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The Hunger Beyond Naming: Compulsive Eating, the Twelve Steps, Apophatic Theology, and the Neurobiology of Recovery

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ABSTRACT

Compulsive eating is increasingly described in the language of addiction, yet the construct remains contested. Most people with obesity do not meet food-addiction criteria, and many who do are not obese. This paper proposes that three vocabularies rarely brought together describe the same clinical phenomenon from complementary sides: the neurobiology of reward, the practical theology of the Twelve Steps, and the classical tradition of apophatic, or negative, theology.

The neurobiological literature shows how the gap between desire and satisfaction is exploited. It documents the dissociation of incentive "wanting" from hedonic "liking", striatal dopaminergic adaptation, the recruitment of stress systems in negative reinforcement, interoceptive confusion, and the reward-maximizing design of ultra-processed foods. Glucagon-like peptide-1 (GLP-1) receptor agonists can now quiet craving, but clinical experience suggests that patients are often left facing an unfamiliar silence that pharmacology cannot interpret.

The paper argues that compulsive eating is best understood as a disorder of closure: a compulsion to close the gap between desire and satisfaction. Apophatic theology is, by contrast, a discipline of the gap kept open. Drawing on Pseudo-Dionysius, Maimonides, Gregory of Nyssa's doctrine of unending desire, Wolfson's critique of theomania, and the Lurianic concept of *tzimtzum*, the Twelve Steps are read as an applied apophatic practice. Step One functions as an unsaying of the self; the formula "God as we understood Him" is a deliberate refusal to fix the divine in a concept; and recovery transforms desire rather than abolishing it.

A mapping of the Steps onto theological, neurobiological, and clinical registers is offered as a set of testable hypotheses rather than established mechanisms. Clinical cautions are addressed, including the risk that rigid abstinence models pose to patients with eating disorders, weight stigma, and the uneven evidence base for Overeaters Anonymous. The paper closes with practical recommendations for the consulting room.

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Introduction: The Patient at the Counter

Consider a composite patient, assembled from many and identifying none. She is fifty-two, a nurse, and she tells her physician: "I am never hungry, and I am never satisfied". She has dieted successfully many times; she has lost the same forty pounds three times over. Her eating is rarely a meal. It is a ritual performed late at night, standing at the kitchen counter, often without tasting what she eats. Last year her internist started a GLP-1 receptor agonist. The constant internal chatter about food, what patients now call "food noise", went quiet within weeks. And the silence frightened her. "I don't know what to do with the quiet", she said.

That sentence marks the place where the neurobiology

of appetite ends, and another kind of inquiry must begin. Contemporary pharmacology can now attenuate craving with a precision unimaginable a decade ago. It cannot tell the patient what the craving was carrying, nor what she is to do in the space it leaves behind. The present paper is an attempt to address that space. It argues that three vocabularies which rarely share a page are describing a single phenomenon from different sides, and that each supply what the others lack.

The first vocabulary is neurobiology. Over two decades, Volkow and colleagues have shown that obesity and substance addiction share overlapping circuitry in dopaminergic reward, prefrontal control, and the stress systems of the extended amygdala [1]. I have summarized that literature for an addiction

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audience elsewhere [2]. The second vocabulary is that of the Twelve Steps, which Ernest Kurtz, the historian of Alcoholics Anonymous, condensed into a single phrase: the recovering person discovers that he or she is "Not-God" [3]. The third vocabulary is apophatic theology, from the Greek *apophasis*, "unsaying". It is the tradition, shared in different forms by Jewish, Christian, and Islamic thought, that approaches the ultimate by negation, refusing to let any image or concept stand in for what it points toward.



The claim of this paper can be stated in a sentence. Compulsive eating is a hunger that has been given the wrong name, and recovery begins not when we find the right name for it, but when we stop naming it too quickly: when patient and clinician learn together to leave a space unfilled. This is a hermeneutic claim as much as a clinical one. It treats the patient's eating as a text that says more than it seems to say, in keeping with a broader program of reading the patient as a sacred text rather than a data set [4]. It is also an integrative claim. I have argued elsewhere that the twelve-step model and the classical medical model are not rivals but complementary grammars of the same suffering [5]. What follows extends that argument to the case of compulsive eating, and adds a third grammar, the apophatic, that neither of the others possesses.



The paper proceeds in stages. It first examines the contested status of "food addiction" as a construct. It then reviews the neurobiological evidence for a reward system that wants more in anticipation and registers less in receipt and considers what GLP-1 pharmacology does and does not accomplish. At the hinge of the argument, it proposes that compulsive eating is best described as a disorder of closure. It then turns to the apophatic tradition and reads the Twelve Steps as its practical application, with the Lurianic doctrine of *tzimtzum* supplying a model for the clinician's own restraint. It closes with a proposed integrative map, a set of clinical cautions, and recommendations for practice.

The Contested Construct: Food Addiction, Eating Addiction, and Stigma

Before any theological reading, the evidence deserves an honest accounting, because the addiction frame for eating is neither settled nor harmless. The most widely used instrument, the Yale Food Addiction Scale (YFAS), was developed by Gearhardt, Corbin, and Brownell to map the diagnostic criteria for substance dependence onto eating behavior: loss of control, persistent desire and failed attempts to cut down, continued use despite adverse consequences, tolerance, and withdrawal-like distress [6]. Its revision, YFAS 2.0, aligned the instrument with the eleven criteria of DSM-5 substance use disorder and added a severity gradient [7]. In a systematic review of YFAS studies, Pursey and colleagues found that roughly one in five participants across pooled samples met criteria for food addiction, with higher prevalence among those with overweight or obesity and among clinical samples [8].

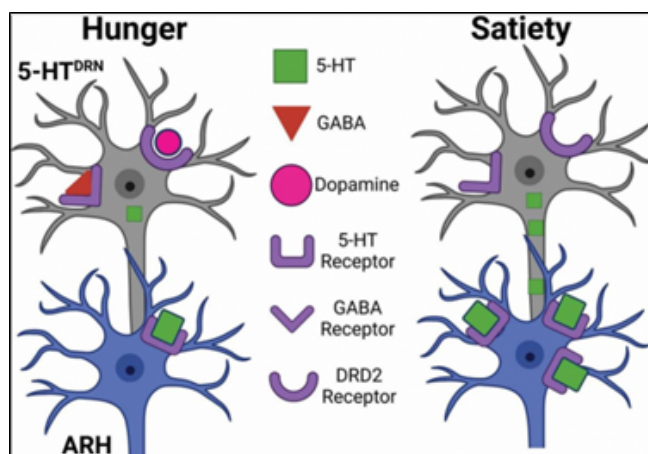
Those figures establish that something clinically real is being measured. They do not establish what it is. Three objections deserve careful attention.

The first is phenotypic. Obesity is a body size; food addiction, if it exists, is a behavioral syndrome that sometimes produces that body size and sometimes does not. Most people with obesity do not meet YFAS criteria, and a meaningful minority of those who do are of ordinary weight [8]. Ziauddeen, Farooqi, and Fletcher, in an influential critique, cautioned that the addiction model of obesity risks explaining too much: the neurobiological overlaps are real but partial, the human imaging findings are inconsistent, and the heterogeneity of obesity, with its strong genetic, metabolic, and environmental determinants, resists capture by any single behavioral model [9]. A clinician who equates a high body mass index with addiction commits a category error.

The second objection concerns the object of the addiction. Alcohol, opioids, and nicotine are discrete substances whose consumption is optional; food is necessary for life. Hebebrand and colleagues argued that there is little evidence for a specific substance in food that produces dependence in the way ethanol or morphine do, and proposed that "eating addiction", locating the problem in the behavior rather than in a nutrient, better captures the phenomenon [10]. This distinction matters therapeutically. A substance model points toward abstinence from the substance; a behavioral model points toward the restoration of a relationship to an activity one cannot give up.

The third objection is ethical and concerns stigma. Puhl and Heuer's review documented how pervasive weight bias is across employment, education, and health care, including among physicians, nurses, and dietitians [11]. An addiction label can cut both ways. It can relieve moral blame by relocating the problem in neurobiology rather than character. It can also stack a second stigma, that of the addict, on top of the first. Which effect predominates depends heavily on how the clinician speaks.

These objections do not dissolve the construct, but they do discipline it. In comparing substance and process addictions across treatment modalities, I have argued that compulsive behaviors share a final common pathway of loss of control despite harm, even when their objects differ [12]. I have also argued that the addiction debate reproduces, in secular form, an ancient theological argument between predestination and culpability, between illness and moral failure [13]. Neither pole is adequate on its own. The position taken in this paper is that the addiction model is a useful lens rather than a settled diagnosis. It illuminates a subset of patients, those whose eating has the phenomenology of compulsion, and it must be held with the same apophatic reserve the paper will later recommend for theological language: as a name that points toward something without claiming to contain it.



The neurobiology of a hunger that cannot close Wanting is not liking

The most clinically useful distinction in the neuroscience of appetite is the separation of "wanting" from "liking" developed by Robinson and Berridge. Their incentive-sensitization theory proposed that repeated drug exposure sensitizes the mesolimbic dopamine system that attributes incentive salience to reward-related cues, producing escalating craving that is dissociable from the pleasure the drug delivers [14]. In later work they refined the distinction [15]. Wanting is incentive salience: the dopaminergic tagging of cues as attractive and worth pursuing. It is what makes the refrigerator door luminous at eleven at night. Liking is the hedonic impact of a reward now of consumption, generated by small opioid and endocannabinoid "hotspots" in the nucleus accumbens shell and ventral pallidum.

The decisive finding is that the two systems dissociate. With repeated exposure, wanting can sensitize while liking does not, and may even decline [15]. This yields precisely the paradox the

composite patient voiced: never hungry, never satisfied. She is not pursuing pleasure; she reports little of it. She is pursuing a cue-triggered promise of satisfaction that the food itself no longer keeps. The phrase is worth holding, because it will return in theological form. An object that promises more than it can deliver, and is pursued for that promise, is what the prophetic tradition calls an idol.

A Reward System Reset by Repetition

Several lines of evidence suggest that the reward system of some people with obesity has adapted in ways reminiscent of substance dependence. Using positron emission tomography, Wang, Volkow, and colleagues found reduced striatal dopamine D2 receptor availability in individuals with severe obesity, inversely related to body mass index [16]. Johnson and Kenny gave rats extended access to a palatable "cafeteria" diet; the animals developed compulsive eating that persisted in the presence of a cue predicting punishment, their brain reward thresholds rose, and striatal D2 receptor expression fell; lentiviral knockdown of striatal D2 receptors accelerated the development of this reward deficit [17].

In humans, Stice and colleagues used functional imaging to show that a blunted striatal response to the consumption of a palatable milkshake was associated with future weight gain, particularly among carriers of the Taq1A A1 allele, which is associated with reduced D2 receptor density [18]. And Gearhardt and colleagues found that YFAS scores were associated with heightened activation in reward-related regions in anticipation of palatable food and with reduced lateral orbitofrontal activation during its consumption [19]. The composite picture is of a system that wants more in anticipation and registers less in receipt.

A caution is essential. These are correlational human studies and animal models. The direction of causality remains debated: reduced D2 availability may predispose to overeating, result from it, or both. Findings have not always replicated, and critics have noted that imaging patterns in obesity do not map neatly onto those in drug addiction [9]. The evidence supports a clinically recognizable pattern in a subset of patients, not a universal mechanism of obesity.

The Dark Side: Eating to Stop Feeling

Koob and Volkow describe addiction as a recurring three-stage cycle: binge and intoxication, withdrawal and negative affect, and preoccupation and anticipation, each with a characteristic neurocircuitry [20]. In the later stages of the cycle, what Koob has called the "dark side" of addiction, the brain's stress systems, including corticotropin-releasing factor and dynorphin in the extended amygdala, are recruited, and the behavior is increasingly driven by negative reinforcement: relief from dysphoria rather than pursuit of pleasure. Many patients with compulsive eating describe this shift explicitly. The eating has become anesthetic. It does not make them feel good; it makes them feel less.

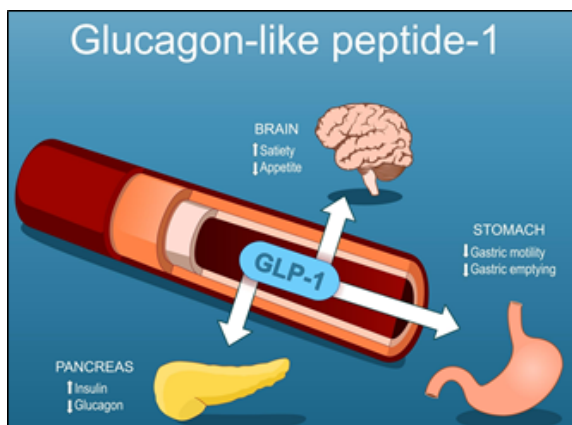
Here interoception becomes central. Craig's work placed the insular cortex at the heart of how we represent the physiological condition of the body, integrating signals of temperature, pain,

visceral state, and homeostatic need into a felt sense of the self [21]. Hunger, satiety, anxiety, loneliness, fatigue, and shame all arrive through overlapping interoceptive channels. A person trained over years to answer every bodily unease with food will come to misread the body systematically, experiencing an ache of grief or a surge of shame as a call to eat. I have argued that clinicians share a parallel vulnerability: our own interoceptive reactions to larger bodies shape clinical judgment in ways that are rarely examined and that contribute to unconscious bias [22].

The engineered object

It would be a serious error to locate the whole problem inside the patient. Hall and colleagues conducted an inpatient randomized crossover trial at the National Institutes of Health in which twenty adults were offered ultra-processed and minimally processed diets, matched for presented calories, sugar, fat, sodium, fiber, and macronutrients, for two weeks each, and allowed to eat as much as they wished. On the ultra-processed diet, participants consumed roughly five hundred additional kilocalories per day and gained weight; on the minimally processed diet they lost weight [23]. Schulte, Avena, and Gearhardt found that the foods most associated with addictive-like eating were highly processed foods combining added fats with refined carbohydrates and a high glycemic load, combinations that are rare in unprocessed foods [24].

These are objects engineered, deliberately or by commercial selection, to maximize wanting. To speak theologically, they are made to present themselves as more than they are. In earlier work bridging neural circuitry and what I have called intangible experience; I argued that neurobiological mechanism and meaning are not competing explanations but two descriptions of a single event [25]. The ultra-processed food is, on one description, a supernormal stimulus to the mesolimbic system. On another, it is a bade thing that promises fullness and cannot give it. Both descriptions are true, and the clinician needs both.



When the noise stops: GLP-1 agonists and the limits of pharmacological closure

GLP-1 receptor agonists have transformed obesity medicine, and interest is growing in their effects on reward beyond food. GLP-1 receptors are expressed in mesolimbic structures, and preclinical studies have long suggested that their activation attenuates the rewarding effects of alcohol and other drugs.

In a randomized, placebo-controlled trial in adults with alcohol use disorder, Hendershot and colleagues found that low-dose once-weekly semaglutide reduced laboratory alcohol self-administration and craving, along with some measures of real-world drinking, although not all drinking outcomes differed from placebo [26]. Patients taking these agents for weight loss frequently describe a quieting of intrusive thoughts about food. That report is so far largely clinical and anecdotal rather than systematically measured, and it should be treated as a hypothesis for study rather than an established effect.

These drugs deserve to be welcomed, and nothing in this paper argues against their use. But their success sharpens rather than resolves the question the composite patient raised. In a critical review of Anna Lembke's *Dopamine Nation*, I argued that a purely neurochemical account of recovery, however elegant, leaves the person's own question unanswered [27]. Lembke's model of a pleasure-pain balance, restored by abstinence and tolerance of discomfort, is clinically useful; it nonetheless treats the craving as noise to be reduced rather than as speech to be interpreted.

When the craving goes quiet, the patient meets what the craving was covering. For some, that is simply relief. For others, like the patient at the counter, it is an encounter with an empty space: the grief, loneliness, or unnamed longing that the eating had been answering. The clinical literature has little to say about this experience. The contemplative traditions have a great deal to say about empty space, and not all of it is bad news.



Compulsive eating as a disorder of closure

Here is the hinge of the argument. Neurobiologically, the wanting system is an apparatus for closing gaps: between cue and reward, between prediction and outcome, between a bodily state and its correction. In health, the gap opens and closes in rhythm. One becomes hungry, eats, and is satiated; the system rests. Compulsive eating is that apparatus running without a stopping rule. Every unease registers as a gap, and every gap demands the fastest available closure. Because liking has faded while wanting has sensitized [15], the closure never quite arrives, and the demand repeats.

Psychologically, the same pattern holds. The patient is attempting to close the distance between what she desires and

what she has, between who she is and who she feels she ought to be, between the ache she cannot name and a remedy she can reach with her hand. Food is the most available closure in the modern environment: cheap, legal, socially sanctioned, engineered for immediacy. The tragedy is not that she wants too much. It is that her wanting has been taught to accept a false object, one that closes the gap for a moment and reopens it wider.

Now consider the theological discipline this paper proposes to bring alongside the clinical one. Apophatic theology is, at its core, the refusal of premature closure. It will not allow any image, concept, or name to close the distance between the seeker and what is sought. It keeps the gap open, not as a punishment or a deprivation, but as the very place where relationship occurs. If that description is accurate, then apophatic theology is not decorative ornament on a clinical argument. It is a training, refined over fifteen centuries, in exactly the capacity that the compulsive eater has lost: the capacity to remain in the presence of an unclosed desire without collapsing it onto the nearest object.

This formulation has a practical corollary that runs throughout what follows. Treatments that aim solely at closing the gap by other means, whether through perfect dietary control, pharmacological suppression of appetite, or a rigid rule system, may reduce eating while leaving the underlying disorder of closure untouched. Treatments that help the patient tolerate and inhabit the gap address the disorder itself. The best clinical care, I will argue, does both.



The apophatic tradition: unsaying, silence, and unending desire
The apophatic tradition is vast, and only three of its teachers can be considered here. They are chosen because each contributes a distinct element to the clinical argument: the limit of concept, the dignity of silence, and the transformation of desire.

Pseudo-Dionysius: beyond affirmation and negation

The anonymous writer of the late fifth or early sixth century known as Pseudo-Dionysius the Areopagite gave the Christian West its vocabulary of negative theology. In the brief treatise *The Mystical Theology*, he describes the soul's ascent as a progressive stripping away of every concept, first the lower and then the higher, until it enters a "darkness" beyond understanding. His final move is the decisive one. The cause of all things, he writes, lies beyond not only every affirmation

but every negation as well [28]. The apophatic is not simply the replacement of positive statements with negative ones. It is the recognition that even our negations are concepts, and that what we seek exceeds them too.

For the clinician, the Dionysian lesson is epistemic modesty in the face of what the patient's hunger is about. Every formulation, whether "emotional eating," "reward deficiency," or "food addiction," is an affirmation that captures something and misses more. The clinician who holds formulations lightly, affirming and then unsaying them, stays closer to the patient than the one who has decided in advance what the hunger means.

Maimonides: negative attributes and silence as praise

In the *Guide of the Perplexed*, Maimonides argued that no positive attribute can be predicated of God without implying composition or comparison, and that the only legitimate theological language is negative: to say what God is not, and thereby to purify the mind of false images. The more negations one grasps, the nearer one draws to apprehension, while never arriving at a positive concept. He concludes the discussion by citing Psalm 65:2, *lekha dumiya tehillah*, "for You, silence is praise" [29]. Silence, in this reading, is not the absence of devotion but its most accurate form.

Maimonides gives the clinician a model of silence that is not empty. The composite patient experienced the quieting of food noise as a void. Maimonides would suggest that silence can be a mode of presence, even the highest one. That reframing does not come by argument; it comes by practice. But it is available, and the recovery traditions, as we shall see, have found practical ways to teach it.

Gregory of Nyssa: a theology of unending desire

Of all the apophatic writers, Gregory of Nyssa offers what may be the most clinically consequential idea. In *The Life of Moses*, he reads Moses' ascent of Sinai and his plea to see God's glory as an allegory of the soul's journey. Moses is granted to see God only from behind, and Gregory interprets this not as a refusal but as the form of the vision itself. To see God, he argues, is never to reach satiety in the desire to see. The soul is stretched forward endlessly, each attainment becoming the starting point for further desire, a movement later readers have called *epektasis* [30].

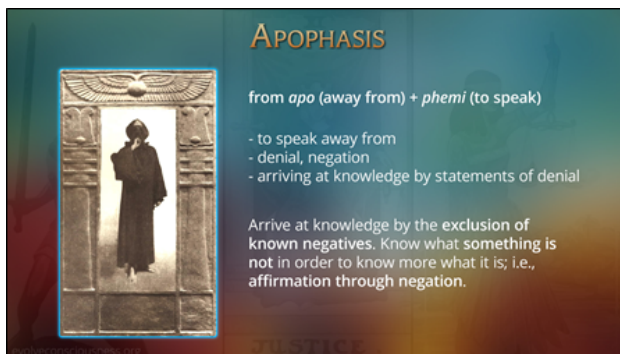
The radical feature of Gregory's theology is that unending desire is not frustration. It is participation. The gap between desire and its object is not a defect to be repaired but the very shape of the soul's relation to an infinite good. Gregory thus gives us something almost no medical model possesses: a theology of hunger that is not a pathology. The problem in compulsive eating, on this reading, is not that the patient hungers. It is that her hunger has been attached to an object finite enough to seem to close it, and so it never learns what it is for.

Apophasis and its counterfeit

Elliot Wolfson's work sharpens these classical sources for the present argument. Wolfson describes the religious temptation he calls "theomania": the compulsion to fix the divine in

an image, a name, or a doctrine that can be possessed and deployed [31]. Apophasis, for Wolfson, is the discipline that overcomes theomania, not by abolishing language about the divine but by keeping every such utterance open, provisional, and self-effacing. The structural parallel with compulsive eating is striking. Theomania and compulsion share a single form: the demand that a finite object deliver an infinite satisfaction, and the repetition that follows when it does not.

I have developed related arguments in two recent papers. The first proposes that not-knowing, uncertainty, and doubt are epistemic virtues in medicine as in religion, foundations for humility rather than failures of competence [32]. The second proposes a "third grammar" for the clinical encounter with suffering, one that neither explains suffering through theodicy nor dissolves it into archetype, but holds it in an open, unconsoling presence [33]. Both are apophatic in structure. Both bear directly on how a clinician might accompany a patient into the silence left by a quieted craving.



The Twelve Steps as applied apophasis

The Twelve Steps were not written by theologians, and their authors would likely have been bemused to find them read alongside Dionysius and Maimonides. Yet the Steps encode, in practical and democratic form, several of the central moves of the apophatic tradition. Overeaters Anonymous, founded in 1960, adapted the Steps of Alcoholics Anonymous with minimal alteration, substituting food for alcohol in Step One [34]. The reading that follows applies to that adaptation.

Step One: apophatic anthropology

Step One reads, in the Overeaters Anonymous form: "We admitted we were powerless over food, that our lives had become unmanageable". Before any statement about God, the Steps begin with a negation about the self. This is apophatic anthropology: an unsaying of the self's claim to be the one who can close the gap. Kurtz's title, *Not-God*, names the move precisely [3]. The recovering person does not first discover who God is. She first discovers who she is not.

Gregory Bateson, in a remarkable 1971 paper, offered a cybernetic account of why this admission is therapeutic rather than defeatist [35]. The drinker's attempt at sobriety, Bateson argued, is structured as a symmetrical contest with the bottle, a battle of wills in which the self-imagines it stands outside the system it is caught in. Each victory invites the next challenge. "Hitting bottom" is not a moral collapse but an epistemological

correction: the self-stops imagining it is the controller of a system of which it is in fact a part and enters a complementary relationship with something larger than itself. Bateson regarded this shift as more accurate, not merely more comforting.

Psychological research supplies a mechanism. Wegner's work on ironic processes of mental control showed that effortful attempts to suppress a thought can make it return more frequently, particularly under cognitive load or stress, because the monitoring process that searches for failures of suppression keeps the unwanted content primed [36]. A patient who relies on willpower alone to banish thoughts of food may be feeding the very preoccupation she is fighting. Clinically, this should make us wary of prescribing willpower as the whole treatment. I have argued that addiction occupies the boundary at which the language of free choice becomes inadequate, not because the patient lacks agency, but because agency itself has been reorganized by the compulsion [37]. Step One is not defeat. It is the end of a false theology of the self.

Steps Two and Three: a name held open

Steps Two and Three introduce the most theologically interesting phrase in the recovery literature: "God as we understood Him." Critics have read the phrase as vagueness or as a concession to pluralism. I read it as apophatic reserve. The Steps decline to define the Higher Power, and that refusal is precisely what allows an atheist, an Orthodox Jew, and a lapsed Catholic to sit in the same room and work the same program. The Higher Power is named, but its name is held open, and the individual's understanding is expected to change over time.

I have argued that Step Two, "came to believe that a Power greater than ourselves could restore us to sanity," can be practiced in a post-belief world precisely because it asks for openness rather than doctrine [38]. I have also argued that recovery theology must hold divine transcendence and immanence in tension rather than collapse one into the other, since each collapse produces its own pathology [39]. A purely transcendent Higher Power becomes distant and punitive; a purely immanent one becomes indistinguishable from the self. In Hasidic terms, I have proposed that the *yechida*, the innermost point of the soul in which the individual and the divine are not two, offers one way of speaking about a Higher Power that is neither external object nor mere projection [40]. And I have traced parallels between the Steps and the graded spiritual discipline of Ramchal's *Mesillat Yesharim*, in which moral and spiritual progress is similarly understood as a sequence of practices rather than a single conversion [41].

Wolfson's warning about theomania [31] identifies the danger on the other side. A Higher Power that is too well understood becomes an idol. And here the clinical turn is unavoidable. The compulsive food is a god too well understood. It is always available, it always answers, and it is never enough. Recovery, on this reading, replaces a god who answers too quickly with one who is allowed to remain partly unknown.

Steps Four through Ten: honesty about the idol

The inventory steps ask the recovering person to examine resentments, fears, and patterns of harm, to disclose them

to another person, and to make amends. In the context of compulsive eating, a central task of the inventory is to identify what food has been asked to do: soothe, reward, numb, punish, or keep company. This is, in apophatic terms, the unmasking of the idol. It is also, in neurobiological terms, the mapping of the cues and internal states that trigger incentive salience. Both descriptions point to the same clinical work.

Step Eleven: silence as practice

Step Eleven prescribes "prayer and meditation" to improve conscious contact with the Higher Power "as we understood Him." This is the Step at which the Maimonidean teaching that silence is praise becomes a practice. For the compulsive eater, meditation offers repeated, low-stakes rehearsal in remaining with an unresolved state: an urge noticed and not obeyed, an interoceptive signal attended to rather than answered. Whether contemplative practice alters craving through identifiable neural mechanisms remains a question for research. That it offers the patient a way of inhabiting the gap rather than fleeing it is the claim of the tradition and the testimony of many in recovery.

Desire transformed, not abolished

The great danger of any recovery language is that it becomes a program of desire-suppression, and people with compulsive eating have usually spent their lives in such programs. Gregory's theology of unending desire offers a different path: desire that is not abolished but redirected toward an object that, by its nature, never closes [30]. Jung said something similar in his 1961 letter to Bill Wilson, co-founder of Alcoholics Anonymous. He described the alcoholic's craving as the equivalent, at a low level, of the spiritual thirst of our being for wholeness, and he offered the formula *spiritus contra spiritum*: spirit set against spirit [42].

In recent work on the theology of recovery, I have argued that the higher object toward which desire turns must remain irreducibly double: neither a personal voice that answers every request nor an impersonal ground that absorbs the self [43]. I have likewise argued, with a Hasidic image, that the heart cannot reach the spring it longs for, and that this impossibility is normative rather than tragic, since a heart that reached the spring would cease to be a heart [44]. And I have traced a relational theology that runs from Hasidism through the Twelve Steps to the bedside, in which the divine is encountered neither as object nor as abyss but in the relation itself [45]. The implication for compulsive eating is direct. The gap is not the disease. The demand to close it, at once and with a finite object, is.



Tzimtzum and the clinician's restraint

The Jewish mystical tradition gives the apophatic insight a cosmological form. In the Kabbalah of Isaac Luria, as Scholem reconstructed it, creation begins not with emanation but with withdrawal: the Infinite, *Ein Sof*, contracts itself, *tzimtzum*, to make room for a world that is not itself [46]. The resulting empty space, the *chalal* or *makom*, is not a mere deprivation. It is the condition under which anything other than the Infinite can exist at all, and therefore the condition of any relationship between the divine and what is not divine.

I have developed the clinical implications of this doctrine in several papers. The *tzimtzum* model distinguishes an epistemological reading of the clinical encounter, in which the clinician's task is to know the patient, from an ontological one, in which the clinician's task is to make room for the patient to be [47]. The *makom*, the place opened by divine withdrawal, can be read as the therapeutic space itself, a space that exists only because someone has declined to fill it [48]. And I have argued that surrender, in the recovery literature, is best understood as an ontological revelation rather than a behavioral concession: the self does not lose itself in surrender but discovers its actual place in a larger order [49].

For the patient with compulsive eating, *tzimtzum* reframes the silence left by a quieted craving. The empty space is not the absence of help; it may be the precondition of it. But the doctrine applies with equal force to the clinician. When the composite patient's food noise went quiet, the natural impulse of every professional around her, the author's included, was to fill her silence at once: a new meal plan, another medication adjustment, a tidy psychiatric formulation. Each of these may have been appropriate. Yet each also risked repeating, on the professional side, the very disorder of closure the patient was trying to leave behind.

I have described the clinician's corresponding discipline as self-kenosis: a deliberate contraction of the clinician's own need to know, fix, and explain, to make room for the patient's own meaning to emerge [50]. This is not therapeutic passivity. It is an active restraint, sustained against the pressure of time, protocol, and the clinician's discomfort with an unsolved problem. The therapeutic task, in this model, is to accompany the patient into the space the craving leaves, without rushing to furnish it.

An integrative map and a research agenda

The argument so far can be consolidated in a single table that reads each Step across three registers: the theological move it makes, a proposed neurobiological reading, and a corresponding clinical practice.

The caveat in the table's legend is essential and should not be softened. The middle column is a set of hypotheses about how the practices of recovery might engage the mechanisms reviewed in Section 3. None has been established. Yet each is testable, and together they suggest a research agenda.

First, studies of patients treated with GLP-1 receptor agonists could characterize the experience of reduced food preoccupation systematically, using validated measures of craving, affect, and

meaning, and could ask whether patients who report distress at the "silence" benefit from structured psychological or mutual-help support. Second, prospective studies of Overeaters Anonymous and twelve-step facilitation for compulsive eating could test whether changes in YFAS scores are mediated by the constructs the Steps emphasize, such as acceptance of limited control, spiritual or existential meaning, and social affiliation. Third, experimental work could test whether contemplative training specifically reduces cue-reactivity to palatable food, and whether any such effect is associated with changes in interoceptive accuracy or insular function. Fourth, qualitative research could explore how patients themselves understand the relationship between their eating and their longing, since the patient's own interpretation is not a confound in this model but part of the phenomenon under study.

The map also has value independent of its empirical confirmation. It gives the psychiatrist, the internist, the therapist, and the sponsor a shared vocabulary. The same patient may hear about incentive salience in one office, about a Higher Power in a church basement, and about her relationship with her mother in a third setting. An integrated frame allows these conversations to reinforce rather than contradict one another.

Clinical cautions

An argument that joins neurobiology to theology invites enthusiasm, and enthusiasm in clinical matters requires restraint.

Table 1: The Twelve Steps read across theological, neurobiological, and clinical registers. The neurobiological column states proposed correspondences for research, not established mechanisms.

Step	Theological move	Proposed neurobiological reading
1	Apophatic anthropology: "I am not God"	Top-down prefrontal control alone is insufficient against sensitized incentive salience; effortful suppression may rebound
2-3	A name held open: "as we understood Him"	Shift from effortful self-control toward relational and social regulation of affect
4-10	Honesty about the idol	Identification of cues and internal states that trigger wanting
11	Silence as praise	Rehearsal in tolerating unresolved wanting; interoceptive attention
12	Desire turned outward	Social reward and belonging as competing reinforcers

Four cautions are essential.

Eating disorders: Some Overeaters Anonymous groups and related fellowships define abstinence through rigid food rules: the elimination of specified foods, weighed and measured portions, or fixed meal schedules. For a patient with binge eating disorder alone, structure of this kind may be helpful. For a patient with a history of restriction, purging, or anorexia nervosa, it can reinforce the disorder under the banner of recovery. The same apophatic logic that this paper commends, the refusal to let any single rule close the question, applies here with force. Before recommending any abstinence-based program, clinicians should screen for restrictive and compensatory behaviors and, where they are present, coordinate with eating-disorder specialists.

Weight is not a diagnosis: The addiction frame should be applied to behavior and suffering, not to body size. A patient with a high

body mass index who eats without loss of control does not have food addiction, and a patient of ordinary weight who does may be overlooked. Weight stigma is pervasive in health care [11], and clinicians should be wary of adding moral weight to physical weight. I have written about the ways shame in medical settings obstructs healing, and about the use of recovery principles to replace shame with dignity [51]. Language matters. "Compulsive eating" and "loss of control" describe experience; "food addict" risks describing a person.

The evidence base is uneven: For alcohol use disorder, the evidence for twelve-step approaches is now substantial. The 2020 Cochrane review by Kelly, Humphreys, and Ferri found that manualized Alcoholics Anonymous and twelve-step facilitation interventions performed at least as well as, and on continuous abstinence often better than, established treatments such as cognitive behavioral therapy [52]. For Overeaters Anonymous, the evidence is far thinner. Qualitative work, such as that of Russell-Mayhew, von Ranson, and Masson, suggests that members experience the fellowship as helpful for physical, emotional, social, and spiritual well-being [53], but controlled outcome data are sparse. Clinicians should present Overeaters Anonymous as one option among several, not as an established treatment.

Integration, not replacement: The Steps complement medical, nutritional, and psychological care; they do not replace them [5]. Pharmacotherapy, including GLP-1 receptor agonists where indicated, evidence-based psychotherapies such as cognitive behavioral therapy for binge eating, treatment of comorbid depression, anxiety, and trauma, and attention to sleep, pain, and social circumstances all remain the foundation of care. The contribution of the apophatic and twelve-step frames is to address a dimension of the patient's experience, meaning, longing, and the capacity to tolerate an open question, that these other treatments do not typically reach.

Implications for practice

What does this framework change in the consulting room? Six practices follow from the argument.

- 1. Ask what the food is carrying.** Before discussing diet or medication, ask what eating does for the patient soothes, rewards, numbs, punishes, keeps company, fills time. Naming the function before the food shifts the conversation from the object to the gap it has been asked to close.
- 2. Separate wanting from liking.** Ask the patient whether the last bite was enjoyed. Many discover, sometimes with surprise, that it was not. That discovery, which puts the incentive-sensitization model into the patient's own words, is often the first crack in the compulsion.
- 3. Leave the silence open.** When medication or abstinence quiets the craving, explore that space before filling it. Ask what the patient notices in the quiet, what feelings have become more audible, and what she might want if food were no longer the answer.
- 4. Hold the name open.** Where the patient is open to it, invite reflection on a higher power or source of meaning without defining it. Respect unbelief as fully as faith. The formula "as you understand it" is itself a clinical tool.
- 5. Refer to community, with screening.** Offer twelve-step or

other mutual-help groups as one option among several, after screening for restrictive and compensatory eating-disorder behaviors.

6. **Examine yourself.** Clinicians' reactions to bodies, to hunger, and to relapse enter the room whether invited or not. The discipline of self-contraction applies first to the clinician's own need for closure.

These practices share a stance more than a technique. I have elsewhere described the Serenity Prayer, with its distinction between what can be changed and what must be accepted, as a clinical framework for patients confronting catastrophic illness [54]. The same distinction applies here. Some of the patient's hunger can and should be changed: by medication, by structure, by the reduction of ultra-processed foods in her environment. Some of it is not a problem to be solved but a dimension of being human, and the clinician's task there is not to fix it but to help the patient carry it without collapsing it onto food.



Conclusion: for you, silence is praise

Maimonides ends his discussion of divine attributes with the Psalm: *lekha dumiya tehillah*, for You, silence is praise [29]. The composite patient with whom this paper began was frightened by the quiet when the food noise stopped. Over the following months, with a great deal of help, in a group, with a sponsor, and in therapy, she came to experience that silence differently: not as an emptiness to be feared but as a space that could be inhabited. She still wants. She will always want. Gregory of Nyssa would say that her wanting is her dignity, not her disease. What changed is that her wanting no longer must close on a plate.

This paper has argued that three vocabularies illuminate one hunger. Neurobiology shows how the gap between desire and satisfaction is hijacked: how wanting outruns liking, how the reward system adapts under repetition, how eating becomes a means of stopping feeling, and how the modern food environment is engineered to exploit all three. The Twelve Steps show how ordinary people have learned, in practice, to live within that gap: by admitting the limits of the self, by holding the name of the higher power open, by examining the idol, by practicing silence, and by turning desire outward toward others. Apophatic theology tells us why the gap is not merely tolerable but holy: because the ultimate object of human longing cannot

be possessed, and because the longing itself is a form of relation to it.

I have argued elsewhere that the theology of addiction must be a theology of sacred brokenness rather than of moral failure or mechanical defect [55]. Compulsive eating fits that description. It is a disorder of closure in a being made for openness. The appropriate clinical response is neither to shame the hunger nor merely to suppress it, but to help the patient discover what it was for. The hunger beyond naming is not a problem to be solved. It is a place where patient and clinician can meet.

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