Reading for subsection 2 (*Nine Basic Affects: Drive Auxiliaries and Shame*):

Subject: ***Hunger/Disgust/Shame***
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To: Tomkins-Talk

Although some of our members have devoted the bulk of their careers to the study and treatment of eating disorders and surely know more, I've worked in therapy with quite a few such patients and have developed a number of working hypotheses that might spark some response from our group. Let's start with the conclusion: Save for the rare and poorly studied primary disorders of the firmware for the drive hunger, all of the clinical conditions lumped as eating disorders occur in people who have profound difficulties in understanding and managing innate affect, and who have learned to use the emotionality that normally surrounds eating as the basis for their management of all affect. Treatment aimed solely at limitation of disordered eating always fails, for it ignores the ideoaffective complexes for which the symptom pattern (script) had evolved.

The humorist James Thurber once wrote that normal is that which operates in accordance with its design," and our Tomkins-based concept of affect and drive leads to some pretty clear understandings of hunger. First of all, the normal drive is triggered by a reduction below some preset level in the amount of some nutrient needed by the organism. We experience this as a desire for some foodstuff; the drive-based desire initiates a search for that material and then tells us how to consume it. A drive tells the organism what it needs, when it needs it, and initiates consummatory behavior even when that organism is not capable of "knowing" any of the above.

Simply because hunger (for any nutrient) must begin at some level and rise, fall, or remain level at some density, hunger must trigger affect. In general, mild hunger triggers distress and extreme degrees of hunger trigger anguish—infants usually cry when they are hungry. When food is sensed by eye or nose, the onrush of stimuli often triggers interest-excitement. As Tomkins said, we are protected from possibly dangerous food by two built-in mechanisms, nose-based equipment for odor (most likely with programming based in the amygdala or nearby hypothalamic structures) preset to respond favorably to certain ranges of odorants and unfavorably (with dissmell) to others. An analogous mouth-based system analyzes soluble molecules on the basis of their taste (and certain insoluble substances on the basis of their shape), providing the disgust response to substances that fall outside an acceptable range of taste. Finally, when an individual begins to consume the substance for which hunger had been triggered, the drive signal stops. The cessation of this drive signal and the consequent associated decrease in the negative affects associated with that signal are competent triggers for the affect enjoyment-joy.

Already it should be clear that if an individual for whom the management of affect has become troubled does make a shift to a food-based system of affect management, dissmell and disgust must play a role far greater than that seen in normal life. Say, for instance, that the individual has experienced so much intrusion or impediment to otherwise normal interest-excitement that a shame-interest bind develops (a script that says every time interest is triggered, it will be blocked by shame, so don't bother getting interested in anything). If this sequence is translated to the hunger system, then it means that any food I eat will be awful for me, so I must remain in control of my intake at all costs. More often, in anorectic patients, we come to understand that control of food intake is a perfect analogue for control of affect; such translations from the affect system to the drive system are only brought into play when the affective environment of an individual has been simply awful and the parental empathic failures egregious. Psychotherapy with such patients, to me, always requires meticulous attention to affect triggered over a range from minute and barely discernible to the tornadic or volcanic. Only when the patient believes that the therapist is able to resonate with, experience therefore through empathy, and provide solace for affect, can the patient even begin to relinquish the icy control of oral intake that until then masquerades for affect control.

In those who are bulimic, then, I see another pattern. If you have never suffered an illness characterized by nausea and vomiting, then you can't know the feeling that comes on one when a spell of vomiting has ceased. It is a strange kind of quiet in which one is suffused with self-disgust, self-dissmell, and shame. In the post-emesis phase of the binge-and-purge cycle one has been emptied of backed-up affect — calm at the expense of self-esteem. I don't have time today for a fuller description of the affects involved in gorging, but I think I presented some of that in a late chapter of *Shame and Pride*. Empirically, most of us have found that bulimic patients do better (at least during certain phases of treatment) when the SSRIs can be used to quell some of the extraordinarily noxious degrees of disgust, dissmell, and shame that are found in this clinical family. In general, then, hunger acts as an analogue for interest-excitement, forced emesis as an analogue for shame as its impediment/inhibitor, and the full battery of thoughts and feelings associated with shame come into play as horrific determinants of one's identity. Any therapy that reduces pathological shame will help bulimic patients; any therapy that does not address shame is likely to produce superficial improvement in the patient's condition that leaves the patient vulnerable to recrudescence of symptoms (and consequent severe shame for failure).

This latter comment deserves some expansion: I do not believe that bulimia is a mortal sin, and discuss openly with patients that purging is a skill rather than a crime. When people are placed under terrible emotional pressure, the kind of affective overload that would make the strongest of us reach for more than one drink or more than one plate of ice cream/pizza or whatever is our favorite detour away from the steely-eyed determination to face all triggers for affect and solve the problem they present—when previously bulimic people are placed under such duress, they will eat in order to purge. Think of it as a system that you know and understand, Old Faithful, the quintessential transitional object, etc. If one of your patients goes through such a moment or period of lapse from control, do not address the lapse but do pay immediate attention to the affective overload for which the tried-and-true mechanism was brought into play.