EATING FOR SAFETY, NOT SURVIVAL:

LESSONS FROM SCHEMA THEORY FOR EATING DISORDER TREATMENT

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Abstract

Using the framework of schema theory from cognitive anthropology as implemented by Roy G. D'Andrade (1995) and Claudia Strauss and Naomi Quinn (1997), the current study analyzes the language use of participants in an eating disorder support group meeting, of three interviewees who have a history of at least one eating disorder, and of three interviewees who have played a role in eating disorder treatment: a licensed professional counselor who works as a research associate for a biomedical organization, a registered dietician who works in private practice at an organization with a multidimensional approach to food and body issues, and a recent graduate of a master's in acupuncture and Oriental medicine program who intends to specialize in the treatment of eating disorders. The study took place in and around Portland, OR. It culminated in four schemas related to eating from the viewpoint of individuals with eating disorders, which pointed to an underlying metaphor linking eating and being. The practitioners' language use reflected acknowledgment of these schemas and of the metaphor driving them at varying degrees. Therefore this study concludes that eating disorder treatment necessitates a complementary approach involving biomedicine primarily in extreme cases, the holistic thinking of Oriental medicine, the philosophy of intuitive eating, and support from loved ones—at the table and elsewhere.

Introduction: Food for Thought on Metaphor and Eating Disorders

Loose translations have gotten people into a great deal of trouble before—children translating mom's "maybe" to "yes" when asking dad for permission to have a sleepover, a student using an online translator and ending up writing a Spanish paper about the right that bears' arms have rather than the second amendment to the United States Constitution—yet not many question the biomedical diagnostic process by which patients' descriptions of their own suffering receive specific names as the physician sees fit. The case of eating disorders exemplifies how this medicalization of language, beginning with the naming process of diagnosis, affects perceptions of suffering and can dictate how it progresses. As Ethan Watters writes, "[T]he expectations and beliefs of the sufferer shape…suffering" (2010:3).

The biomedical model has ignored these expectations with respect to eating disorders, which has adversely affected the eating disorder treatment that it provides. Focusing on anorexia nervosa (AN) specifically, Richard A. O'Connor and Penny Van Esterik attribute the low success rate of the related treatment programs to the way in which "the discourse on anorexia…detaches from" the "anorexic's experience and values" (2008:6-7). According to Evelyn Attia, MD, the current (fourth) edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-IV, lists bulimia nervosa (BN) as the only other eating disorder besides AN, but the revised DSM-V set for release in May 2013 will likely classify binge eating disorder (BED) as an eating disorder instead of an eating disorder not otherwise specified (EDNOS) (2011:ITC4-3-ITC4-4).

The framework of schema theory from cognitive anthropology facilitates the current study's objective of investigating how to steer the discourses on AN, BN, and BED in a new direction: towards the emic or insider perspective. According to Roy G. D'Andrade, a schema refers to "the organization of cognitive elements into an abstract mental object…with default values or open slots" that suitable specifics can variously fill (1995:179). He came up with "the *germ* schema…held by most Americans" but found that it represented merely "a simplified version of the findings of scientific medicine" (D'Andrade 1995:129). D'Andrade thus concludes

that in order "[t]o understand folk beliefs about illness"—the emic perspective—uninfluenced by the hegemony of biomedicine, one must acquire "[k]nowledge of relevant cultural schemas" (D'Andrade 1995:130). In the current study, the identification of schemas about eating held by people with eating disorders will provide insight into the folk or emic perspective not of illness per se, but of what biomedicine calls a mental illness as well as a disease. After all, these classifications of eating disorders represent "abstraction of" biomedicine's "all-powerful disease metaphor," to quote Mary M. Lay (2000:102).

Oftentimes the linguistic evidence of schemas takes the form of metaphor. According to George Lakoff and Mark Johnson, "*The essence of metaphor is understanding and experiencing one kind of thing in terms of another*" (1980:125). While this definition seems adequate, the conclusions that they draw regarding metaphor have received criticism from Claudia Strauss and Naomi Quinn (1997) for not factoring in the possibility that schemas share a relationship with metaphor. The latter's analysis of the metaphors used by the husbands and wives whom she interviewed in order to construct an American model of marriage led her to conclude that these metaphors reflected an underlying schema that people share for thinking about marriage (Strauss and Quinn 1997:142-144). This appears to challenge the view held by Lakoff and Johnson (1980) "of metaphor as underlying conceptualization" (Strauss and Quinn 1997:152), but Gary B. Palmer (1996) offers an explanation of their perspective in terms of schema theory. In the general metaphor "AN ARGUMENT IS A BUILDING," an example given by Lakoff and Johnson (1980), "the knowledge of arguments maps onto the schematic cognitive model of a building" (Palmer 1996:222-223). Gaining a more complete understanding of metaphor, then, requires schema theory's contextualizing of the basic points put forth by Lakoff and Johnson (1980).

Drawing from schema theory, including the implications of metaphor, the current study will offer an answer to O'Connor and Van Esterik's call for a return to the "anorexic's anorexia" that does not resemble "the disease" treated in "many institutions" (2008:6), as well as the bulimic's BN and the binge eater's BED. This will also involve bringing in other scholars who

have attempted to illuminate the emic perspective regarding eating disorders, particularly Catherine J. Garrett (1996, 1997). She describes AN and recovery as two phases in an ascetic rite of passage (Garrett 1996, 1997). Phrasing her argument in Durkheimian terms, Garrett conceives AN and recovery, respectively, as "'negative' and 'positive' parts of the same ritual practices of ongoing initiation into maturity and a consciously fuller way of living, through a symbolic encounter with death" (1996:1504). The participants in her Australian study described "their anorexic years" as "painful" but "necessary for their subsequent self-transformation" (Garrett 1996:1501) and their recovery narratives followed a mythological structure (Garrett 1997:267), contrasting with the biomedical description of eating disorders in terms of mental illness and the disease metaphor.

The schemas compiled in the current study come from the language use of three interviewees covering the whole spectrum of eating disorders in order to represent the emic perspective. Three additional interviews with practitioners who have played a role in eating disorder treatment allowed for the analysis of the degree to which their different etic or outsider approaches acknowledge these schemas. The language use at an eating disorder support group meeting in the research base—Portland, OR—supplemented insights gained from interviewing. The hypotheses for the current study include: 1) that the interviewees with eating disorders will have the same schemas, regardless of differences in their eating behaviors, and 2) that the language choices of the practitioners will show acknowledgment of these schemas at varying degrees, depending on the philosophy of their training.

Background Information: Biomedicine's Unfilled Prescription at the Language Pharmacy

Diagnosing an "eating disorder" with this name narrows the scope of treatment to behaviors surrounding eating. For example, O'Connor and Van Esterik point out the problematic categorization of AN as an "eating" disorder, offering the alternative names "*exercise* disorders" for many cases and "ascetic disorder" for every case (2008:6). Additionally, the press that eating

disorders have received has tended towards the depiction of people with extremely slim bodies. Although this accounts for most cases of AN, BN can also occur in people of normal weight or slightly above it, and BED tends to manifest in overweight or obese people. The isolation of BED in the EDNOS category also contributes to the association of eating disorders and thinness. These biased representations have sensationalized the emaciated body resulting from an eating disorder while perpetuating the view of overweight and obese people as diseased only in the sense that they have no restraint. Although at first it seems that the description of AN and recovery as stages in a rite of passage (Garrett 1996, 1997) has the same potential to sensationalize eating disorders as does the biomedical counterpart, it actually puts recovery, not AN, in a desirable light. In this paper, the use of the term "eating disorders" to refer to AN, BN, and BED unless it appears in a biomedical context, in which case it refers to only AN and BN, serves to avoid contributing to the bias against BED (and fatness) leading to its exclusion from biomedical eating disorder discourse. Although some cited material refers to AN as just "anorexia" for the sake of brevity, technically this term means "lack of hunger," which could arise from some other ailment, hence the use of AN and "anorectic" versus "anorexic" wherever possible.

In addition, William Withey Gull took care in naming "anorexia nervosa" as such. Erin O'Connor argues that "through its strategic use of parentheses," Gull's 1874 paper entitled "'Anorexia Nervosa (Apepsia Hysterica, Anorexia Hysterica)'…marginalized competing nomenclatures" (1995:535). Gull saw the aversion to food typical of AN as "attributable neither to hysteria" because it occurred in men as well as women "nor to a failure of the digestive system" based on medical observation but rather as "the primary symptom of an as yet undescribed nervous disease" (O'Connor 1995:535-536). Gull became the "first to conceptualize anorexia nervosa as a distinct clinical entity with a standard procedure for differential diagnosis and a 'reliable' method of treatment" (O'Connor 1995:536). While he may have made a mistake in arguing for framing AN "as a discrete disease," Gull at least recognized and emphasized "its status as a unique neurosis" (O'Connor 1995:535). If "anorexia nervosa" describes a willed lack

of hunger imposed by a neurosis in the brain, one can assume that the term "bulimia nervosa," coined by Gerald Russell in 1979, describes a neurologically mediated "ravenous hunger." Because BED does not have a combined Greek and Latin name, it does not require this sort of etymological explanation.

The DSM-IV diagnostic criteria for AN include "refusal to maintain body weight at or above a minimally normal weight for age and height," defined as "body weight less than 85% of that expected;" an "[i]ntense fear of gaining weight or becoming fat;" a "[d]isturbance" in one's perception of "body weight or shape" evident in "denial of the seriousness of the current low body weight;" and "[i]n postmenarcheal females, amenorrhea," or "the absence of at least three consecutive menstrual cycles" (Attia 2011:ITC4-5).

Diagnosis of BN according to the DSM-IV requires the following: "[r]ecurrent episodes of binge eating" (consuming more food than most people would eat in a brief time and feeling a "lack of control over" the consumption); "[r]ecurrent" and "inappropriate compensatory behavior to prevent weight gain" such as self-induced vomiting, misuse of medications, fasting, or excessive exercise; and undue influence of "body shape and weight" on "[s]elf-evaluation" (Attia 2011:ITC4-6). In addition, these criteria must not occur only during episodes of AN (Attia 2011:ITC4-6). The DSM-IV defines "[r]ecurrent" as twice weekly for three months, but because this frequency does not seem to have an association "with significant differences in the disease course or outcome compared with fewer binge-purge episodes," the upcoming DSM-V has proposed considering once weekly episodes sufficient for diagnosis (Attia 2011:ITC4-6).

BED, like BN, presents with "regular episodes of binge eating" that bring about "a sense of lack of control" (Attia 2011:ITC4-6). While the DSM-IV defines the frequency of these binge episodes as twice weekly for six months, the DSM-V has proposed that once weekly episodes for three months meet the diagnostic criteria (Attia 2011:ITC4-6). BED stands apart from BN in that it does not come with "compensatory behaviors aimed at weight loss" (Attia 2011:ITC4-6).

These diagnostic criteria hint at the intended essence of the biomedical idiom: objectivity through quantification and categorization. The biomedical commitment to objectivity, encoded linguistically, hinders the success of eating disorder treatment. Helen Gremillion provides an example of the biomedical approach to eating disorder treatment based on 14 months of ethnographic fieldwork in a hospital program in the United States (2002:383-384). The program offered inpatient and outpatient services and a multidimensional approach to treatment including behavior modification, individual therapy, group therapy, family therapy, and biological interventions such as tube feedings when necessary (Gremillion 2002:386). Treatment teams included a pediatrician, a psychiatrist or psychologist, a nutritionist, several staff members (nurses and/or counselors), and perhaps a psychiatric intern or medical student (Gremillion 2002:388). This collaboration between the physical health and mental health sectors represents biomedicine's attempt to deal with the challenge that eating disorders pose to the Cartesian dualism inherent in the biomedical philosophy. O'Connor and Van Esterik write that "Cartesian dualism" provides the "intellectual answer" for why healthcare has "moved so far away from the anorexic's anorexia," because "in dividing mind and body and individual from society," it "fights any realistic social and cultural understanding of disease" (2008:7). The "institutional answer" comes from AN's medicalization, which O'Connor and Van Esterik equate with its mystification: "[B]y isolating the sick and sickness from their surroundings, biomedicine has complicated diseases like anorexia and obscured their causes" (2008:7). As the current study will show, these findings apply to BN and BED as well.

The program studied by Gremillion also featured a structured eating schedule during hospitalization consisting of "a closely monitored, 100 percent liquid diet in the beginning, followed by calorie counting, agonizing choices from menus, and sometimes the threat of tube feeding" in the event of a patient's failure to meet "daily calorie quotas" (2002:387). At a typical meal, a nurse watched the patients eat and recorded the number of calories they each consumed (Gremillion 2002:389). Some patients even brought calculators, and Gremillion saw a patient

correct the nurse's calorie count (2002:389). The program had rules about food consumption, like that a patient had to finish a banana in order for its caloric value to count, and the patients ritually weighed every morning (Gremillion 2002:389).

Framed in a language aimed at objectivity, these practices seemed detrimental rather than helpful to the patients, according to Gremillion (2002). For example, the program's protocol involved establishing a "discharge weight," often identical to a patient's "exercise weight" deeming exercise medically safe, and an "admission weight" essentially telling patients that they would most likely lose weight after discharge and would need hospitalization again in the future (Gremillion 2002:387-388). In reinforcing "[t]he team's claim that their opinions were unified and unambiguous" (Gremillion 2002:404), these non-negotiable terms "re-create forms of bodily control" that already comprise the "defining features of anorexia" (Gremillion 2002:390). Gremillion thus reaches the conclusion that "biomedical terms," as currently conceived, cannot explain "the lived, material realities of…anorexia" (2002:382).

The history of dietetics provides another important example of the corrupting effect that this biomedical language has had on the conceptualization of eating disorders and, ultimately, on eating disorder treatment. Richard Wrangham writes that "cooking" not only "makes our food safer, creates rich and delicious tastes," and "reduces spoilage," but it also "increases the amount of energy our bodies obtain from our food" (2009:13-14). Thus, argues Massimo Montanari, one can describe "dietetics" as "born with cooking" (2006:51). While dietetics used to speak "the same language as cuisine, a language compatible with…that of the senses" (Montanari 2006:55), it evolved "into a science of dietetics within the theory and practice of medicine" (Montanari 2006:51). Beginning in "the seventeenth and eighteenth centuries, dietetic science began to speak a different language, one based on chemical analysis and experimental physics" and "no longer tied to sensorial experience: Who knows the flavor of carbohydrates or the taste of vitamins?" (Montanari 2006:57). This has led to a "gap that we have difficulty bridging" because "dietetic science profoundly affects our way of gathering at the table" (Montanari 2006:57) but does not

support intuitive eating, or eating in response to hunger and fullness. It provides an eating instruction manual via meal plans and other dietary aids (or hindrances) in a language foreign to the digestive system and the senses. This impedes the healing process of patients with eating disorders who need to relearn intuitive eating.

The biomedical process of seeking out cures for diseases seen as curable—including AN, according to Debra Ferreday (2203:287)—looks quite different from the sort of healing that people with eating disorders need. Biomedicine generally tries to cure diseases with pharmaceutical drugs, but no drug exists for eating disorders. Nonetheless, biomedicine still tries to make the disease metaphor work by identifying comorbidity factors with known pharmaceutical interventions. For example, Attia et al. puzzled over their finding that "compared to placebo, the antidepressant fluoxetine conferred no additional benefit to the inpatient treatment of underweight patients with anorexia nervosa" because they knew that patients with AN "frequently exhibit symptoms of depression…known to respond to antidepressants" (1998:550). Similarly, Walter H. Kaye and B. Timothy Walsh explain that "the notion of using antidepressants for BN emerged because of the high frequency of symptoms of depression and anxiety" (2002:1679) and Susan McElroy et al. tested the efficacy of the anti-epilepsy agent topiramate in obese individuals with BED based on its association with appetite suppression and weight loss in clinical trials with epilepsy patients (2003:255). Interestingly, the pharmaceutical trials for AN and BN target emotion while the one for BED targets fatness, providing further evidence of the bias in the biomedical understanding of these so-called diseases.

James I. Hudson et al. recently reviewed the National Comorbidity Survey Replication (NCS-R) that they facilitated in 2007 and recalculated the estimated lifetime prevalence of DSM-IV AN, BN, and BED in the United States as 0.9, 1.5, and 3.5 percent among women and 0.3, 0.5, and 2.0 percent among men, respectively (2012:164). Based on their estimates of the number of people suffering from eating disorders, Hudson et al. expected to find that a low proportion of these people had received treatment (2007:356). However, they found that "a high proportion of

cases did receive treatment for comorbid conditions" (Hudson et al. 2007:356). They conclude that this indicates a need for treatment providers to screen more thoroughly for eating disorders even if patients do not present with complaints about eating problems (Hudson et al. 2007:356). It may also hint at the inefficacy of the programs sought for the treatment of emotional problems related to eating disorders: "[T]he most common site of treatment" consisted of "the general medical sector" for AN and BED and "the mental health specialty sector" for BN (Hudson et al. 2007:352), which comprise the two main players in the biomedical model for eating disorder treatment. Additionally, in a study of obese women, N. E. Sherwood et al. found that binge eaters have a higher likelihood of dropping out of weight loss (obesity treatment) programs than those who do not binge (1999:491).

The failure of the disease metaphor to explain and treat eating disorders also becomes evident in the material on pro-ana (AN) and pro-mia (BN) websites. According to Patricia A. Adler and Peter Adler, these online communities "offer tips on how to avoid eating and hide eating disorders" and view them "as a lifestyle choice and not a medical or deviant issue" (2007:39). They aim to subvert the biomedical model of eating disorders (Ferreday 2003:285), but according to Mebbie Bell they attempt to do so by "appropriating its terms" (2009:152). For example, pro-ana and pro-mia websites "detail diagnostic criteria and 'teach' individuals how to perform a 'normal' body in order to evade" the biomedical authority marking anorectics and bulimics "as both diseased and deviant" (Bell 2009:152).

Interviewing recovered anorectics, O'Connor and Van Esterik heard testimony that "treatment sometimes aggravated their affliction and inspired resistance" (2008:7). They offer an alternative to "medicine's isolating" in "anthropology's contex[t]ualizing" (O'Connor and Van Esterik 2008:7). Through this method, "the anthropologist can broker an appreciation of context, diversity and holism that few health care professionals have the time, training or detachment to provide for themselves" (O'Connor and Van Esterik 2008:9).

This use of "cultural brokering" (O'Connor and Van Esterik 2008:9) sounds very similar to the "ethnomedical program" brought into the anthropological limelight decades ago by Arthur Kleinman (1978:662). "[C]omparative ethnomedicine" recognizes a difference between "'emic' and 'etic' categories" of health problems and devotes "primary attention to the everyday context of health and health problems in families and in the popular culture generally," in contrast to older traditions in medical anthropology, which tended "to produce a 'medicocentric' view of the medical system…not directly concerned with…patient-practitioner transactions" and "to take for granted biomedical categories (e.g., 'disease,' 'diagnosis,' 'preventive measures,' medical system')" as "universal, culture-free, and therefore unproblematic" (Kleinman 1978:661-663). The "cultural brokering" proposed by O'Connor and Van Esterik involves taking a strategy that medical anthropologists typically enact "*between* cultures"—Kleinman (1978), for example, discusses ethnomedicine in an intercultural comparative context—and utilizing it "*within* our own culture" as a way of "translating a biocultural disease for today's biology-or-culture thinking" (2008:9).

A complementary approach to eating disorder treatment based upon this "cultural brokering" method (O'Connor and Van Esterik 2008:9) would reframe eating disorders more appropriately than the biomedical world, which can mystify and sensationalize eating disorders to the point that they seem like acceptable or even desirable identities. It would operate more along the lines of an ethnomedical "approach…that challenges the biomedical paradigm," offering "a systematic critique…of the biological language of medicine and psychiatry" and proposing "a new language…for examining the relationships among biology, experience, and meaning in the social construction of sickness as a phenomenon of the everyday world" (Kleinman 1978:663). This complementary framework, relying upon a new and different linguistic toolbox, would offer an alternative to the biomedical, pathologizing approach and language. It would return eating to a normal, intuitive activity, reconnecting it with its primary goal of nourishing the body and fueling the brain.

Theoretical Approach: You Think What You Say

In English, one can speak of "'sinning' with dessert, 'being good' with veggies, or 'confessing' a late-night binge" (O'Connor and Van Esterik 2008:8). Conversely, one "hungers" not just for food but for affection, "spices" a pot of chili and "spices" things up in the bedroom, and reaches "satisfaction," ideally, after sexual intimacy and after a meal. Language's ability to provide insight into conceptions serves as the basis of schema theory, which sees the brain as a system of filing cabinets or schemas that contain different folders depending on the experiences that the owner of that brain has had and the cultural values that the person has internalized. Strauss and Quinn have supported the focus on internalization in their proposal to rethink the concept of culture in terms of schema theory because cultures do not exist as independent entities, but refer to the regular sharing of schemas (1997:7). They argue that definitions of culture have neglected the psychological aspect of meaning: The meaning-making side of culture belongs to the intrapersonal realm of internalization because meanings reside not in signs but in the people who interpret them (Strauss and Quinn 1997:253).

Jack Hitt touches on a practical application of schema theory, quoting forensic linguist Robert Leonard: "'[H]umans perceive language…according to schemas, which lead to misperceptions as much as perceptions'" (2012:29). In detective work, Leonard says, eyewitnesses and confessions provide the "'two shakiest types of evidence'" (Hitt 2012:29). This applies to eating disorder discourse in the true origin of what Gregory T. Smith et al. call the "likely culture-bound, post hoc explanations women construct for themselves in order to try to explain behavior…actually driven by a biological, universal cause" (2006:226). These explanations actually come from external constructions of AN's causes: a regurgitation of explanatory models such as "thin-ideal internalization" according to J. Kevin Thompson and Eric Stice (2001:181) or "malignant mothering or sexual abuse" according to O'Connor and Van Esterik, or even the pursuit of virtue proposed by O'Connor and Van Esterik themselves, despite

their argument that this truly represents the essence of AN (2008:6). Although eating disorders do not have roots in eating or food at all, they evolve into dealing with precisely these concerns (O'Connor and Van Esterik 2008:6). Consequently, the current study examines schemas related to eating from the viewpoint of individuals with eating disorders and analyzes the extent of the role that they play in the various treatment philosophies of practitioners who have experience providing eating disorder treatment.

Methodological Approach: The Skinny on Feeling Fat in a Health-crazed Culture

As it turns out, the practitioners involved in eating disorder treatment do not easily accept requests for participants in research projects. This could stem from a number of reasons, namely lack of time and the doctrine of doctor-patient confidentiality called the Health Insurance Portability and Accountability Act, commonly referred to by the acronym HIPPA, which became for this project the HIPAApotamus in the room (so large it pushed the elephant straight out of the metaphor). In addition, a trend emerged in the type of organization that turned down the invitation to participate in the current study, based in Portland, OR. The original plan for research involved emailing interview requests to a residential treatment center applying the biomedical approach in a unique environment intended to support spiritual wellbeing and an inpatient/outpatient clinic following the biomedical philosophy, both specifically devoted to providing eating disorder treatment; an Oriental medicine institution with no obvious connection to eating disorder treatment but that may have had some insight regarding it; and an organization with a multidimensional approach to food and body issues including but not limited to eating disorders. Libby, a registered dietician who works at this last organization here called "Chicken Soup for the Healthy Soul" (CSHS), agreed to interview and help find other interviewees for the current study.

By contrast, the two eating disorder treatment programs both declined: The residential treatment center at least reviewed the proposed questions before declining due to a full plate, so

to speak, while the inpatient/outpatient clinic declined outright. The Oriental medicine institution did not reply to the initial email, but a recent graduate of its master's in acupuncture and Oriental medicine program—Piper—agreed to interview after Libby identified her as having an interest in eating disorders. This suggests that the first email to the Oriental medicine institution simply did not address the right person.

Libby distributed interview requests for this study via four methods: in an email to members of the Columbia River Eating Disorder Network (CREDN), through a flier in the CSHS office, in the affiliated newsletter, and on the CSHS Facebook page. The interview requests did not mention "eating disorders" specifically nor did they allude to the linguistic lens of the study, describing it instead as related to "food and body image." The distribution of interview requests by Libby resulted in all of the responses from people with eating disorders—Korie, Earl, and Suzann—and one from a licensed professional counselor—Lucy, age 41—who works as a research associate for a biomedical organization and has counseled adults and adolescents with BED in two separate trials (interview with author, December 17, 2012). The interviewees—all female, by chance—selected their own pseudonyms.

Libby, also 41, used to do research at the same organization as Lucy, conducting studies on weight loss and weight loss maintenance (interview with author, January 7, 2013). After seven years, however, she could not help but notice a disturbing pattern: The research participants lost weight only to regain it later. "I just really felt like we…made them focus too much on their weight and even though we were calling it 'lifestyle change,' …people basically had a mentality that it was dieting," she says. Facilitating groups at a clinic with a likeminded therapist who became another founder of CSHS, Libby "realized…that there was a whole community of people doing this work," which included "a movement called 'Health At Every Size'" and "a philosophy called intuitive eating." As a yoga teacher, Libby also wanted to "combine the mindfulness and self-acceptance practices of yoga with" these ideas.

Libby's discovery of the sort of community that supported her philosophy about food and body image brings up a potential sampling bias in this study: the "orthorexic culture" of Portland, where "people obsess about eating correctly." They "may be vegan for ethical reasons and they may be vegan because it's a great way to restrict large groups of food," Libby explains. For the current study's objectives, the nature of this potential bias seemed preferable to that presented by the easily accessible but even more selectively populated college environment, although the latter option may have garnered more interviews.

The health-crazed Portland culture does provide a unique opportunity to investigate alternative forms of eating disorder treatment such as those provided by CSHS and Oriental medicine. In her final year of schooling for a master's degree in acupuncture and Oriental medicine, Piper, age 31, did a project on acupuncture and the treatment of eating disorders (interview with author, January 9, 2013). Piper found that "a lot of people with eating disorders…haven't completely learned to become comfortable with emotions." Coupling this with her finding that the two practitioners whom she interviewed saw positive results in their patients with eating disorders, Piper concluded that acupuncture can serve as a "valuable tool" in the treatment of eating disorders: "Acupuncture can really…help people to connect with their bodies and connect with their emotions in a way that's more comfortable than they may have previously experienced," she says. As soon as Piper receives her license to practice, she plans to specialize in eating disorders and digestive conditions, working alongside therapists, counselors, and physicians: "I see acupuncture as having a complementary role in eating disorder treatment," she says. Piper's future partner specializes in pediatrics, which will complement her focus considering the young age at which eating disorders usually emerge.

Since age 13 or 14, Korie, now 28, has had an "eating disorder" that in the interview she left unspecified and also referred to as "issues with food," similar to the phrase "eating issues" from the interview questions (interview with author, November 24, 2012). Subtle cues in her language suggest the purging subtype of AN, as opposed to the solely restricting one: She denies

having bingeing tendencies but admits to "a history of purging" and "restricting." For the purposes of this paper, identifying Korie's specific eating disorder does not matter. Although Korie has struggled with an eating disorder since adolescence, she did not seek treatment until three years ago, and even then not until her therapist whom she saw for other reasons suggested that she do so. She continued with general therapy and started group therapy at CSHS, where she saw Libby and a counselor. In addition, she saw a psychiatrist separately "just for prescription stuff." Now she almost exclusively does dialectical behavior therapy (DBT). Korie says that her eating disorder has never reached the point at which medical attention such as hospitalization would have become necessary.

Earl, age 29, entered treatment for the first time at the same age (13 or 14) as Korie's eating disorder started (interview with author, November 30, 2012). Her parents brought her into the clinic. The first email from her, indicating her willingness to participate in this project, said that she has struggled with "anorexia and bulimia." After this, she did not mention her specific eating disorders again. She received medical treatment and took part in a support group that did not really classify as therapy. Earl had 10 different hospital stays ranging between two days and two weeks and then spent about three months in a residential treatment program at a hospital in Wisconsin. When she came back to Portland she saw a nutritionist, a doctor, and a family therapist. Family therapy has remained "the core, the most consistent thing" in Earl's management of her eating disorder. She returned to the residential treatment program in Wisconsin twice more, the first time for two months and then for about four months after having about five individual therapists. Since then Earl has consistently seen a doctor and a nutritionist, in addition to a family therapist. Before finding Libby, Earl did not find professional nutritional advice particularly helpful. During her interview, Earl released information on the eating disorder support group meeting included in the current study (December 7, 2012).

Suzann, age 33, sought help for her "emotional eating" and "binge eating" just one year ago after the results to an online quiz that she took recommended it (interview with author,

November 27, 2012). She found the quiz on one of the websites featuring eating disorder treatment facilities and programs that popped up, ironically, when she conducted a Google search for a new diet. Suzann feels as though she has spent her whole life on a diet. She has had a preoccupation with food since as early as second grade, when it took the form of worrying about "having enough food and being comforted by food." In sixth grade "it became about what food is good, what food is bad, how much to eat, how much not to eat." She feels thankful that at a young age she did not know that "you could control your weight by eating less," adding, "I'd be bulimic if I had known that." Twice in the past year, Suzann went to the residential treatment center that turned down the invitation to participate in the current study. She has also seen dieticians at a hospital in Portland. She currently does therapy at an unspecified location and sees Libby at CSHS, where she also participates in groups aimed at making people feel good about their bodies.

The interview questions as well as the consent form had to say "eating issues" rather than "eating disorders" and in general had to have a very broad tone to limit the influence of their wording on the interviewees' linguistic choices. The questions to reveal explanatory models of health problems devised by Kleinman (1980:106) provided a loose framework for the interview questions in order to test the extent to which eating disorders conform to the criteria generally associated with health problems such as severity, duration, causation, and treatment. The interviews occurred between late November 2012 and early January 2013 at bakeries, coffee shops, or dining areas of grocery stores in order to provide a neutral environment in contrast to a home or clinical setting. The data came from detailed interview notes, crosschecked against iPhone recordings of the interviews. Their storage on a password-protected computer ensured safe-keeping. Data analysis took place using the Find function in Microsoft Word in order to locate patterns and uncover schemas. The quotes omit fillers such as "um," "uh," "you know," "like," et cetera. An ellipsis indicates the omission of a word or phrase with semantic value and an em dash follows an unfinished thought.

Analysis: A Four-Course Menu of Schemas

Appetizers (Caution: Consumption May Increase Risk of…)

For people who eat normally, hunger serves as reason enough to eat and fullness indicates the need to stop eating. Korie, Earl, and Suzann, however, respond quite differently to hunger. Even though she feels hungry, Earl says, "I restrict a lot during the day." This has led her to become accustomed to the feeling of hunger: "I'm really used to being really hungry." Korie has a similar response to hunger: "[I]f I'm hungry, a lot of times I try to ignore it first." Suzann has worked hard on heeding hunger and fullness cues—on "just trying to eat when I'm hungry," she says. Korie, Earl, and Suzann all to varying degrees need to work on eating only when they feel hungry and whenever they feel hungry. If not hunger, what drives their eating?

Normal eaters think of hunger as nothing more than the need to eat and they know that they need to eat to survive, but they also think of eating as a normal activity—whether it occurs in a ritual context in which bread symbolizes the body of a man who died for their sins or at the family dinner table where bread represents bread. Korie, Earl, and Suzann, however, have developed a different schema about eating that makes the act of eating "such a big deal," as Earl said in the support group. The schema says,

Eating is scary because it is ambiguous.

As a consequence of this schema, Korie, Earl, and Suzann foster significant anxiety over their hunger because it indicates the need to eat. Hunger, and by extension fullness, merely exacerbates this "anxiety about food," as Earl says. She adds, "[F]ood makes me feel more vulnerable because it makes me feel more in my body." This suggests that Earl thinks of eating in terms of fear. Earl, who has struggled with both AN and BN, mentioned anxiety five times during her interview and Suzann, who has struggled with BED, mentioned it once during hers. Like Earl, she talks about food in terms of fear: "[B]efore, I didn't want to have candy around and things like that because I was *worried* that I would just eat it all the time" (emphasis added).

Korie, the least verbose and most vague of the three women, does not mention anxiety specifically but she does describe overanalyzing how she should respond to hunger: "[A] lot of times it's—there's a lot of thought around it and how I'm going to approach it so, it's a struggle." Korie has "a lot of thought around" eating because of its ambiguity—she does not know exactly how and what she should eat. This ambiguity makes eating scary; it turns eating into a beast with which she has to "struggle." In addition, people often talk about having to face their fears. Regarding eating, Korie says, "[I]t's something I have to face. That's how I see it."

In a personal account of what in retrospect he recognizes as his struggle with AN, Scott Korb also describes eating as scary (2007:86). "I called my fear of food 'vegetarianism'" and later veganism, when the fear escalated: "I became more scared of food," he says (Korb 2007:86). He describes himself "as a scared vegetarian and later as an apparently terrified vegan" (Korb 2007:89). One of the anorectic women interviewed by Merav Shohet describes her eating behaviors as "'this weird anxiety'" that "'got named,'" with the consequence that after diagnosis she developed an "'obsession with treatment'" (2007:359)—of an "eating" disorder, not a general anxiety. This illuminates "the damaging power of diagnostic labels" (Shohet 2007:374) and shows the importance of the anorectic, bulimic, and binge eater perspectives, here represented via schemas. "I think that labeling someone with a disease can be limiting," says Piper, the interviewee who recently received her master's in acupuncture and Oriental medicine. Although "helpful for doctors," Piper recognizes, biomedical diagnosis can lead them to "have assumptions about patients, too."

Piper says that Oriental medicine sees each health problem as "an imbalance" rather than a disease. This encourages her to listen to people's perspectives of what they need: "I am trained to let people talk," she says, "…because most people know what they need." From the practitioners whom she interviewed for her project and from her own patients with eating disorders, Piper has heard words of fear: "[T]hey say that they experience a lot of anxiety." This supports the first-course schema, *eating is scary because it is ambiguous*. Yet the diagnostic

criteria for BN and BED do not mention fear, and those for AN reduce this fear to a symptom that it can cause: "[i]ntense fear of gaining weight or becoming fat" (Attia 2011:ITC4-5). This symptom comes from a related schema, discussed below.

Second Course: Salad (No Matter What the Stomach Feels Like)

People who have normal eating schemas seek out foods for which they hunger and do not question this craving. For them, not having a precisely defined way of eating—how much to eat and what to eat—that perfectly satisfies their physiological needs does not come with a feeling of anxiety. As Korb has realized: "There is no perfect eating. There is no perfect not eating. There is only eating or not" (2007:89). For Korie, Earl, and Suzann, this ambiguity generates fear, implying that the combination of anxiety and perfectionism contributes to the development of an eating disorder. A mother in the support group said, "I worry about my daughter being a perfectionist…and so maybe some of her problem has to do with that." Korie, Earl, and Suzann respond to the fear created by eating's ambiguity by trying to find a way of eating that makes them feel safe, suggesting a second schema:

There is a way I can eat that will make me feel safe.

In an attempt to make eating not scary, to make it unambiguous, the three women have tried to define a way of eating that makes them feel safe. However, this way of eating exists as an abstract, unreachable notion with which they become obsessed. Earl and Korie's attempt to define this safe, unambiguous way of eating involves eating very little and purging—and, for Korie, exercising excessively as well—when they feel as though they did not eat in this way. Earl has tried to narrow the sort of eating that creates fear by defining certain foods as frightening and others as safe. "I still have the types of food that I eat, like I have a very limited scope that I feel comfortable with so I tend to eat the same thing every day," she says, "so when there's new things introduced, like on business trips, it's stressful." Earl feels comfortable with vegetables ("I

tend to be attracted to vegetables") and uncomfortable with foods containing fat. She addresses this in family therapy: "Sometimes I'll have a goal of eating fat…because eating fat is scary."

Making eating not scary involves making it unambiguous by having a clear idea of how and what one should eat, but unlike Korie and Earl, Suzann has tried to do this not via a limited scope of safe foods but through comfort foods like candy. In the throes of her emotional and binge eating, Suzann says, "[F]ood was like my joy, it was my excitement, my life." This points to a difference in interpretation regarding the schema *there is a way I can eat that will make me feel safe* between the anorectic, bulimic, and binge eater mindsets. For Suzann, it translates into "the mentality that food will solve everything." Dieting, therefore, directly conflicts with her interpretation of this schema. It removes from her diet the comfort food that she thinks will make her feel safe, so it makes her feel anxious. When comfort foods do not keep the promise in their name, she goes back to dieting for a time, until the anxiety reaches such a high level that she acts on her interpretation of this schema by once again bingeing on comfort foods.

Libby would describe this as "the pattern of thoughts, feelings, and behaviors" that Suzann and many others "tend to cycle through over and over again." This reveals a major assumption behind the name "binge eating disorder." It makes bingeing seem like the problem, the abnormal behavior, when people need "to call restricting the problem" and to see "that bingeing is actually in a lot of cases self-care," according to Libby. To support this conclusion, she cites the concepts of "homeostatic" and "hedonic" bingeing from a book by Yoni Freedhoff, MD, and Arya M. Sharma, MD, PhD (2010). They write that "the majority of patients who struggle with binge-eating episodes do not eat regularly throughout the day," meaning that "true physical or homeostatic hunger (a need for calories) rather than a hedonistic emotional need for comfort foods (appetite)" likely precipitates the binge (Freedhoff and Sharma 2010:24).

While Freedhoff and Sharma see these types of bingeing as mutually exclusive (2010:24), Libby's clients say that "they do a little bit of both." Suzann does: She describes seeking comfort from food but also refers to herself as a chronic dieter. Freedhoff and Sharma

also imply that homeostatic bingeing does not classify as BED because eating more regular, protein-rich meals will suffice to resolve it (2010:24). However, as Libby points out, this echoes the many people who "call the bingeing the problem" when in actuality people need to address the restricting, or "the diet mentality." The issue goes further than stomach-deep; giving Suzann a new rigidly defined way of eating would not encourage her to eat intuitively, nor would it address the anxiety driving the schema that has made her negotiate her food intake in pursuit of safety.

Eating disorders have only a tangential connection with body weight. Some carry the weight of the world on their shoulders; anorectics, bulimics, and binge eaters feel the weight of the world in their bodies, regardless of their actual body weight. How much they weigh depends in part on their interpretation of this second-course schema—whether it makes them reach for a few vegetables or for a whole bag of candy. The finding of Hudson et al. associating lifetime AN and low current BMI contrasts with that associating BED and current severe obesity (2007:353). The scale measures weight but not weight concern, with which Korie, Earl, and Suzann have all struggled. However, the DSM-IV does not support the view that AN, BN, and BED exist on the same spectrum because it isolates the latter in the EDNOS category. In addition, it does not include weight concern among the diagnostic criteria for BED, in contrast to those for AN and BN. This may explain why "binge eating receives little attention from primary care providers," according to Scott J. Crow et al. (2004:351). One giant impediment to BED screening stands in their way: obesity.

The phrase "obesity epidemic" evidences the conceptualization of obesity as a disease, Natalie Boero points out (2003). This label implies that fat people cannot possibly have become fat as a result of some other problem because it makes their fatness itself the problem. The exclusion of weight concern from the diagnostic criteria of BED, coupled with the view of obesity as a disease, hinders those following the biomedical model from overriding the larger cultural stereotype of particularly corpulent humans as guiltless gluttons. Even the Bible cautions against alimentary indulgence: "And put a knife to thy throat, if thou be a man given to appetite.

Be not desirous of his dainties: for they are deceitful meat" (Proverbs 23:2-3, KJV). The association of gluttony and immorality, which has a corollary in that of thinness and virtue, continues today: O'Connor and Van Esterik fall victim to their own observation that "contemporary culture moralizes eating" in calling the identity pursued in AN a "virtuous identity," despite their interviewees' description of "[t]heir restricted food intake" as "adventurous or even accidental" (2008:6-8). Influenced by the cultural connotations attached to food and body size, people may look at Suzann and think that she cleans out the fridge or the cabinets without a care in the world when in reality she thinks about weight as much as Korie or Earl: daily. In a study by Kathleen L. Eldredge and W. Stewart Agras, the obese participants who did not have an eating disorder demonstrated significantly less weight and shape concern than those with BED (1996:80).

The assumption that their bodies gave away where they fall on the eating disorder spectrum could explain why during the interviews, Korie, Earl, and Suzann seemed to avoid the name for their specific eating disorder like a bad word, instead using the umbrella term "eating disorder" or another phrase in a similar vein. Korie said that she had an "eating disorder" but did not specify which one. Only Earl ever mentioned "eating disorders" in the initial email correspondence, also specifying which ones have affected her, and only Suzann divulged what sort of eating issues she had in her interview. Suzann revealed the following in one email prior to her interview: "[F]or some reason, I feel compelled to mention, I'm not thin. I'm actually considered obese. Weird huh?" By contrast, the other two women did not feel compelled to mention their thinness, nor did they think it weird. Rather, Earl says, "It's weird to me that I'll be in a room where people are thinner than me." Perhaps the framing of obesity as a disease, coupled with the isolation of BED in the EDNOS category, has led to the perception that people who develop eating disorders have thin bodies. For example, in a case study reviewed by Daniel P. Hunt et al. in which a 27-year-old man with a history of obesity presented with fatigue, myalgias (muscle pain), weakness, loss of libido, and extreme weight loss but no lack of appetite, EDNOS

became the final diagnosis after the doctors tried via an exorbitant number of tests to explain the patient's problem as some sort of exotic physiological issue (2012:157, 168). His maleness also may have affected the diagnosis.

Meanwhile, on the thin side of the spectrum, in an article on her path to discovering that she had an eating disorder, Cole Kazdin writes the following about her body: "I was average, athletic-looking. But the feeling was fat. Gross, horrible, unspeakable" (2013:5). Korie uses similar words: "[I]n the morning if I feel like I'm gross or whatever," she says, "…it definitely, definitely affects everything that I eat for the day." For Korie as well, how she feels about her body matters and does not necessarily reflect her perception of her body shape outside of these feelings. Earl echoes these women: At times, she says, "I feel gross, I feel heavy, and it tends to be very connected to how I'm doing emotionally." Earl stresses that she experiences a *feeling* of fat:

> I know that when I eat food, whether it's carrots or a cookie, I have anxiety, and the way I experience that anxiety is in my body. I have this going on internally when I eat. Some people with eating disorders truly have body dysmorphia and think they're fat when they're not. I didn't have that. Even though I'll say that I feel fat, I know I'm not fat. The food is connected in that it causes anxiety.

Earl's feeling of fat comes from anxiety. Her assertion that "some people truly have body dysmorphia" may actually reflect the persistence of distorted body image as a diagnostic criterion for AN and BN despite the emergence of contradictory evidence as early as the 1990s: In the first meta-analysis of extant research on body-image and eating disorders, Thomas F. Cash and Edwin A. Deagle III found that with respect to body-image assessments, "attitudinal measures produced significantly larger effects" than "perceptual size estimation (i.e. distortion)" and "that bulimic and anorexic groups did not significantly differ from one another in their perceptual distortion relative to controls" (1997:113-114).

This highlights a main problem with classifying eating disorders as mental health illnesses. Call her crazy (after all, she does have a mental health illness, some would say), but Earl can sit down calmly, or as calmly as an anxious person can, and tell someone her thoughts

about eating in addition to which of those thoughts she knows not to have any grounding in reality. She knows that feeling fat does not make her fat. Can schizophrenics separate these two spheres, the seemingly real from the actually real? Maybe they can—with pharmaceutical assistance. But Earl's ability to make this distinction suggests some sort of underlying, subconscious process that caused her to choose not to eat, which she says she did: "For me there was a point when I made a choice not to eat." Neuroscience can explain the significance of this wording. It also informs schema theory in that cultural understandings, which can develop into schemas, rest on neuronal connections not easily broken, leading to their durability (Strauss and Quinn 1997:90). At a lecture in Portland, neuroscientist David Eagleman (2012) described the neural "battle" that occurs beneath our consciousness during the decision-making process. We have many input channels acting like a "multiplicity of selves" but only one output channel. As unsettling as it sounds, the unconscious brain drives decision-making. This begs the question, what the heck is the brain thinking in developing an eating disorder? Why did Earl's brain decide not to eat and why does applying one's anxiety to food seem like an out?

Uncovering the answers requires delving into the unconscious of someone with an eating disorder, or, for lack of the science and tools to do so, at least hypothesizing what it may entail. There one might find an input channel that contributes to the neural battle, offering the apparent wisdom that anxiety comes from ambiguity, or not knowing when and why it will strike. The appropriate combination of environmental and genetic ingredients creates the recipe for an eating disorder: an attempt to create a known, consistent outlet for anxiety. As Korie says, "We have to eat!" Unfortunately, the attempt to systematize and regularize anxiety by expressing it during the inevitable, necessary intake of food succeeds *too* well. Systematized and regularized anxiety becomes precisely that: It faithfully pays a visit any time Korie, Earl, and Suzann even think about food.

This schema therefore turns food into an obsession with finding a clearly defined, unambiguous way of eating—a way of eating that makes Korie, Earl, and Suzann feel safe.

Suzann's description of her response to hunger illustrates this: "I think that that's where the…food thoughts come in, the…obsession." She uses this same word in describing her hope for what her future relationship with food will entail: "I guess most of all not an obsession with food." Korie offers a similar vision: "I hope that it will be less obsessive, like I can sit with food well and that I don't constantly try and compensate for things that I've eaten." Earl's food-related thoughts can interfere with her social interactions: "I enjoy people and am able to be fully present, but I can be preoccupied," she says. The woman interviewed by Shohet also describes having an "'obsession'" with food (2007:359). Korb recalls, "my obsession grew worse" (2007:86). The final question of the SCOFF Questionnaire, a biomedical tool used for identifying AN and BN whose acronym comes from the first letter of the all-caps word in each of its five questions, asks, "Would you say that FOOD dominates your life?" (Attia 2011:ITC4-3). Although this shows awareness of the obsession that food becomes for people with AN and BN, it does not recognize that people with BED also become obsessed with food or that this obsession comes from fear.

Not only does food become an obsession, but eating it also becomes a secret. Korb recalls: "[E]ating had become an almost entirely private ritual—as embarrassing and holy, I guess, as weighing myself every day…I so often refused to eat with people" (2007:87). Both Korie and Earl do not eat that much during the day. "I usually don't eat a lot for lunch," Korie says. She can eat with other people, but afterward she sometimes purges—in secret. Earl says, "I restrict a lot during the day." Her minimal daytime consumption stems from how she feels when eating in front of people: "I get embarrassed when people see me eating…People often feel compelled to comment on what I eat. I don't know if it's because I eat weird things; I eat lots of vegetables." Sometimes Earl binges and purges in the evenings—when her coworkers cannot see her. When asked if she feels isolated or weird at all when eating with other people, Suzann replied: "Most of the time I'm not with other people…when I'm eating."

Denial goes hand in hand with secrecy. Korie, Earl, and Suzann all initially denied that they had an eating disorder. Suzann found out that she needed eating disorder treatment through taking a quiz that she happened upon while searching for another diet. Earl's parents brought her in for treatment, a not uncommon story for those with AN. Katherine A. Halmi, MD, writes that family members concerned about weight loss typically bring in patients with AN (1998:1994). Individuals with AN who decide on their own that they need to see a doctor usually do so to address nonspecific complaints such as weakness, dizziness, and lack of energy (Halmi 1998:1994). Korie, for example, did not seek eating disorder treatment until her therapist whom she saw for other reasons suggested that she do so: "I was very hesitant to even admit anything until six months into therapy," she says. The responsibility of recognizing certain general complaints as symptoms of starvation or eating disorder psychopathology often lies in the hands of healthcare providers. However, in a study by J. G. Johnson et al., the percentage of patients recognized as having an eating disorder by their clinicians came to just nine, in a sample size of 268 patients with eating disorders (2001:1462). This broke down to 10 percent of the patients with BED and less than three percent of the patients with BN (Johnson et al. 2001:1462).

This denial may in part account for why against the backdrop of overdiagnosis in a medicalized world enumerated by Dr. H. Gilbert Welch et al. (2011), eating disorders often go unrecognized by physicians. The biomedical model recognizes that AN and BN "patients commonly deny or underreport the symptoms of an eating disorder" (Attia 2011:ITC4-2). According to Cynthia M. Bulik et al., "experiencing…denial" affects BED patients as well (2007:147). However, biomedicine attributes the denial associated with these conditions to the mental pathology of an eating disorder (or an EDNOS), seeing it merely as a diagnostic criterion in the case of AN without uncovering what it intends to deny. Korie says, "[D]enial: It works well." Like secrecy, it works well at maintaining the obsession with food that derives from the intention to find a way of eating that does not engender anxiety—a very valuable goal according

to the schemas that Korie, Earl, and Suzann have. Not many people want to hear that their way of coping with anxiety has developed into a whole different problem.

The secrecy and denial exhibited by people with eating disorders along the whole spectrum indicates a similar line of thinking. They hide their eating habits because they have invested in them as a way of alleviating their anxiety and do not want others to interfere with their intent to find a way of eating that makes them feel safe. Kazdin writes, "I was in my own witness protection program, living…life under a new identity: 90-pound Cole" (2013:5). If another person witnesses an individual with an eating disorder eating, schemas could collide: People with eating disorders think of the behaviors that they keep secret as self-preserving—as a form of "protection," writes Kazdin (2013:5)—but on some level they know that the rest of the world thinks of these behaviors as destructive. According to Strauss and Quinn, "[N]egative social schemas can lead people to avoid interactions that might provide disconfirming evidence that would change their schemas" (1997:91).

This accounts for secret eating of any kind—bingeing or the consumption of a few carrots—and secret purging. It explains why Earl prefers not to eat in front of people even when she consumes mainly vegetables, typically yielding the not exactly horrible comment, "'Oh, you're so healthy,'" and why binge eaters binge in secret even though they tend to eat completely different, not-so-healthy things. Although Suzann does not directly say that she does this, she implies it in her admission that she typically eats alone and in one of the "food rules" that she has had in the past: not having candy in the house due to her fear that she would eat the whole bag in one sitting. Putting two and two together implies that she binges in secret. Albert Stunkard first described the condition now called BED as Night Eating Syndrome (NES), alluding to the secrecy of binge episodes: Nocturnal bingeing occurs while potential witnesses of the episode sleep.

American medical students, residents, and physicians work extra hard to keep their eating disorders secret, according to Betsy Bates Freed and show more resistance than others to

acknowledge that they need help (2012:1, 4). "'It takes so much energy to keep the secret,'" says Dr. Vicki Berkus, medical director of the eating disorders program at Sierra Tucson Treatment Center in Arizona (Freed 2012:4). A study of eating disorder prevalence among American medical students has not occurred since December 1985, showing the increased taboo nature of this topic in the medical community (Freed 2012:1, 4). This heightened incidence of eating disorders and exacerbated climate of secrecy may stem from the unfortunate truth that the traits such as "perfectionism…and anxiety'" putting one more at risk for developing an eating disorder also help aspiring doctors do well in medical school, says Dr. Jennifer L. Gaudiani, assistant medical director of the ACUTE Center for Eating Disorders at Denver Health (Freed 2012:4).

Through conservative words like "comorbidity" and "risk factor" that recognize merely an association of some kind between rigidly defined disorders, the biomedical language hinders those who speak it from realizing the integral role that anxiety plays in the development of an eating disorder. For example, Bulik et al. found that "childhood overanxious disorder represented a significantly elevated risk" for AN and BN (1997:105). In a different study comparing obese women with and without BED, Bulik et al. discovered an association between binge eating and "markedly higher lifetime rates of…any phobia" (2002:76).

While those operating within the biomedical model may have a vague notion of a relationship between anxiety and eating disorders, the language of their profession still distinguishes anxiety disorders from eating disorders and treats them separately. Thus, the use of anxiolytics (anti-anxiety medications) in the treatment of eating disorders has focused on behaviors surrounding eating: Judith M. E. Walsh, MD, MPH, et al. write that the utility of these medications with respect to AN lies in their treatment of "the fear of loss of control" and the "fear of weight gain" (2002:582). In addition, their administration occurs "before meals to reduce the anxiety associated with eating" (Walsh et al. 2002:582). This treatment model does not recognize that the anxiety surrounding food on which it focuses has developed as a way to cope with anxiety about life, supporting the common critique of biomedicine that it treats the symptoms but

not the underlying cause. Due to the inefficacy of the disease metaphor, classifying AN, BN, and BED as anxiety disorders rather than eating disorders would still not yield the necessary changes in the conceptualization of these conditions to make the biomedical model of eating disorder treatment stand on its own.

Third Course: Entrée (No Assistance Given During This Course—Wait Staff on Break)

As if anxiety about eating did not already give them enough trouble, Korie, Earl, and Suzann also express self-blame for having an eating disorder—or, prior to diagnosis, for having a strange relationship with food. This hints at the following schema:

I am to blame for how I eat; how I eat is my problem.

Referring to her eating disorder, Earl says, "It's really incorporated just into the way that I am." In the support group, she recalled, "I did feel like I'm the problem…and that was running through my head." This matches nearly exactly what another woman in the support group expressed. Here she will go by the name Bianca. She says, "You get stuck in, 'It's my problem. It's already burdensome.'" As a result, she adds, "I will not pick up the phone and say, 'I'm in a really, really bad place right now.'"

The sentence structure of the following quote from Suzann suggests that, like Earl and Bianca, she places responsibility for her relationship with food, and for fixing it, within herself: "I've spent a lot of time on…where it came from and trying to understand that, and I do find value in it because it…would help me to…change the thoughts in myself and the habits in myself." Suzann could have said that trying to understand how she developed her particular relationship with food would help change these thoughts and habits, but she inserted the direct object pronoun for first person singular, "me," making herself the agent of the sentence, the one who ultimately has acting power over her thoughts and habits.

All of the interviewees with eating disorders had a hard time answering the question about whether they think of their respective eating issues as a disease, possibly because of the

variable role that personal responsibility plays in different conditions. Suzann's response reveals her ambivalence:

> When I think of disease I think of diabetes or cancer or…something in the body so I think…even with…anxiety…when I started experiencing that and going to a doctor and doing research I would find that…it's the same as having diabetes, but it's just in a different part of the body…but …there's two different opposing sides, I guess. There's…the everyday people, who are culture or whatever, and then there's the medical community, and being from the medi—I mean the culture or the everyday person, I still have a hard time believing that…eating disorders are diseases but when I'm…doing that research about what the medical community thinks is a disease then I can see their points too, why they think that.

Interestingly, Suzann turns a question about whether she would call her eating issues a disease into an answer about whether anxiety classifies as a disease. Perhaps subconsciously she sees them as related. The ambivalence in her response may reflect the split in thinking between "the everyday person," with whom she identifies, and "the medical community," which has undoubtedly influenced how she thinks about her eating issues. She even has a Freudian slip in starting to refer to herself as a representative of the medical community. This suggests the failure of the disease metaphor to resonate with people who suffer from eating disorders.

As if to prove Suzann's point about the disconnect between biomedical thinking and that of the everyday person, Lucy, a representative of the medical community to which Suzann referred, readily classifies eating disorders as diseases but only those in the DSM. She does not recognize all "eating issues" as eating disorders:

> [I]f you're talking about something that has a clinical diagnosis of anorexia nervosa or bulimia nervosa or now even binge eating disorder because it's in the new DSM, do I want to categorize that as a disease? …[Y]es in terms of its access to treatment and…validating it as worthy of treatment. But when you say something like 'eating issues,' …it's so broad or so vague that a lot of people can have hang-ups or issues or irrational behaviors that don't fall into the diagnosis of an eating disorder.

Lucy's devotion to the biomedical paradigm narrows her conceptualizations of disease to those given in the DSM. She implies that she did not think of BED as a disease or even as an eating disorder until the proposal arose that it become one in the new DSM. While discussing the types of questions she asked as a counselor in the trials on BED by comparing them to those she might

ask in "a different population," Lucy distinguishes these populations based on the DSM definitions of their conditions: "The focus would be different but…if it's insomnia or depression or anxiety or binge eating, you're looking at…making some kind of a behavior change so you're gonna ask some very similar questions." In line with the stringent DSM categories, Lucy separates conditions such as anxiety and binge eating. This directly contrasts with Suzann's answer.

While Libby poses questions to patients with BED designed "to challenge…thoughts" that she describes as "unrealistic or irrational," the questions that Libby poses to her clients better reflect Korie, Earl, and Suzann's feeling that they developed eating disorders based on the way that they exist in the world—that it had a seemingly logical purpose, even if they do not name it. For example, Libby likes to ask: "At what age did you decide your body was a problem?" This reflects the self-blame that Korie, Earl, and Suzann feel regarding the way that they eat. It even uses the metaphorical language that these women use, describing their fear in terms of eating and by extension, their bodies. Because Libby works primarily with chronic dieters fed up with failing to lose weight or maintain weight loss, for most of her clients the feeling of discomfort with their bodies comes "generally from an outside source, whether it's a medical provider" or "kids at school," so she often rephrases the question as: "[A]t what age did you come to know your body was a problem?" She also likes to ask, "What else would you be thinking about if you weren't focused on your body right now?" Variants of "the ickiness of life" generally provide the answer. This further shows recognition of the metaphorical language that Korie, Earl, and Suzann use regarding eating.

Libby has found that the biomedical idiom does not allow her to express her clients' thinking and beliefs. For example, she would not use "the word 'disease'" to describe her clients' relationship with eating. She also hesitates to "use the word 'disorder'" because "even that puts people in a label." She elaborates:

> I do not like pathologizing people…Some of my clients have been in treatment for 20 years and…they've maybe weight-restored but they haven't healed. So there's a lot of debate in the eating disorder world about what is recovery, and if you say it's weight restoration and medical stability, I think we're leaving a lot of people unhealed. I find if…we're too into the disease model and the medical model…we show up with less curiosity and we don't treat people like individuals and…I just don't find that that is effective. I try to…be curious…with every client and…believe that the capacity and potential to change is within every…one of them and if we put them into these disease categories…I think we…simplify things too much and we don't meet their unique needs in the world.

Libby brings attention to a major consequence of the language barrier between patient and physician. Not only do people with eating disorders fault themselves for their eating behaviors while biomedicine calls eating disorders diseases, but they also differ from the biomedical model with respect to their definitions of recovery. Since the eighteenth century, writes Carlos J. Moreno Leguizamon, the biomedical "definition of 'health'" has "underlined material, physical and visible dimensions," including "the absence of illness in the body" (2005:3303). While the biomedical model may define Libby's clients who have maintained a healthy weight as recovered, they still feel that they need treatment. This adds to the feeling of self-blame that they foster for the way that they eat.

Earl has a notion of an eating disorder as "a mental health disease" but she does not feel that this applies to her own case. This notion could come from her work in the mental health field or from the biomedical treatment that she has experienced. It seems that the biomedical classification of eating disorders as mental health illnesses does not align with the personal responsibility that Earl feels for her eating disorder. As discussed earlier, she cannot forget that she decided not to eat. Korb also recognizes that he made this choice: of "deciding what I would and would not eat," he says (2007:85). Earl sees this choice as a "multidimensional" and "not necessarily physiological" phenomenon with "psychological" and "biological" components: "a disease in one sense" and "a really complex response to being alive" in another.

Earl elaborated on this in the support group, wondering if her eating disorder signifies a "pattern that's engrained" and describing a constant fear that life presents. "How do we live in

that fear?" she asks. "I deal with it usually with my eating disorder." In the support group she also debunked the theory that one stressful life event "triggers" an eating disorder in people who have a predisposition towards one. Rather, she said, "It's all triggering to me." This contrasts with Lucy's biomedical "protocol" of "identifying triggers." She said that because binge eating had arisen more recently in the adolescents with BED, in that trial she could "more easily…find the links back to the root cause." However, looking at what Earl said about life itself as triggering, one cannot write off as a coincidence the development of eating disorders during adolescence in many cases and the expansion of one's world in this "transitional time that intensifies the need to find and express one's identity" (O'Connor and Van Esterik 2008:8). This in itself can serve as a "trigger" for an eating disorder in people with anxiety. It explains why eating disorders tend to emerge in adolescence even though people who develop them have struggled with anxiety for years in many cases: During this phase of life, anxiety takes on a new existential flavor. Thus one could view an eating disorder as an attempt to alleviate anxiety about not having a clear purpose or role in life by defining one's identity through the way in which one eats.

The mythological structure of the AN recovery narratives analyzed by Garrett (1997:267) supports the connection between existential anxiety and eating disorders. In her study, "each participant's story contained echoes of archetypal myths about death and rebirth, initiation, salvation, and self-transformation" (1997:267-268). According to Claude Lévi-Strauss, "[M]yth grows spiral-wise until the intellectual impulse which has originated it is exhausted" (1955:197). As a structuralist, Lévi-Strauss takes interest in what myth *does*: It does not solve anything and may lack a clear moral or lesson, but it does allow people to worry through contradictions that make them uneasy until they exhaust themselves and have no choice but to put their anxiety to bed. In other words, myth alleviates existential anxiety. This sounds quite like the "goal" envisioned by the subconscious of Korie, Earl, and Suzann in deciding to adopt a maladaptive obsession with food.

The use of food to grapple with the meaning of existence makes sense in that humans need food to survive and when they do not eat properly, they put their lives in jeopardy. This aligns with Garrett's description of asceticism as "necessary confrontation with death" (1996:1501): self-denial in the sense of denying oneself the intake of sustenance conducive to survival, which can include restricting and bingeing. Binge eaters hear from their doctors the same mortality scare tactics as do anorectics and bulimics. While the bias in the biomedical world seeing cases of eating disorders resulting in emaciation as more urgent than those causing one to become overweight or obese has some grounding in physiology because the starved body has a greater chance of confronting death before the corpulent one, overweight or obese people with BED, like thin anorectics and bulimics, also have an increased risk of potentially fatal complications. In addition, Vernon R. Young and Nevin S. Serimshaw offer a review of rather unethical starvation studies revealing that "the body" accommodates "to prolonged starvation" (1971:14). Yet skinny people with eating disorders are often force fed while fat ones with eating disorders are not force not-fed, or forced to have their stomachs stapled, for example. Doctors confronted with cases of the latter may *highly recommend* dieting or weight loss surgery, but Boero notes that "fat people engaged in…weight-loss efforts don't see their fatness as a public health crisis so much as they experience it as an impediment to social acceptance" (2012:3). Garrett's more all-encompassing definition of asceticism in conjunction with the role of anxiety in myth may suggest that people with BED, like those with AN, embark on a "*spiritual quest*" or "pilgrimage" to fulfill "a hunger for meaning" (1996:1490-1491) that allows them to think about death, by bringing them closer, if not close, to it.

A study by Edward J. Schork et al. appears to challenge the idea that anxiety about an ambiguous existence drives anxiety about food: "[T]he near absence of psychopathological features" among recovered anorectics "questions the view that anorexia nervosa occurs in the context of an individual suffering from other psychiatric illness, such as…anxiety disorders" (1994:121). However, this finding could also give force to the interpretation of the anorectic

experience offered by Garrett: If AN recovery narratives reflect a mythological structure (1997:267) and myth serves the function of alleviating existential anxiety according to Lévi-Strauss (1955:197), the lack of anxiety symptoms following recovery from AN suggests that recovery comprises the final stage of a rite of passage initiated by AN. This interpretation reflects the sort of anthropological contextualizing called for by O'Connor and Van Esterik (2008:7) with respect to AN, but it may apply to BN and BED as well on the basis that similar anxious impulses influence the development of these conditions.

With this context, it makes sense that Earl does not buy into the etic biomedical and Freudian explanations for how eating disorders surface: "I used to envy people who were raped or sexually abused because I didn't have anything like that." Korie does not find explanations of this type appropriate either, including the theory emphasizing the influence of cultural ideals of beauty as represented by thin models: "I think with young girls, absolutely…it plays a role but I have a hard time blaming other things." Instead, Korie takes responsibility for how she eats: "I think it's a tendency. I have a tendency toward having an eating disorder just based on my personality."

Korie's response to the disease question further reveals her sense of personal responsibility: "I don't know. I don't think it's a disease necessarily. I don't know how to say it. Bad habit? No, I always think I can will my way out of it but I'm realizing I can't…It might be easier if I saw it as a disease." This last admission may mean that Korie feels as though seeing her eating disorder as a disease would possibly alleviate her self-blame for it. Placing the cause of disease in the genes can lead people to consider it out of their control, but because Korie does not see her eating disorder as a disease, she does not experience this sentiment:

> [I]t's more the way that I'm wired basically…but it's not necessarily…the family history or whatever, as useful as that is, but I feel like a lot of that sometimes becomes an excuse, where you're like, 'Well, this is what happened to my family and this is why I'm like this,' so…I take a lot of responsibility for it so I feel like I should be able to totally control it.

A dictionary reveals that "wiring" refers to a part of the body's physiology or neurology that determines or controls something such as a capability or disorder. For Korie, it contributes to both; her personality influences her eating disorder and her capability to take control of it. This segues into the final course on the schema menu.

Fourth Course: Dessert (Only One Helping)

The second question on the SCOFF Questionnaire in the eating disorder diagnostic process asks: "Do you worry you have lost CONTROL over how much you eat?" (Attia 2012:ITC4-3). To its credit, this question about control actually invokes a schema held by Korie, Earl, and Suzann:

How I eat is a locus of control.

When caught up in the eating disorder mindset, Korie, Earl, and Suzann link control and their consumption of food. The irony that food, usually the consumed, becomes the consumer of their lives and thoughts in their attempts to control their eating does not change their association between eating and control. For example, Suzann sees bingeing as a sign of losing control, which led her to put a taboo on candy: due to the fear "that I would lose control," she explains. Korie and Earl's inclination to purge represents a way of attempting to gain back control that they feel they lost through consuming food. Their restricting also shows a form of control that normal eaters do not exhibit. Korb describes his restricting as a form of control: "I had gone so far in controlling my diet" (2007:86). Kazdin has a similar view: "In treatment, the therapist told me there are things in life I might not always be able to control," she paraphrases, and then describes disagreeing, based on her diet of frozen grapes and cigarettes that sustained her for years (2013:5).

Korie started DBT when "it was a little less in control," where "it" refers to her eating behaviors. Also referring to her eating behaviors as "it," Earl says, "I try to be aware of what I'm doing and be honest with myself about it and when I'm not aware, that's when it tends to spiral

out of control." Similarly, Suzann, referring to her eating behaviors as "that," says, "I think it's hard to think back because I currently am more in control of that."

This schema does not require acceptance that one has an eating disorder. Even before Korie accepted this, she could sense that her attempt to control food had gotten out of control: "I figured something was probably off with my responses to food." This suggests that people with eating disorders can simultaneously feel the need to control food and also that this need has reached levels beyond their control.

Interpretation of Results: Taking "You Are What You Eat" to a Whole New Level

What good does it do to look at schemas about eating if eating disorders do not have their roots in this activity? It can show what eating represents in the minds of people with eating disorders. While struggling with AN, Korb says, "My mantra became the cliché 'We should eat to live, not live to eat'" but "this…meant I was still more or less scared to live" (2007:86-87). In other words, his fear of food came to symbolize his fear in life. Korie, Earl, and Suzann also connect eating to their very existence, but in slightly different ways depending on their eating behaviors. Korie says, "I judge myself basically on what I eat." Sometimes she also predetermines what she will eat based upon her judgment of herself, as revealed by how she manages her eating: "by how I feel about myself that day," she says.

In the support group, Earl said, "I'm such a self-critical person." She cannot separate her "feeling of inadequacy" from her "feeling of heaviness" or feeling of "fat," which comes from eating in a way that does not make her feel safe. For Earl, as for Korie, these feelings come from within. Suzann, on the other hand, feels that other people will judge her based on what she eats, as revealed by a story that she tells about a trip to the grocery store:

> [W]hen I got to the checkout, the person at the register was just kind of looking at the food and looking at me, looking at the food and looking at me, and then I got insecure like was she thinking I shouldn't eat this because a lot of, some of it was candy, or snack-type foods…? If I'm eating something that typically would be off of a diet, like not allowed on a diet, I get self-conscious.

The distinction between Korie and Earl's self-criticism based on their perceived inability to live up to their own standards versus Suzann's self-criticism based on her perceived inability to live up to social standards aligns with the findings of a study by Elizabeth M. Pratt et al. (2001) on types of perfectionism and eating disorders. They found a correlation between socially-prescribed perfectionism and several eating disorder measures important to BED, particularly self-esteem (Pratt et al. 2001:183). Self-oriented perfectionism, however, did not correlate with the eating disorder symptoms present in BED, but the control group of people without eating disorders scored significantly lower on self-oriented perfectionism than did the BN and BED groups (Pratt et al. 2001:183).

This generated the idea for an experiment involving the substitution of ontological words from the verb "to be" for those to do with eating in the schemas shared by Korie, Earl, and Suzann. The results of this experiment suggest a possible metaphor that their relationship with eating represents (Table 1). Lakoff and Johnson write that metaphor goes beyond the conceptual realm and has the capacity to "structure an everyday activity" (1980:124)—like eating, for Korie, Earl, and Suzann. They take apart the metaphor "ARGUMENT IS WAR" to explain how this works: "ARGUMENT is partially structured, understood, performed, and talked about in terms of WAR" (1980:124-125). In other words, "We can actually win or lose arguments" (Lakoff and Johnson 1980:124). Applying this logic to the schemas held by Korie, Earl, and Suzann, one could say that, for these women, EATING IS BEING. They talk about eating in terms of being, which for them is a state of fear. Thus, when they think about or eat food, they experience anxiety.

Table 1: A Possible Source of the Eating Disorder Schemas

Eating Disorder Schema	Ontological Schema
Eating is scary because it is ambiguous.	**Being is scary because it is ambiguous.**
There is a way I can eat that will make me feel safe.	**There is a way I can be that will make me feel safe.**
I am to blame for how I eat; how I eat is my problem.	**I am to blame for how I am; how I am is my problem.**
How I eat is a locus of control.	**How I am is a locus of control.**

Through the eating disorder schemas, anxiety about life in general becomes channeled into anxiety about eating. It does not matter that Korie, Earl, and Suzann act differently on the schemas and the metaphor that they share, because "the meaning of a metaphor may vary radically within a culture," depending on the entailment that one holds of the concepts involved (Lakoff and Johnson 1980:130). For all three women, the eating disorder schemas come out of the ontological ones in a subconscious attempt to reduce the prevalence of anxiety from the entire life sphere to that of eating. This supports the claim that "metaphor…unites reason and imagination" (Lakoff and Johnson 1980:134). The connection between food and self inherent in the metaphor EATING IS BEING also shows that developing an eating disorder represents an attempt to find identity, purpose, and meaning through food.

Conclusion: A Generous Helping of Holism, Intuition, and Love—Biomedicine Used Sparingly

Biomedicine, rooted in Cartesian dualism separating body and mind, cannot comprehend that a psychological process could override a physiological one: People with eating disorders, "in living a truth that Cartesian dualism denies, become patients that modern medicine doesn't know how to cure" (O'Connor and Van Esterik 2008:9). For this reason, contextualizing eating disorders through the "cultural brokering" method proposed by O'Connor and Van Esterik (2008:9) necessarily involves their demedicalization. While O'Connor and Van Esterik "set out to

contextualize anorexia," they ended up "demedicalizing the syndrome" because "in imposing this arbitrary Cartesian distinction, medicalization makes anorexia into a mental illness—the mind's war on the body" (2008:7). O'Connor and Van Esterik therefore do not endorse "isolating anorexics as abnormal" through medicalization because it makes eating disorders into "a total mystery" (2008:7), encouraging them to become acceptable identities. They see a need to "put the person back in context" (O'Connor and Van Esterik 2008:7).

The first step towards contextualizing eating disorders involves hearing the emic perspective. For example, O'Connor and Van Esterik attempted to look at AN according to how anorectics see it. This revealed a view of AN as "an intense mind-with-body activity" (O'Connor and Van Esterik 2008:7), illuminating the utility of Oriental medicine's holistic thinking in eating disorder treatment. It also showed AN as a misguided attempt to construct an identity (O'Connor and Van Esterik 2008:7). The anorectics in the study by Garrett (1996, 1997) described AN in a similar way: as a maladaptive rite of passage. Thus their recovery stories reflected "overcoming and transformation" and "continuing spiritual search" rather than the "static perfection" implied by the biomedical narrative of AN as a linear progression from diagnosis to recovery (Garrett 1997:270).

Recovery does not abolish the need for meaning or for a sense of identity, but entails a shift in the expression of these needs. Thus, while ritual behavior maintains AN, BN, and BED through secret eating, for example, it must also maintain recovery (Garrett 1997:268). By providing an externally imposed means of separating people with eating disorders from the other people at the table, however, the recovery rituals offered by the biomedical model such as meal plans and calorie counting increase the isolation that people with eating disorders already experience in their own secret eating. A complementary approach to eating disorder treatment could make up for this "absence of appropriate reincorporation rituals" in the biomedical model (Garrett 1996:1490). For example, Jean L. Kristeller and C. Brendan Hallett (1999) investigated the effects of different meditation practices on 18 obese women with BED. With six weeks of

meditation, the number of binges dropped significantly; "perceived levels of eating control, sense of mindfulness, and awareness of hunger…and satiety cues all increased significantly;" and anxiety fell significantly (Kristeller and Hallett 1999:361).

The second step in the contextualization of eating disorders involves investigating the cultural context in which they emerge. In the United States, this would reveal a culture that perceives obesity as a disease, a view perpetuated by biomedical discourse. It suggests that American culture itself has some kind of horrible disease if the majority of people who saw 5-foot-3 Kazdin in her size double zero dress told her she looked great: "99 percent of the people I saw and worked with every day told me I looked amazing and asked what my secret was" (2013:5). If she had revealed her "secret," they may have eaten their words: "Throwing up. Starving. Exercising compulsively" (Kazdin 2013:5). No one would ever ask Suzann to reveal her secret, even though she also eats secretly, because no one sees obesity as desirable. But emaciation—now *that* gets the positive attention, whereas Suzann receives judgmental stares. This bias affects eating disorder treatment as well. At an Academy of Eating Disorders conference that Libby attended, the very first slide in the Health at Every Size (HAES) lecture displayed an important message, she recalls: "'We are asking people with higher body weights to do the very things we are asking people with eating disorders to stop doing.'" In other words, Libby explains, "[W]e're asking fat people to weigh themselves obsessively, to track their calories obsessively, to keep food records, to exercise at Biggest Loser levels, eating-disordered levels of activity. These sorts of rituals maintain AN and BN, yet somehow the prevailing wisdom on weight loss suggests that they will help obese individuals who may have BED. How does this make sense?

Libby provides further evidence supporting the benefit of the demedicalization of eating disorders in that the biomedical model does not place emphasis on intuitive eating. It instead defines people's needs according to a generalized food pyramid with serving sizes and calorie counts. This means that eating disorder treatment involves meal plans based on the same

quantifying approach. In the trials on BED in which Lucy participated, "[E]verybody was doing food monitoring." In the support group, however, Earl's husband pointed out that this tactic turns those involved into a sort of "food police." None of the interviewees saw this approach as helpful. As Korie says, "I've got the calculator in my head already so, don't need that." Korie likes DBT because it gives her "guidelines" but "they avoid calories." Suzann describes feeling like a fish out of water upon release from the residential treatment center:

> [I]t was really hard for me to stick with the plan. They…sent me home with meal cards and copies of their menus and things like that and…I told them that, each time I was there, I told them, this still felt like a diet to me 'cause that's what it was all about, …meal plans. I mean the only difference was that we didn't focus on calories but there was still portions…and eating every couple of hours.

Suzann did not benefit from the advice that the dietician working in a hospital had to offer either: "I was already obsessing about food, and then I had someone obsessing right with me."

Earl finds Libby helpful because her approach does not rely so much on meal plans, focusing more on "emotions around food." For Libby, "using intuitive eating" means helping clients "connect with hunger and fullness cues and work on neutralizing food so that the apple is emotionally equivalent to the chocolate bar and then they get to just decide what it is they want." Libby says that this intuitive approach to eating needs to come before the nutritional advice, whereas biomedicine takes the opposite view, expecting people to make sense of eating based on abstract nutritional guidelines. "When I do get into nutrition," she says, "I tend to work with it from that perspective of being sustained." Libby practices what she preaches: Arriving for her interview at a bakery, she said something like, "Usually I'd go for a cookie, but for some reason that just doesn't sound good right now." Instead she went for a Perrier mineral water because she could feel that her body wanted it. The biomedical approach and the media have complicated food, separating it from its primary role as sustenance for the body and the brain.

The ontological and eating disorder schemas that Korie, Earl, and Suzann have point to the need to relearn not just intuitive eating but intuitive being, or being comfortable in one's own body and mind. Healthy rituals such as meditation can provide assistance in this regard: In their

study on meditation in obese women with BED, Kristeller and Hallett found it "likely that meditation contributed to becoming detached and non-critical toward the self, an aspect of mindfulness that appears important to the success of" eating disorder treatment (1999:362). Suzann has learned that in order to "become comfortable" with herself she has to abandon the attempt to diet. Korie and Earl also need to become comfortable with themselves, not just their bodies. While biomedical treatment addresses the symptoms of eating disorders such as body weight, eating disorder treatment must also address the schemas that have made people with eating disorders "lose" this intuition. In biomedicine, a diagnosis of an "eating disorder" focuses treatment on the realm of eating, missing the big picture of what anxiety about eating a whole bag of candy or a few vegetables represents—that it serves as a metaphor for a much greater anxiety about life in general. The family therapy that Earl does takes a different approach. It addresses her "self-criticism and anxiety" issues, she says, and "the way I am in the world." In other words, "The therapy we do is focused on that more than 'did you have breakfast today.'"

The biomedical model's "emphasis on recovery tends to isolate individual sufferers" (Ferreday 2003:285), causing it to backfire when dealing with people like Korie, Earl, and Suzann who foster self-criticism and self-blame for the way that they eat. The biomedical model of eating disorder "treatment increasingly centers on *creating the desire for health*" because "[i]mposed weight gain" (or weight loss) can increase patients' feelings that they lack "control of their own identities" (Gremillion 2002:392). Citing health as a reason to recover shows complete disregard for the meaning of the metaphor EATING IS BEING—that eating has taken on the anxiety of being, making one's existence revolve around food. Therefore this reasoning will not urge people with eating disorders to embrace recovery because they eat for safety, not survival. In the support group, Earl described herself as such a self-critical person that she even criticized herself for not recovering. She emphasized the importance of "letting go of recovery" as defined by the biomedical model, at least, echoed by Suzann's plea to "make food normal, make food—take away that obsession or that taboo-ness of it." Suzann has discovered that making food

normal involves reconnecting with hunger and fullness—with intuitive eating. This does not come in the form of meal plans or food rules like the one putting a taboo on candy, her groups have stressed: "[W]e focus on…keeping it in the house and knowing that it's always available but that I don't have to eat it all the time, and that part has really helped me." By contrast, the treatment program observed by Gremillion (2002) created rules for patients that only added to those they had already developed for themselves.

The groups in which Suzann participates also emphasize a different kind of scale from that used to measure weight: "They spend a lot of time talking to us about the hunger and fullness scale and so I did that for a little while," she explains, "…pay attention to how, what hunger feels like and then throughout the meal what levels I go on the scale." This works in conjunction with learning to trust oneself, Suzann says, and "that no food can be labeled bad or good, so it's a source of energy." In DBT, Korie also works on responding to her hunger: "[T]he goal is that I'm, it's kind of like, figuring out the hunger cues, which is incredibly challenging if you've ignored them for 10 years." She has found DBT especially helpful because it involves "a lot more accountability stuff." In other words, she can take control of how she eats, which needs to happen in order for her to rediscover intuitive eating. Because Korie, Earl, and Suzann see their eating behaviors as their problem and as a locus of their control, eating disorder treatment should let them take the reigns as much as possible. This does not mean that extremely emaciated individuals at risk of heart attack and other potentially fatal complications should not receive IV feeding. On the contrary, biomedicine's role in eating disorder treatment should consist of dealing with emergency cases. In non-urgent cases, however, weight gain (or weight loss) should involve intuitive eating and mindfulness exercises rather than meal plans that further mystify food even once people with eating disorders have reached a healthy weight.

Treatment must combine this degree of autonomy with healthy social interaction. Garrett found that in searching for life's meaning, people with AN ultimately discover it in the connections that the private rituals around their obsession with food prevented them from

maintaining. In contrast to the biomedical model, her interviewees defined recovery as the "reestablishment of these connections" that they feel they had "more or less lost during their anorexic period" (Garrett 1997:2006). Piper mentions the importance of "talking to people about…healthy ways to deal with…emotions…that they can turn to instead of eating disorder behavior" and one such way involves sharing problems with others. Support groups therefore need to also involve people who do not share the eating disorder schemas. For example, Earl's husband and Bianca's husband and mother also attended the support group in which these women participated. A number of other family members also attended, without the person in their family who has an eating disorder. The group's discussion did not focus on how many calories they had consumed that day, in contrast to the treatment program that Gremillion (2002) observed during her fieldwork. It focused on the sharing of problems by everyone, including the people who did not have eating disorders.

Through her own story, Kazdin expresses the importance of the role played by relationships with people in addressing an eating disorder: She reached her "moment of clarity" with her eating disorder through "falling in love" (2013:5). Kazdin writes, "Although we're often told that you can't love someone else until you love yourself…I couldn't love myself until I fell in love with someone else" (2013:5). Suzann describes her hopes for her relationship with food in terms of those for her relationships with people. "I would say…my future with food would be the same that I want in my personal life: more variety, more excitement," she says. Thus, recognizing that other people worry too, and that the world will not end if one eats a bit of fat or a lot of it, may help people with eating disorders tackle their obsession with food—to get over or give up the ontological schema that a certain way of being or a certain identity will make them feel safe. For this reason, Earl has found family therapy very helpful:

> [A]t some point with my eating disorder it became 'What is my life about?' because I came really close to death a few times, so I could ask myself, 'What do I want to be?' and for me it's about truth and experiencing love in relationships and a sense of being loved and loving, and renouncing all of the things that feel important…but aren't really important.

Normalizing food necessarily involves eating (and being) with loved ones who do not have eating disorders. This insight from Earl also further supports the metaphor connecting ontology and eating for people who have eating disorders; for Earl, recognizing that she has the ability to ask herself, "What do I want to eat?" like intuitive eaters do allows her to ask herself, "'What do I want to be?'" Hopefully, one day, these questions will not engender as much anxiety as they have in the past.

How does this happen? How do people like Korie, Earl, and Suzann learn to live with fear without leaning on their eating disorders? Kazdin (2013) may not have a universal answer, but she offers a source of hope. When she told the man with whom she had fallen in love that she had decided to seek treatment for her eating disorder, he told her that he shared everything in her life—the pain she feels and the issues she confronts. After this, Kazdin says, "For the first time in a long time, I felt safe" (2013:5).

Appendix A: Interview Questions for People with Eating Disorders

1) What pseudonym would you like to go by in the reported findings of this project?
2) How old are you?
3) How did you come to be affiliated with [CSHS]?
4) What aspect of your relationship with food did you need help with?
5) What sort of assistance have you sought in dealing with eating issues?
6) How much do you think about food?
7) How much do you think about weight?
8) How do you manage your eating (WHAT to eat, WHEN to eat, HOW MUCH to eat)?
9) Do you do certain things surrounding eating that you feel are unique to you?
10) How much does food contribute to your sense of body image?
11) Do you think of your eating issues as a disease and if not, how would you describe them?
12) How do you feel and act when you get really hungry?
13) What do you hope your future relationship with food will entail?

Appendix B: Interview Questions for Practitioners

1) What pseudonym would you like to go by in the reported findings of this project?
2) How old are you?
3) How did you come to be affiliated with [CSHS]?
4) How do you help people who have eating issues?
5) Do you think of eating issues as diseases and if not, how would you describe them?
6) Do you find value in trying to help people figure out the cause of their eating issues?
7) What sorts of questions do you ask people with eating issues?
8) When do you feel successful in counseling people with eating issues?

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