on Lewis' discussion of the patient's shame responses in treatment, to include the therapist's experience of shame in interacting with the patient. He suggests that when the therapist errs or is responded to defensively by the patient, the therapist's shame can lead to defensive, shame-filled responses by the therapist.

Shame is described as a deeply hidden, but pervasive emotion. Simply put, shame is a feeling directed toward who one is, whereas guilt is a feeling that is directed toward an act. Shame is a passive experience in response to rejection or external trauma, whereas guilt is an active effort to adapt or compensate for conflicted desires. Humiliation, inferiority and embarrassment are terms that also may signify feelings of shame (Lansky 2003: Morrison 1984). One experiences shame when he or she perceives the self negatively from the point of view of another.

Shame, therefore, is a response to rejection, stigma or social disapproval. Lynd (1958) asserted that shame is associated with self-esteem and that it demonstrates consciousness of a whole self. More recently, infant researchers have observed and coded early affective response to threats or trauma as arousing feelings of shame (Sander 2004). Feelings and experiences in infancy, as Barth (2008) has noted, are important implicit experiences that impact the later development of meaning. If we allow that experiences of shame by the infant are encoded as implicit memories, the feeling of what happens (D'Amosio 2000), then later experiences may in part be associated with, or reactivate, these shameful, encoded memories. Loewald (1955) points to this possibility when he describes the way that memory traces of trauma from early in childhood, which are not well integrated, are subsequently associated with later experiences (Nachträglichkeit). In this complex process, the memory traces give meaning and import to the new experience that further complicates the individual's contemporary struggle.

Although shame responses are understood to be associated with the earliest experiences of self, they can also be a response to conflicted strivings. Breuer and Freud (1893–1895) first noted that shame was the affect that gave rise to repression of memory, and the formation of hysterical symptoms. The defensive process of repression occurred to protect against "the incompatible idea," a thought that conflicted with one's view of how one should think or feel. Breuer and Freud's early formulation about shame included the idea that to avoid shameful feelings, memories were repressed and emerged as symptoms or repetitions. Lansky (2003) has expanded on this aspect of shame. He suggests that shameful feelings emerge as the result of the person's inability to meet up to his or her ego ideal. He preserves Breuer and Freud's (1893–1895) idea of shame as an intrapsychic process that defends against other affects such as anger or anxiety, or that leads to the formation of symptoms. In considering the association of shameful feelings for patients who binge or purge, such behavior is often a secret behavior that may reinforce the patient's sense of defect. As I noted earlier, eating behaviors also are a strategy employed by the patient so that she or he can keep painful affects out of awareness (Chiozza 1999). An example of this might be the patient with anorexic behaviors, who focuses almost exclusively on food intake, so that she or he won't have to remember the feelings related to parental criticism or rejection.

Lewis (1971) in examining sessions with patients found that although infrequently acknowledged by therapist or patient, shame responses are a common aspect of all sessions. Her research further suggests that feelings of shame can be aroused when the patient feels distant, rejected, criticized or exposed by the therapist. She adds that because the anger or rejection from an outside source is experienced passively, experiences of shame leave the person vulnerable to depression. Additionally, Morrison (1986) suggests that rage expressed by a patient may be an expression of shame. Understanding shame as an important part of the therapeutic process is another way to think about Barth's point that for eating issues to be revealed, the patient needs to feel secure. Said differently, the patient needs to not feel shame when revealing the secret to the therapist. If we allow that one way that the therapist alleviates the patient's guilt is by being the benign superego, then the therapist may alleviate shame by acceptance of the patient as she or he is. One way that the therapist demonstrates acceptance is by listening (Morrison 1984).

In applying some of these ideas about shame to people who binge, purge or starve we could consider that there is often a great deal of secrecy and shame around eating behaviors. We know this from what our patients report or don't report. Purging, for example, is often done in secret and the patient may not reveal the behavior or may not discuss incidents of purging. When a patient does express such behavior, in my experience, it is often best to listen and explore feelings and experiences that were associated with the behavior, rather than to be overly focused on the purging itself. If we consider that the patient is experiencing a great deal of shame about the behavior then our focus and attention on the behavior may further exacerbate the sense of exposure and feelings of shame. Overemphasizing the behavior may lead to patient compliance or he or she may feel unable to speak with us about it, and avoid treatment.

Millie is a case in point. This was a patient who had done it all—starving, purging and compulsive overeating. She was a seasoned patient. When she first came into treatment she was thin, but over time she began to gain a substantial amount of weight. She described a history of having her food excessively restricted. According to Millie, her mother had been obsessed about weight, her own and her daughter's. For as long as she could remember, Millie was expected to stick to a rigid diet. Not surprisingly, Millie became obsessed with food, and would continually try to sneak food. When caught she would be humiliated, beaten or be sent to her room. Both Millie's father and mother were critical of what they perceived as Millie's fat body.

Over the years, Millie struggled with compulsive eating. At times she was a little chubby, and her mother would ridicule her. Millie's mother's focus was on dieting, while her father's emphasis was on how a woman's body looked. Millie's father let her know that he considered model thin to be the right look for any woman, including Millie. As an adult, eating was a continual challenge for Millie. At times she would diet excessively or abuse laxatives and at other

times she would become overweight. As I said, at the beginning of treatment, she was slender. She spoke of her painful experiences with her mother and her feelings about food. One of my early comments to her as I listened to this history was to say something about how her mother seemed overly concerned with food. I do not know exactly what I said, but I think that I was trying to acknowledge how Millie might have felt intruded on by her mother. Millie heard this as my minimizing her experience and was furious with me. In that moment, she raged about my inability to take her experience seriously.

One way to think about her response was that she was trying to ward off feelings of shame. Speaking about her mother, as Millie was sharing her shaming experience of mother with me, may have caused Millie to feel as if I were part of a familiar model of interaction in which mother shamed her for her eating behavior. Recognizing that I had stepped into something, I listened attentively to her feelings. It seemed to me that any attempt on my part to explain my intentions would continue to arouse the feelings of shame that were part of her memories about food. As our understanding of trauma and memory has evolved, we further understand that when traumatic memories are aroused, past and present are not easily distinguishable. Thus, traumatized patients may have a difficult time separating what is happening between themselves and their therapists, and the powerful feelings that are associated with the affective memories stirred up by the therapeutic process. These thoughts helped me to be quieter with Millie and allow her to tell her story. As her rage abated, I attempted to empathize with her feelings of intrusion, helplessness or shame.

As the therapeutic process continued, she began to gain weight. She hesitantly acknowledged after 6 months that she was compulsively eating, and would often do it in secret. In sharing this with me in a more collaborative way, I felt that Millie was asking me to comment. I acknowledged how painful it must feel to again struggle with eating, but perhaps we could try to understand it. I did not focus on trying to help her stop her behavior, or try to interpret it. For example, I was tempted to suggest that gaining weight was a way to protect herself from connection with me. Although there were other ways that I might explore with her how difficult it was to trust me, I felt that connecting this to her weight gain might again be experienced as critical and shaming, rather than an effort to understand. Instead, I allowed her to control when discussions about her weight occurred, and I tried to convey an acceptance of her as she was, including her need to eat. I cannot say that at times I wasn't alarmed at her weight gain, but I also knew that this had happened before.

Over a period of 2 years, as Millie was able to express her shame and sense of damage, she was also able to better organize her experiences as a child. As she was able to consider that her childhood experiences were not all her fault, her sense of shame and inability to tolerate my thoughts reduced. The reverse was probably also true. As she felt less shame and sense of defect, she was able to understand that she was not at fault for what had happened during her childhood. She recognized the damage she was doing to herself in overeating, talked about it with me, and allowed me to support that it was important to take care of her health. She began to take steps such as going to the doctor, and developing a healthier lifestyle. This time she approached changing her eating behavior differently. Instead of starving and exercising to excess, she more moderately reduced her eating and started walking with friends.

The alleviation of her sense of shame and defect continued to impact her world. She found a job she liked, her relationships improved and she began to accept her body for what it would be. To summarize, shame is a response to feeling rejected, and criticized by the self and others in the external world. Moreover, although deeply felt, shameful feelings may be camouflaged by other behaviors such as overeating, starving or purging. Fear of rejection and attendant feelings of shame may be aroused in a number of ways.

Therapists too are vulnerable to shame. If our ideal is that patients will share all their secrets with us, then we are likely to experience disappointments in ourselves when we find out otherwise, thus potentially leading to our own feelings of shame. For example, with my patient who told me after the first year of therapy that she had been sexually abused as a child, I did have to explore my feelings of surprise and defect that I had not picked up on this history before. With Millie, when she revealed that she was binging and gaining weight, I was concerned that my not knowing or noticing this was something I was doing wrong. Being defensive about not knowing could leave the therapist vulnerable to feelings of anger or rejection toward the patient for keeping this information secret. Alternatively the therapist might become overly focused on the symptom once it is revealed to compensate for his or her perceived failure. Recognizing these responses in ourselves is an important aspect of our own growth. By not talking about their mistakes or confusion, therapists too can be vulnerable to keeping secrets, and struggling with attendant feelings of shame and defect.

Conclusion

Barth (2008) has provided us with a detailed case example of the way that secrets are revealed in the therapeutic process. As she describes her patient, there are a number of

phenomena that might shed light on what happened. In particular, fostering Alice's attachment to the therapist, affective awareness, and belief in her own worth all facilitated this patient's ability to share her hidden eating disorder with her therapist. To this discussion, I have elaborated on the way that shameful affect or sense of defect may contribute to secrecy on the part of the patient. My patient Millie responded with rage and avoidance when I attempted to talk about what had occurred in her family. In Alice's case she kept a secret for many years. She also missed sessions. Missing sessions might have occurred for many reasons, but in part this action might have been an unconscious attempt to hide from the therapist when her sense of shame or defect was too overwhelming.

As psychoanalytic theory continues to evolve, we have increasingly expanded our understanding of mental processes to include the physiological processes that are part of mental life. Affect, thoughts and attachment are part of a mental system, which as therapists, we are attempting to influence. In this paper, I have attempted to look at one way that shameful feelings may impact a patient's attachment and construction of meaning in the therapeutic dyad. In conclusion, I would like to thank Diane for getting us started on this journey of exploration about secrets.

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