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## A two-Paper Examination of Secure Body Attachment in the Prevention and Treatment of Eating Disorders

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## Abstract

ABSTRACT

A TWO-PAPER EXAMINATION OF SECURE BODY ATTACHMENT IN THE PREVENTION AND TREATMENT OF EATING DISORDERS

Author: Suzanne B. Daly, LCSW

Supervisor: Marcia L. Martin, PhD

These two papers seek to build the argument that the particular physical presence of the body is a significant aspect of the attachment relationship between two people, and, for the purposes of this theoretical-conceptual dissertation, most notably between two females. Since body dissatisfaction is increasingly normative for women today, maintaining a secure attachment to one's body occurs against the grain of cultural practices that constrict, exploit, and separate women from their bodies/bodily needs. This makes it particularly challenging for women to feel good enough in their own skin/body, let alone serve as a good enough model for someone else. Thus, mothers and female clinicians alike need to have a blueprint on which to rely when they encounter a shared body experience with their female children/clients. The first paper will argue that without a model of secure attachment to the body, females are more likely to develop an attachment to cultural ideals as an extension of primary relationships and at the expense of their own bodies, moving them from exposure to action in the form of eating disorders. The second paper will expand on paper one by illustrating how the therapeutic relationship, through its responsiveness and consistency, can invite a type of reenactment of the proximity-seeking behavior that results in the creation of a "secure base," which can be used by the client to experience a sense of secure attachment and begin to shift the nature of her attachment to her own body.

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A Two-Paper Examination of Secure Body Attachment in the Prevention and Treatment  
of Eating Disorders

Suzanne B. Daly

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Supervisor of Dissertation

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A TWO-PAPER EXAMINATION OF SECURE BODY ATTACHMENT IN THE  
PREVENTION AND TREATMENT OF EATING DISORDERS

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Suzanne B. Daly

## DEDICATION

This dissertation is dedicated to my partner and my playmate, Vincente Grosso – a person who truly epitomizes the good enough Winnicottian body. Through his ability to make enough room for hate in love, he has shown me the meaning of secure attachment.

## ACKNOWLEDGMENTS

This page is reserved for a special recognition of some of the most important and influential women in my life. To all the women who engender the Women's Therapy Centre Institute in New York City, I will be forever grateful to you for providing me with a sisterhood I have always longed for. You are a force to be reckoned with, and through you, both collectively and individually, I have acquired the distinctive language that helps my patients to actually heal. To my supervisor, Andrea Gitter, thank you for providing me with a good enough supplemental body through which I continue to grow and trust my own inner wisdom. You have exemplified the premise of this dissertation; no body is a body that can be extrapolated from its context. You have helped me see the fundamental connection between psyche and soma - in my patients, in my own experience, and in all the spaces between. To my therapist, Ellen Singer Coleman - you embody the type of clinician I aspire to be - self-reflective, honest, brave, and unwavering. You have provided the type of holding environment that I have always needed but never had the words to express. Thank you for tailoring the tiny invisible stitches that have made me more whole. To my dear friend and number one on my speed dial, Joanne Messina, I can only express to you my deepest appreciation through the words of Maya Angelou; "Love heals. Heals and liberates. I use the word *love*, not meaning sentimentality, but a condition so strong that it may be that which holds the stars in their heavenly positions and that which causes the blood to flow orderly in my veins." You fulfill my need for twinship. Thank you for your endless love and support - without which, I am quite certain the blood would not flow orderly in my veins. To my committee member, Robin Hornstein - you are a gem. I knew it the moment I interviewed you for my qualitative research class. Thank you for inviting the body into the consulting room. You have been a catalyst for this work. Last, but certainly not least, to my chair Marcia Martin - low and behold confidence is transferable. You have provided a different prism through which my self and my spirit are refracted. Thank you for leading me further towards the elusive delight of recognition and repair. This dissertation would not have been possible without you.

## ABSTRACT

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“The body speaks no known language, yet it serves, time and again, as a framework for communicating the psychic scenes of the internal theatre” (McDougall, 1989, p. 53).

## SHARED INTRODUCTION

According to Applegate (2000), theories are formed from intuitive reflection on a case-by-case basis, and “This praxis evolves from a rich interweave of art, craft, bits and pieces of theory, and the intersubjectivity of each client-clinician system” (p. 150). This two-paper theoretical-conceptual dissertation has evolved in much the same way. In my work as a female clinical social worker specializing in the treatment of problems relating to food, feeding, and the body, I have become acutely aware of the particular needs of the developing female body as a special area that demands further investigation. I will be looking specifically at how females’ relationships with and attachment to their own bodies take shape in female matrices, beginning with the mother/daughter dyad, and later with female therapists treating female clients suffering from problems relating to food and the body.

This work posits that the particular physical presence and meaning assigned to the body finds its actual roots in significant aspects of the early attachment relationship between mother and daughter with particular emphasis on how culture passes through a mother who embodies gendered social norms that reflect the idealized body. The focus on women is not intended to suggest that men are not affected by the cultural emphasis on body dissatisfaction, nor is it designed to imply that fathers do not play a significant role in the attachment experiences of their children; rather, the purpose here is to narrow the focus and consider the role of body attachment as it relates to the prevention and treatment of eating disorders in female dyads. The first paper considers the contribution of the cultural body ideals as they influence the attachment nexus that takes shape

between mother and daughter, with specific attention given to the implications of an insecure attachment to one's body. Biological and psychological components will be addressed in exploring the impact of attachment/relational trauma on a female's developing self and susceptibility to eating disorder symptomatology played out against the backdrop of an oppressive sociocultural landscape. The second paper examines how the client-therapist relationship can repair the problems that emerge when an insecure attachment to the body is modeled and passed along from mother to daughter.

As a profession, social work has always been concerned with the biopsychosocial approach to treatment which looks at the person-in-the-environment, but has focused less on helping clinicians understand the complementary phenomenon, "the situation-in-the-person." Thus, what is "outside" often gets "inside" and shapes the way a person grows, thinks, and feels (Berzoff, Flanagan, & Hertz, 2011, p. 122). Social workers are routinely involved with clients whose lives are profoundly influenced by "outside" traumatic, painful, or degrading bodily experiences. While in our culture, the female role is complex and contains many, and sometimes contradictory, responsibilities, appearance standards continue to be fundamental to how women are defined. As many scholars have argued, to be "woman" is to be an object of viewing pleasure, and thus the physicality of the body is primary in importance. As suggested by Davis and Vernon (2002), by embracing the misogynistic values of the culture regarding women's bodies, women, as mothers and as therapists, often can pass on a legacy of female devaluation. If a mother receives and internalizes the cultural pressures that focus on the female body, such as self-denial and body scrutiny, she conveys this body insecurity to her daughter and thus transmits aspects of anxious attachment, characterized by excessive approval-seeking and concern about

acquiring the love of others. Given this sustained, intimate connection with the body and its many and varied conditions, the shared body experience between two females (mother and daughter and female clinician and female client) deserves greater attention in social work theory and practice frameworks.

A shared body experience, for the purposes of this dissertation, refers to the common fantasies and fears that arise from living in a female body, and points to the need for inquiry about the assumed malleability of women's bodies in relation to sociocultural ideals. The predominant framework for this two-paper theoretical-conceptual dissertation includes an understanding of culture, which is part of what Hartmann (1958) called the "average expectable environment," and the cultural context, which must inform careful assessment and intervention. Nowhere is this more applicable than in the field of eating disorders where clinicians encounter women who risk their lives to inhabit what the culture has fabricated as "an average expectable female frame." Since body dissatisfaction is an increasingly normative experience for women today, it can be particularly challenging for mothers and female clinicians to feel secure enough in their own skin/bodies in order to supply a secure body attachment for developing females (children and clients) to use for their own embodiment. Mothers and female clinicians alike need a blueprint on which to rely when they encounter a shared body experience with their female children/clients.

According to Winnicott (1958), the ability to tolerate, enjoy, and make use of healthy solitude is developed paradoxically in the presence of another. This two paper dissertation reasons that the ability to tolerate, accept, and enjoy one's body comes from being in the presence of another who can tolerate, accept and enjoy her own body despite

any real or imagined flaws, as measured against the cultural ideals. A mother/clinician who accepts societal messaging that objectifies women, will likely treat her own body as an object to be worked on and mistrusted, thus, undermining the daughter's/client's ability to form a secure body attachment (i.e. feeling that the body is trustworthy and entitled to good care). As suggested by Schore (1994), this analysis recognizes that "there is no dichotomy between the organism and the environmental context in which it develops. The physical and social context in which development occurs is more than merely a supporting frame; it is an essential substratum of the assembling system" (p. 63). Thus, for the purposes of this dissertation, Winnicott's (1971) concept of "potential space" between the individual and her environment will be utilized as "the location of cultural experience" (p. 95).

In a culture that celebrates slenderness, as a child grows, she especially needs her mother to be secure enough in her own body in order to provide adequate holding and containment. In infancy, a child needs her mother's body as a secure base to soothe and contain, as well as "to poke and probe, to possess ruthlessly, to explore fearlessly" (Looker, 1998, p. 242). Mothers with secure attachments to their bodies do not feel easily threatened by their children's desire to explore their bodies, and can maintain a sense of feeling 'good-enough' despite the cultural expectations. These mothers are less likely to be preoccupied with the cultural ideals, thus allowing their daughters to simply exist - what Winnicott references as 'going on being.' On the other hand, a mother's insecure attachment to her own body perpetuates the notion that a woman must learn to dissociate from her body's needs, rather than from the noxious cultural messages about the ideal body. This insecure body attachment can serve as the tipping point that moves a woman

from exposure to action in the form of an eating disorder when confronted with cultural ideals. Paper one utilizes attachment theory to aid in the understanding of and handling of the shared body experience between mother and daughter. Through this shared experience, maternal behaviors that indicate an insecure attachment to the body get passed down to daughters and serve as the perfect aperture through which daughters not only receive, but also internalize the thin ideal and, as a consequence, develop strong, culturally determined object relationships.

Over the past few decades, there has been growing concern with both the ways in which Western culture contributes to the high rates of eating disorders, depression, anxiety disorders, and psychosomatic problems among females, and the pronounced increase in risk that occurs in early adolescence. Although there is agreement that eating disorders are not only psychiatric in nature, but also symptomatic of a larger social problem, the literature has not adequately addressed the issue of understanding why some individuals exposed to sociocultural messaging around a body ideal internalize those messages and ultimately develop eating disorders while others do not. Although the effect of these cultural influences is significant, familial influences undoubtedly contribute to the complexity surrounding the etiology of eating disorders. By placing the emphasis on the role of attachment/relational trauma resulting from mothers who are not securely attached to their own bodies, paper one will develop an argument that the intergenerational transmission of body insecurity is the foundation trauma that leaves women more susceptible to identifying with the popular cultural messages. Given that most perpetrators target vulnerable, insecure beings, this analysis will include an examination of how consumer culture presents images to women in much the same way;

sociocultural ideals target vulnerable, preoccupied, and insecure bodies that are in desperate need of approval, acceptance, and recognition, and they are deliberately designed to subliminally and opportunistically influence their inner object formation via visual, aural, and symbolic means (Gutwill, 1994a).

While the research indicates that an insecure style of attachment to primary caregivers can leave children more susceptible to the development of an eating disorder, attachment theory and eating disorders are rarely discussed in the literature in terms of how one's attachment style to one's own body can influence the course and nature of symptoms. Paper one will demonstrate the way in which eating disorder symptomatology functions as an attachment disorder, replicating the earlier caregiving experiences, including the nature of the mother's care for and attachment to her own and her daughter's body. Attachment theory recognizes that the maternal–infant relationship serves as the psychobiological regulator for the development of the infant's brain and for the evolution of the nature of its emotional self. This analysis will apply attachment theory to the evolution of the nature of the physical self, thus illustrating how the development of a secure attachment to one's body can function as a buffer against pervasive sociocultural influences in a way similar to the neurological and psychological advantages of forming a secure attachment to primary caregivers. Therefore, it is not just the nature and quality of the attachment relationship between female child and mother, but also the learned style of attachment to the physical body that places women at an increased risk and vulnerability to the later development of eating disorders.

During the past thirty years, attachment theory (Bowlby, 1980) has emerged as one of the most important conceptual frameworks for understanding affect regulation and

human relationships (Mikulincer & Shaver, 2007). Although eating disorder symptoms like starving, bingeing, bingeing and purging, and over-exercising have been considered in terms of how they function as an attempt to regulate one's affect and psychological state depending on one's earlier attachment experience, attachment theory is only recently being applied to research on eating disorders (e.g. Illing, Tasca, Balfour, & Bissada, 2010). While attachment security provides a reliable platform for the development of independence and affect regulation, not surprisingly, the research to date indicates that women with an eating disorder have higher levels of attachment insecurity than those without an eating disorder (Barone & Guiducci, 2009; Fonagy et al., 1996; Illing et al., 2010; Troisi et al., 2006; Ward, Ramsey, & Treasure, 2000). Individuals with high attachment anxiety tend to depend on others for acceptance of their physical appearance (Park & Beaudet, 2007), and early separation anxiety and anxious adult attachment have been linked to body dissatisfaction in research involving women suffering from anorexia and bulimia (Troisi et al., 2006; Troisi, Massaroni, & Cuzzolaro, 2005). In a heterogeneous sample of women seeking treatment for eating disorders, Tasca et al. (2006) found that adult attachment insecurity may lead to negative affect and body dissatisfaction, the latter being linked to restrained eating. Studies like that done by Cole-Detke and Kobak (1996) share the common understanding that individuals with anxious attachment seek to compensate for the sense of loss of personal control that they experience in interpersonal relationships by shifting attention to their physical body as the problem and using food to regain effective control.

The case of Naomi<sup>1</sup> will demonstrate the attachment nexus that takes shape through her relationship to her mother, the cultural symbols, and subsequently to food, eating, and her own body. Drawing upon Naomi's attachment experience in relation to her mother, paper one will illustrate how a mother's insecure attachment to her own body can be transmitted to her child, triggering in that child an insecure attachment to her body, and rendering her vulnerable to the concrete and distorted solutions that the culture has to offer. Without a securely enough attached mother to serve as the earliest "translator" of basic bodily needs, Naomi never acquired the language to express her own feelings or the mental imprint/neural map of what it means to feel good-enough in her own body. This case demonstrates the ways in which attachment is critical as both a protective and risk factor, providing a greater understanding of the potential for resilience as well as the presence of vulnerability in relationship to one's body. The attachment between female caregiver and daughter, and subsequently between daughter and her own body, represents an important area that demands further examination to more fully understand the complex connection between attachment, body security, and sociocultural triggers, and eating disorders.

In the face of environmental triggers that explicitly target women and their bodies, the intergenerational link between women is critical to consider. This exploration does not view the mother-daughter relationship acontextually, but instead, it recognizes the delicate interplay between intrapsychic, familial, and cultural factors that literally and figuratively shapes women's relationships to their own and each other's bodies, thus contributing to the multi-determined nature of attachment relationships and eating

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<sup>1</sup> The name and other details about this client and her family have been changed to protect her identity.



disorders. Rather than blame mothers, this examination seeks to add to the literature by identifying a particular pathway of pathogenesis in the development of eating disorders: the replication of patterns of insecure attachment that play out at the concrete, bodily level between caregiver and child, most commonly, mother and daughter. If in this scenario mothers are seen as message bearers with regard to their daughters' bodies, it is a result of the ongoing objectification and sexualization of girls and women that has made them, and indeed all of us as a society, complicit, albeit not blameworthy, in the creation and maintenance of bodily cultural ideals.

Where traditional theories often suggest that pathology is passed from mother to daughter, a feminist reformulation suggests that daughters are in fact motivated by a desire to remain connected to their mothers, and as a result, unconsciously replicate their mothers' patterns of behavior. For some women, maintaining the attachment to their mothers at the bodily level is emblematic of their survival given the context in which a woman's ideal appearance is socially constructed. Thus, by perfecting the body through dieting, we can imagine that to some degree daughters with eating disorders are mirroring their mothers' attempts to find longed for recognition and visibility. Accordingly, mothers and daughters need to be considered within a relational matrix that includes an examination of their relationship to their own bodies and subsequently, to cultural symbols. Moreover, this analysis theorizes that the more insecure the attachment women have to their own bodies, the more securely they will attach to cultural symbols. Cultural symbols are then easily repositioned in the psyche as transitional objects, or parental substitutes, that fuel disordered eating as a continuity of earlier care of, and experiences relating to, the body.

Although our view toward secure attachments is shaped most influentially by our first relationships, paper two is built on the premise that we are also quite resilient. Bowlby (1988) emphasized that positive experiences in a partner relationship can bring about the reconstruction of an originally insecure attachment working model; a partner or therapist can provide a "secure base" for exploring and dealing with early insecure attachment experiences. According to Wallin (2007), "If our early involvements have been problematic, then subsequent relationships can offer second chances, perhaps affording us the potential to love, feel, and reflect with the freedom that flows from secure attachment" (p. 1). The second paper will expand on paper one by illustrating how the therapeutic relationship, through its responsiveness and consistency, will invite a type of reenactment of the proximity-seeking behavior that results in the creation of a "secure base," which then can be used by the client to experience a sense of secure attachment and begin to shift the nature of that attachment to her own body.

To gain insight into continuity and change of intergenerational transmission of attachment, it is crucial to pay attention to the working model (or mental representation) of attachment experiences of caregivers. Studies have found that attachment is malleable, such that, with new experiences (e.g. psychotherapy, adult trauma), individuals can move from insecure to secure states or vice versa throughout their lives (Bakermans-Kranenburg & vanIjzendoorn, 2009; Waters, Merick, Treboux, Crowell, & Albersheim, 2000). Similarly, it is reasonable to believe that a client can be helped to move from an insecure to a secure style of attachment to her own body when the therapist is herself securely enough attached to her own body. Thus, paper two seeks to synthesize developmental psychology with practical formulations to promote the development of a

more sophisticated theoretical framework that can fully potentiate the worker's use of her body-self as a catalyst for change.

By expanding upon Winnicott's concept of "potential space" to include the female therapist and her female client as another location of cultural experience, paper two presents an opportunity for relational repair in the clinical setting of eating disorders. Through Winnicott's (1989) notion of 'indwelling,' a therapist who lives comfortably enough in her own body can help the client achieve a congruent and integrated sense of a 'good enough' body-self in a way similar to how the 'good enough' holding environment can enable the infant to navigate from secure attachment and attunement to a capacity for separateness. Holmes (2001) states, "What good therapists do with their patients is analogous to what successful parents do with their children" (p. xi). It follows that in the absence of parents who are able to provide a secure attachment to their own bodies, potentially successful treatment must start with a clinician who lives comfortably enough in her own skin/body. This sense of a secure base arises from the attuned therapist's effectiveness in bearing witness to the client's experience of the therapist's body, while also helping the client tolerate, modulate, and communicate difficult feelings about her own body.

As Ferenczi stated as early as 1912, "It definitely looks as if one could never reach any real convictions at all through logical insight alone; one needs to have lived through an affective experience, to have so to speak, felt it in one's body, in order to gain conviction" (as cited in Brabant, Falzeder, & Giampieri-Deutsch, 1992, pp. 193-194). Thus, it is up to female clinicians to communicate not only verbally, but also non-verbally, that they are sitting in the room with their client in bodies that eat, need, and

desire without constriction, in order to see, hear, and feel what is happening in their clients' body-selves in a deeper and fuller way. Building on the themes of the roles of attachment/relational trauma and consumer culture in the development of eating disorders introduced in paper one, paper two will examine the ways in which the therapist can serve as a good-enough Winnicottian body to help repair the damaged body-selves that often present in the consulting room.

One such way, for example, is in the therapist's ability to engage in a sociocultural dialogue around the body - one that includes the client's feelings about her own body, about the therapist's body, and about the culturally sanctioned body. By virtue of the felt security generated through such affect-regulating discussions of the body, the therapeutic relationship can provide a context for helping the client to access and make sense of disavowed or dissociated experiences of her body in relation to her mother. The therapist's role here is to help the client both to deconstruct the learned insecure attachment pattern to the body of the past and to construct a new secure attachment pattern to the body in the present that will help the client to dissociate from the cultural messages rather than from her own body. These conversations are crucial in providing the client with an opportunity to repair past injury by forming a secure body attachment that prepares her to step out into the culture with the resilience necessary to avoid getting swallowed up by the inevitable overexposure to cultural ideals.

In order to encourage discussions of the therapist's body in clinical social work practice, paper two will situate the body in a larger theoretical framework within which it can be explained; this framework is object relations theory viewed through an intersubjective lens. Concepts from object relations theory will demonstrate the

importance of the body in the clinical exchange by highlighting the parallel between Winnicott's 'good enough' mother and the 'good enough' therapist's body as crucial to developing a satisfactory holding environment. A therapist can apply concepts like Ogden's (1994) analytic third and Benjamin's (1995) definition of intersubjectivity to facilitate the client's movement beyond object relating to object usage, while simultaneously helping the client to move past an insecure attachment to her body and towards a more secure style of relating to her body and its manifold needs. An analysis of this type of clinical exchange will highlight how a therapist can provide a protective shield for her client by modeling a secure enough attachment to her own body and inhabiting a 'good enough' Winnicottian body. This analysis does not suggest that clinicians need to be fully healed from food, eating, or body image issues in order to work with clients with eating disorders; rather, it serves to highlight the importance of clinicians being aware of and addressing their personal issues in therapy and supervision.

In a field in which the clinical encounter is ripe for projective identification as the body is often measured against the cultural ideals, it is striking that the role of the therapist's body in the treatment of eating disorders has received such limited attention in the literature (Lowell & Meader, 2005). Although the clinical literature validates that transference and countertransference issues are particularly powerful in the treatment of eating disorders, it generally neglects the exploration of these issues specific to body image (Costin, 2009) or to the therapist's actual body (Burka, 1996; Lowell & Meader, 2005; Orbach, 2004). Studies also indicate that clinicians are having trouble allowing their bodies to be the subject of discourse (DeLucia-Waack, 1999; Lowell & Meader, 2005; Shisslak, Gray, & Crago, 1989; Warren, Crowley, Olivardia, & Schoen, 2009). As

Gutwill and Gitter (1994) suggest, women's relationships to cultural symbols are rarely explored in the clinical setting. The authors argue that psychotherapists have historically had difficulty consciously articulating socially caused trauma, and as a result, they are not accustomed to asking clients how they feel about symbols of fatness and thinness in Western culture.

By utilizing the case of Beth<sup>2</sup>, paper two will demonstrate how a client's past experience of relational and bodily trauma can begin to be repaired within the therapeutic relationship. When object relations is coupled with an intersubjective perspective, each theory breathes life into the other and, when used efficaciously, can help provide a blueprint for dealing with the shared body experience in the treatment of eating disorders. Clinical excerpts will illustrate specifically how engaging the client in a purposeful discussion about the clinician's body can be a turning point in the psychotherapeutic process, as Beth and the therapist (this writer) work to negotiate competition and envy expressed in body-centered comments. In a short amount of time, unconscious longings emerge as a result of exploring the meaning behind the client's thoughts and feelings about the therapist's body, providing clinical data to illustrate how the client can be helped to move from object relating to object usage when the physical body is invited into the consulting room.

In sum, the first paper of this two-paper theoretical-conceptual dissertation considers that the learned style of attachment to the physical body can place women at an increased risk and vulnerability to the later development of eating disorders. The second paper examines how the client-therapist relationship can repair the problems that emerge

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<sup>2</sup> The name and other details about this client and her family have been changed to protect her identity.

when an insecure attachment to the body is modeled and passed along from mother to daughter. Both mothers and daughters, and subsequently female clinicians and female clients, need to be considered within a relational matrix that includes an examination of their relationship to their own bodies and to cultural symbols. Through the creation of the good enough holding environment in which the sense of attunement and feeling of being emotionally held by a securely attached therapist's body, the client gradually moves to a more autonomous position, allowing her to inhabit her own good enough body.

THE IMPORTANCE OF A SECURE BODY ATTACHMENT IN THE PREVENTION  
OF EATING DISORDERS

Naomi

*I was 9 years old when my mother asked me to join Weight Watchers with her. The invitation just confirmed what I already knew – she thought I was fat and needed to lose weight. I only lasted a day or two before my hunger for more food became too powerful to resist. I stopped going to Weight Watchers and started sneaking food. I think it was then that a sense of shame invaded me – I had no will power, I had no self-control around food. When I tried to talk to my mother about my feelings, all she could say was, ‘What are you going to do about it?’*

Naomi was aware from a young age that she was a "bigger" girl. She remembers at the age of five comparing her thighs to the girl sitting next to her at school and feeling “huge.” Her home echoed the current cultural taboos around food, eating, and the body - except, of course, where her older brother was concerned who her mother said could eat whatever he wanted. Not much food was kept in the house, except for things that were fat free and low carb. Naomi recalls her mother saying to her in recent years, "You know what I eat all week - dog food. I don't care what it tastes like, it just needs to fuel me," a statement Naomi understood as code for, ‘as long as it doesn't make me fat.’ Her mother did not trust herself around food and in many ways communicated to Naomi that food was dangerous, especially if it was enjoyed. When her mother ventured to eat something that tasted good, she made it clear to Naomi that she was being “bad” and that she either had to have “saved up” all week for it, had a great workout that day, or would need to resume her diet with full ferocity the following day. The body warranted constant



inspection, management, and monitoring in Naomi's home, much like the fat-phobic cultural surround that stresses the need for bodily control and obsession. Even Naomi's father fell victim to these beliefs by closely monitoring his food intake and exercise habits, and berating his aging body. Naomi longed to have food in the cupboards and meals prepared for her. What she really craved, but could not possibly find the words to express, was a good enough, stable, and secure maternal body to rely on while she developed into her own body, and tried to navigate the vicissitudes of life. Instead, she adopted the family model that translated real life problems onto the contours of the body. Naomi, left to find her own resolutions, turned to Jenny Craig who offered her the promise that, "If you've failed on other diets, this time can be different." She was primed to receive the magical solutions that Jenny had to offer, and Naomi felt hopeful about her perfectly rationed pre-packaged meals and personal weight-loss consultant. After months of elevating Jenny's rule and shedding fifty plus pounds, she developed a dangerous case of Anorexia.

### Introduction

Attachment theory has become a leading conceptual framework for understanding the primary importance of the human bond. With the advances in neuroscience, we now have empirical evidence to support that in the absence of meaningful connections and secure attachments, human beings struggle persistently to modulate arousal/affect and develop healthy, adaptive relationships, not only with others but with their own bodies as well. Historically, however, the relational needs of infants and children have been dramatically underestimated, or, often worse, neglected entirely. Developmental psychiatrist Daniel Siegel (1999) looks at how parent-infant attachment affects mental

functioning throughout life, and explores the pathways by which interpersonal experience shapes the structure and function of the brain. He provides a synthesis of the neurobiological research, underscoring exactly how crucial the safety and containment provided by adults is to infants and children. In a culture that valorizes an unattainably thin female body, women are too often deprived of the safety, security, and containment that come from mothers who live comfortably enough in their own skin/body. In the absence of mothers who can manifest a secure body attachment, this paper argues that the resulting insecure body attachment provides the pathway by which cultural symbols, as an extension of primary caregiving, shape mental functioning and attachment patterns to the body throughout the life course.

Previous research has supported a strong correlation between popular consumer culture and the development of eating disorders and body image disturbances (Hesse-Biber, 1991, 1996; Kadish, 2012; Kilbourne, 2002; Stice, 2002; Wolf, 2002). Hesse-Biber, Leavy, Quinn, and Zoino (2006) agree that eating disorders, although primarily psychiatric in nature, are also symptomatic of a larger social problem; however, the authors do not adequately address the issue of understanding why some individuals exposed to sociocultural messaging around a body ideal internalize those messages and ultimately develop eating disorders while others do not. By placing the emphasis on the role of attachment/relational trauma resulting from caregivers who are not securely attached to their own bodies, this paper will develop an argument around how and why messages are assimilated differently by different women who are all exposed to the same potential sociocultural triggers. In this regard, it is essential to consider that the relational misattunement in which a child's feelings and experiences are ignored or invalidated by a

caregiver, can be easily exacerbated by the mother's insecure attachment to her own body. The result is often a foundation trauma that leaves developing females more susceptible to identifying with and attaching to popular cultural messages that lead them to experience multiple layers of trauma, and places them at greater risk of moving from exposure to action in the form of an eating disorder framed as an attachment disorder.

A secure attachment in the most general sense is defined for the purposes of this paper as both a psychologically and physically mediated attainment that provides the primary defense against trauma-induced psychopathology (Schoore, 2001). Exploring eating disorders through an attachment lens provides a useful conceptual framework to understand how the development of a secure attachment to one's body can function as a central buffer against pervasive and even traumatic sociocultural influences, mirroring the neurological and psychological advantages of forming a secure attachment to primary caregivers. Thus, the secure body attachment helps the child defend against culturally induced body insecurity and the pulls to actively participate in body altering practices. Given that human infants are dependent on the externally mediated interactive regulation of their primary attachment figures, it follows that the ways in which a mother relates to and responds to her own physical and bodily needs, as well as to those of her daughter, will act in ways to organize the child's developing self as she learns to relate to her own body.

While attachment research has provided conclusive evidence to suggest that there is an intergenerational transmission of attachment style from parent to child, and that particular style of attachment (secure or insecure) comes to dominate subsequent relationships, this analysis theorizes that there is a simultaneous intergenerational

transmission of attachment style to one's own body. Although the body is not typically considered in attachment terms, Orbach (2006) believes that we can imagine quite easily how attachment dynamics play out at the physical level and what difficulties at that level mean in terms of the securely or insecurely organized sense of bodily self that an individual develops. Thus, while the early brain develops its intelligence, emotional resilience, and ability to self-regulate (restore equilibrium) through the anatomical-neuronal "shaping" and "pruning" that takes place within the face-to-face relationship between child and caregiver (Siegel, 1999), a similar pruning and shaping occurs simultaneously via the body-to-body communication between daughter and mother. Both mutually influence the nature and quality of the attachment relationship.

The good enough mother, while expected to create a secure attachment through repeated reciprocal, attuned somatic and verbal communication with her infant, is also required to provide successful containment, namely the mother's capacity to both reflect the infant's internal state, as well as represent that state for the infant as a manageable experience (Fonagy & Target, 1997). A mother struggling with body dissatisfaction, however, is faced with an even more formidable task in having to provide successful containment of her daughter's body experience. Research suggests that a mother's preoccupation with eating issues and body issues may diminish positive and effective parenting and parent-child communication, particularly with daughters (Agras, Hammer, & McNicholas, 1999; Lunt, Carosella, & Yager, 1989; Park, Lee, Woolley, Murray, & Stein, 2003; Park, Senior, & Stein, 2003; Patel, Wheatcroft, Park, & Stein, 2002; Stein et al., 2006), thus increasing the likelihood of attachment trauma. Moreover, this paper reasons that the more dissatisfied a mother is with her own body, the more powerfully she

will attach to the cultural symbols, leaving her more likely to manifest an insecure attachment relationship to her own body as well as to the body of her developing daughter.

In this paper, the inability to respond to - or to respond in discord with - the body's actual physical and emotional needs, is considered an insecure attachment to the body. The case of Naomi serves to make the connection that without a secure model of attachment to their own bodies, mothers are more likely to be misattuned to their daughters' emotional and physical needs and, as a result, supply a pathway to directly transmit and reinforce cultural messages to their daughters. This repeated chronic misattunement to the child's emotional and physical needs creates what Siegel (1999) references as a 'mental image,' or as Stolorow (2011) suggests, a 'purified ideal,' of the ideal body inside the child (rather than a relationally negotiated good-enough body), which further epitomizes the Western values of autonomy, independence, and bodily control. Although these values alone are not necessarily problematic, they become problematic when they do not emanate from a secure base. As we see with many daughters like Naomi, they are unable to achieve the necessary developmental task of differentiation from and linkage with their mothers, and subsequently with their own bodies. Instead, young women are primed to develop a strong attachment to cultural symbols as an extension of primary care, compromising their body-self relationships.

The securely attached mother, in contrast to Naomi's, is better able to distinguish and respond accurately to her infant's cries. Likewise, the mother who manifests a secure body attachment is assumed to demonstrate a pattern of relating to her body in accordance with her own individual nutritional need, hunger, appetite, and pleasure. The

importance of the adult's composure needs to be emphasized in attachment theory as it relates to the body - a level of tranquility is essential. The goal is to minimize, not compound, the feelings of fear, shame, embarrassment, and guilt that the child may already be experiencing in her developing body amidst a back drop of restrictive cultural ideals. Thus, the mother's ability to live in her body and relate to her body's needs in a calm and welcoming manner, will greatly influence and support the development of a secure enough body attachment in the daughter. If a mother has the capacity to be accepting of her own body in the face of restrictive cultural ideals, her daughter is more likely to experience containment and receive attuned communication, wherein the mother can be present for her daughter's experience of her own body. In this way, the mother can view the child's body with benign eyes, communicating to her an acceptance of what is seen, regardless of how discrepant her body might be from what the culture sanctions. Borrowing from Siegel (1999), the daughter's subjective experience of her body is thus held inside her mother's mind, and the child develops a secure attachment to her body as her bodily feelings are fully sensed. She is provided the capacity to live comfortably inside her own body experience, knowing that her own set of bodily needs are acceptable even if they are different from her mother's (differentiation), and that she will still remain deeply connected to her mother (linkage).

In a culture that assigns great value to a thin female frame, offering this kind of secure body attachment can be particularly challenging. Women learn from an early age that persons living in larger bodies experience less cultural privilege and are more likely to be viewed as deficient and problematic, making them subject to systematic disadvantage and culture shaming. As a result, women with insecurely attached and

vulnerable bodies become easy targets, especially for the consumer culture to prey on. While individuals are attachment seeking, and secure attachments help to promote mental and physical health, the culture also serves as a facilitating environment for intrapsychic life, wherein people attempt to feel interpersonally connected (Gutwill, 1994a). Furthermore, feminist critiques consider the ways in which cultural symbols are subject seeking and are designed precisely to penetrate one's private world by presenting images to women that subliminally and opportunistically influence their inner object formation via visual, aural, and symbolic means (Gutwill, 1994a). Consumer culture, in this analysis, is understood as a traumatogenic agent given that sociocultural ideals, like most perpetrators, target vulnerable, preoccupied, and insecure bodies that are in desperate need of approval, acceptance, and recognition (Gutwill & Gitter, 1994).

Bordo (1993) supports the idea that the cultural transmission of symptoms is multilayered and pervasive, suggesting that culture works “not only through ideology and images but also through the organization and the family, the construction of personality, the training of perception – as not simply contributory but *productive* of eating disorders” (p. 50). Theorists like Benjamin (1988) and Chodorow (1978), by directly bringing culture into the analysis of maternal influence, emphasize the ways in which culture is unconsciously passed along in and through the family, particularly noting the dynamic between mother and daughter. Studies provide evidence to support the likelihood of transmitting eating pathology from mother to daughter (Francis & Birch, 2005; Patel et al., 2002; Sherkow, Kamens, Megyes, & Loewenthal, 2009). The culture that Chodorow (1978) described years ago as promoting the reproduction of mothering, has now become

a culture that advances the reproduction of culturally induced body practices (i.e. dieting, body checking).

Gutwill and Gitter (1994) argue that females develop a cultural, object relationally determined body image, often congruent with what they have witnessed inflicted upon other females in their lives (most notably mothers) by an exploitive culture. In this way, consumer culture “fosters extensive ego involvement in the isolated world of internal, addictive object relations, far removed from the potentially healing effect of interpersonal relationships” (Gutwill & Gitter, 1994, p. 200). As more and more women are reared to believe that anatomy is destiny, cultural symbols become transitional objects in charge of maintaining the primary attachment to caregivers. These types of symbols, therefore, take on a parental role, putting the symbol-makers, vis-à-vis consumer culture, in an even more advantageous position (Gutwill, 1994a). In encouraging women to attach to its unrealistic body ideals, the culture requires that women dissociate from their bodies’ needs in an attempt to attain the ideal. In this instance, psychic splitting is utilized as a defense to maintain an attachment relationship to cultural symbols which become stand-ins for an earlier absence of care in an otherwise unsafe world. Without a model of secure attachment to the body, children like Naomi are becoming less resilient and more vulnerable to cultural pulls and persuasions to engage in body altering practices.

This paper will explore the important interpersonal elements of communication that help to either foster or hinder the development of neural integration at the bodily level. Massive failures in bodily attunement leave the child unable to listen to the internal cues of her own body. As we will see with Naomi, she never developed the capacity to recognize internal signals that many of us take for granted. Her mother's need to dictate



the fate of Naomi's body (as measured by the cultural ideals) left Naomi feeling even more insecure, unacceptable, and unlovable. Her mother, preoccupied with fulfilling her own needs to prescribe to the demands of the diet, could not attend accurately to her daughter's signals, often dismissing Naomi's bids for proximity. Consequently, Naomi struggled to know who she was and how she felt at a fundamental level. Without a securely enough attached mother to serve as the earliest "translator" of basic bodily needs, Naomi acquired neither the language to express her own feelings nor the 'neural map' described by Siegel (1999) to create the sensory representation of a good-enough body.

By identifying an individual's attachment style to her own body and recognizing its role as a protective or risk factor against the potential development of eating disorders, prevention efforts can better target and enhance important aspects of the mother-daughter relationship as they relate to the reciprocal and mutual influence of the culturally sanctioned body. This research is important for scholars and practitioners in Westernized societies in which a growing body of literature has highlighted risk factors for body dissatisfaction (Shroff & Thompson, 2006; Stice, 2002), but only limited research has explored protective factors that promote a positive body image in women. This analysis will highlight the importance of a secure attachment to the body, as modeled in and through the mother-daughter dyad, as an understudied factor in the prevention of eating disorders. With the availability of a securely manifested maternal body to rely on, more women may be able to dissociate from the cultural messages, rather than from their own bodies.

Although our view of secure attachments is shaped most influentially by our first relationships, we are also quite malleable. This paper, therefore, seeks to inform the development of a reparative model for the treatment of eating disorders by utilizing attachment theory, developmental trauma theory, and object relations theory to add to the understanding of what heightens susceptibility to environmental influences, while also addressing a potential way through which a secure body attachment can ameliorate the damage caused by those influences. The case of Naomi will exemplify the ways in which the nature of the attachment experienced in relation to the mother, coupled with the mother's insecure attachment to her own body, can be transmitted to a child, triggering in that child an insecure attachment to her body, and rendering her vulnerable to the concrete and distorted solutions that the culture has to offer. Naomi, through her relationship to food and to her body, replicated the inconsistent and often withholding and neglectful caregiving environment she experienced early on and which persisted throughout her childhood and adolescence. This case demonstrates the ways in which attachment is critical as both a protective and risk factor, providing a greater understanding of the potential for resilience as well as the presence of vulnerability in relationship to one's body. The attachment between mother and daughter, and subsequently between child/woman and her own body, represents an important area that demands further examination to more fully understand the complex connection between attachment, body security, and sociocultural triggers, and eating disorders.

### **Attachment and the Body**

This section will use attachment theory to draw a parallel between an individual's style of attachment to her mother and an individual's learned (or transmitted) style of

attachment to her own body and bodily needs. Attachment theorists like Fonagy (2001) have insisted that in order for the child to know her own mind, she needs the mind of another caregiving adult. Siegel (1999) uses evidence from neuroscience to indicate that, “attachment establishes an interpersonal relationship that helps the immature brain use the mature functions of the parent’s brain to organize its own processes” (p. 67). While secure attachment is a crucial component of healthy emotional and cognitive development, this paper posits that a secure body attachment is also crucial in establishing an interpersonal bodily relationship that helps an immature body use the experienced functioning and relating of the mother's body to organize its developing body-self attachment. In other words, in order for the child to know her own body, she needs the body of a caregiving adult. Depending on the nature of the mother’s own bodily attachment, the child will be either protected against or become more vulnerable to developing an attachment disorder, such as an eating disorder, later in life.

Although attachment is typically described in terms of mental processing of information based on cognition and affect to create models of reality, Ogden, Minton, and Pain (2006) take a corrective stance by suggesting that, “attachment patterns are also held in place by chronic *physical* tendencies reflective of early attachment,” which also influence certain models of reality for the developing child’s body (p. 47). These physical tendencies are encoded as procedural memory, and the patterns of relating manifest as proximity-seeking, social engagement behavior (e.g. smiling, movement toward, reaching out, eye contact) and defensive expressions (e.g. physical withdrawal, tension patterns, hyper - or hypo-arousal). Thus, understanding attachment patterns at the physical level can inform their corresponding physical tendencies.

Krueger (2002) notes that the primary sensations at the very beginning of life are physiological and tactile, and the primary form of communication immediately after birth between mother and child is through touch, with visual and auditory stimuli playing a greater role as time goes on. Given that attachment needs are initially experienced and expressed primarily as body-based needs, i.e. needs related to handling and holding, the quality of the attachment relationship needs to be considered in terms of the caregiver's consistent and accurate attunement and response to the infant's body through reciprocal sensorimotor interactions (Ogden et al., 2006). Krueger (2002) states that, "the close and careful attunement to all the sensory and motor contacts with the child, forms an accurate and attuned body self in the child" (p. 7). The caregiver's ministrations, sensory joining, and quality of physical handling of the infant links body and mind experiences in the child and forms the basis for self-regulation (Krueger, 2002). Moreover, an infant's affect regulatory structures develop through the attuned interactive regulation between the mother's body and the infant/child's body, in turn, helping the infant/child to progress from dependence on external regulation to the capacity for internal regulation (Schoore, 2001). When all of this occurs, social engagement, secure attachment, and regulatory abilities are strengthened in the developing child.

Following this progression, a mother's secure or insecure pattern of relating to her own body and to that of her daughter will influence corresponding physical tendencies that lead to either a secure or insecure body attachment for the daughter. In order for the daughter to identify and respond to her own individual bodily needs for nutrition, she needs a securely attached and regulated maternal body to assist her in proceeding from a dependency on her mother to meet her need for food, to trusting her own internal

regulatory system to respond to hunger and achieve satiety. As we see in many women diagnosed with eating disorders, however, there is often a disruption in attachment and affect regulation, as well as a pronounced distortion in the formation of a healthy, integrated body-self relationship.

Naomi, a prime example of someone who has experienced a disruption in attachment, was deprived of the critical link between body and mind experiences due to her mother's insecure relationship to her own body, and subsequent misattunement. Naomi's mother took cues from externally mediated stimuli to determine the amount, timing, and quality of the food she was to eat. She avoided/dismissed her body's calling for nourishment or rest, and instead adhered to the constraints of her diet and exercise regime; in the same way, she dismissed Naomi's bids for proximity by instead inviting her to join Weight Watchers. Thus, she demonstrated an insecure avoidant style of relating to her own body, to her daughter's affective experience, and to her daughter's body. As a way to maintain the attachment relationship to her mother, Naomi grew up to replicate these same patterns in relationship to her own body. As a result, Naomi was unable to form an accurate and attuned body-self – her mind was cut off from affect and her own body's physiological needs. Instead, she developed a dependency on external cues that originated with her mother's reliance on cultural mandates to dictate her own appetite, hunger, and self-worth.

The social engagement system between mother and child is built on a series of face-to-face, body-to-body interactions, whereby the mother is in charge of regulating the child's autonomic and emotional arousal; it is further developed through attuned interactions with a mother who responds to the infant's signals with motor and sensory

contact, long before communication with words is possible (Ogden et al., 2006). Attachment interactions between infant/child and mother, therefore, require very clear negotiations in physical space as the child learns to tolerate moments of 'me' and 'not me,' which include the child's experience of the mother's body as 'my body' and 'not my body.' Although the body is not typically considered in attachment terms (Orbach, 2006), the physical body plays a key role in mediating attachment patterns for the infant. Freud (1961) recognized the importance of the body years ago by stating that the ego was first a body ego, suggesting that bodily experiences are the center around which the ego is developed and that a person can adopt another person's bodily demeanor or bodily symptom through a direct bodily identification. Aron (1998) posits that if our self is first and foremost a bodily self, then our relational experiences are first and foremost bodily experiences as well. Stolorow and Atwood (1992) have highlighted how affect attunement is communicated primarily through the caregiver's sensorimotor contacts with the infant's body. The quality of the attachment that is established in the infant, therefore, is influenced first and foremost by a bodily sense formed by the infant's experience of sensations and movements in the body of the caregiver (Krueger, 2002; Stern, 1985).

Anzieu (1989) suggests further that the ego is not just a body ego, but also a 'skin ego,' similar to Stern's (1985) conceptualization of the 'core self.' He argues that the baby acquires the perception of a bodily surface through the contact with the skin of her mother when she is being cared for. In the early mother-child relationship, a fantasy evolves of a skin belonging to both mother and child – the fantasy of merger that comes from 'one skin for two' not unlike McDougall's (1989) understanding of 'one body for

two.’ Depending on the nature of the handling and holding of the baby, the mother may convey a range of emotions simply through her skin to skin contact, i.e. tenderness, warmth, and love, or disgust and hate. As Winnicott (1965) specifies, however, “...it is only when all goes well that the person of the baby starts to be linked with the body and the body functions, with the skin as the limiting membrane” (p. 59). Aron (1998) interprets Winnicott as deducing that because the skin has an exquisite receptivity to sensory stimulation, it possesses the qualities of a transitional object that can be experienced by the developing child as both me (subject) and not me (object). Aron (1998) writes, “Gradually this fantasy of a shared skin gives way, allowing for separation to take place as the child internalizes both the skin and the mothering environment” (pp. 21-22).

In Naomi’s case, however, she was not able to achieve a state of psychosomatic unity or ‘indwelling’ of the psyche in the soma (Winnicott, 1971) that comes from specific relational conditions under which the baby’s body is appropriately attuned to, handled, stimulated, soothed, mirrored, and held by caregivers (Aron, 1998). She was left to internalize an insecure body-self relationship, which was first transmitted through the skin-to-skin contact with her mother. Naomi was born six weeks premature. After being discharged from the neonatal intensive care unit after only a few days, Naomi required much more frequent body-to-body contact in the very early weeks of her life since she had even more difficulty than the average infant regulating her own body temperature. To this day, Naomi reports that she "hates the cold." While growing up, she described that there was little to no physical contact in her family. Hugs were sparse, and body-to-body contact with her mother felt awkward or even sometimes prohibited. Naomi now wonders

if her mother was disgusted by or overwhelmed by her needs for contact, closeness, and care. We could imagine that if Naomi's mother felt so strongly about needing to rigidly monitor her own body, weight, and shape, that pregnancy and caregiving may have been particularly difficult for her. Naomi may have absorbed a sense very early on through skin-to-skin contact that her body and bodily needs were unacceptable, or, even worse, detestable.

In thinking specifically about the forming of body acceptance, in normal development the child acquires a sense of herself as acceptable and lovable through the earliest, preverbal interactions with others. The most notable interaction is with the mother or, as Lemma (2009) suggests, "the object of desire" (p. 753). It is through the sensual, bodily components of this earliest relationship that a 'desirable' body-self can be formed with an expectation that the self will be loved. Love, however, is transmitted through not only the 'felt security' (Siegel, 1999) that comes from an adequate physical maternal holding environment, but also a mother's communication of acceptance of what is seen when she looks at her daughter (Lemma, 2009). The mother's face provides the first emotional mirror for her daughter; however, the quality of the mother's mirrored reflection is reinforced through tactile and vocal exchanges as she relates to the baby's body. The baby's expressions of her attachment needs, like grasping, sucking, laughing, and crying, and how these are responded to by the mother through her gaze, touch, interest, and understanding will all contribute to the child's development of her body-self and body image (Krueger, 1989; McDougall, 1989; Schilder, 1950). In turn, the baby somatically encodes the affective experience of being seen by her mother and of her mother's handling of her body. Some might add that the baby also encodes what she



witnesses in the way her mother relates to her own body. If all goes well, physical sensations coalesce into a more integrated experience of the body-self (Spitz, 1965), and the child is able to achieve a state of indwelling, which in this paper is considered to be a secure attachment to the body.

In poor attachment experiences like Naomi's, Lemma (2009) suggests that a mother may use her 'gaze' to project unwanted, 'ugly' parts of herself onto the baby only to then condemn the baby for not matching up to her ideal, or the cultural ideal, making it difficult to distinguish at times what is coming from the mother and what is coming from the culture. Naomi remembered that when she was nine years old, she wore a new pink halter-top to the summer yacht club party. She recalled feeling particularly excited about her outfit, despite her perception of being a "chunkier kid." "It was my favorite color and such a pretty shirt - all the other girls were wearing them," she remembered. After prancing around all night, Naomi was told by her mother on the drive home that she was never to wear that shirt again. "It showed too much skin," she declared. Naomi knew that her shirt was no different from the tops that the other little girls were wearing. The only difference to Naomi was that she experienced herself as a noticeably bigger girl. Furthermore, she knew that her mother was suggesting that she was too fat to wear it. Her mother's seemingly narcissistic use of Naomi's body as a reflection of herself prevented the recognition and acceptance of Naomi's body as it was developing and taking shape. Such exchanges exposed Naomi to a critically scrutinizing maternal gaze, which acted as an extension of the culture and precluded her from developing a secure sense of well-being in her own body, laying a foundation for insecurity and shame.

Naomi's body became the receptacle for her mother's scrutinizing projections. Due to her mother's incredible fear of fatness, we can imagine that when Naomi's mother looked at her daughter, she saw something unacceptable in herself, but instead located this badness in the body of her daughter. Naomi had no choice but to take on this burden of the fatness, much like Fairbairn's (1951) conceptualization of the "burden of the badness" (p. 65). The "badness" in this case was the qualities undesirable to Naomi's mother - the fat, dependent body. These "bad" features became bad objects with which Naomi identified through primary identification (Mitchell, 1981). If only she were thin, Naomi believed her mother's love would be forthcoming. Because it was too unbearable to live with the reality that her mother's body was not a securely manifested and regulated maternal body upon which she could rely, Naomi had to preserve the illusion of the goodness of her mother's body and body practices as a potential safe haven for her in an otherwise unsafe world. She acquired outer security at the price of sacrificing internal body security, while perpetuating the fantasy of omnipotent control (Fairbairn, 1951); if the "badness" resided inside Naomi's body, she preserved the hope, albeit a false one, that through reducing her body size she would gain her mother's acceptance and love, and strengthen their connection. Therefore, according to Fairbairn (1951), the first in a series of internalizations, repressions, and splits takes place. Naomi's mother and the soon to be internalized cultural symbols represented the 'good objects' for Naomi, while the diet became her moral defense to preserve the attachment relationship to her mother.

Given that attachment is recognized as a biological imperative rooted in evolutionary necessity that motivates an infant to seek proximity to a caregiving adult (Bowlby, 1982), it makes sense that Naomi maintained an attachment relationship to her

mother regardless of the cost to her own body or to her own emotional experience. Having grown up with a mother who was insecurely attached to her own body, Naomi was biologically driven to adapt to her mother's style of attachment by both replicating and internalizing an insecure attachment to her own body (one of inadequacy and disgust) and the mothering environment (one of withholding, deprivation, and neglect). Naomi was deprived of the necessary developmental achievement described by Aron (1998), whereby the fantasy of a shared skin could not be sufficiently dispelled in order to allow for separation. Instead, Naomi learned to defensively inhibit any behavior that could disrupt that bond because her survival, and the survival of the attachment relationship, depended on it. Later, when Naomi's mother invited her to join Weight Watchers, she had no choice but to accept her mother's invitation because it was the only possible link to connectedness. Naomi developed certain rules for processing information with regard to food, feeding, and the body, including rules that governed the female body. Naomi's insecure body representation reflected her mother's feelings towards her own body and to that of Naomi - both mediated by the current cultural ideals.

Naomi's mother, preoccupied with cultural ideals around appearance, became inappropriately and narcissistically invested in the appearance of Naomi's body. When the body's surface is over-invested with concern, attention, and projection of the mother's needs, Lemma (2009) notes that this leads to experiences of merger, which can hinder developmental processes around separation/ individuation. Secure attachment hinges on the opposite occurrence - a caregiver's ability to mentalize (Fonagy, Gergely, Jurist, & Target, 2002) her child, which refers to her capacity to recognize the child as a separate person with his or her own motivations, desires, and needs. In other words, in order to

promote empathic connectedness, the mother needs to be able to perceive the child's world, identify with it, and align with it, while simultaneously realizing that the child is a separate person (Ogden et al., 2006). This capacity in the caregiver enables the child to develop a secure sense of self and understand her own and others' motivations, desires, and needs as separate but negotiable. Through sensorimotor and emotional alignment (the empathic matching of one's own state to that of another), both mother and child experience a sense of calm and relaxation (Jaffe et al., 2001; Schore, 1994; Siegel, 1999; Stern, 1985). The mother, in essence, 'contains' (Bion, 1962) the child and fosters her self-regulating capacities, not unlike Winnicott's concept of the 'holding environment.' When two people who are interacting achieve moments of matching or mirroring each other's nonverbal expressions of subjectively experienced emotion, they are engaged in mutual "affect regulation" (Schore, 1994). Furthermore, according to Schore (2003), "affect regulation is not just the reduction of affective intensity, the dampening of negative emotion. It also involves an amplification of positive emotion, a condition necessary for more complex self-organization" (p. 78).

Young women need to learn that the body, even when it is perceived to be discrepant from cultural ideals, can be experienced as manageable. The development of flexible, adaptive strategies in the face of body dissatisfaction can result in body resiliency and a capacity to feel good enough in one's body despite the skewed cultural messages. As Schore (2003) stated, "The process of re-experiencing positive affect following a negative experience may teach a child that negativity can be endured and conquered" (p. 143). When it comes to maternal insecurity, especially when it relates to the mother's feelings about food, eating, and her own body, a daughter is deprived of the

transition from negative (having a negative thought or feeling about her body) to positive (having a conversation that can enhance the daughter's understanding of the meaning of a good-enough body in the face of unrealistic cultural aspirations). Such states of misattunement without repair are accompanied by severe alterations in the biochemistry of the immature brain, especially in areas associated with the development of the child's coping capacities (Schore, 1996, 1997).

Because Naomi's mother was not sufficiently capable of relating to or honoring the full range of her own body's needs, her ability to mentalize Naomi's emotional and physical needs was severely compromised. Furthermore, as a result of her insecure attachment to her own body, she fostered a sense of emotional and physiological dysregulation in Naomi. Naomi's mother amplified her experience of negative emotion, especially when it related to her body experience. Naomi's pleas for connection became coded in 'diet talk' as she attempted to get recognition from her mother by joining her mother's hated body experience. In turn, Naomi was deprived of the critical developmental task of establishing the capacity to take a reflective stance towards the body and bodily ideals. Reflective functioning, according to Fonagy et al. (2002), includes "both a self-reflective and an interpersonal component that ideally provides the individual with a well-developed capacity to distinguish inner from outer reality, pretend from 'real' modes of functioning, intrapersonal mental and emotional processes from interpersonal communications" (p. 25). Naomi, without the necessary skills to critically evaluate the restrictive sociocultural messages, was left more vulnerable to the belief that her body, rather than the messages, was problematic.

On the other hand, if the mother can recognize her daughter as having a separate body with its own separate set of needs, desires, set point, and hungers, the mother helps her daughter learn that they can occupy different bodies and remain deeply connected. Through the mother's ability to contain (Bion, 1962), and hold (Winnicott, 1965) her child's experience of her own body both literally and figuratively in her mind, she demonstrates recognition of the child's physiological and affective states, as well as her own ability to deal with them effectively. Fonagy (2001) suggests that secure attachment is the direct outcome of successful containment, namely the parent's capacity to both reflect the infant's internal state, as well as represent that state for the infant as a manageable experience.

In contrast to Naomi's experience, interactions with an attachment figure who is responsive to an infant's need triggered proximity-seeking while simultaneously providing a secure base from which an infant can begin to engage and explore the outside world, facilitates the optimal functioning of the system. According to Bowlby (1988), these kinds of positive interactions promote the formation of attachment security - a sense that the world is safe, that attachment figures are helpful and reliable when called upon, and that it is possible to explore the environment curiously and engage effectively and enjoyably with other people because there is a safe haven to return to. This process is much like Mahler's (2000) conceptualization of practicing in which a toddler's emerging sense of autonomy and separateness is enabled by a supportive and available caregiver. It follows then that interactions with a mother who is securely attached to her own body will communicate to her daughter that her body is a safe place to live in and from, that she can reliably respond to her own and to her daughter's individual nutritional and

emotional needs, and that it is possible for the daughter to explore her mother's body inquisitively and engage effectively and enjoyably with her own body's needs, because there is a secure body to return to. Thus, building on the infant's development in physical, cognitive, and social-emotional spheres, the body attachment relationship extends the infant's experience of pleasure on a bodily level and provides increased opportunity for exploration and learning about the body, allowing the baby to rely upon the caregiver's relationship to her own and her baby's body for judgment and protection.

As witnessed in secure attachment, the reciprocal, repeated enactment of felt need and caregiver response, enables the child to internalize a template for safe relatedness, and solidifies her ability to regulate, manage, and predict her environment. In a secure body attachment, a similar exchange can be observed specifically in the feeding experience and in the relating that takes place between the bodies of the mother and the child. In secure body attachment, we can imagine that there is congruence between external actions and internal states; the child can match interior psychological and physiological needs with the appropriate physical behavioral response. If a child's attachment figures are sufficiently sensitive and responsive to their own bodies' needs for sensation, touch, movement, physiological arousal, and other physical needs (e.g. food, warmth, fluids), they will be more likely to accurately read the child's bids for bodily attachment needs, and the child has a greater chance of developing a secure sense of her self in her body. If the mother can accurately read and respond to the child's need for food, without projecting her own feelings about food and her body onto the child, the child has the opportunity to internalize a template for safe relatedness to food that

reinforces the child's ability to regulate her own internal cues to feeding and tending to her body's nutritional, physical, and emotional needs.

The child with a secure attachment to her body will recognize her internal cues for hunger, and respond with food. A similar matching will occur between other physiological needs and behavioral responses, e.g. thirst, movement, rest, and so on. The very securely attached child will learn to respond to her own hunger specifically with the type and amount of food that her body is calling for (as opposed to the food with the least amount of fat or calories), and stop when her body feels sated (rather than when the diet prescribes and in the absence of compensatory behaviors). She will learn to demonstrate flexibility in food choices in synchrony with her body's needs, and adopt a model of resiliency in her body that can allow her to feel good-enough in her own skin, despite the cultural bodily ideals. In this way, a secure attachment to the body mirrors the advantages of forming a secure attachment pattern to the caregiver that promotes proximity (closeness) and exploration (distance) of the physical space of the caregiver's body, and, by extension, the child's body.

### The Body Narrative

Beyond the physical and emotional spheres of interaction, the secure attachment also allows for processes of affective sharing and opportunities for the infant to learn from the parent's experience (Applegate & Shapiro, 2005). As Aron (1999) suggests, "All children observe their parents' personalities. They attempt to make contact with their parents by reaching into their parents' inner worlds. The Kleinians have emphasized this point vividly through concrete metaphors of the infant's seeking literally to climb inside



and explore the mother's body and to discover all of the objects contained inside. Children imagine with what and with whom their mothers are preoccupied" (p. 251). Adults with secure attachments do not feel easily threatened, are able to effectively regulate their affect, and, rarely engage in intense self-blame and self-criticism. Likewise, mothers with secure attachments to their bodies do not feel easily threatened by their children's desire to explore their bodies, and can maintain a sense of feeling 'good enough' despite the cultural expectations. As a result, these mothers are less likely to be preoccupied by the cultural ideals at the expense of their daughters' 'going on being.'

The importance of a child receiving secure, affective messages, coupled with the finding that the coherence of the caregiver's autobiographical narrative is the most robust predictor of a child's attachment to the parent, sheds light on the significance of neural integration for both mental health and nurturing interpersonal relationships (Siegel, 1999). Similarly, the mother's ability to talk about her experience of her body can also be seen as an equally robust predictor of the child's attachment to her own body, and again underscores the importance of neural integration that can happen at the bodily level when the experience of the body is talked about openly between mother and daughter. Thus, how a mother talks about her body in the presence of the child is an important indicator of the nature of the bodily attachment that will likely be transmitted to the daughter. For example, if a caregiver is able to describe a significant trauma history coherently, with moderate affect (rather than overwhelmingly or in a highly distancing style) and with a degree of self-reflection, that usually is an indication of secure (rather than some form of insecure) attachment (Berzoff, Flanagan, & Hertz, 2011). Similarly, if a mother who survived an eating disorder or struggles with some degree of body dissatisfaction is able

to coherently discuss her body with her daughter with moderate affect and with a degree of self-reflection, the daughter will feel more calm around her mother's body and her own.

Moreover, if the mother can identify her own feelings of not being good enough given the cultural expectations, consider her daughter's potential reactions, feelings, and needs, and think through the cause and effect of sharing these bodily issues, the daughter has a greater chance of establishing a secure attachment to her own body. Naomi, however, was deprived of an experience whereby her mother could remain consistent, organized, and mindful of the current context when it involved negative emotions or the body experience. The dominant narrative around the body was impoverished, evidencing primary indicators of an intergenerationally manifested dissociative and avoidant attachment to the body. Naomi's mother was unable to invite discussion or even acknowledge the problematic nature of her own or her daughter's negative feelings towards the body, preferring instead to discuss the importance of adhering to a diet and exercise regime. She was too clouded by her own body image struggles to offer Naomi the kind of conversations and critical analysis of the culture that could potentially insulate her from the assaultive nature of the cultural messages. Naomi's mother felt easily threatened by food and held a deep sense of insecurity in her body. She regularly engaged in intense self-blame and self-criticism of her own body, rendering her body an unsafe place for either her or Naomi to explore. Looker (1998) states that children need their mother's body for soothing and containment, as well as "to poke and probe, to possess ruthlessly, to explore fearlessly" (p. 242). It was clear to Naomi that she was not to question her mother's relationship to food or to her body. Her mother's mind-body

dissociation made it difficult for Naomi to connect to her in any meaningful way. She grew up to genuinely lack knowledge about her mother's body and the physical consequences of defying internal needs like hunger.

Naomi's mother remained disconnected from the wants and needs of her own as well as her daughter's body, making blanket statements that fused them together in their separately hated bodies; "I know exactly how you feel" her mother would say. She attempted to join her daughter with statements like, "We're in this together," but Naomi was instead left feeling increasingly hopeless, as she wondered what the fate of her life would be considering that her mother, at fifty-something, still clearly hated her own body. Naomi experienced her mother's dissociation and inability to "stand in the spaces between realities without losing any of them" (Bromberg, 1996, p. 516) - the reality of her own body, Naomi's body, and the culturally sanctioned body. Naomi developed a psychic gap in self-care and general distrust of her own body and its physiological and emotional signals. She adopted an insecure working model of attachment to her mother, to her mother's body, and to her own body. She demonstrated a disconnect between interior need and external behavior by isolating when desiring closeness, and similarly, not eating when she was hungry. By not responding to her emotional and physical needs, Naomi became further removed from her sense of self and, as a result, she was increasingly depressed, mistrusting and fearful of her body, and despondent about her future. Her body and her inner world of failed attachment relationships left her incredibly alone in the world, unable to forge relationships with others. Naomi's attachment to the diet mentality intensified.

Given that many of today's parents grew up immersed in the Western culture of dieting and weight obsession, it is important to consider the misattunement that can result from mothers who are conflicted about food and body image. One of the best measures of body dissatisfaction is the discrepancy between how an individual perceives her body and her judgment of how she would like to look (Gardner, Friedman, & Jackson, 1999) in relationship to cultural ideals. Mothers like Naomi's, who are wedded to cultural beliefs about the body, may lead their daughters to experience them as preoccupied, absent, or as overflowing with her own negative projections. As a result, children like Naomi compulsively control their appearance so as to "make themselves intelligible" (Kilborne, 2002, p. 27) in the eyes of their mothers. The more Naomi experienced her mother as withdrawn/inaccessible and ambiguous, the greater Naomi's imperative to turn against her own body. In other words, the conviction of her body-based badness became a perverse way of paying attention to herself in an effort to defend against an even more tormenting reality - the terrorizing aloneness she really felt as a result of her attachment trauma.

#### Attachment Trauma

Developmentally, relational theorists suggest that responsive caregivers help organize and make sense of a child's affective experiences through affective attunement and recognition, which provide a sense of togetherness and mutuality (Bromberg, 2006). Affective attunement is a shared experience between child and caregiver, based on empathic understanding of the child's internal world and developmental needs. At a time when the culture increasingly sends messages that there is something inherently wrong with the average female form, girls are in desperate need of affective attunement when it

comes to the female body experience. By providing the child with a coherent perception of self and a trustworthy experience of others, repeated experiences of affective attunement establish the foundation for later satisfying interpersonal relationships in a way similar to the establishment of a secure attachment relationship (Bromberg, 2006). Accordingly, by providing a young girl with a coherent perception of the body and a trustworthy experience of the mother's experience in relation to her own body/bodily needs as well as those of her daughter, the resulting affective attunement establishes the foundation for later satisfying bodily relationships.

On the other hand, disturbances in early relationships with caregivers where attunement and mutuality are absent "set in motion a complex process through which the child must build an interpersonal world from what is available" (Mitchell, 1988, p. 289). This process serves to distort a child's subsequent capacity for relatedness (Mitchell, 1988) and to impair her capacity for affective self-regulation (Bromberg, 2006), which in turn can lead to psychopathology. Eating disorders are a prime example of an attachment disorder that can result when attunement and mutuality are absent, especially when it comes to the experience of the body. The interpersonal world that Naomi had to build on was based on control and autonomy that was most easily achieved through managing food, feeding, and the body.

Stolorow (2011) states that, "One consequence of developmental trauma, relationally conceived, is that affect states take on enduring, crushing meanings. As a result of recurring experiences of misattunement, the child acquires the unconscious conviction that unmet developmental yearnings and reactive painful feeling states are manifestations of a loathsome defect or of an inherent inner badness" (p. 28). Naomi

acquired this sense of inner badness, as her body took on crushing meanings not only to her but also to her mother. For Naomi, her body represented a way to split off the pain of maternal misattunement by demonstrating her ability to resist the calling of her own physical and emotional needs. If she did not need anything, she did not have to face preemptive disappointment. She learned to not need food to meet her physical yearnings in the same way that she learned to not rely on people to meet her emotional longings.

Daughters who are confronted by restrictive bodily ideals need assistance from embodied, caring mothers to help them tolerate, contain, and integrate the various possibilities around physical development. From the assertion that trauma is constituted in an intersubjective context wherein severe emotional pain cannot find a relational home in which to be held (Stolorow, 2011), it follows that the experience of body dissatisfaction is exacerbated rather than contained in the absence of caregivers who are attuned to their own bodies' needs, and feel good-enough in their bodies despite the inevitability of their flaws. Thus, misattunement to the child's painful emotional reactions to her body renders her bodily experience intolerable, and a source of a trauma. As Ogden et al. (2006) suggests, early interpersonal trauma is not only a threat to physical and psychological integrity, but also a failure of the social engagement system. If the perpetrator of this trauma is a primary caregiver, it includes a failure of the attachment relationship, undermining the child's ability to recover and reorganize, to feel soothed or even safe again. The child's opportunity to effectively utilize social engagement for care and protection has been overridden, and the child is more likely to experience overwhelming arousal without the availability of attachment-mediated comfort or repair.

Attachment failures left Naomi feeling like a failure at everything, despite much evidence to support the contrary. She was not provided the opportunity to recover from 'bad body fever,' a syndrome identified by Hirschmann and Munter (1995) to describe women's rampant body-hatred, thus preventing her body from developing into a place where she could safely reside. She was haunted by feelings of "nothingness," and at those times often found herself curled up on her parent's kitchen floor, pained by her physical hunger but unable to ingest even a morsel. Naomi's mother could not provide a protective shield for her against painful affect and difficult feelings and consequently the painful affect and difficult feelings that stemmed from unmet needs were directed towards her body. At the age of five, Naomi already suspected that she was "too much" - her thighs took up too much space and her need for food exceeded what the diet prescribed and what her mother modeled. She claimed an inner badness that only shrinking down to an acceptable size could ameliorate. Naomi learned to strive for a thin body as her 'purified ideal' since her caregivers did not welcome her 'negative' feelings.

For the most part, Naomi reports that her mother was inaccessible and reacted to her expressions of emotions and stress with irritation, showing only minimal or unpredictable participation in the various types of arousal regulating processes. When Naomi returned from college on a break early in her first semester, she was miserable and deeply pained by her experience, wondering if she had made the wrong choice of schools. She asked her mother about the possibility of transferring, to which she replied, "If you want to get the paperwork together for a transfer, go ahead but you'll have to wait out the year." After some thinking, Naomi returned to her mother later that break and said, "I

hate my body.” Her mother recommended she diet to lose weight, confirming for Naomi what she already suspected - there was something deeply wrong with her physical being.

Naomi’s mother often assumed that her daughter’s needs were the same as her own, and that it was best that her daughter adopt her approach to life. Naomi’s mother relied on unrealistic and prejudiced messages about beauty to dictate her own as well as her daughter’s self-worth. Naomi found a solution in Jenny Craig and her carefully rationed, pre-packaged meals were just what she needed to control her appetite, not unlike her mother’s delicacy of ‘dog food.’ Naomi firmly believed that she needed to command more control of her food intake to prove that she was worthy of existing in her family and in the world at large. Furthermore, she needed to prove that she could take care of herself, and not rely on anybody else, just as her family values had taught her. Naomi learned at an early age that she could simplify things for herself by not allowing herself to have emotional needs. She existed on crumbs both literally and figuratively. Like her mother, she became locked in a painful battle fought on and against her body.

When Naomi, in treatment for an eating disorder, phoned her mother to tell her that she was having a particularly difficult day with food, her mother responded, “I cannot stay on the phone with you when you are like this. I hope you understand.” Naomi did not understand. Feeling even more alone, she tried once again to connect with her mother the following morning. Her mother asked her if it made sense why she could not speak with her when she gets “like that,” and hoped that Naomi had “learned her lesson around what to do when she gets into those bad places.” The only thing that Naomi learned from that interaction was that she should feel ashamed of herself for reaching out to her mother and for not handling things better on her own. Despite her attempts to



engage her mother in genuine ways, it was impossible for her mother to meet her emotional needs, or to simply bear witness to her emotional experience, especially when it came to food, feeding, and her body.

Naomi's mother, through her insensitivity to and rejection of her daughter's needs, exhibited one dimension of insecure attachment - avoidance (Ainsworth, 1979). This kind of attachment figure may withdraw from helping during difficult tasks (Stevenson-Hinde & Verschueren, 2002) and is often unavailable during times of emotional distress. Caregivers who discourage proximity-seeking behavior of the infant, responding instead by withdrawing or pushing the child away, trigger insecure-avoidant behavior patterns in that infant (Ainsworth, Blehar, Waters, & Wall, 1978). These mothers who typically dislike physical contact, except on their terms, and often experience a great deal of difficulty with dependency themselves due to their own attachment histories, discourage emotional expression of dependence. These parents do not like "lap babies;" they discourage, or even punish, crying and other expressions of dependence. In Naomi's family, crying was not an acceptable form of expression. If there was ever something wrong, Naomi did not receive assistance to figure out what was bothering her. Instead, she was told to figure it out on her own or "go for a run to calm down and think about what it was that you wanted to say." Naomi remembers standing paralyzed in the kitchen on a number of occasions - panicked that she would make the wrong food choice. Rather than assist Naomi to discover what her body was hungry for, her mother became enraged by her helplessness. Instead of modulating Naomi's extreme levels of stimulation and arousal that were too overwhelming for her to manage independently, Naomi's mother induced even higher levels of agitation in her daughter.

Naomi learned to inhibit expressions of distress, and as she grew up, she adapted to this affectively laden somatic communication of unavailability by expressing little need for proximity, and showed little interest in adult offers for contact.

Because Naomi's mother was unable to achieve affect attunement, and could not identify physiological and psychological stimuli in a way that would be helpful to and supportive of Naomi, Naomi never developed the capacity to deal with emotional and interpersonal stressors. Women with anorexia nervosa and their mothers commonly have a dismissive attachment style (Ward et al., 2001). Correspondingly, Naomi assumed a dismissive stance towards the importance of attachment in adulthood. She often distanced herself from others, undervalued interpersonal relationships, and viewed emotions with cynicism. With a compromised social engagement system and limited access to internal states, Naomi minimized her attachment needs for people and for food. Like her mother, she was incredibly fearful of dependency, and even thought it was an "ugly" word. Naomi felt "greedy" for needing anything, especially from her mother. Thus, she avoided situations with her mother or others that stimulated attachment needs. Faced with a relatively dismissive mother, Naomi was deprived of the opportunity for interactive regulation. Consequently, she came to prefer autoregulation - a process through which she engaged in self-stimulating and self-soothing behaviors that are not dependent on another's presence (Cozolino, 2002; Schore, 2003). With the tendency to curtail the expression of emotion, Naomi learned to modulate her arousal in solitude. She developed a similarly insecure-avoidant style of attachment to her own body by denying her body's need for food or attention, thus mirroring that insecure attachment which led her to either seek proximity in an anxious way, or inhibit the need for closeness altogether.

When the physical experience of the mother's ministrations are misattuned to the child's signals pertaining to sensation, touch, movement, and physiological arousal, as well as to her sensitivities/vulnerabilities regarding sensory input and other physical needs (Ogden et al., 2006, p. 42), the child fails to secure a sense of her self in her own body. Due to Naomi's exposure to her mother's insecure-avoidant body attachment, she established an initial sense of her self and of her body as "too much" and "too needy." She suffered from a deep conviction that she could not occupy her body while maintaining mutually safe and intimate contact with the person she needed most - her mother. Naomi's craving for attention and longing to be physically held went underground as she capitulated to her mother's demands that she be the person her mother wanted her to be: thin, exacting, tough, independent, and productive, not round, soft, fat, sensitive, and emotional.

As a result of this persistent misattunement, Naomi established a defensive self-ideal (much like Winnicott's concept of a 'false self'), representing a self-image split off from the offending affect states that were perceived to be unwelcome or damaging by her caregivers. Living up to this affectively separate ideal (controlling bodily need and appetite) was a central requirement for maintaining harmonious ties to her parents and for upholding any ounce of self-esteem Naomi could assemble. The emergence of any previously prohibited affect (sadness, upset, disappointment, anger) was experienced by Naomi as a failure to embody the required ideal and represented an exposure of the underlying badness that immediately flooded her with feelings of isolation, shame, and self-loathing.

As we see from Naomi's experience, body insecurity and shame emerges from the internalization of early relational experiences of caregivers who are insecurely attached to their own bodies; the messages sent from these caregivers fail to secure a sense of competence and well-being in the child. Attunement to the bodily self and needs is therefore also a crucial component of physical development, and influences one's attachment style to one's own body, often manifested in one's relationship to food and feeding, and one's degree of body satisfaction or dissatisfaction. Because Naomi's mother's attachment to her own body was weak, Naomi adopted an insecure pattern of relating to her own body. Naomi's mother, struggling with her own body dissatisfaction and culturally idealized standards, contributed to Naomi's inability to establish a securely based internal observing object that could look at her self with benign eyes. Thus, Naomi internalized a more critical, scrutinizing other, rendering an insecure attachment to her body and leaving her more susceptible to assume a noxious relationship with the cultural expectations in order to maintain the attachment to her previously persecutory mother object.

#### Attachment to Cultural Symbols

Attachment patterns, formed in infancy, usually remain relatively stable throughout childhood and adulthood (Brennan & Shaver, 1995; Cozolino, 2002). A child's primary attachment pattern is typically formed in relationship to the mother, and this pattern is usually generalized to subsequent relationships (Ogden et al., 2006). Moreover, children usually interpret experiences in light of their internal working models rather than change their working models to fit new experiences. As a result, it is easy for children to interpret the culture in terms of their pre-established working models of

attachment. Similar to family or peers, “people are unconsciously driven to attach to their world – whether in compliance, defiance, or both – in ways similar, though not exactly the same as those by which they naturally attach to their mothers and to their nuclear families” (Gutwill, 1994a, p. 18). In mass consumer culture, individuals seek object relationships with not only people, but also with the dominant cultural symbols. Consumer and public culture therefore serve as a relational matrix that women (and men) attach to both consciously and unconsciously, such that social symbols representing the “ideal” become internalized.

In Naomi's family, her mother preached the importance of independence and self-care and self-control, which for her was represented by a thin body supported by the culture. The body, with its unruly forces, appetites, and needs was a threat to control in Naomi's family. In contemporary culture, with its pervasive focus on fitness, body image, and the use of cognitive strategies to control physical urges and behavior, bodily needs and appetite were seen in Naomi's family as things that must be tempered and restrained if the intellect is to prevail. Even the experience of eating food turned into a series of “moral decisions,” with certain foods labeled “good” and others “bad.” Naomi's mother fell victim to advertisers' promotion of the “good food/bad food” dichotomy, such that eating the “right” foods made her, and subsequently Naomi, feel that they were on the road to “salvation.” Eating the “wrong” food or eating for pleasure, on the other hand, conjured up feelings of guilt, shame and even the need to “atone” for their sins (Hesse-Biber, 2006; Solomon, 1988, 2003).

It is no surprise that Naomi grew up to be seduced by concrete solutions that promised her the hope of belonging - not only to her family, but to the larger cultural

surround or “culture home” (Bloom, Gitter, Gutwill, Kogel, & Zaphiropoulos, 1994) as well. The desire to belong can be so strong that it can override more basic needs like safety and security, and, within the context of mass consumer society, compel individuals to find ways to attach to the cultural ideals no matter the cost to their bodily integrity. As Naomi entered the social world she was greeted by a cultural mirror which reinforced her traumatic attachment experience and consolidated her already well-established sense of badness. Cultural symbols offered her the hope that achieving a thin body would provide redemption from her inner badness, and these symbols became easily repositioned in her psyche as extensions of the messages she had received in her family of origin. The solutions offered to Naomi by consumer culture to restrict her body’s needs, however, were not benign or even neutral. Instead, they were inherently tantalizing and simultaneously rejecting, resonating unconsciously with the pattern of attachment Naomi experienced in relation to her own mother. Naomi’s problems with feeding and relating to her body became a socially constructed continuation of the attachment trauma. Under these circumstances, sociocultural ideals operate like most perpetrators by manipulating the needs and desires of those most vulnerable.

Since women are routinely assaulted by the symbolic landscape of the consumer culture, Gutwill and Gitter (1994) offer an explanation as to how the culture makes its entrance into the psyches of women similar to other traumatogenic agents, like sexual or physical abuse. Sexual assault controls and terrorizes by overt means, and is usually accompanied by some kind of mind control; the ideology of consumer culture works in much the same way. Living in fear of food and being fat with hatred towards one’s body, creates an everyday experience of destructive and assaultive self-criticism that too often

resembles the outcomes of sexual violence, and severely threatens one's bodily integrity. As suggested by Herman (1992), "Traumatic events generally involve threats to life or bodily integrity" (p. 33). Bollas (1987) suggests that control over the 'other' (in this case, the cultural oppressor) may be expressed through attempts to remodel the bodily self and search for a transformational object that will give birth to a new and improved version of the self.

In order to repair the subjectivity that was thwarted in her development as a result of attachment trauma, Naomi learned to identify with the object that offered her the hope for transformation: the consumer culture. In order to attach to the culture's unrealistic body ideals, however, Naomi had to dissociate from her body's needs in an attempt to attain this ideal. Dissociation in this analysis is both a psychological maneuver and a cultural demand (Gutwill & Gitter, 1994). According to Little (1957, 1986), both psychological and sociological experiences actually encourage delusional transference onto the body. The attachment to cultural messages and ideals is considered to be a form of trauma bonding. Trauma bonding, according to Herman (1992), is a pronounced tendency to use highly abnormal and dangerous relationships as a normative template for what relationships are supposed to be. Naomi's relationship with food and her body demonstrate the twisting of normal attachment behavior into something perverse or cruel. She developed an internal relationship with this seductive object representation, splitting off part of her ego to maintain a state of constant attachment. In service of the absolute need to be in relationship, Naomi developed an internal world of cultural object relationships.

In another sense, in an attempt to prevent or deny separation from her mother, Naomi was primed to attach to cultural symbols as transitional objects, creating a cultural dependence in place of her mother's actual physical and emotional presence. For Winnicott (1971), the cultural symbol can become a passage to transcend traumatizing separations and endure reality - with the world external to and separate from the self. But it is also a construct around which people interact, thus providing a channel for both intrapsychic and interpersonal relationships (Gutwill, 1994a). However, unlike Winnicott's (1971) benign transitional phenomena, these transitional objects of the images and symbols of the thin, hard, young, and restrained female body are meant to control those who symbolically attach to them (Gutwill, 1994a). The assault on the female form is then reactivated on a daily basis in the symbolic landscape of the culture that prevents the wounds from ever healing over (Gutwill & Gitter, 1994).

Feminist psychodynamic theory recognizes that the development of women's body image includes the internalization of culture. "...In many psychoanalytic theories, the culture is either not seen or is reduced to one isolated factor rather than a force that is continuously shaping and interacting with the individual" (Bloom, et al., 1994, p. xii). Wolf (2002) agrees that the many theories about women's food crises have stressed the private psychology to the neglect of public policy, looking at women's shapes to see how they express conflict about society rather than looking at how their society makes use of manufactured conflict over women's shapes. Other theories have focused on women's reactions to the thin ideal, but have not asserted that the thin ideal is proactive - that is, there is a public social order that has a material vested interest in promoting troubled eating for women. The advertising world invites females in to feel more lovable by



participating in its promises, and attaching to its objectivity. The more insecurely attached a woman is to her own body, the more securely she will attach to the cultural symbols. As women like Naomi and her mother attach to unsatisfying objects in the form of images of women in mass consumer culture, they are left even hungrier for physical and emotional nourishment.

Given the toxic nature of today's unrealistic cultural expectations that hypnotize and pervade the female experience, it is easy to succumb to the pervasive message that our physical beings are lacking, insufficient, or even detestable. As the case of Naomi illustrates, as early as five, she was beginning to find fault with her own body - her 'fat thighs' were too big compared to those of others in her class. She was already feeling as though she was taking up too much space. The foundation trauma of misattunement, coupled with the intergenerational transmission of an insecurely attached body-self relationship from her mother, left a perfect whole for the culture to reinforce. Cultural symbols of thinness and fatness therefore have the potential to invade the human psyche as they did Naomi's, especially when the child is exposed to early attachment trauma. This can create in the child a malignant self-loathing, a deep mistrust of others, and the template for an attachment disorder that is carried into adult life. The eating disorder, therefore, serves as both a mechanism for relational reenactment whereby the sufferer replicates with her body the care she witnessed and experienced earlier in relation to her mother and her mother's body, and a way to detach from the reality such that her needs will go unmet in relation to others. Naomi found a way through her eating disorder, to prolong the discovery that the burden of the badness did not reside inside of her, but

rather, was a reflection of the culturally enforced object relationally determined body image that was transmitted through her mother.

### Conclusion

Consumer culture offers a tantalizing and imperious solution to taking pleasure in and feeling powerful by believing that the body is an object needing repair. Women's bodies had previously been exploited in hundreds of ways - silently. Now the invasion has been exponentially multiplied and hidden behind the "happy, giving face of the corporation" (Gutwill, 1994a, p. 11). Herman (1992) posits that hysteria is still (over one hundred years since Freud discovered it and covered it back up again) the combat neurosis of the sex war; similarly, it appears that eating disorders are the combat neurosis of the war on women's bodies. It is not simply the size of the female body that has changed; "mass industry went for the very fiber of fantasy life. Targeting the most primitive of people's needs and their more adult aspirations toward freedom and armed with the psychological weapons provided by advertising, mass culture has aimed at nothing less than the institutionalization, the rationalization of fantasy life around sales that focus predominantly on female slimness and beauty" (Gutwill, 1994a, p. 11). In turn, women develop a culturally enforced object relationally determined body image, and then openly share their worries about eating, size, and shape, creating a female solidarity around these norms.

As we see with Naomi, from an early age she was invited to join the diet with her mother. Her mother tended to ignore or suppress her own internal signals for hunger and satiety, only to have them overridden by the cultural prescriptions. Naomi's mother preferred reason and logic over emotionality, and advanced respect for a tight, trim body

while fearing fatness. Naomi picked up on the looming fear of being or becoming fat from her mother, and soon adopted dangerous polarizing dichotomies: thin is good and fat is bad, certain foods are good while others are bad. These dichotomies around body size and food correlated closely with the dichotomy of attachment: self-sufficiency and autonomy are good, and dependency, vulnerability, and help-seeking behavior, are bad and even shameful. Naomi's capacity for dieting and her ability to get gratification and praise from that behavior was strongly internalized and psychologically enforced by her familial system. The ideal of thinness was etched into the structure of her feminine psyche. Although it is impossible to fully insulate daughters from the adverse effects of fat stigma and body hatred that, as an aspect of the larger cultural environment, become encoded in internal mental representations, a mother's ability to integrate a positive body-self representation can serve as a protective factor. These secure body attachments, in turn, help the child to become appropriately skeptical of culturally induced body practices in a potentially hostile environment.

The need for body security, however, is often overlooked in our culture today. In healthy body image development, the primary caregiver needs to supply an auxiliary body function, much like the auxiliary ego function that Winnicott (1974) talks about, boosted by the sensitive adaptation of the mother to her baby's basic needs. Unfortunately, many women are exposed to 'primitive agony' (Winnicott, 1974) via their mother's body dissatisfaction even while they are still in the womb. The struggles of burgeoning mothers to accept and embrace their changing bodies, is further exacerbated by a cultural agony that communicates to women that there is something inherently wrong with the average female form. This is not only true in pregnancy, but in accepting

the body's natural response to maturation - slowing metabolisms, fluctuations in weight and shape, and signs of aging over the course of the lifespan.

Just as Benjamin (1988) posits that an analyst who does not permit her own subjectivity to be recognized is one who offers to be experienced as an object rather than a subject, a mother who cannot discuss her body as both object and subject with her daughter, runs the risk of reinforcing the toxic cultural messages that propagate the objectification of women's bodies. When the mother serves as the facilitating environment to transmit cultural ideals to the child through an insecurely attached body, the child is primed to attach to cultural symbols as an extension of primary attachments, and is greatly at risk of moving from exposure to action in the form of an eating disorder. As Harris (1998) suggests, psychic life, including body life and body ego, is self-experience socially constructed through intersubjective and interactive dialogues in social life, family matrices, and analytic treatments. Children who are confronted by restrictive bodily ideals need assistance from embodied, caring adults to help them tolerate, contain and integrate the various possibilities around physical development. In the absence of those caregivers, female treating clinicians with a secure attachment to their own bodies can offer their clients greater relational repair in and through the intersubjective experience of the good enough body.

REPAIRING INSECURE BODY ATTACHMENT: THE INTERSUBJECTIVE  
EXPERIENCE OF THE PHYSICAL BODY IN THE TREATMENT OF EATING  
DISORDERS

Introduction

Cultural attitudes toward dieting and a body ideal have made it difficult for many girls and women to satiate their bodies' desire for food in a way that balances individual nutritional needs, hunger, appetite, and pleasure. Western sociocultural values of appearance have been found to significantly contribute to eating pathology through the promotion and ascription of value to a virtually unattainable thin physique while stigmatizing fatness (DeLucia-Waack, 1999; Stice, 2002). Social mandates communicate contradictory and confusing messages about the female body and appetite by stressing the need for bodily control and obsession in a fat-phobic culture, while simultaneously encouraging over-consumption and indulgence. Since Rodin, Silberstein, and Striegel-Moore (1985) coined the term 'normative discontent,' authors continue to note the all too ordinary experience of body dissatisfaction amongst women (Cash & Henry, 1995; Hutchinson, 1994; Maine & Kelly, 2005; Orbach, 2009). Treatment providers living in Western cultures receive the same restrictive messages about beauty, bodies, food, and attractiveness as their clients (Matz & Frankel, 2005). Even the most critically minded therapists have to do some work to resist the cultural pulls and persuasions that pervade the female experience.

Feminist psychoanalytic writers have built on a contemporary understanding of countertransference to include the therapist's transference relationship to the culture at large (Bloom, Gitter, Gutwill, Kogel, & Zaphiropoulos, 1994). This "cultural

countertransference" refers to the therapist's transference to culturally established images of perfection for women (i.e. the idealized female body). Cultural countertransference is contained within relational matrices as well as within the connections an individual makes to the symbolic systems of his or her culture (Bloom, 2002; Gutwill, 1994b). Most women naturally compare themselves to the cultural ideal, while also comparing themselves to other women in terms of how they measure up to this ideal. The practice of comparing is typically even more pronounced for women suffering from eating disorders because they often overvalue appearance and the physical body in interpreting the world; thus, they are likely to be hyperaware of the treatment provider's appearance (Warren, Crowley, Olivardia, & Schoen, 2009). The therapist's physical stature, therefore, is likely to evoke thoughts and feelings for the client whether it is talked about in the room or not, and the meaning the client assigns to the therapist's body can be an important element in the life of the therapy. As a result, women's relationships to each other's bodies in the female therapeutic dyad, which is mediated by the cultural ideal, represent an important area of investigation.

Bodily appearance denotes physical appearance (i.e. body size, weight, shape, or dress), as well as the level of comfort or discomfort in one's body (i.e. calm, relaxed, centered, fidgety, or anxious); both are equally important unavoidable disclosures in the clinical encounter. Burka (1996) states that "the therapist's body has great significance for the patient, and the therapist's actual and symbolic physicality plays a very important role in the patient's experience of aliveness and in the vitality of the therapy" (p. 274). Using a contemporary psychoanalytic understanding of countertransference, Burka (1996) asserts that the specific visual transference and countertransference relationship

contributes to the shared, unconscious ways in which both client and therapist experience their bodies. The therapist's body, therefore, is an important transference object for the client: "It is a body that represents the imaginative and cross transference needs of the therapist and the patient. It is not a 'natural' or 'neutral' body. It expresses the relational complexities between the two people in the room" (Orbach, 2004, p. 149). Burka (1996) recognizes, however, that the client's perception of the therapist's physical self is not only determined by the visual experience of looking at the therapist directly, but also heavily influenced by fantasy, internal object representations, and the current cultural meanings attributed to the appearance of the body.

Thus, the therapist's body is always present in the room; however, it is not always an analytic object. In extending the ideas of Ogden (1994), the therapist's body turns into an analytic co-constructed body if it becomes "a carrier of psychological meanings that had not existed prior to that moment" (p. 75). Inviting discussions of the therapist's body can therefore facilitate the client's movement beyond object relating to object usage. In contrast, an analyst who does not permit her own subjectivity to be recognized is one who offers to be experienced as an object rather than a subject (Benjamin, 1988). It follows then, that, the analyst who is unwilling to discuss her body as a subject runs the risk of reinforcing the toxic cultural messages that propagate the objectification of women's bodies.

Despite these important conceptualizations about the therapist's body and its impact on the life of the therapy, the role of the therapist's body in the treatment of eating disorders has received limited attention in the literature (Lowell & Meader, 2005). Some psychoanalytically oriented theorists have published personal reflections describing how

aspects of their own body size and shape have affected treatment with clients (Burka, 1996; Jacobs & Nye, 2010; Lowell & Meader, 2005; Orbach, 2004, 2006), and several other therapists working from a feminist psychoanalytic perspective, have written about the therapist's body image and its effects on treatment (Costin, 2009; Gutwill, 1994b; Rabinor, 1995). Studies also indicate, however, that clinicians are having trouble allowing their bodies to be the subject of discourse (DeLucia-Waack, 1999; Lowell & Meader, 2005; Shisslak, Gray, & Crago, 1989; Warren et al., 2009). Moreover, although the clinical literature validates that transference and countertransference issues are particularly powerful in the treatment of eating disorders, it generally neglects the exploration of these issues specific to body image (Costin, 2009) or to the therapist's actual body (Burka, 1996; Lowell & Meader, 2005; Orbach, 2004), and, one might add, to the therapist's perceived or actual comfort in her own skin/body.

As Gutwill and Gitter (1994) suggest, women's relationships to cultural symbols are rarely explored in the clinical setting. The authors argue that psychotherapists have historically had difficulty consciously articulating socially caused trauma, and thus they typically do not know how to ask clients how they feel about the cultural symbolization of bodily ideals, or what they experience in relation to actual body parts (i.e. ribs, waist, lips, arms, breasts, or buttocks) that are pictured all around them. In addition to developing a spoken language around the actual body presences, the other essential piece in this model of protection and repair is the clinician's ability to communicate with conviction that she herself does not buy into the seductive spells of the culture. As Ferenczi stated as early as 1912, conviction is felt in the body. Thus, in order to see, hear, and feel what is happening in their clients' body-selves in a deeper and fuller way, it is up



to female clinicians to communicate not only verbally, but also non-verbally that they are sitting in the room with their client in bodies that eat, need, and desire without constriction. These conversations are crucial in providing the client with an opportunity to begin to repair past injury by helping her to form a more secure body attachment that prepares her to step out into the culture with the resilience necessary to avoid getting swallowed up by the inevitable overexposure to cultural ideals.

This paper, therefore, seeks to strengthen the argument that the body is not an isolated entity that can be extrapolated from its context; instead, the particular physical presence of the body is a significant aspect of the reality of the therapist that forms the context in which all psychotherapy occurs (Burka, 1996). Intersubjectivity, for the purposes of this paper, refers to the developmentally achieved capacity to recognize another person in her body as a separate center of subjective experience (Benjamin, 1988). The intention here is to show that the therapist's objective body must also be considered for its contribution to the subjectivity of the therapist, and that facilitating the client's recognition of the therapist's body as a subjective body is an important part of therapeutic development for clients with eating disorders. This means, above all, giving up the myth of an isolated body in order to create room for the third body to emerge, analogous to Ogden's (1994) conceptualization of the analytic third. Key Winnicottian concepts, including holding environment, ego relatedness, transitional object space, object relating and object usage, and the true and false self, will be particularly useful in illustrating the importance of the therapist's body when working with clients diagnosed with eating disorders.

In the following case example, Beth, a 20-year-old college student, and the therapist (this writer) work to negotiate competition and envy expressed in body-centered comments. The case will be used to exemplify how a client's past experience of relational and bodily trauma can begin to be repaired within the therapeutic relationship. Clinical excerpts will illustrate how engaging the client in an honest and purposeful discussion about the clinician's body can be a turning point in the psychotherapeutic process. In a short amount of time, unconscious longings emerge as a result of exploring the meaning behind the client's thoughts and feelings about the therapist's body, providing clinical data to illustrate how the client can be helped to move from object relating to object usage when the physical body is invited into the consulting room.

#### Beth

Beth first contacted me in January, and although she seemed interested in starting therapy it took several communications to finally schedule our first session. She showed up at my office appearing extremely guarded. Beth looked frightened and her eyes appeared hollow and distant. Without hearing a word of her story, I knew that she was living in a war-torn body. She sat nearly motionless on the couch, showing very little affect and having great difficulty expressing herself verbally. Beth had almost an autistic feel to her – she looked at me with a gaze that barred little capacity for connection. She shared that she had one failed attempt at treatment last summer when she left inpatient after only a few days and against medical advice. For the most part, Beth downplayed the severity of her symptoms; however, something about her silence spoke otherwise. Her fear was palpable, and I could tell that she was just as afraid of me as she was of food. Of the symptoms she disclosed initially, she seemed more willing to discuss her restriction

because that was the part of her that she was most proud of. Beth made it clear that her goal was to lose weight, and although she did not say it directly, she longed for a body that was long and lean, much like mine. I believe that what she really longed for, but did not yet have the understanding to express, was to feel comfortable enough in her own body, no matter what she weighed. I could tell how entrenched her symptoms were and referred her to an intensive outpatient treatment program (IOP), in addition to her weekly individual sessions with me. Surprisingly, she followed up right away and started IOP that very next week.

Over the course of the next several months, I learned that Beth was a college student at a local university. She reported having virtually no friendships or romantic relationships at school, and preferred to keep to herself. She was essentially socially and sexually anorexic. Her days consisted of planning, measuring, and counting her food, while making sure to keep up with classes and her internship. In between, she compulsively exercised at any chance she got. If she was not perfectly minding her food intake, one ‘bad’ choice sent her down a tumultuous path of violent bingeing and the occasional purge, if all went well. Beth remained convinced that her eating disorder existed simply because she was fat. She told me that it started her junior year of high school as an attempt to lose weight in order to fit the mold of a classic ballet dancer. Beth remembered being triggered by a YouTube video of a nine year old who won a ballet competition, and ever since she longed for that body. She believed that if she could just get back to the weight she was in high school, her life would be “so much better” and she would be more comfortable making friends. She had a hard time considering that her rigid, restrictive, punitive practices of self-starvation could be problematic or reflective of

the care she received as a child; instead, she blamed herself for not having the willpower to control her appetite. Overall, Beth saw herself as one big fat failure. This kept her feeling psychically alone and undeserving of anything. She was consumed by the never-ending battle towards thinness.

Beth is the youngest of three girls, and the oldest two (three and five years her senior) have always been closer in friendship. Beth expressed envy towards her oldest sister for claiming the state championship in tennis her senior year of high school, while Beth desperately sought to be noticed through running track and dancing ballet. Her middle sister developed bulimia around the same age that Beth became symptomatic in high school, and she continues to feel that her sister is not recovered because she is thinner than Beth. Beth's mother works mainly the nightshift as a home healthcare aid and her father is busy as a high-powered attorney. Beth expressed some irritation towards her mother for her desire to diet and exercise to lose weight, mirroring the cultural pressure that Beth already felt. Overall, Beth was operating in the world on her own, never asking for support. I learned from the therapist at the IOP that Beth sat through eight weeks of family night alone because she could not imagine asking her parents to come.

After a few months of treatment, Beth had completed IOP and started seeing me twice a week, in addition to weekly nutritional care and the recommendation for family treatment. She benefited from psychopharmacological intervention to help ease the intensity of her urges to binge. It became evident that a relationship was forming between us when she began reaching out to me via email. Sometimes in these emails she would share her binges with me, something that was too shameful to share in person, while

other times, she benefitted from just reaching out and getting a response. I applauded her efforts to make contact and encouraged her to bring her feelings into session so that they could find a 'relational home' (Stolorow, 2006). She was able to maintain some relationships with the clients she met in IOP, and she started to notice sometimes that having support prevented her from relying on food. However, she still remained relationally stunted and tortured by her thoughts of food and negative feelings about her body. She dreaded the nights when she dreamed of eating and woke up believing that she had eaten. Occasionally she would cut herself by scraping a razor blade over the bones of her hips and ankles in the event that she could not purge after a binge. Beth said that she just wanted to "feel something," but more than that, she believed that the scrapes helped to disguise her "fat."

It became clear from Beth's history, that she had developed an insecure - ambivalent attachment style. The ambivalent infant typically has a parent who is inconsistent and unpredictable in her responses to the infant. The attachment figure may be more consistent in responding to overtly expressed dependency needs; however, the intervention is typically ineffective in calming the infant due to the lack of attunement (Ogden, Minton, & Pain, 2006). The inconsistent responsiveness of her attachment figures taught Beth to increase signaling for attention, escalating distress in order to solicit caregiving (Allen, 2001). Beth says that she first developed her eating disorder symptoms in high school as an attempt to get the older girls on her track team to show care for her. In line with the ambivalent infant, Beth grew up to have great difficulty modulating distress and became more vulnerable to under-regulatory disturbances. As a result, Beth, like similar clients, found isolation stressful: "Because they have trouble

tolerating solitude, they cling to relational contact, becoming overly dependent on interactive regulation but simultaneously experiencing a lack of ability to be easily calmed and soothed in relationship” (Ogden et al., 2006, p. 56). Beth’s behaviors with food represented an attempt to modulate her own affect. As her conscious awareness of her own loneliness grew, so did her preoccupation with food, eating, and the body.

A few months into treatment, Beth’s hopelessness that she would ever get better intensified. She was having a hard time understanding that her powerful binges were an attempt to counteract the intensity of her physical and emotional deprivation. “I can’t fight this myself anymore. Everything is getting worse. I’m six days in with symptoms. My motivation and want to do anything is shot. I want an out.” Beth fantasized about going to inpatient, and was convinced that this was the only way that she was ever going to get better. She hated the fact that she didn’t “look” like she had an eating disorder because her weight was not low enough. Her symptoms were not visible from the outside, and she felt desperately and angrily misunderstood, unimportant, and invisible. We thought long and hard together about what would be best for her, and I remained attentive to her inner experience, despite her having so little to say about it.

Sometimes we sat in silence and I attempted to breathe in sync with her so that she could feel the attuned presence of another. I held tight to my desire to understand her in a way that others had not, and made this very clear to her through my unconditional acceptance of her and her symptoms, no matter how “revolting” they seemed to be. As she slowly began to take me in as a good object that she could depend on, she opted not to go into residential treatment. I knew that somehow we needed to access the inner rage that she was taking out on her body in the most violent and active ways, but I was

uncertain as to how, given that she had so much trouble verbalizing her thoughts and feelings. I remained very attuned to my body experience in the room with her, modeling the presence of a good-enough Winnicottian body that could tolerate her rage, and waited for an opportunity to discuss the transference.

### The Development of the Winnicottian Body

The importance of the body in treatment can be seen as early as 1923 when Freud (1961) recognized that the ego was first a body ego suggesting that bodily experiences are the center around which the ego is developed and that a person can adopt another person's bodily demeanor or bodily symptom through a direct bodily identification. Winnicott (1975), however, shifted the emphasis away from intrapsychic drive theory and towards a two-body psychology in which bodily experiences occur within the maternal caretaking environment and form the basis for the developing self. "There is no such thing as an infant" according to Winnicott (1965); there is only a mother/infant nursing pair (p. 39). Object relations theory posits that the first exchanges between a caregiver and her newborn baby are universally physical and visual. The dynamic, affectively laden visual interplay between mother and baby shapes the baby's earliest experiences of object relating, which is then internalized and lays the foundation for the child's internal world (Diamond, 2001). Ego relatedness is formed between infant and caregiver when this intricate mutuality permits the infant to discover her own identity vis-à-vis the caregiver relationship.

Winnicott (1971) proposed that the mother's body is the infant's first object; created by the caretaker's satisfaction of the infant's physiological needs, it exists both as a separate entity and simultaneously as a mutual creation of the mother/infant pair.

During actual absences, or at times of discontinuity between felt need and caregiver response, the infant becomes aware of the separation or ‘potential space’ between self and other (Applegate, 1990). The baby in turn learns to regulate her own affect during times of physical and psychic separation by using transitional objects (symbols) to self-soothe. Winnicott (1965) argued that it is by means of this paradox inherent in the use of the symbol, that the baby’s disappointments and longings contribute to the growth of desire and the possibility of fulfillment rather than the schizoid withdrawal that comes from too much disappointment in the absence of reliable transitional objects.

It was clear from Beth’s presentation, however, that she had experienced more disappointment than her vulnerable self could bear. Beth’s ability to regulate her own affect was severely impaired, and she was void of an internalized parental introject that she could rely on to self-soothe. Rather than feel loved and cared for, Beth felt tyrannized by the gaze of the other. Without meaningful relationships and connection, Beth was failing to thrive. She was quite literally rubbing herself raw, which is how I imagine one feels in the absence of attuned mirroring and reflection from parents. Pain felt better to Beth than feeling how desperately alone she was in the world. Our contact proved scary for her, and I could tell for a while that she needed to restrict me too, just like the food, because she was afraid of unlocking her insatiable hunger for connection.

If the ‘good-enough’ therapist, like the ‘good enough’ mother, can construct a holding environment for the client that permits an optimal level of physical and psychological safety, allowing the client to openly share and explore her innermost thoughts and feelings freely, the therapist can begin to repair the damages of early childhood misattunement (Berzoff, Flanagan, & Hertz, 2011). In treating a woman with



eating and body image problems, it becomes even more critical to create a holding environment in which she feels safe enough to be both protected and free to experience her body as her own, in order that spontaneous interactions, feelings, and experiences can occur. A crucial piece in creating a safe holding environment comes from the therapist's ability to model a secure enough attachment to her own body. In the words of Orbach (2004), "if we are interested in making it possible for our clients to be in their bodies and feel them as generative and animated, then a far more demanding engagement is required of us in relation to our own bodies and personal tendencies, discontents, and longings" (p. 107). In a culture that promotes body insecurity, however, this is not an easy task for female clinicians. In working with Beth, I knew that it was crucial for me to create a space that would allow her to feel accepted and loved, despite her hated body. I was also aware that I would not have been able to adequately provide this kind of a space for her had I not been aware of my own vulnerabilities when it came to my body, and continued to work through my issues with regard to my body.

Burka (1996), in discussing her practice as a self-described overweight therapist, shares that earlier in her professional life when she had fewer theoretical tools and very little of her own therapy, she did not feel equipped to deal directly with patients on the issue of her body size. She further acknowledges that the issue rarely came up – which she attributes to that "special blend of patients' attunement to their therapists' vulnerabilities and their own need for compliance" (p. 256). If and when the issue did come up, she was uncertain of how to deal with it. In time, however, Burka (1996) gradually became better able to talk comfortably about her patients' reactions to her body

and to handle these reactions like other transference responses as useful information for the therapy.

Therapists and parents alike are confronted with the daunting task of being ‘good enough’ to attune to clients’/babies’ changing needs amidst the backdrop of cultural ideals. Lemma (2009) proposes that what the mother sees as she looks at her baby will be shaped by the quality of the relationships felt to reside inside her, not least the quality of the relationship between, and with, her own internalized parents. The extent to which the mother is occupied by her own internal objects, including the ‘mother culture,’ may lead the baby to experience her as preoccupied and absent or as overflowing with her own projections. I suspect this is what happened with Beth. Beth’s mother appeared to be preoccupied with the restrictive cultural norms. Beth said she rarely saw her mother eat, and that she was always talking about calories and ways to lose weight. When Beth shared with her mother that she hated her own body and felt fat, her mother suggested she talk to her nutritionist and set a goal for how she could lose the weight. Thus, a caregiver like Beth’s may further destabilize her child’s body by acting as a ‘culture carrier’ during child development through mirroring the cultural expectations to the child (Applegate, 1990, p. 89).

As Orbach (2006) suggested, bodies are not born but rather acquired in relationships with key caregivers. She believes that bodies have their own history arising out of the attachment nexus and the internalization of the bodies of their caregivers, as well as the bodies caregivers recognize in their infants and children. Through the nature of her insecure attachment to her mother, and the ways in which she imagined her mother to judge her bodily appearance, Beth developed a controlling preoccupation with the

body's appearance – hers, her sisters, and that of every other female she came into contact with, including me. Kilborne (1995) coined the terms “psychic size” and “size anxiety” as resulting from interpersonal situations and the dynamics of shame and the perception of body image. “Psychic size” is comprised of experiences of smallness and largeness with respect to parental figures, fantasies of being large or small, and the meanings of such experiences and fantasies in specific two-person situations. “Size anxiety” includes the anxiety about being a particular size with respect to a significant other (real or fantasized). Beth always felt ‘bigger’ than those around her, even after reaching her lowest weight. She learned to assess her own needs by watching others, taking special interest in women who appeared thinner than her. This often meant going against her own body's wants and needs for food and exercise, hoping that through emulating the tactics of others she would assume a thinner frame.

The sociocultural theory of body image assumes that there are societal and cultural forces that impact women (Stice, 1994). This sociocultural perspective links disordered eating and body image problems in certain cultures to those cultures' elevation of thinness as a significant aspect of beauty while stigmatizing fatness (Bloom et al., 1994; Fallon, Katzman, & Wooley, 1994). Theorists posit that when women psychologically internalize the thin ideal, body-dissatisfaction is the result. Thinness in Western culture is often associated with femininity, desirability, success, and social class. Utilizing a developmental and psychodynamic context, Krueger (2004) conceptualized body image as occurring in stages where aspects of the body are experienced and increasingly integrated mentally to create a cohesive sense of identity in the individual. If there are disruptions in these developmental stages, arrests in body-self formation and

integration will occur. The individual requires an object relationship to move through these stages of body and self-development, and, according to the contemporary psychodynamic perspective, as these interpersonal experiences are internalized, they, along with sociocultural influences, become the primary contributors to the development of body image (Bloom et al., 1994; Krueger, 2004).

The women we see in the consulting room often present with bodies that are in a state of arrested development and in need of a good enough body to rely on, one that can facilitate movement from object relating to object usage in order to enable body integration (i.e. secure attachment to one's body). These women are in bodies that have not been adequately held, cared for, or mirrored by early caregivers, or by the culture at large. In the absence of early life experiences of attuned mirroring, intrusive aspects of the visual culture fill in for the missing reflection from early caregivers. Without knowing her own mind or her own body through a healthy reflective mirror, a woman's exposure to the restrictive cultural ideals can lead to psychological splitting and undermine a feeling of 'going-on-being' (Winnicott, 1956). Beth was truly spilt. She stood frozen between the world of food and the world of people, troubled and psychically alone. She could only feel good enough to go on being if she ate "good" foods. If she slipped and ate "bad" foods, she experienced a momentary sense of physical and psychic annihilation.

#### Using the Postmodern Body Transferentially

In applying Winnicott's (1975) interpersonal account of visual and bodily experience to the treatment of eating disorders, we can deduce that there is no such thing as a client's body; there is only a client's body in relation to the clinician's body. Just like the transitional space that Winnicott (1971) described as both 'me' and 'not me' for the

developing child, client and therapist share a transitional body space where communication is formed in bodily action. Object relations theories recognize that human beings are object (relationship) seeking; however, in mass consumer culture, individuals seek object relationships with the dominant cultural symbols as well (Gutwill, 1994a). The transitional body space, therefore, is also influenced by the external aspects of culture which interact with each person's self and object representations of that culture (Applegate, 1990). Although Winnicott has been credited for being a "radical environmentalist, arguing as no analysts had before him that the child and its developing sense of self were shaped by the caretaking style of the parents" (Cushman, 1995, p. 253), he and other earlier authors have been criticized for minimizing the importance of the subjectivity of the mother for the baby's healthy development. Similarly, psychoanalysts have been criticized for minimizing the crucial importance of the subjectivity of the analyst for the vitality and authenticity of the analytic process, especially when it comes to the physical body (Aron, 1999). Aron (1999) takes a corrective stance theorizing, "A two person psychology is really a two-body psychology; it is not just a meeting of minds but of persons including bodies" (pp. 267-268).

The postmodern body, therefore, is a significant element in the unconscious life of the therapy – "the therapist's intersubjectively created body; the patient's intersubjectively created body; and the creation of one body for two, the body that represents the shared unconscious life of the therapist/patient pair" (Burka, 1996, p. 268). Perhaps nowadays, it is more accurate to say that, "there is no such thing as a baby without a mother and/or father, siblings, grandparents, extended family, and, ultimately, a country, a neighborhood, school, religious and cultural affiliations" (Berzoff et al., 2011,

p. 153). A baby is also influenced by the values of the particular political and economic system she is exposed to growing up. Similarly, in the clinical arena, “The bodies we occupy are the embodiment of our parental bodies and our sibling bodies, their relationship to our bodies, their wishes for our bodies, their projections onto our bodies, and our making of their bodies in our bodies (Orbach, 2006, p. 94). Thus, the unconscious experiences of both the client’s and the therapist’s bodies are influenced by the familial and socio-culturally defined ways that each participant has learned to evaluate body appearance and, in turn, contributes to the intersubjective relating in the room.

Since comparing and contrasting is the way in which clients with eating and body image disturbances interact with the world, transference, in the language of eating disorders, is a visual transference (Petrucci, 2007), and, one might add, somatic transference. In this regard, the body of a clinician provides an important transference object for the client, and the body the client perceives is one that is created in and through the therapy relationship. The therapist’s ability to live comfortably in her own body will also influence the client’s perception of the therapist’s body, regardless of its actual size, and serves as a significant aspect of the transference relationship. Using an intersubjective lens, transference and countertransference are therefore co-constructed in the relational space between client and clinician forming an “intersubjective system of reciprocal mutual influence” (Stolorow, 1994, p. 10). The therapist’s body is present in the treatment room as both a concrete object (expressing its physical reality to the client as measured in pounds and inches), as well as the symbolic container of the holding and supporting environment for the client (Burka, 1996). The therapist’s body becomes the

analytic object if, at a particular moment in the therapy, it becomes a carrier of psychological meanings for the particular client (Ogden, 1994).

If the therapist encourages the client to put words to the visual transference, the client has the opportunity to experience her body as a separate entity ('not me') from the therapist's body, thus allowing for the possibility of differentiation and growth in the potential space between them. In this intricate and intimate exchange, the therapist lends not only her ego but also her body ego that communicates a sense of bodily well being to the client, similar to the sense of security internalized via the ministrations of the good enough mother. The surrogate body of the therapist and the supplementary body that the potential space gives rise to may allow the milieu which disrupted the client's embodied being to slowly take new and healthier form (Rumble, 2010). The two participants jointly create a third psychology: "the intersubjectively generated experience of the analytic pair" (Ogden, 1994, p. 94) that can lead to the co-constructed body. However, an analyst who does not permit her own subjectivity to be recognized is one who offers to be experienced as an object rather than a subject (Benjamin, 1988). If bodies are treated solely as objects without the possibility for recognition of the other's body as a subjective body, the result can be a defensive internalization of unprocessed affect that shifts the domain from intersubjective to intrapsychic (Benjamin, 1995). Furthermore, "what cannot be worked through and dissolved with the outside other is transposed into a drama of internal objects" (Benjamin, 1995, p. 40).

In the case of Beth, it appeared that she had been left alone too often to deal with the drama of her own internal objects - those of her disembodied and poorly attuned caregivers, as well as the cultural admonitions around female appetite and desire. Her

intense preoccupation with food, eating, and the body represented a real attempt to construct a self from a sense of nothingness. To Beth, I represented the good, desirable, and culturally ideal object. I could feel her eyes track the movement of my body at times when I got out of my chair to reach for something even though she never said a word. Although I knew she was starting to feel truly cared for by me and that she told me that our contact felt good for her, I could feel on another level that she was harboring feelings towards my body. I picked up on subtle physical reactions to my body being compared (i.e. I got a sense of ‘all eyes on me,’ being watched, or sometimes even feeling like it was a bit harder to breathe). Having an understanding of the attachment nexus that had taken shape, helped to clue me in to just how preoccupied Beth was with my body, even on a non-verbal level.

The transference that forms in the client-therapist relationship increases the likelihood that the client will recreate with the therapist the type of attachment that she formed with her caregiver, which includes the attachment that took shape with regard to the body. For example, clients with insecure-avoidant attachments tend to dismiss or minimize the importance of close relationships, including the therapeutic relationship. Similarly, it is often the case that a client with this attachment classification will be prone to denying feelings about the therapist’s body, and will likely feel as though the therapist’s body does not have anything to do with her, and see little relevance in discussing it. The therapist dealing with such a client may feel unimportant or even helpless.

In contrast to the avoidant-dismissive attachment style, Beth manifested an insecure - ambivalent style of attachment, which was often characterized by an anxious



preoccupation within the context of close relationships. Accordingly, she craved close relationships and longed to be cared for. Beth quickly became preoccupied with her therapy, wishing for more frequent contact with me, often making attempts to stay connected between sessions and brooding over the meaning of my comments. She also remained highly preoccupied with my body. Beth often wondered about what I ate, how much I exercised, and admitted to using fantasies of me and my relationship to food to influence her own eating behaviors. Children like Beth, with an insecure ambivalent attachment, struggle to develop feelings of security with the attachment figure. As a result, Beth possessed little or no sense of security in her own body and instead, coveted my body and attempted to emulate my body practices, believing that then she would inhabit a body type like mine. Understanding Beth's attachment style helped to prepare and sensitize me to the importance of listening in a particular way to her descriptions of her body and her interest in my body, as well as recognizing the importance of discussing all of it.

Beth finally let me know her feelings about my body in an email after another session of trying to reframe the restrictive part of her as the problem, and credit the binge as the healthy part of her self that was trying to get an emotional need met. I wondered with her what it would be like to allow her body to have the kinds of foods it really wanted and needed in order to stop the cycle of bingeing and purging. Beth wrote, *I just think I cannot allow myself certain foods until I lose weight. And I am going to be honest with you that it is hard to hear from people that I can, who I feel are thinner than me.* She quickly followed with another email stating, *I want to apologize for my last paragraph. I was out of line and extremely insensitive and rude. I am really really sorry for making*

*those remarks.* I responded to Beth in a return email, letting her know that I did not think she had anything to apologize for. I told her that I thought it was important that she was expressing her feelings so honestly, and that it's only natural that she might have feelings about my body. I wondered what other feelings she had about my body and encouraged her to bring them into session the following day.

When Beth lashed out at me, she was taking a huge risk to bring forward anger and frustration that had lain dormant for many years. Most importantly, she was taking the risk of trusting me with some of the 'true self' (Winnicott, 1965) that she could only remotely express after many months of our working together. At our next session I commended Beth again for her bravery in sharing her feelings about my body with me. I told her that it was usually the case that females talk about their bodies, albeit negatively, so I could understand if she had feelings about mine. She gently nodded, and I invited her into a further discussion about my body. Beth told me that she thought it was hypocritical of me to encourage her to eat whatever her body beckoned for, when she imagined that only thin people were deserving of those foods. On the flip side, she wondered if I even ate certain "bad" foods. She said that she imagined that I only ate "healthy foods" because I was thin, and that she was curious about my exercise habits. I think what she was really asking me is, are you safe? Can you really understand what I am experiencing? Do you find your body to be an acceptable place in which to live? Is it even possible to exist in the world and feel okay about your body? And what might be the hope for me? I responded to Beth in session by saying,

T: You know Beth, I can really understand and appreciate all of your questions about my body. Maybe it even feels unfair that I have this body. What I share about my body though, I want to be in alignment with you – meaning that I will only share things that I think will be helpful to you and your recovery. I am afraid

that if I share what I eat or how much I exercise that you will use that as your model to live by which will only lead to more disconnection for you. And what works for my body may not necessarily work for your body because we are in different bodies with different needs. What I can tell you is that I teach this model of attuned eating and staying close to our physical and emotional hungers and needs because I believe in it and I live it. So really a piece of cake is the same to me as a salad or a sandwich or anything else. I don't believe that we deserve to live in deprivation. I do happen to come from a family of giants, and I am in fact the runt in my family. I didn't choose this body so I guess you could say I won out in the genetic lottery given that I am aware that I am in a privileged body according to the current cultural standards. But even though I have been granted this body, it has been an incredible challenge and took a lot of work for me to feel ok enough in this body. Whoa - I've just said a lot – how are you feeling now?

B: Calmer I guess. Just knowing that you didn't really have control over the body you got makes me feel better.

T: So it's helpful to know that not all thin people deprive themselves to be in a thin body?

B: *(she chuckles)* Yeah.

T: You have mentioned your mom dieting and wanting to lose weight. So I'm wondering if it feels really hopeless for you – that even at her age, she is still not okay with her body. It must be hard to believe that anyone can exist in the world and be okay in their bodies.

B: I think you're right. I get really angry with my mom sometimes...

It took time to get all of this out of Beth, and it took a great deal of prodding on my part, because given the chance, Beth would have preferred to say nothing. However, if I had ignored this key piece in her email, the treatment would not have changed course so dramatically. There is a good chance that the intersubjective space would have collapsed inward and Beth would have been left alone again with her own 'drama of internal objects' - this time with feelings about my body and hers. After our exchange, I felt an emotional connection between us that did not exist before because we were now more than just objects; we were subjects in the room, making sense of the world together.

The next morning I woke up to an email from Beth that said:

*The true feeling of loneliness was felt tonight. I lay in bed feeling the pain. Nothing could mask it, not TV watching, not YouTube viewing, not reading (although reading women food and god made me realize how lonely I was). Binging wasn't even on my radar. The thought was in my head...but four levels*

*back. It wasn't enticing. I just felt the feeling. I wanted so badly to reach out to somebody but I have nobody to turn to. Everyone has their lives, their friends. I'm not thought of unless I bring attention to myself and I've reached a point where being an attention seeker is not enjoyable. I have no relationships where the friendship is both ways. This feeling is dragging me down and I don't know what to do. Nothing seems soothing because all I want is the relationship. I can't sleep...I'm looking and looking but nobody is there. It's not normal to enjoy going to treatment. But I do. It's the only time I can feel good and cared for. I look forward to every session with you because it's not lonely. Best, The lone fighter*

She followed with another email the next day in which she wrote:

*As much as this feeling stinks, I can't imagine feeling it if it wasn't for you. Your support and encouragement have got me to this step. I do sometimes think of you as my savior. I'm fighting ANA [Beth's personification of Anorexia] this morning. But it's a different feeling. I'm fighting her because I'm feeling the pain which is making me not want to eat. I can't remember a time when it had nothing to do with weight. I was always the one who said my eating disorder was about weight. I still believe that is how it started but I am realizing I do use it to cope.*

For the first time, Beth realized that her eating disorder was not solely about her weight. Analysis of the body image transference provided a critical bridge from the superficial world of defense and resistance to the rich, unconscious function and metaphor of Beth's eating disorder symptoms (Jacobs & Nye, 2010). This proved to be a turning point for Beth in her treatment. When a client like Beth is made to feel safe enough to authentically express a negative feeling about her therapist's body without facing retaliation or withdrawal from that therapist, she will have the chance to see that she has destroyed her projection of the therapist, and the therapist and her body have survived (Petrucci, 2007). Beth could feel the real presence of another who would not find fault with her for expressing an authentic feeling like anger. By providing this good enough Winnicottian body that could tolerate Beth's projections, I helped her move from object relating to object usage. In that moment, Beth and I became subjects in the transitional body space where we could both reflect on and talk about our bodies so that

the separateness ('not me') between us no longer felt so alienating for Beth. Together we began to create an intersubjective space where there was room to tolerate the full range of her ambivalence and rage about her body and mine. Beth was then able to reflect on her own subjective experience (as she did in the email after session) by verbalizing her real longing for a relationship with someone like me. I became important to her and she to me.

Over the course of the next week, Beth expressed her desire to know more about me, until she realized aloud, "I guess I am thinking of it as a way to feel like a relationship rather than a one sided sharing. But I think I just realized it's because I don't have this in my life." She was starting to learn how desperately she wanted relationships in her life, and that she was hungry for more than just food. She started to verbalize the anger she felt towards her mother for making her body and the world feel so unsafe for her to live in and from. The case of Beth helps illustrate how body image transference that is invited into the therapeutic 'play' space by the therapist in a way that is exploratory, yet not necessarily disclosing, can foster intimacy, insight, and revelation (Jacobs & Nye, 2010). Particularly critical for me was the challenge to be emotionally involved and to show aspects of my real self while maintaining appropriate professional boundaries. This is an important balance that the clinician must consider when it comes to disclosure in order to stay attuned to the client's needs at a particular moment in the therapy. It would not have been helpful for Beth had I disclosed my eating and exercise habits. In fact, it may have even been harmful. Beth benefited from knowing that there was a way to stay connected to me despite my being in a different body. It helped her to

see that I was a real person who was willing to make myself vulnerable to her in a way that still kept her protected.

As suggested by Mitchell (1993), “When working with a client what might be most crucial is neither gratification nor frustration, but the process of negotiation itself, in which the analyst finds his own particular way to confirm and participate in the patient’s subjective experience yet slowly, over time, establishes his own presence and perspective in a way that the patient can find enriching rather than demolishing” (p. 196). When a purposefully receptive climate around the body is nurtured in the psychotherapeutic treatment, the verbalized detail of a woman’s experience of her own body as well as that of the therapist can emerge. When the therapist can withstand the client’s questioning about her own body, sometimes providing answers and other times allowing the client to imagine in her own mind, a more thorough examination and understanding of the client’s attachment nexus and inner experience can be achieved. Furthermore, the direct exploration of the client’s unconscious beliefs and fantasies about the therapist’s body within the context of a safe holding environment may help to prevent potential acting out and regression by the client (Jacobs & Nye, 2010).

In working with clients with eating disorders, sometimes a client will invite the therapist in, but more times than not it is up to the therapist to invite the client in. Petrucelli (2007) candidly advises, “...If you can be yourself as a therapist and if you encourage your patients to be open about themselves and about how they perceive you, then the things they say about you, things you may not want to hear, enhance their ability to be themselves in more ways than they could before they began therapy. Now, they do not have to protect the connection by throwing parts of themselves away” (pp. 252-253).

By providing a relationship that can receive and bear a sense of a hated, fragmented, or rejected body, therapists begin the processes that will not only address a client's pain, but will also deconstruct the defenses that have developed to manage that chaotic, disorganized, or insecure body that represents the body subjectivity of that client (Orbach, 2004). This is challenging work, but absolutely essential in the promotion of body reintegration, acceptance, and healing.

Research suggests that securely attached clinicians demonstrate flexibility in their clinical work (Slade, 2008), and that experienced clinicians are flexible in their interventions (Daly & Mallinckrodt, 2009). Attachment theory can embolden practitioners to pay attention to their own attachment nexus in order to participate more openly in body discourse. A secure enough attachment to one's body can provide the necessary foundation to embrace the therapeutic potentiality of meeting at a more "intimate edge" (Ehrenberg, 1974), wherein the clinician is willing to be open to a dialogue that includes the shared body experience. As Ehnrenberg (1974) observed,

A meeting at the "intimate edge" is not simply intellectual, in which case either participant would be involved in an exercise of his own cleverness rather than in a more personal profound exchange. Nor is it simply affective, since it is quite possible for either participant to be emotional without ever being touched by the other. Nor is it simply personal, since sharing intimate details about oneself might be no different than a recorded speech in which the words act as barriers not bridges. The essential qualities of the kind of engagement I am describing are *reciprocity and expanded awareness through authentic relation*. Finding and making explicit the point of optimal closeness and distance in the relationship, a point which is constantly changing from moment to moment, provides the kind of experience in which the participants' awareness expands via the relationship as they clarify what they evoke and what they respond to in each other. This can only move in the direction of new experiences of mutuality and intimacy, and towards increasing self-knowledge and individuality (p. 435).

Embracing this "intimate edge" helps female clinicians model what it means to be a woman in a body and still possess subjectivity. This requires finding the place of

maximum self-expression and maximum self-awareness when it comes to authentic relating about the shared body experience. Clinicians who can create a space for the body, allowing their clients to explore similarities and differences, fears and fantasies, and subjective and objective realities as they together navigate cultural currents that assume the malleability of women's bodies, will build increasing self-knowledge and autonomy in their clients. Thus, a clinician who inhabits a good enough body can use the therapeutic relationship to expand the good enough holding environment, demonstrating the meaning of secure enough attachment to the body. Borrowing from Bromberg (1993, 1994), it is important to provide the right relational conditions so that the body will possess the extraordinary capacity to negotiate continuity and change simultaneously.

If, on the other hand, a clinician's anxieties around her own body are too severe, a client may be forced to adopt a false body that is in charge of protecting the clinician's anxieties in the same way that Winnicott (1965, 1971) believed that children comply with the needs of their caregiver by adopting a false and distorted self. "If we can't talk about both bodies in the treatment room, won't the patient have to present less than his/her full self, much in the same way this occurs for the infant in response to maternal anxieties and taboos?" (McEneaney, 2007, p. 134). Moreover, a clinician's anxiety around and nature of attachment to her body is likely to impact the quality of the therapeutic attunement, receptivity, and mirroring. If in treating Beth, I had been preoccupied by my own thoughts or feelings of bodily dissatisfaction, I may have been at risk of reinforcing the original trauma by modeling an insecure attachment to my body, or missed the crucial opportunity that arose as a result of the client's projections. A therapist who has not addressed her own issues around eating or her body, is likely to feel ill-equipped to deal



directly with clients on the issue of her own body and risks allying with aspects of the culture that objectify women.

To the extent that a clinician does not openly acknowledge the client's experience of her own body as well as that of the clinician as an important meeting place of shared cultural location, the therapy relationship itself runs the risk of perpetuating the silence that has historically surrounded the female experience, and perhaps further relegating the body to contain rather than be a subject of conversation. Gutwill and Gitter (1994) reinforce the importance of considering the consumer culture in theoretical orientations, and state that, "To the extent that the impact of the 'toxic culture' is unacknowledged by object-relations theory and remains unconscious, cultural wounds and cultural abuse are hidden and secret" (p. 201). This analysis offers clinicians a framework for understanding the potential for transmitting dominant cultural taboos around the body if body discussions are not included in treatment. When a therapist is herself living in an insecurely attached body, the client may be forced to experience her own body with ambivalence or avoidance. The client can be transported from the depths of internal work to the surface of the body and the socio-cultural world of ideals. As Namir (2006) demonstrates, clients need the possibility for "communicative embodiment" (p. 222). Thus, clients with eating and body image problems need therapists to manifest secure enough body attachments in order to demonstrate a sense of embodiment and to live from that place in the therapeutic space.

As Brown (2009) suggests, "Just as therapists working with the survivors of complex trauma convey that the terrible things done to clients were not their fault, so too, a culturally competent therapist must acknowledge that whatever privilege she or he has

accrued by accident of birth is not her or his fault” (p. 175). Moreover, a therapist who can observe her bias and privilege is better equipped to comprehend the complex phenomenon of representation. These phenomena are more than simply transference or countertransference because the things represented are “currently active in the social environment rather than in past experiences that are symbolically or unconsciously evoked or transferred into the therapeutic environment. The dynamics of representation, even when symbolic, are not merely unconscious representations of personal history; they are the interpersonal and political realities in which therapy takes place” (Brown, 2009, p. 175). Thus, clinicians need to be aware of and willing to talk about the type of body they are living in - culturally privileged or not - in order to expand and promote subjectivity. In an effort to repair a client’s damaged body-self relationship, it is helpful to teach body-literacy in the consulting room. This includes fostering clients ability to decode the media, reframe the current cultural standards as restrictive and oppressive, normalize sociocultural pressure and the difficulty of feeling ‘good-enough’ in one’s body, and opening the discussion to include the client’s questioning of the therapist’s body or body practices. Talking about both bodies in the room, as both are impacted by the cultural messages, promotes body socialization.

### Conclusion

Contemporary relational theory augments traditional psychoanalytic views by stressing the real relationship the client has with the therapist. In this analysis, this also includes the real relationship a client has with the therapist’s body. When object relations is coupled with an intersubjective perspective, each theory breathes life into the other and, when used efficaciously, can help provide a blueprint for dealing with the shared

body experience in the treatment of eating disorders. According to Applegate (1999), “A successful clinician lends his subjectivity but does not lose it. He honors the range of the clients’ affects by recognizing them and thus recognizing the whole person generating them. It is in such transaction that the clinician’s and the client’s subjectivity can meet in the potential space of the clinical encounter and give rise to an enhanced capacity for intersubjectivity in both” (p. 218). Since the shared body experience is a significant element in the intersubjectivity of the female analytic pair, successful clinicians in the field of eating disorders must be explicitly aware of their experience of and attachment to their own bodies, as well as the constant cultural pulls towards body dissatisfaction.

Allowing for the practitioner’s body to be used as a good-enough Winnicottian body that can receive the client’s curiosity, inquiry, and exploration about her body can be an enormous challenge for female therapists today, especially if they have struggled, or continue to struggle, with similar issues as their clients. As suggested by Mitchell (1988), changes take place both outside the therapy situation as well as in the therapeutic relationship itself, where the therapist and client find different ways of being together that are not limited by the client’s previous constrictions or restraints, especially as they relate to the body. Thus, clinicians need to be able to rely on trained supervisors, other clinicians, and their own therapy for real and authentic conversations that can help examine the full range of countertransferential feelings and understand the experience of body dissatisfaction within its cultural context. If the body can be invited into professional forums, it may help to demystify the dangers of talking about the body during a clinical encounter, and eventually help the clinician find different ways of handling the shared body experience with her client. Furthermore, learning to care for

one's self physically, emotionally, and psychologically, staying connected to feminist ideas, and engaging in spiritual behaviors, might help clinicians to lend their subjectivity without losing it in the midst of body scrutiny. With more open discussions that acknowledge the difficulty of this work without demonizing women for having conflicting feelings about their bodies, clinicians may become more capable of providing a 'good-enough' Winnicottian body that can tolerate being the subject of discourse in the service of their client's recovery.

## SHARED CONCLUSION AND IMPLICATIONS

Social work, from the time of its inception, has “lived at the edges of the mainstream of scientific discourse” mainly because of its need to respond to unpredictable, ambiguous professional episodes, as would a first responder to a crisis (Applegate, 2000, p. 150). When it comes to the body, however, it is my belief that social work has stayed far too conventional by participating in the silencing of the body in therapy. The clinicians from the Women’s Therapy Centre Institute in New York City understand that, “We are in the midst of a serious public health crisis: few people experience their bodies as their own, as the place to live in and from, but rather relate to their bodies as a project to be worked on, forever” (List Serve Communication, March 15, 2014). Research that focuses on the place and role of the body within the therapeutic relationship is important for scholars and practitioners in Westernized societies because it recognizes the relational transmission of attachment issues that can take place in and through the body. The preceding two-paper analysis emphasized the importance of a secure attachment to the body, and while acknowledging the critical role of the mother-daughter relationship in establishing a secure base for attachment, also focused on the therapeutic relationship as an understudied factor in repairing the insecure body attachments that contribute significantly to the development and maintenance of eating disorders.

Bowlby, Ainsworth and others suggest that early attachment experiences have a significant influence on later life experiences. Secure attachment offers a base from which children can safely explore their environment and ultimately can provide them with protection against physical, social, and emotional risks. While the literature has

focused on the role of early attachment experiences in creating a sense of physical and emotional security, it has failed to consider the role of early attachment in informing a sense of visual and visceral body security. An understanding of how a secure body attachment demonstrated in and through the mother-daughter relationship can serve to shield women from attaching to cultural symbols and ultimately prevent the development of eating disorders is critical to clinical practice. In the absence of such a demonstrated secure body attachment, however, the client-therapist relationship offers a possibility to repair the problems that emerge when a mother is herself insecurely attached to her own body and this style of attachment is modeled and passed along to her daughter. Thus, by identifying the nature of an individual's attachment to her own body and recognizing its potential role as a protective or risk factor against the development of an eating disorder, prevention efforts can better target and enhance important aspects of the mother-daughter relationship as they relate to the reciprocal and mutual influence of the culturally sanctioned body.

The case of Naomi demonstrated the ways in which an intergenerational transmission of an insecure body attachment by a mother who was inadequately attuned to her own and her daughter's needs, renders both mother and daughter especially vulnerable to culturally sanctioned messages that, by aggrandizing a thin body ideal, can exacerbate this insecurity and malattunement and trigger an eating disorder. As a result, an early attachment/relational trauma is compounded and reinforced by a culturally induced trauma perpetrated by the internalization of social symbols representing body "ideals." The case of Beth establishes the ways in which the therapist's body, used as both an object and a subject of discourse in the treatment of eating disorders, provides a

vehicle through which early insecure attachment experiences can begin to be repaired. However, in order for such a discourse to be successful in ameliorating the consequences of early insecure attachment, a clinician must herself live in a good enough body that provides a safe holding space in which a client can fully experience her own body and move toward a more secure body attachment.

This two-paper dissertation argues that comprehensive assessment and intervention with developing females requires parents and clinicians alike to pay closer attention to the “outside” of cultural experience balanced with an appreciation for the “inside” of the ways in which individuals perceive and process factors in the external environment according to their own unique development, attachment experience, and psychology. Social work as a profession has sought to achieve greater integration between external factors such as culture, race, class, and social roles, and the ways they become internalized by the self. Given that culture is a part of the “place where we live” (Winnicott, 1971, p. 104) and functions as the larger holding environment of the therapeutic relationship, cultural representations are an important part of the potential space – the paradoxical third place that taps into internal and external experience simultaneously for both client and clinician (Applegate, 1990). The body in the 21<sup>st</sup> century can be seen as a personification of culture: “the place in which the individual writes out her understanding of the meaning and possibilities that exist for her; as the place she tells of her standing in the world – the world of the family, the sexual world, the school, the wider public sphere, the gendered world, the world of class, of consuming, of possibility and impossibility” (Bloom et al., 1994, p. x).

Failure to consider each person's experience with cultural object-relations formation prevents a full picture from emerging in the treatment of people suffering from eating disorders. The clinical challenge is to keep an eye on the paradoxical third place where external aspects of culture transact with each client and therapist and their object representations of culture, as well as with the shared body experience that emerges in the consultation room. In acknowledging the potential for projective identification, this dissertation seeks to inform another less fully explored issue regarding uncontrolled and unrecognized countertransference, as it relates to the body; such countertransference can lead to the misinterpretation of transference if the clinician does not herself have an accurate, good-enough, or securely-enough attached body-self to rely on. Clearly it is important for a clinician to be consciously attuned to her own vulnerabilities about the body-self in order to avoid communicating unconscious messages to her clients. Attending to the client's need for a dialogue around the body, therefore requires the therapist to develop a discerning awareness of her own body. Moreover, this dissertation emphasizes that both the actual body and body image need to be considered through a relational or intersubjective presence, and that a meaningful relating between bodies requires anchoring in the material presence of the other, whether it be a caregiver or a clinician. We can imagine from this critical analysis of attachment, trauma, and object relations that intergenerational issues in relationship to the communication of aspects of Western cultural stigmatization, especially with regard to the notion of a body ideal, highlight the developmentally reparative role of the clinician whose own intergenerational experience is significant. This theoretical and practical work has



implications for all types of psychotherapeutic processes, extending beyond the female-to-female matrix.

Effective practice with clients requires that clinicians become more aware of and talk more about how these external factors impact not only the client and the therapist, but also the intersubjectively created third space. In this way, body dissatisfaction as evident in the Western world can be recognized as a trauma shared by many women, and these shared traumas can present greater opportunities for therapeutic intimacy in clinical discussions. According to Tosone (2006), both the therapist and the patient undergo transformations in the cognitive, affective, behavioral, and spiritual realms as a result of exposure to an externally shared traumatic event. She states, "True therapeutic intimacy implies exposing our imperfections, but not in a deliberate, self-revealing way. Instead, our peccadilloes emerge spontaneously through the unavoidable enactments that occur in the course of treatment. This stance raises the question of whether intimacy necessitates self-disclosure on therapists' part" (p. 95). At a time like 9/11, Tosone (2006) argues that the intimacy through self-disclosure felt inevitable rather than consciously chosen. I would argue, that in the case of the shared body experience in a culture that perpetrates threats to the female body, intimacy through self-disclosure around the body/bodily presence and experience is also inevitable.

The implications of inevitable self-disclosure as it relates to the material body means employing a framework that embraces the therapeutic potentiality of meeting at a more "intimate edge" (Ehrenberg, 1974), wherein the clinician is willing to be open to a dialogue that includes the shared body experience. Ideally the "intimate edge" is a place of maximum self-expression and maximum awareness of the individuality and

boundaries of self and other for each participant in the therapeutic dyad. It is the point where each participant becomes acutely aware of her own active participation in a particular interaction, the choices she makes, and where she ends and the other begins. My hope is that clinicians will continue to challenge the old taboos about inviting the therapist's body into the consulting room as a focus of discussion, and think more about finding the particular intimate edge that best suits each of their individual clients. With the development of a more sophisticated theoretical framework that can fully potentiate the worker's use of her body-self as a catalyst for change, perhaps more women will be helped in securing a good enough body-self attachment.

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