



## CLINICAL STUDY DAYS 2 CLINICAL CASE

### *It's a family affair: A case of bulimia nervosa*

*Yael Baldwin*

ybaldwin@mhc.edu

**Abstract:** This case presentation discusses how Yael Baldwin worked analytically within an eating disorders treatment team setting with a woman suffering from bulimia. The case explores how one can work at the level of speech and desire even when the therapeutic setting tends toward working at the level of demand. Baldwin describes how the treatment worked at the level of the signifier, and how via speech the patient was able to connect her symptom to her family history, to repetition, and to various identifications with family members. The case also highlights how the symptom was linked to the patient's relationship to knowledge and truth.

**Key words:** bulimia; eating disorder; knowledge.

**Resumen:** La presentación de este caso muestra el trabajo psicoanalítico de Y. Baldwin en el marco de un equipo de tratamiento dedicado a Trastornos de Alimentación, con una mujer que padecía de bulimia. El caso explora de qué modo se puede trabajar considerando la dimensión del lenguaje y del deseo, aún cuando el marco terapéutico tienda a orientarse por la demanda. Baldwin describe de qué modo el tratamiento señala la dimensión significante y como la paciente pudo vincular su síntoma a su historia familiar y a la repetición, así como a varias identificaciones con los miembros de la familia, vía el lenguaje. El caso también destaca de qué modo el síntoma estaba ligado a la relación de la paciente con el saber y con la verdad.

**Palabras clave:** bulimia; trastorno de alimentación; saber.

The setting for this case was a prestigious university's college counseling center where an implicit goal was to keep students safe from harm, hopefully suffering less, attending classes, and producing academically (occasionally athletically), thus keeping students, parents, and the university (with its \$45,000 a year fee) more content. The

center felt a demand to see as many students as possible and the aim was to get them *functioning* in the shortest duration of time to make room for other students in need. Treatments aimed more at “adaptive socio-educational solutions”<sup>i</sup> than at working at the level of desire. It was thought one semester (roughly 4 ½ months) could do the trick. However, students presenting with eating disorders were given more time and support; there was an Eating disorders treatment team that included individual therapists (a position I held for one year), medical doctors, nutritionists and coping skills group therapists.

What I found in working with this team was what Lacan deems the discourse of the master affected both the pathology and the treatment. The patients were already under the spell of a commanding signifier “be thin!” (without complaining or causing trouble) that would please the master, and the treatment team served the discourse of the contemporary master in its desire to heal (with its own demand “Eat! And get better!”), and to get the student-patients producing again.<sup>ii</sup> Such demands, coming from students, parents, and administrators, were taken literally and reigned over and above an analytic discourse with its focus on a desire for knowledge and the subjectivity of the patient.

Once an eating disorder was diagnosed, a specific protocol for conducting treatment went underway. With its emphasis on medical intervention, the team’s doctor provided evaluations (including weigh ins), as well as various prescriptions from Progesterone for amenorrhea, Prozac for depression, and even prescriptions for when a patient should binge and purge (the idea being it would help control symptoms if put on a specific prescribed schedule!); the nutritionist provided “nutrition therapy” with obsessive charts and lists of all food intake; and many of the therapists worked with CBT, cognitive behavioral therapy, and DBT, Dialectical behavioral therapy, all of which combined produced a treatment team product. Having been on other treatment teams, this one seemed particularly utilitarian.

Binging and purging and/or starving oneself, labeled “restricting,” were considered “obstacles” and “dysfunctional” and much of the treatment was oriented toward riding the subject of these symptoms. Yet often what was deemed “dysfunctional,” was what brought the patients I saw into therapy and allowed them to face up to their alienation and specific positions. This was the case for a patient I’ll call Jane. In the midst of this setting, as the “individual therapist,” I took up Jane’s symptoms in a psychoanalytic light. I was more interested to explore and understand

what her symptoms were saying that she could not, than to most efficiently eradicate them. While we weren't engaged in a psychoanalysis, the work was based on a psychoanalytic ethic regarding the subject. I didn't think it my job to guide her life, but rather to offer her a space to speak what hadn't been spoken, a space for the subject of the unconscious. I offered Jane my ear.

Jane, a college senior, came to see me with a mode of satisfaction that no longer worked for her the way it had. Her "eating disorder" provided entry to therapy. Fitting the prototype of the eating disordered patient, the treatment team deemed her technically anorexic given her "restricting" for over a year and her BMI, body mass index, of under 17.5, and bulimic given her frequent purging (at least four times a week). She hadn't sought therapy directly; rather she'd gone to the University's medical services complaining of stomachaches. A doctor sent her to the counseling center. She told me her "bad stress-related stomach problems" began the summer before her junior year. Her digestive system wasn't working properly.<sup>iii</sup> There were *things she couldn't digest*. Through our work, what she couldn't digest eventually unfolded in her speech and not just her stomach and bowels (she was also diagnosed with irritable bowel syndrome).

When I asked what she couldn't digest, she replied: "rich and greasy things." *"It just sits* there making [her] nauseous" until she needs to throw up. "Rich and greasy" proved descriptive signifiers, for Jane came from a well-off (rich) family, peppered with some greasy characters, particularly her father, who as I'll discuss, mainly just sat drunk in his chair making Jane sick (albeit on an unconscious level). Not being able to digest the rich and greasy, she began making herself throw up "for relief." I asked, relief from what? Ultimately, as unfolded, she sought relief from knowledge that couldn't be spoken.

At the beginning of our work, her only relief was to rid herself of these indigestibles in a bodily fashion, without words. This pattern "evolved" as she put it into what she called a "phobia" for rich and greasy food and an eating disorder. She said it felt "out of control" and she couldn't stop without help. The symptoms, she said, were related to high stress and "to being by [her]self." Her boyfriend, whom she'd dated through college, lived across the country, and she was applying to graduate schools. Both factors kept her from socializing. She also had a particularly difficult major (considered one of the hardest at the university) that required a lot of study time. Years ago, the brand Nike used the slogan: "Just do it." Jane did a major she

didn't enjoy because it was "safe, practical, structured" and "guaranteed good work possibilities," meaning a wealthy income. She had interpreted that this was her parents' desire. She "just did it" for the Other. Her own desires, needs and wants were less important. These myriad factors led her to feel isolated and alone in her suffering.

Jane also presented as if she had nothing to say about her self, family, thoughts, feelings, or history. She smiled and gave vague short answers, keeping herself out of the picture, behind a wall. Jane isolated herself behind a veneer of perfection. She presented as "the every woman" (or "all women"<sup>iv</sup>) of the University, an ideal of her specific cultural milieu—a product of the subjectivity of our times. Looking like she stepped out of the pages of a fashion magazine or television show, she was very thin, long haired, impeccably groomed, smiling and silent. Very bright and a hard worker, she was a high achiever in school. She kept herself hidden and unemotional. She didn't like crying, "it was a hassle because it made [her] eyes puffy and makeup run." She also found "sadness annoying and draining." She came from a wealthy, educated family that displayed what she came to call "a surface cohesiveness." But beneath the perfect veneer, both she and her family were in shambles. Through this, Jane was a silent sufferer;<sup>v</sup> her eating disorder was how she spoke this suffering. It allowed her to critique the veneer of a surface bourgeois perfection modeled on a modern consumerist culture of glow-in-the-dark white teeth, with perpetually cheerful successful working women, who stay super thin and done up, while juggling family and work. Jane's eating disorder said: It's a lie. I'm hungry. I need more. I'm NOT satisfied—a private yet political protest via the body. I encouraged Jane to speak, in so doing she revealed the role her eating disorder played in relation to her family; indeed, it was a family affair.

Jane applied to graduate schools in the field both her parents worked in, which provided a strong point of identification with them. She grew up with her parents running a dental related business, a line of work she referred to as "dealing with people's mouths all day" and "being in someone's mouth all the time." She revealed her ambivalence about following in their footsteps when she said "part of me doesn't want to get better, but I have to get better before I go to graduate school." In sessions, she occasionally wept questioning how she could go into a health care profession without being healthy herself. Her symptoms expressed ambivalence about her career path; they also provided potentials for separation and connectedness to the

family. Not going into their field would provide separation. Jane also came to recognize how she maintained connections via her symptoms.

In a conversational move that highlighted identifications and a return of the repressed she articulated how her favorite binge foods related to family members. Pasta was her sister's favorite and Jane had fond memories of them making pasta together (which upon further association revealed a memory of her sister, who had an explosive temper, punching Jane in the kitchen), peanut M&M's were her father's favorite (though associations of his ingesting while sitting impotently on his easy chair were not ultimately pleasing), and *Payday* chocolate bars were her mother's favorite (her consumer driven mother was also very fond of the actual pay day). Jane binged and purged on these foods and eventually discussed how she craved connections with these people. Besides the specificity of ingredients, Jane's symptoms provided multiple points of identification with each family member.

Jane's younger sister Joy suffered an eating disorder for six years, withdrew from college and was admitted to inpatient care weeks before I first saw Jane. Jane's mother visited the sister in hospital and family discourse centered around Joy's disorder. While Jane's mother knew about Joy's eating disorder, Jane said in our first session, "but Mom doesn't know about me." The mother's lack of knowledge surfaced repeatedly in Jane's speech. When Jane first experienced her stomach troubles a year prior to our meeting, she had a knowledge her mother lacked and it made her sick.

This knowledge, it was revealed, was that Jane's father was having an affair (the other woman also shared the parents' profession). Jane found out because her boyfriend was friends with the other woman's son. The idea that Jane knew something her mother didn't was devastating; Jane knew too much. She said she didn't want that knowledge. The excess of knowledge made her "too *full* of anger." The only time she'd felt that emotional was when her high school boyfriend suddenly died from an accident. At that time, she said, she was "too *full* of hurt to cope." Jane's knowing about the affair while her mother didn't lasted three weeks. Jane begged her father to tell the mother, but he didn't. Jane hinted and the mother guessed. When the mother found out, she filed for divorce. The father swallowed sleeping pills. Jane said she was more upset about having the knowledge than she was about her father's suicide attempt. Exploring this statement, Jane revealed that having knowledge regarding the truth about her father that her mother lacked, a knowledge her father refused to cough up, proved repetitive of an even earlier pattern that affected Jane negatively.

Jane's parents ran a family business. Her father worked mornings and came home in the afternoon when the girls returned from school. Jane's mother worked afternoons into the evening. Jane said her mother worked very hard, but her father disliking the work, worked less and less. Jane's mother took over many of the duties; the father shirked his responsibilities. When he came home he sat in his easy chair and drank (though he hid that it was alcohol) until he went to bed early, in a separate bedroom, as soon as the mother came home. Nobody spoke about the father being an alcoholic. Jane said her mother didn't know. Jane would come home and just do her schoolwork, blocking out her father's behavior. Her sister was more emotional about it. One day, Jane was 14 and Joy was 10, the father was so drunk he fell out of the shower. While in treatment Joy told Jane she recalled pulling pieces of glass from the shower door out of her father's naked body. Joy told Jane she was there, but Jane didn't remember.

When Jane first came to therapy she was angry with her father over the affair. Her father was the enemy; Jane was the mother's ally. Before, "I didn't blame her at all; just blamed Dad," she said and added, "I want to be mad at mother and don't want to be mad at her." Jane protected her mother from knowledge before—knowledge of the father's drinking—it was tiring. During the course of our work she expressed anger towards all three family members. Jane's mother didn't allow herself to see that her husband, while taking care of the girls, was an alcoholic. Jane's maternal grandmother finally wrote a letter to Jane's mother expressing concerns about the father's alcoholism. The mother asked Jane if it was true; Jane said she thought it was. It thus took another woman to provide the mother with a knowledge Jane had and the mother lacked. That knowledge was that beneath the veneer there was chaos related to the father's oral pathology, an addiction Jane said ruined the family. Referring to her eating disorder, her oral pathology, Jane said, "I can't control it. I feel addicted."

When the knowledge of the affair became public, the father left the family and the family business. Jane lost her connection to and contact with her father. She said the loss incurred when the marriage dissolved in divorce. However, she came to see the loss was instated a long time prior. During Winter break, Jane saw an advertisement for her father's new business. She spoke about how hurtful that was, as if she and her family were disposable, abandoned. She felt thrown away, purged. She said, "he's awful, but he is a father. It's eating away at me." She missed his presence. She said, "He cut himself off from the family." A castrated father, his absence from her

life still ate away at her. By the end of our work, which was cut short because neither of us was continuing at the University, Jane articulated her desire for a relationship with her father and her desire for an ideal father, which he was not. For she came to articulate her uncovering of a drunk, impotent father, glued to his chair; this *so called master* failed his wife and kids. Jane also came to articulate her position as the one who stoically knew the truth: that her father was a liar and a cheat. The pain sprang from knowing what others failed to see and not being able to say it.

At the beginning of our work, Jane suffered as her unconscious was in the position of truth relating to the fall of the father. She articulated this, made it explicit, and came up with new meanings. There's much more to be said; the symptoms and her associations coughed up a wealth of identifications with each family member.<sup>vi</sup> Also Jane articulated what the binges and purges did for her; they gave her something to do in the face of loneliness, distracted her from her life, and provided an "escape from the pressure;" "force[d her] to relax" and "drain[ed]" her. Note the treatment team, ever championing so-called "coping skills," wanted me to explore "alternative methods for relaxation" with Jane. I was more interested in the symptoms' meanings. There was something sexual about her description. She felt spent, emptied, finally relaxed, needing to lie down afterwards and able to fall asleep. She experienced a feeling of satisfaction with a shame attached. A *jouissance* emerged in the purge that provided an enjoyment she failed to find elsewhere. She filled herself until she was overwhelmed with the fullness, recall her statement that the excess of knowledge made her "too *full* of anger" and "too full of hurt to cope with it." So she throws up the excess of knowledge. She said, "emptiness is better." By bingeing she ingests, accumulates, posses, produces, she said she "celebrates," and then by purging, she revokes it, throws it up, provides a different kind of production, highlights the waste, the disposable, the abandoned. She found it difficult to let go of this satisfaction, this connection to the waste product.

During our work, Jane's *jouissance* moved somewhat from one stuck in a peculiar pleasure that came from bingeing and purging (with its limit of language), to make room for a *jouissance* that came from speech. Other things shifted. She socialized more and said she'd never had so much fun at University and wished she hadn't spent her previous four years so isolated. She felt more connected to people *besides* her family. She also spoke more, to me and to others, and became more

visible. While I don't have time for details, she also repositioned herself somewhat differently regarding the family constellation.

Unfortunately, our work came to a premature end. While no longer restricting, Jane still binged and purged. She did not easily let go of this satisfaction or her desire for this form of dissatisfaction. The treatment team wanted Jane to enroll in an intensive eating disorder treatment program. While transitioning from my care, Jane tried this treatment. She said while it offered a lot, it failed to provide room for her to speak. This wasn't surprising for it's a system that turns to more and more avenues besides speech to treat eating disorders. Instead she transferred to a psychoanalytically trained private practitioner in the area. Jane said she felt she could speak with her. What Jane taught me is that the hysteric exists<sup>vii</sup> and still desires to speak!

---

<sup>i</sup> Marie-Hélène Brousse, editorial in *Mental Online* (11), December 2006, p. 3.

<sup>ii</sup> In the case I will discuss, the patient's mother had said to the patient upon her request that her mother pay for more intensive treatment: "I'm already paying for your sister's treatment. I don't have that much money. Please, just eat and get better. Do it for me." Jane, the patient discussed in this case, experienced a similar reaction from the treatment team in their demand—"eat and get better."

<sup>iii</sup> Her digestive tract symptoms were also a point of identification with the males in her family as she told me that her paternal grandfather had similar stomach problems.

<sup>iv</sup> During the course of our work, there was progress from the move from the 'all women' to *a woman*.

<sup>v</sup> Jane was considered the stoic one. The mother used to tell the story that when Jane was around seven years old, her father pulled one of her teeth but failed to "do enough numbing" and in spite of the pain, only a single tear rolled down Jane's cheek.

<sup>vi</sup> While first revealing that her sister suffered from an eating disorder, Jane later came to recognize her mother as having anorexia. Spoken about less was that her father also suffered from bulimia when Jane was between the ages of 6 and 10. She had borrowed the symptoms of others—it was all in the family.

<sup>vii</sup> As Marie-Hélène Brousse states in "Death and resurrection of the hysteric" in *Mental online 11*, "Dead, the hysteric? Certainly not. She has changed with the times and unveils a new politics that no longer consists of supporting the sexual rapport" (p.39).