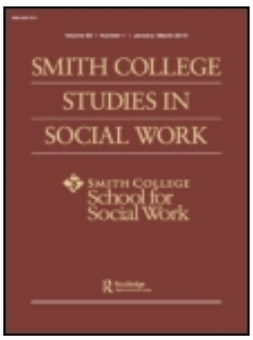

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Co-Construction With a Binge Eating Patient: A Case Analysis Through a Relational/Intersubjective Lens

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This article explores the relational process in a long-term psychodynamic psychotherapy case of a patient with binge eating disorder and the subsequent impacts on treatment when the therapist also struggles with disordered eating. This in-depth case study seeks to examine the reciprocal influence of the subjectivities experienced by the patient and therapist on the formation, maintenance, and quality of the therapeutic relationship and the course of treatment. Drawing on intersubjective theory, a narrowed focus on transference/countertransference dynamics seeks to examine the complexities of a relational approach in the treatment of binge eating disorder. A review of the literature suggests that an exploration of this dimension of treatment breaks new clinical ground and serves to provide more specified and nuanced perspectives for clinicians treating this population. Several clinical vignettes are provided to illustrate the concepts under examination. The use of case composites and thick disguise of patient information has been used to protect confidentiality in this analysis.

KEYWORDS binge eating disorder, relational theory and treatment of binge eating disorder, use of self in treatment with eating disorders, therapists with eating disorders, case studies and binge eating disorders

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INTRODUCTION

The clinical literature on relational psychotherapy/intersubjectivity is abundant, especially regarding the understanding of concepts such as the formation, maintenance, and quality of the therapeutic relationship and the impacts of that relationship on therapeutic action. However, there is a very limited body of literature on the intersections of intersubjective therapeutic action and the treatment of noncompensatory binge eating disorder (BED), especially using in-depth case studies illustrative of this approach. Commensurate to this scarcity of research on relational approaches for the treatment of BED, the literature on the etiology, diagnosis, and treatment of this disorder is strikingly limited in comparison to the extensive literature on anorexia nervosa and bulimia nervosa.

The recent inclusion of BED as a discrete diagnostic category in the newly published 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*; American Psychiatric Association, 2013) hopefully heralds a time of more rigorous clinical and research focus toward improved treatment for people struggling with this often undiagnosed, misunderstood, and even maligned disorder.

As the alarming rise of obesity in America and the medical and psychological sequelae that often accompany obesity create ever-escalating public health concerns, a narrowed and refined focus on BED and its high correlation to obesity become even more critical for clinicians treating this often life-threatening disorder (Callahan, 2013). Additionally, the high comorbidity rates of BED and depression have significant clinical implications for those struggling with BED and often result in an insidious reinforcing cycle and consequent exacerbation of each of those disorders (Safer, Telch, & Chen, 2009). This high co-occurrence of these disorders further reinforces the need for more advanced and empirically validated research and treatment.

As described by the patient under review in this article, individuals diagnosed with BED usually describe a lifetime struggle with binge eating symptoms and weight control (Wilfey, Wison, & Agras, 2003). The clinical vignettes in this article help illuminate and articulate the intrapsychic conflicts and impacts experienced by many patients with this disorder. This patient's painful struggle with shame, self-loathing, hopelessness, and even suicidality highlights the serious impacts on physical, psychological, and relational functioning. As outlined in Gabbard's (2000) article on the ethical mandates of protecting patient confidentiality in clinical case publication, this article utilizes a combination of composite analysis as well as thick patient disguise.

As evidenced in the review of the literature on BED, few case studies illustrate the complex psychodynamic vicissitudes of patients struggling with BED and treatment nuances exposed in relational approaches to treatment of the disorder. Additionally, the literature yields few examples of case-oriented

explorations of the complex relational dynamics experienced in the work between a therapist and a patient who struggle with BED.

Three important psychodynamic themes emerged in the clinical work with this patient and are explored in the article. This article reveals that discussions of the therapist's and the patient's weight tends to be taboo in psychotherapy, not unlike the theme of race in clinical encounters. Additionally, a dance of sameness and difference between the two subjectivities of therapist and patient is inevitable where weight is concerned, resonating with Freud's (1918) construct of the "narcissism of minor differences." Finally, victim–victimizer–bystander dynamics outlined in the contemporary trauma writing of Basham and Miehls (2004) as well as the contemporary iterations of the paranoid-schizoid phenomena in the work of Ogden (1989) and Gabbard (1995) illuminate the complex object relations dynamics that emerge in the case material.

LITERATURE REVIEW

In her review of the origins, influences, and evolution of the relational tradition in psychoanalysis, Adrienne Harris (2011) asserts that one of the key questions emerging from this approach is how the therapist uses her own subjectivity to advance the treatment with the patient and how she also understands that her presence, "in ways knowable and unknowable," alters the unconscious and conscious experience of the patient. Harris discusses how the therapist must consider the multiple ways our subjectivities are revealed to the patient through our appearance, affect, manner of inquiry and response, as well as our verbal and nonverbal communications. She contends that these multiple articulations function as constant and sometimes powerful ways of knowing and disclosure to the patient (Harris, 2011).

Bromberg (1996) further offers that the relational experience between therapist and patient is constantly shifting and constructed by the input of two people with "multiple points of view." This ever-dynamic process can be the source of constant surprise to clinician and patient alike and can cause both to experience much more than what is offered in the actual verbal content of what is being shared in the session.

In their own relational work with eating-disorder patients, Lowell and Meader (2005) explored the impact of the body size of the therapist on the patient. The authors report that patients with eating disorders frequently want to disown or compartmentalize their whole bodies or parts of their bodies due to extreme self-loathing. They also report that despite the voluminous literature on eating disorders in general, little has been written about the impact of the therapist's body on the therapeutic relationship and course of treatment with the patient. They assert that discussions of the influence of the therapist's body and the patient's body and the intersection of the two

are crucial to the treatment and the maintenance of a therapeutic alliance (Lowell & Meador, 2005).

Gabbard (1995) writes in his exploration of the evolutions of the psychoanalytic understanding and use of countertransference, that the relational tradition now conceives of countertransference as a "joint creation" between therapist and patient. Gabbard further explains Ogden's (1989) articulation of intersubjectivity as a shift away from a positivist frame regarding the use of countertransference and toward an idea that therapist and patient move along a dialectical continuum of mutual influence, a constant dance between subjectivity and intersubjectivity (Gabbard, 1995).

Tantillo, Bitter, and Adams (2001) wrote that relational approaches assert the primary need for patients with eating disorders to experience mutually empathic relationships to work through the ambivalence, denial, and fear that keep them stuck. These authors wrote that within the dialectical nature of relational work, the patient who is dealing with an eating disorder comes to better understand the impact of her struggles with disordered eating and her past and present relationships with others who have been significant in her life (Tantillo et al., 2001).

Bloomgarden (2000) explored the boundaries of explicit self-disclosure and its clinical utility when a therapist has a history of an eating disorder. The author asserted that in the context of a relationally based therapy, purposeful self-disclosure can be helpful to the patient in establishing a "real" connection with the therapist. Bloomgarden also underscored the need for more clinically based research in this arena of relational work.

In their exploration of the object relations of bulimic women, Pollack and Keaschuk (2008) wrote that the relational themes that emerged in the study of two independent studies of college women show strong patterns between dependency and yearning for close relationships and strong feelings they will be rejected and abandoned in these relationships. The authors highlight that clinical implications point to the need for therapists to understand how food is often used to manage the object-relational dilemmas experienced by their patients.

Similarly, Krueger (1997) asserted that food is often used by the individual or introduced by the family to soothe, distract, reward, defend, or to substitute as an attempted self-object experience. He extended this idea to underscore that patients often experience the eating disorder as an integral part of the self, necessary for the maintenance of their functioning and place in the world.

Finally, in his exploration of relational themes with eating disordered patients powerfully apropos to the work with my patient, Bromberg (2001) eloquently wrote,

> The person who eventually shows up at the therapist's office, no matter how she chooses to define her "presenting problem," is someone

> whose real problem is that she is totally at the mercy of her own feelings—someone who is enslaved by her inability to contain desire as a regulatable affect. (p. 13)

In my decision to write about my clinical encounters with my patients, I sought consultation with Glen Gabbard, MD, and referenced his work in the *International Journal of Psychoanalysis* on the multiple clinical and ethical considerations and recommendations commensurate with the publication of clinical material (Gabbard, 2000). Gabbard's presentation of the dilemmas inherent in writing about clinical material includes the conflict between honoring and protecting patient confidentiality and the advancement of clinical education and growth in the field. Gabbard asserts that this dilemma can be addressed through several methods such as (1) patient consent, (2) "thick disguise" of patient-identifying information, (3) the process approach, (4) the use of patient composites, and (5) and the use of a colleague as author. He also wrote that authors can combine several of these methods in dealing with this important dilemma. As I see a group of female patients who struggle with BED in my practice, I employed several strategies including the thick disguise of patient information and the use of composites to capture the repetition of relevant themes emerging from this clinical population and relevant to my own inclusion in the population of women struggling with disordered eating.

CLINICAL CASE ILLUSTRATION

Clare is a 44-year-old White woman who I have been seeing in once-weekly psychotherapy for just over 1½ years. She identifies as religiously agnostic but was raised in a Catholic faith tradition. Clare is progressive in her political and social views, is college educated, and maintains that she is "underemployed." She dually attributes her employment status to the impact of institutionalized sizeism on her vocational advancement and what she calls her own "lack of ambition." The construct of sizeism is understood as a form of discrimination against persons based on their weight and/or height. As noted in a recent study by Yale University's Rudd Center for Food Policy and Obesity (Kellington, 2012), sizeism is "comparable to rates of racial discrimination in the workplace" and results in lower wages, prejudicial hiring practices, wrongful termination, and the perpetuation of stereotypes of overweight people as "lazy, unmotivated, lacking in self-discipline, and less competent."

Clare is married and lives with her husband, and the two experience intense marital struggles centering on mutual feelings of disconnection, feelings of victimization as each feel judged and criticized by the other, and the impacts of financial mismanagement and strife. The marital ebb and flow

is also punctuated by Clare's vacillation in self-esteem, her black-and-white thinking, and her projective processes as she frequently assigns absolute meaning to her husband's feelings about her. The two struggle to maintain physical intimacy, and Clare reports that she often feels they "live as roommates of convenience." Clare and her husband frequently struggle financially and experience conflict as each assigns blame to the other in the realm of financial mismanagement. Clare actively grieves the imperfections in her marriage and the sustained sense of loss around "what I thought marriage would be" and the realities of day-to-day life in a marriage. She describes anger and resentment toward her husband for his tendency to "passively" critique her on numerous subjects but oftentimes finds herself agreeing with his critiques as she engages in the emotional self-flagellation to which she is long accustomed. Clare alternatingly feels guilty for her own treatment of her husband as she is often verbally demeaning to him in a manner that she describes as volatile and dysregulated. She expresses little to no hope about the possibility of marital contentment of relative fulfillment in her current marriage and thinks of divorce as inevitable. She frequently expresses existential dread about many areas of her life. "I have no hope" and "This is the way it is going to be" are oft-used statements in my clinical time with Clare. With each expression of certainty about the future demise of her marriage, Clare subsequently expresses hopelessness about any future relationship and sees her obesity as the "deal-breaker" to this possibility.

The patient works for a large bank but mostly works in a solitary manner entering account information into a database. She has little contact with coworkers and does not consider any of her colleagues to be friends. She is college educated but considers herself underemployed in her current position. Clare expresses no wish or aspiration to change her employment situation though she has often wondered aloud in our sessions, "I wonder what it would be like to do something that I really love and am good at, like you do."

Clare has few friends with whom she spends one-on-one time in person though she does maintain a small network of friends via an online community related to her participation in an interactive and ongoing Internet game and via social media outlets like Facebook. She met her husband through mutual friends, but the two maintain little-to-no contact with those friends from their respective pasts. Claire reports "affairs" with other men whom she met online but has never met in person though she did participate in one actual, extramarital during her marriage. She reports that her husband never learned of this affair and frequently alternates between intense feelings of entitlement and shame regarding her infidelity.

The patient has a history since teenage years of diagnosed depressive and anxiety disorders, and a 20-plus years history, by her report, of BED. She has received psychotherapy and medication management for depression and anxiety off and on since college, but her treatment has never focused on BED as a significant diagnostic concern. The patient has struggled with

suicidal ideation through the years of treatment and has been hospitalized once for suicidal intent 5 years ago. She has made no actual attempts. She has a background of emotional and physical abuse from her father, now deceased, and suffered sexual abuse from an older male cousin and several of his friends.

Clare was referred to me by a colleague who was engaged in psychotherapy with her but who felt at an impasse in the therapy. Upon referral, my colleague confided in me that she felt as though she could not help Clare with her eating issues as the patient frequently expressed hopelessness about her ability to change on that level. My average-weight colleague wondered if as an overweight therapist who is interested in the study of BED, I might be able to help the patient more in psychotherapy. I felt positively about the referral and looked forward to working with Clare.

The first time I went to meet Clare in the waiting room, my reaction bordered on shock as she slowly rose from the chair, eyes cast downward, and moved toward me. I was consciously aware of concealing my own response as I absorbed the extent of her obesity and her seemingly difficult movement as she moved toward the waiting room door. I soon learned in the first session that Clare weighs close to 400 pounds. As I explored with Clare her reasons for coming to therapy, her face conveyed a mixture of sadness and shame, her eyes often cast down as she shared her history. My immediate reaction to the patient was one of empathy, sympathy, and a strong desire to help her. As a woman who also is significantly overweight, I found myself making an immediate comparison between the two of us. I remember thinking to myself with an attitude of pity, "Poor girl, I have to help her, she is so much worse off than I am."

As Clare and I continued with our first session, the patient began to cry and to tell me that she was "at the end of her rope" regarding her inability to lose weight and that our engagement in therapy would be her "last chance" to "fix herself." I asked her to help me understand more about how this felt like her "last chance." Through a torrent of agonizing sobs, Clare shared with me that she was "so tired," had "tried everything," and had "been doing this forever." She said she could not continue to fight the battle with being overweight that she felt she had unsuccessfully waged most of her life. The desperate tone of her declarations carried a strong flavor of passive suicidality, but Clare assured me she "was not there yet." She shared with me her concrete goal of losing "at least" 175 pounds and her rigidly-held belief that she would not be able to be happy or should she dissolve her marriage, ever find another love interest any short of this goal. She also told me she could not accept herself if she did not reach this mark. My heart sank as I thought, "How on earth will I be able to help this woman lose that amount of weight." Her desperation also prompted a moment of nihilism in me as I know all too well how agonizing the personal battles over weight can be.

In one of our early sessions, and then again in many other subsequent sessions, Clare pushed her arms out in front of her and held them like clubs. She repeatedly and angrily motioned up and down her body, pointing to different areas of her body like they were disconnected and belonging to someone else saying "I hate this and cannot live with this." The almost disembodied and disavowed sweeping actions of her outstretched arms circling angrily around the areas of her body felt like the actions of a bully on the playground who had cornered an overweight girl and was humiliating her mercilessly. I felt heartbroken for my patient and probably a bit heartbroken for myself, perhaps a moment of mutual recognition that I might not know how to help either of us.

The first phase of our work together alternated between an immersion in Clare's family history, her clinical struggles with anxiety and depression, and her struggles with obesity, self-worth, and perfectionism. We also focused clinical attention on her feelings of hopelessness about her marriage. Mutually agreed upon treatment goals included (1) understanding the influence of her past on her current-day functioning and relationships, (2) ongoing management of her depression and anxiety, (3) examination of her all-or-nothing cognitive style and her relationship between perfectionism and shame, (4) a biopsychosocial understanding of her relationship with food, and (5) and ultimately a transition to increased self-acceptance.

As Clare shared her family of origin history, I learned that her father, a highly intelligent man who had great difficulty maintaining steady employment in executive positions, often mismanaged the family's finances. Subsequently, they alternated between relative wealth and being "flat broke." Clare painted a picture of a narcissistic father who was intensely critical of her and who openly favored her older biological brother, showing a preference for him via material gifts as well as time spent on the brother's interests and academic pursuits. Clare also described her father as a chauvinist who virtually never praised her for her outstanding school performance or any other achievement. She was highly conscious of her futile efforts to gain favor of praise from her father. When Clare began gaining weight as an adolescent, her father constantly commented on her weight gain. By her description, Clare's growing obesity garnered more actual "attention" from her father than did any other time period or topic throughout her development. She described her mother "as a wonderful woman" who gave up her own dreams to support her father's careers and movements between businesses. Clare described her mother as "doing her best" but clearly though Clare's account she could depend on little nurturance and protection from her father's abuse. Her story of her mother was one of resignation and loss, a good and selfless woman who "had nothing for herself" as she spent all of her energy attending to the needs of Clare's father. In her descriptions of her mother, I began to recognize so many attributes of Claire.

After some months in treatment, Clare also shared that she had been repeatedly sexually abused by her male cousin who lived close to the family in the period of early- to mid-adolescence. She said that she had only shared this in therapy once before and with her husband. She expressed hatred for her cousin and stated, "He caused me to hate myself like my father did."

Alternating with the focus on family history and the current-day struggles stemming from early impingements, Clare came to many sessions focused ostensibly on her inability to lose weight and the commensurate self-hatred she experienced daily. She spoke in an all-or-nothing manner about her efforts and was mercilessly harsh with herself even when there were some signs of progress. I found myself relating to her as a cheerleader at times, hoping that she might ease up on her perfectionistic strivings and see some value of the efforts she was advancing. These cheerleading efforts were often met with a sense of hopelessness and even some anger at times as she insisted to me that she had no value to herself or anyone else unless she "got rid" of her extra weight. I started to point out her own patterns of perfectionistic, all-or-nothing thinking, and how she applied these patterns to many areas of her own life but particularly to ideas related to her weight. She often spoke with certainty about the way she "knew" others viewed and perceived her. I challenged her on this while also silently knowing that others might perceive her as she was convinced they would. I wondered to myself if I was being hypocritical even in my attempts to help her be more flexible in her thinking about herself.

Clare also told me that she was more comfortable talking about weight with me than she had been previously in therapy before. I asked her why she thought that was and she said that she trusted me, felt safe with me, and knew that I understood. Clare recited these reasons but said nothing about the two of us obviously being overweight and how that might feel to her. I was conscious of the possible benefit of pushing her on her feelings related to my own obesity, but I realized we were now treading on taboo turf. She had been unable to speak to me about my weight, and frankly I had not been able to go there either. I mused about my reluctance and wondered if weight was similarly difficult to talk about in therapy as were discussions of race.

Later in that same session, I experienced a counterphobic moment and wanted to blurt out some self-disclosure about my own struggles with being overweight. So I asked her if her relative comfort in discussing her weight with me was at least in part because of my own obvious struggles with weight. Clare replied, "I don't think of you like me." I don't know if I was shocked or relieved with her response. She then said, "You are not afraid to talk about my weight with me." Clare went on to share stories of the shame she had experienced in medical settings with doctors and nutritionists who would speak to her about her weight in a humiliating way, much like her father used to do.

I realized that my first reaction to Clare was that I pitied her struggle with weight while also feeling relief that I wasn't as big as she. How ironic that she was now telling me that she didn't see me as like her. Two overweight women in an office observing how different we were from one another. Breaking the taboo would be acknowledging that there was something similar about us. Frequently when I would pick her up in the waiting room, I would notice her unkempt clothes often marked by food stains and her demoralized demeanor as she moved slowly and deliberately down the hallway. I often thought to myself very reflexively, "You don't have to look that way, you could wear clean clothes and carry yourself with some sense of purpose." Flooded with guilt for the seeming insensitively of my feelings, I silently mused to myself, "I might be fat but I care about how I dress and have hope about my life." I struggled with an urge to say something to her about her appearance and hygiene but knew that I could not broach that topic. It occurred to me that I was feeling a pull to become like a nagging mother or a critical father; one who might guide or even shame her for not dressing appropriately or for not displaying some sense of hope or resilience, despite her deep sense of despair and ongoing depression. In those moments of enactment, the tainted mirror of my own self-loathing emerged as I felt the tug away from an empathic stance toward my patient to a one of distance and disavowal of my own struggles.

The recitation of differences between us continued. In one session, after a litany of self-loathing statements about the hopelessness of her situation in life, I asked Clare if she had to think about her value as a person and her weight in such black-and-white terms. I proposed the idea that she might be able to appreciate and accept herself even at her current weight. She responded by saying, "No." "That would not be possible." "I can't imagine being a happy overweight person like you."

I thought to myself, she imagines me as totally different from her rather than similar and different. She obviously doesn't imagine that I could be unhappy about my weight as well—one more dichotomous way of thinking about differences. I'm happy and fat, she's unhappy and fat. There was something residing in both of us that wanted to sharpen the distinctions between us and disavow the similarities. I was finding myself in the same position as the colleague that referred her—feeling deskilled and unsure how I would help her. By framing our differences in such black-and-white terms, she inflicted greater hopelessness on herself. With her all-or-nothing cognitive style, it must have seemed impossible that she could ever become the all-happy person that she fantasized me to be. I also realized that this "all-happy" way of thinking of me and my weight could potentially stir up envy and make it difficult to accept help from me.

As our work together continued, it appeared that Clare's perception of my happiness was victimizing her further. As she continued to share her feelings of hopelessness about her weight and her insistence that losing a

significant amount of weight would be the only acceptable path to more happiness, I began to feel hopeless and helpless about her situation as well. I would often sit in the chair thinking that when Dr. A referred the patient to me, she must have thought that I as the overweight therapist would be a perfect match for this struggling and miserable overweight patient. I felt a bit victimized by the expectations of my average-weight referral source who felt deskilled with Clare but somehow believed that I would know how to help the patient because I was overweight too. Perhaps I was victimized by my own expectations to help her as well as BED and emotional overeating are areas of research and clinical interest for me as well as a personal struggle.

Clare's level of extreme dysphoria one particular session prompted her to admit that is something didn't change soon regarding her weight that she "couldn't go on living." After screening out any imminent risk of suicidality, I started aggressively questioning Clare about her willingness to try other approaches to her struggles with BED and obesity. I reviewed a list of alternatives, including scheduling a visit to a nutritionist whom I knew worked with eating-disordered patients like her. We discussed this as a possibility, and she agreed to attend an appointment with the nutritionist. I felt relieved that another professional might be able to take on her sense of hopelessness and share in what seemed to be an impossible task.

The patient returned to my office after her first appointment and told me the following story when I inquired about her visit. She angrily and tearfully recounted a series of "unacceptable" actions on behalf of the nutritionist. This included an assumption by the nutritionist that Clare "would not be comfortable" in her regular office chair and a subsequent insistence on dragging a "huge" chair from the waiting room in front of other patients and into her office. Clare expressed contempt and anger toward the nutritionist and criticized her for "trying to take the place of my therapist." As she bemoaned the lack of concrete nutritional guidance, her labile expression of emotion shifted from intense anger to sadness and resignation. She tearfully and dejectedly noted that "nothing ever really helps me." As she recounted the details of her disappointing encounter, I thought to myself, "I should have known better to send her there." I explored with Clare whether she felt angry, hurt, or disappointed with me for guiding her toward the nutritionist and she denied any feelings at all toward me regarding the appointment. "You were just trying to help," she said dejectedly.

Clare's helplessness and extreme passivity made me feel hopeless about how to energize and motivate her. I realized that the helplessness that I felt in the consulting room with her was likely how she must about her struggles with weight and life in general.

The splitting of me and the nutritionist into "good" and "bad" was also similar to how Clare constantly experienced herself in good and bad ways: bad Clare was fat and miserable and had no value to herself and others;

good Clare who used to be fit and trim when she was younger and dreamed of being so again had value to herself and others.

DISCUSSION

In deconstructing this clinical material, a number of theoretical points become salient and instructive to clinicians working with BED patients. In this discussion, I focus on three major themes that emerged as a result of the clinical process.

The first theme relates to the taboo nature of discussions of weight between therapist and patient and subsequent impacts on relational dynamics when discussions of these variables are avoided. During much of my work with Clare, I felt like I was navigating uncharted territory with little more than a compass. I realized that there was virtually no literature that featured the clinical phenomenon of an overweight therapist treating an overweight patient and the associated vicissitudes of transference and countertransference. Hence I had little guidance from the literature to sustain me in times of clinical impasse.

It became clear at some point that this particular constellation of therapist and patient constituted a relatively unexplored subject. In the discourse between therapist and patient, the discussion of the dyadic pairing of overweight patient and therapist is often a taboo topic. In this regard, it seemed analogous to the situations involving racial themes in therapy in which similarities and differences in race between therapist and patient were highly charged and often avoided. In Leary's (1995) groundbreaking work on race and psychoanalytic psychotherapy, she notes that discussions of racial issues are most challenging, but perhaps also most illuminating, when done in the consulting room. These issues fall under a broad category that we might term the myth of sameness.

In writing about her own clinical encounters as an African American therapist with patients who are also African American, Leary (1995) is able to give voice to the often underrepresented or ignored nuances that arise in these encounters. Similarly, when examining the case material in this article between a therapist and patient who struggle with BED, the subject of the obvious similarity between patient and therapist was difficult to bring out into the open (Leary, 1995). Lowell and Meader (2005) also wrote that eating disordered patients often deny any feelings about the therapist's body when asked by the therapist. Like race, the shared and obvious struggle with weight is in plain view and cannot be concealed. Because it is so difficult to talk about, however, both members of the dyad may defensively leap into a manic denial of difference. In other words, to avoid discussing the complexities of the situation, both may assume that the internal experience of the other is similar and thus foreclose upon opportunities to express and

explore painful emotions, possible affiliation, or intersections of stigmatized identities.

Beneath this defensive posture, emerges a second theme in the clinical process—what Freud (1918) termed the "narcissism of minor differences." Often in the course of therapy with Clare, I silently thought to myself that my problems were not nearly as egregious as hers. Freud (1918) wrote about this in more global terms as a universal feature of human relatedness:

> It is precisely the minor differences in people who are otherwise alike that form the basis of feelings of strangeness and hostility between them. It would be tempting to pursue this idea and to derive from this "narcissism of minor differences' the hostility which in every human relationship we see fighting against feelings of fellowship and overpowering the commandment that all men should love one another. (p. 199)

In his examination of Freud's writing on this subject, Gabbard (1996) suggests that the recognition of subtle or major difference between individuals often gives rise to a form of hatred. Gabbard also noted that the recognition of differences can be experienced as a form of critique—either against oneself or the other. It was striking to me how my patient and I spent considerable time thinking of how we were different than one another. I often thought, "I am not that big and definitely not self-loathing and miserable." By her own admission, Clare often noted her belief that I was a "happy and successful" overweight person, thereby highlighting a significant difference between the two of us. I often wondered if there were latent feelings of hatred because of that perception as Clare's tone and affect often conveyed some possible underlying anger or resentment. My attempts to uncover these affective states were usually met with a quick and routine dismissal of any negative feelings toward me.

One morning recently she punctuated a story of her mother's current and frequent encouragements to dress better with a compliment to me on my own appearance and attire: "I wish I could dress like you—wear a colorful scarf and clothes that are more fashionable." Pointing to herself in the dismissive way that she often did, Clare said, "See you look good anyway. I don't." I responded with the following observation to Clare, "Your statement seems to suggest that you see us as both similar, but at the same time, very different. I'm wondering what you imagine I feel about being overweight?" Clare was dismissive in her response: "I don't really think about it that much," confirming that this was a taboo subject between us. Envy, of course, may operate side by side with hatred, even when consciously denied.

The third conceptual theme emerged in the therapeutic discourse between therapist and patient and at times, our enactments deteriorated into a victim–victimizer–bystander paradigm. A relational teeter-totter began to emerge where the patient and I alternated roles of victim, victimizer,

and bystander. As noted in Basham and Miehls (2004), the groundbreaking work of Ervin Staub (1989) on group violence and Judith Herman's (1992) subsequent work on trauma and recovery are foundational to the understanding of these victim–victimizer–bystander dynamics. Basham and Miehls (2004) explained that survivors of childhood trauma like Clare internalize a template of victim–victimizer–bystander that goes on to significantly inform and shape the relational world where these survivors of abuse live. The authors describe a process whereby one of these three roles is routinely and repeatedly enacted by the individual and the unconscious conflicts projected onto others with whom they are in relationship. Gabbard (1996) and Ogden (1989) also note that the classical Kleinian construct of the paranoid-schizoid position has been re-conceptualized in contemporary thinking as involving an intersubjective matrix between patient and therapist. In other words, the patient may unconsciously evoke, via projective identification, a corresponding response in the therapist such that a jointly constructed "dance" is enacted between them.

Hence a woman like Clare who has felt victimized all her life unconsciously plays out a drama between an abuser, a victim, and often a bystander. At times, the abuser is projected into others who mistreat her, like the nutritionist, and I, who sent her to the nutritionist. At other times, she identifies with the victimizer and projects her victimized self into the therapist. There were many times that I felt hopeless, impotent, deskilled, and victimized by her expectation that as a "happy overweight person" I would know how to change her. I would regularly find myself losing sleep at night worrying about her becoming suicidal again. Then I would begin to shift into a persecuting object who would subject her to an inquisition when she would helplessly reply, "I have tried everything to lose weight and nothing works." "There is nothing left for me to try." This inquisition would consist of my challenging her belief that she had "tried everything" by reciting a litany of questions related to weight loss approaches, including bariatric surgery, and whether she had actually attempted them. The victimizing inquisition was also fueled by my ongoing, conscious hopefulness and commitment in my own therapy to master my years-long struggle with BED and an emerging resentment when her hopelessness threatened my belief that I could help us both.

Another manifestation of this victimizing dynamic would emerge at times of Clare sobbing and saying, "I cannot live life like this anymore." "It is not worth it to me anymore." Her wholesale and multiple rejections of any attempts on my part to help her see value in her life and her expressions of at least passive suicidality resulted several times in my suggesting hospitalization as a solution for her suicidality. This unconscious expression of aggression from me was experienced as a rejection by Clare of my ability and willingness to tolerate and contain the depth of her misery. Clare responded in hopeless despair and conveyed a feeling of having been betrayed by my suggestion. By proposing to "send her away," I recognized retrospectively

that I was enacting an abandonment scenario described by Barth (2008), who noted it is crucial that the therapist of an eating disordered patient not abandon the patient because of the therapist's own feelings of inadequacy when dealing with the symptoms of the patient. My role as a passive, disengaged bystander could be seen in this abandonment scenario as well as moments where I emerged as an active and rescuing bystander. The shift between these roles often seemed to emerge at the intersection of Clare's current level of hopelessness and the current state of my own struggles with weight and BED. This oscillation between victim–victimizer–bystander dynamics often occurred within the space of a few minutes in our work together.

SUMMARY

Leary (2012) asserted that one of the fortunate outcomes of the evolution of the relational tradition in psychotherapy, especially with regard to race, is that therapists seem more inclined to write candidly about their actual experiences with patients in a manner that benefits collective learning. As revealed in the scarcity of literature on intersubjective dynamics between therapists and their patients who have eating disorders, much can be revealed and understood about the clinical implications at the intersection of these subjectivities. As I have learned in my work with Claire, our separate and shared experiences as overweight women who binge eat cannot be ignored or underestimated within the context of our unique and ever-evolving therapeutic relationship.

Lowell and Meader (2005) extended this idea to speak specifically to the cocreated dynamics between thin therapists and overweight patients and the way in which unexplored intersubjective dynamics about weight can lead to therapists feeling anger, guilt, shame, or impatience in the treatment. They note that the therapist, in order to avoid these unpleasant affects, might seek to adopt a "coaching" type of stance with the patient to unconsciously push along the pace of treatment or to avoid discussions of weight at all. The authors predict the possibility of therapeutic rupture when the taboo of discussing feelings about weight engenders mutually reinforced silence in the therapeutic dyad.

In this commentary, I argued that a systematic attention to the transference–countertransference dynamics helps to avoid the obstacles described by Lowell and Meader (2005). Specifically, I have called attention to three areas of cocreated dynamics between therapist and patient who both binge eat: The existing taboo about discussions of the therapist's and patient's weight and the impact that silence and disavowal of feelings can have on the therapeutic relationship; the narcissism of minor differences and its role in disconnection or over-identification between overweight therapist and patient; and the inevitability of unconscious recreations of

victim–victimizer–bystander scenarios in the treatment and the possibility of rupture in the therapeutic alliance.

In my rewarding and ever-evolving work with Clare, I have learned that the similarities and differences in our struggles with weight and disordered eating constantly influence and cocreate our respective and collective understandings. In Clare's complicated journey toward her treatment goals and her arduous struggle for self-acceptance, I see many of my own struggles. Through ongoing clinical consultation and my own reflective process, I work to draw from my own experiences yet to avoid overidentifying and foreclosing upon curiosity regarding her uniqueness. In her brave fight to make meaning at the multiple intersections of her past, her relationship with food, her depression and anxiety, how she relates, her inner world, and her many contexts, I turn to the words of Bromberg (1993) to help guide my work: "Health is the ability to stand in the spaces between realities without losing any of them" and "This is what I believe self-acceptance means and what creativity is really all about—the capacity to feel like one self while being many" (p. 166).

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