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ORIGINAL PAPER

Psychodynamic Issues in the Treatment of Binge Eating: Working with Shame, Secrets, No-Entry, and False Body Defenses

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Abstract Two clinical moments from patients in treatment for Binge Eating Disorder (DSM 5) are described where a manifest problem with body image difficulty was initially denied. Each patient entered treatment with the desire to lose weight as well as gain a fuller understanding of self and mastery over addictive eating patterns that caused considerable psychological anguish. An integrated treatment matrix of practical, contemporary psychodynamic interventions and more behavioral, experiential and supportive tools allowed each patient to uncover and work through heretofore split off aspects of their bodily selves. Defense mechanisms such as 'no entry' fantasies and 'the false body' that have recently been described in the analytic literature are applied in formulating each case example. The author underscores how therapists must probe for secrets in the personal and family history that are 'hidden, but in plain view' and pursue them in order for the patient to embrace a more coherent, true sense of her/his bodily self. These secrets often contain a less conscious rationale for treating the body poorly and perpetuating hated, shameful and derogatory aspects of body image that may become externalized onto the therapist. These externalizations can further complicate countertransference reactions that must be acknowledged and worked through by the therapist in personal or self-analysis.

Keywords Binge Eating Disorder · Psychodynamic psychotherapy · No-entry defense · False self · False body · Shame · Countertransference · Parentified child · Pathological accommodation · Eating disorders

Introduction

After over 5 decades of research on differentiating binge eating from obesity and other eating problems, Binge Eating Disorder (BED) was included in the DSM 5 edition of the American Psychiatric Association Diagnostic and Statistical Manual (2013) as a distinct clinical diagnosis (American Psychiatric Association 2013; Stunkard 1959). Large population studies reveal that BED is more prevalent than anorexia nervosa and bulimia nervosa combined but often goes unreported by patients to their primary physicians (Hudson et al. 2007; Kessler et al. 2013; Marques et al. 2011). Both of these facts are not surprising to the psychotherapist who encounters eating and body image concerns in practice and bears witness to how difficult it is for individuals to openly acknowledge their problematic relationship to both (Barth 2008; Zerbe 1993a/1995, 2008). Patients who binge admit to their struggle with embarrassment and guilt sometimes only after several rounds of open-ended queries and prompting by the therapist (Banker 2013; Becker et al. 2010). These patients may also attempt to conceal their problems from others, especially loved ones and their physician because of the stigma attached to eating disorders and other psychiatric problems (Barth 2008; Linville et al. 2012; Zerbe 1992). By definition patients with BED do not use compensatory behaviors such as purging, misuse of medication, and excessive exercise, they frequently diet to help manage what they consider to be the aftereffects of their binges. Interestingly, a

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significant number of patients with BED are overweight while a minority of patients is normal to slightly above a normal weight range (Hudson et al. 2007; White and Gianini 2013).

Though these facts often obscure the amount of psychological suffering carried by the patient, they slowly find their way into the office of the therapist as the BED sufferer clamors for understanding and support. Although "feeling disgusted, depressed, or guilty" after a binge is part of the DSM 5 criteria for the disorder, in my experience the body shame and distortions central to the individual's experience are often given short shrift in treatment. The so-called evidenced based approaches employing psychotropic medication and behavior methods tackle binging and the comorbid psychiatric problems that accompany BED such as anxiety, depression, and substance abuse (Alexander et al. 2013; Hudson et al. 2007; Hilbert and Hartman 2013) but rarely the interpersonal and intrapsychic heartaches that emerge only with tincture of time, cultivation of trust, and careful listening by the clinician.

The patient's experiences of their body, on the other hand, may fluctuate day-to-day, and sometimes hour-by-hour, igniting a plethora of affects and images that quickly come to the surface as the psychotherapist gives space for their emergence. Clinical experience has made me wonder if the affective experience (and historical narrative of BED patients in which it is imbedded) is listed in the nomenclature but not the target of evidence based treatment because help for shame, guilt, and embarrassment will never be found in a pill or set of therapeutic exercises, useful as these tools may be for curtailing some of the actual binge behaviors. Sharing one's personal story and having an interested witness (i.e. the therapist) to contain (Bion 1962) and to help metabolize its elements is the only cure I have ever found to alleviate personal anguish. At best, however, this cure is only partial as it cannot take away the losses, trauma, impingements, and other exigencies of an individual life led to manifest such a problem. Like the patient, therapists must come to terms with 'improvement, not perfection' as a goal. The 'talking cure' also takes considerable time with seemingly insurmountable cultural and fiduciary impediments that must be overcome to provide it. These demands of contemporary practice take a heavy, often demoralizing toll on the therapist.

As I hope to demonstrate in the clinical material that follows, when this work can be carried out by both the patient's and the therapist's joint investment, the accrued benefit can significantly diminish an entire range of adverse feeling states and impoverished experiences of self. This positive change likely also impacts others in the patient's life, especially those in the next generation—these close relations may be less prone to the influence of observing or hearing about negative dieting habits and other body image dilemmas (Micali et al. 2014). Deprived of attention and interest from other appropriate sources of comfort, adults unwittingly perpetuate the cycle onto their children who "pathologically accommodate" (Brandchaft et al. 2010) by tuning into the needs of others, thereby sacrificing their personal autonomy and sense of authenticity (Atwood 2012).

Therapists who work with eating and body image problems know that although there is some factual basis to a genetic hypothesis for these diagnoses as is touted in contemporary neuropsychiatry, all too often we hear stories in our consulting rooms of multigenerational criticisms about weight, body type, and appearance that has taken enormous emotional and psychological toll on our patient. The less a person denigrates her/his own body, the less likely she/he is to unwittingly but destructively do so to others, most notably offspring. This denigration will not happen because the genome has mutated. It will happen because the patient changed outlook and found perspective within the context of the therapeutic environment that enables the individual to wrestle with and to confront the uniquely personal reasons they have for their body shame and hatred. Notably, the "secure base" (Bowlby 1988) of the psychotherapeutic process enables this transformation to occur because at last the individual has found an appropriate and receptive audience (i.e. the therapist) who can assist in "beginning to bear the unbearable and to say the unsayable" (Atwood 2012, p. 118).

Rather than present full case histories of two distinct patients, the clinical material that follows will resonate with clinicians because the remarks I choose to elaborate are typically heard in our office practices daily when working with eating problems. The pseudonymous Anais and Anton are composite patients who entered treatment in order to lose weight and overcome their tendencies to binge. Body image difficulties emerged late in the game with Anais as they so often do. Anton, on the other hand, hated being overweight and the cost it had taken already on his health. He pleaded in his initial consultative hour that he would do "Anything, absolutely anything" short of undergoing bariatric surgery so "I don't get diabetes or die of a heart attack early like both of my parents." Saturated comments like the ones each patient made in the 'clinical moments' described below must be unpacked in any psychodynamic treatment; after all, every person is an individual with a unique history that yearns to be told and more fully explored. The benefit of illustrating themes about the body and body image by detailed exploration of a seemingly offhand, hackneyed statement by two individuals lies in assisting clinicians in zeroing in on emotional pain and deep resistances to therapeutic engagement that accompany every treatment of an eating problem.

A Clinical Moment: Anais

> "I feel gross, putrid, and so ugly!" Anais cried out midway through her second weekly session in psychodynamic psychotherapy that had been ongoing for about a year. She punctuated her jeremiad a moment later by adding "And I have just told you I was making progress! What is the matter with me? I don't have to stop at the grocery after work and buy pastries and doughnuts now but I do it anyway! Life is going well but the binging keeps happening and I hate my body. This isn't rational. Do you think I am just a self-destructive snob who tries to look like an intellectual? You would think that with all my education and Patrick's love that I would be over this by now!"

This 35-year-old married Associate Professor of German Literature had quickly turned the tables on me. Moments before her segue to her negative experience of her body and report of continued binges, we were engaged in meaningful dialogue about what she experienced as the unreasonable demands of the editor of her next book and the frustration she felt in her "race against my ever ticking biological clock" to have a second child. Anais initially sought treatment with me for depression and binge eating, conditions she suffered for at least 2 decades prior to her arrival in my office but had never chosen to address before having her first child. In just a few months her symptoms seemed to improve with psychodynamic psychotherapy and psychotropic medication. I also employed several CBT tools for good measure (Barth 2014; Zerbe 2008), such as suggesting food logs to help structure her eating and creating what I term a "psychological breezeway," an explicit recommendation for burdened professionals with binge eating problems to wait at least 5 min before entering their home after work and going right to the refrigerator or their stash of high carbohydrate, sugary, and easily consumed snacks. This intervention is initially aimed to help slow down time from impulse to action, and over months to establish a greater capacity for the patient to think and reflect. As in so many aspects of her life, Anais was compliant and quickly mastered these tasks, telling me repeatedly how useful the therapy process was for her and that while she still had "some bad days with the binges," she also felt a sense of pride and well-being of her ability to master a behavior that had been her master for years.

What puzzled both of us was that while the episodes of binging had themselves decreased in number, when she did binge she felt much worse about herself and her body. I was further struck by how body image disturbance is not listed as a core diagnostic feature in the DSM-5 for BED but yet it was now the symptom that appeared to disturb Anais the most, stealing happiness and a sense of joy from her life (see Smolak and Levine 2015; Kearney-Cooke and Tieger 2015). When she blurted out her predicament, I felt a sense of shame and being caught off guard: How had I failed my patient? Psychotherapy had apparently helped Anais decrease one symptom only to reveal a core of hatred barely beneath the psychological surface that she had not told me about during her evaluation or the initial period of therapy. It had certainly been my clinical experience over the past 3 decades of practice that body shame factors into the clinical presentation of many men and women regardless of formal psychiatric diagnosis. I wondered what core psychodynamic issues Anais might be alluding to by the self reproach of feeling "gross, putrid, and ugly" and the countertransference reaction that she had triggered in me, leading to a personal experience of powerlessness and defectiveness in my attempts to help her.

Shame

Initially, I found myself frequently reminding Anais that her binge eating was troublesome to her but not imminently life threatening. Although this statement was medical fact, self-analysis revealed that my intervention was aimed at reassuring myself that I had something to offer the patient and thereby temporarily but ultimately unsuccessfully diminishing my sense of shame in not addressing earlier her disparagement. Given the chronicity of eating disorders, clinicians are tempted to offer supportive and educational interventions like ones that I had when they may no longer be needed and, in fact, subvert a more effective process of assisting the patient in understanding the deeper roots of the illness and finding meaning in their life. The patient may also appear compliant with the therapist but actually be signally discord with an implicit wish to reveal painful facets of their history of which they are not fully aware. When I stepped back and challenged myself to think about what was transpiring between us, I knew that I would need to interpret more actively Anais' proclivity to repetitively and masochistically defeat herself by punitive outpourings about her body and to wonder why she seemed to be going along with the treatment as she was simultaneously defeating it.

This formulation arose not from any classic, stereotypic application of sadomasochistic dynamics taught in my psychodynamic residency or analytic training but from attunement to how my body slumped, shifted, and was experienced as deficient in vigor when I sat with Anais. In contrast to work with other patients with whom I usually felt sturdy and effective, Anais stirred a virulent, unsettling, physical countertransference reaction of weakness and defect in me. I realized that this was the case because I not only felt different when I was with her than I did with my

other patients, I actually behaved more deferentially and defensively than is my usual style. Recalling Judith Brisman's (2015) apposite question "What's going on? What's going on?" to assist in assessing interpersonal role responsiveness in a closed family or psychotherapeutic setting with eating disorder patients, I wondered if a specific secret or family system dynamic had been successfully projected into and then contained by me in my body. In particular, I wondered if this dynamic centered upon something that made Anais experience a sense of unconscious shame that would have to be teased out in our work for a healthier resolution.

The Secret on the Surface

In earlier publications (Zerbe 2001, 2008), I have urged clinicians to engage the patient by asking how they understand their eating or body image problem arose and to pay close attention to family history that includes but is not limited to the family's physical concerns and body preoccupations. The stories that emerge encompass not only intergenerational messages around weight, shape, exercise, attractiveness, and the like but extend to the impact of illness, disease, fertility problems, and death in members of the family that have often gone unspoken. From these conscious recollections of many patients it becomes impossible to see eating and body image problems as primarily biological (e.g., brain based) or cultural phenomena, replete as these personal histories are with tales of how diet, food, physical activity, beauty and life's unanticipated and unwanted exigencies (e.g., loss) played importunate roles in the lives of patients and family members. The child, our patient-to-be, imbibes from the family nexus and then may overly identify with how central attaining and maintaining particular physical attributes and accomplishments are in their family, and they seek to please and to be accepted by not questioning the very pressures and expectations foisted onto them. Sometimes they are expected to care for a sibling or parent as if an adult or to serve as a 'replacement baby' unconsciously after miscarriage or death of another sibling. 'Mindboggling' is the word that senior clinicians sometimes descriptively use to convey the diversity in the tales of hardship and heartache they have been privy to in the course of a long career listening to patients and their family members.

Expanding upon the classic psychodynamic of impingement on a parentified child whose role is to care for others in the family at a cost to the development of self, Brandchaft et al. (2010) have coined the term 'pathological accommodation' in fleshing out developmental traumas that cause an individual to experience:

> Doubt, indecision, and foreboding about the horrible enduring consequences of disappointing his objects {that} invade the privacy of his own inner world and pervade the arena of important relationships…Feelings of attractiveness come automatically to be replaced by those of repulsiveness, aliveness by malaise, as well-being and happiness cannot be sustained (pp. 154–155).

Anais had already told me on many occasions that her family was avidly involved in sport all of her life and that she enjoyed every aspect of high school and collegiate athletic participation. Unlike other patients in my practice, there was no manifest history of a multigenerational body image problem, excessive dieting or eating disorder in the family of origin, pressure to achieve a particular, 'perfect,' appearance, or need to serve as caretaker for one or more members of the family. In fact, Anais' parents avidly supported their oldest daughter's independence and autonomy, to the point of structuring her studies and athletic activities year round as they did her two younger brothers. Homework, music lessons, volunteer work, and participation in at least one sport were part of this family's ethos; all tasks needed to be completed before any of the children could go out and play, but then their time was their own and playmates and friends were welcomed into the household.

It had always seemed like a busy schedule for a child to my ears but Anais never complained about it; in fact, she said the regimen was "the making of me!" In contrast, the weariness registered in my countertransference reaction of so much structure, few breaks, and high performance felt like it would become "the breaking of me." I began to wonder if I was working too hard in the treatment and that my posture and physical sensation of exhaustion were part of Anais' experience that had not attained consciousness; perhaps there was a 'secret burden' she carried that I had unconsciously identified with over a period of months. This led to a fortuitous question when Anais spontaneously registered her complaints about her editor and the problem she was having completing her book. I asked her if she was having trouble because she did not fully enjoy what she was doing—if it were possible that feeling 'gross, putrid, and ugly' had more to do with disgruntlement with her life choices than her body. Expecting a denial, I was nonplused by her response.

"To tell you the truth, the role of professor is *never* one that I wanted," she blurted. She elaborated that she adored working with children and envisioned for herself a career of teaching a foreign language at an elementary or middle school. "The thought of just being a regular person who got married, had kids, and taught school just doesn't fit in my family where everyone achieves to the max in their area and does something really big and important. No one has to say it outright but everyone expects me to win a Pulitzer

someday," she concluded after I gently pointed out that I thought she might be more weighted down than she realized by ambitions that were not truly her own. Anais had kept an important secret from herself that served many functions but was profoundly self-destructive as reflected in her persistent binging and the very words she had used about her body. Her pathological accommodation to her parents' requirements for high achievement was the context in which I began to understand her inability to sustain the healthier state of mind achieved by the CBT interventions and the repetitive statements she made about her physical defects. I also registered but did not interpret at the time that her comments about her editor were veiled complaints about the transference relationship wherein she experienced the integrated treatment plan of CBT interventions and psychodynamic exploration as more hurdles imposed by yet another person (i.e. the therapist) to jump over.

My bodily countertransference reactions can be understood as part of the "interlocking structures" (Brandchaft et al. 2010, p. 238) created between therapist and patient that became a launching point from which Anais and I could begin to question what she wanted for herself in her life. Her 'secret' was not that her caretakers had malevolently mistreated or sexually abused her, but that she believed that it was her mission to carry out their agenda in her life and that only by so doing could she maintain attachment to them. For her refractory eating disorder and body shame to diminish, Anais required the "sustaining support for fragile tendrils of self-delineation" (p. 175) of the therapeutic relationship to slowly, repetitively, and quietly challenge this mode of maintaining a human connection. The initial revelation of body shame by the patient, resonance in the countertransference of a co-created shame dynamic, and attunement to a split off secret experience of exceedingly high expectation in the family of origin that was 'hidden, but in plain view,' became the leading edge of the psychotherapy process. The journey that Anais and I had embarked upon took a decidedly darker turn into hidden regions from which both a truer sense of self may emerge as disagreement and negative or bitter feelings, and noncompliance can be repeatedly tested in the psychotherapeutic relationship.

Another Clinical Moment: Anton

"There is *nothing* you can tell me about diet, exercise, and the genetics of obesity that I don't already know!" Anton retorted after one more of my failed attempts to inquire about his understanding of why his thrice weekly sessions on the couch had led to change in almost every area of his life other than the one he had originally entered treatment to manage: his binge eating, endomorphic habitus, and alarming family history of morbid obesity, diabetes, and early death due to cardiovascular disease. A moderately successful career in the arts did not preclude Anton from serious study of human physiology, social psychology, and health outcomes. Like many eating disorder patients in our practices, he could argue both sides of the Size Acceptance Movement, recite the latest fads to lose and maintain weight, and tout the benefits of exercise and modest weight loss. He quoted implacably about moderate weight management recommendations but he followed none of them. His recalcitrance to change in spite of what he knew and supposedly wanted for himself left me perplexed and frustrated but also with a distinct bodily state signaling that more than resistance to insight or behavioral change on his part was in play. I felt trapped within my own body in a peculiar way, as if the mere attempt to offer Anton anything new from my clinical point of view hit a rubberized wall that had the bewildering capacity to hurl the idea right back at me. When I recovered my bearings after one particularly loud and discrediting denunciation, images of automated baseball machines from my youth sprang to mind. I pitched an intervention and Anton robotically threw 'my stuff' right back at me, except, so it felt, with double the original intensity and with an impact that immobilized any experience of clinical effectiveness.

The No-Entry Defense

The forcefulness of Anton's projections into me is an example of what Gianna Williams named the 'no-entry' defense (1997). She developed this concept after discovering that among patients she treated with anorexia and bulimia nervosa there was a massive failure in what Bion (1962) called the container/contained relationship because of a highly specific breakdown in the early attachment relationship. I wish to extend Williams' observation of the 'no-entry defense' to patients with BED who may have a similar history of 'disorganized' attachment or other traumatic antecedents in their development that precludes them from taking in therapeutic interventions of all kinds with a violence that may feel like a 'missile in the transference' (Williams 1997).

I believe that the repeated enactment of the no-entry defense on the part of the patient may be one etiology underlying why healthcare providers become frustrated and ostracize these patients in their practice. Efforts that range from providing relatively straightforward and easy to follow dietary and exercise regimens to more detailed behavior interventions are repeatedly rebuffed and can eventually disrupt the treatment relationship because the patient wishes to dispel of them, to turn the intervention itself back onto the clinician. Think of an exceedingly

effective (but so far only fictitious 'Star Wars') missile defense system that is able to reverse a weapon's trajectory once it is launched so that it lands and explodes where it originated, only with double its original, intended force. This is the position in which the clinician lies when working with patients who have a 'no-entry' defense in operation. Not only does the patient preclude useful information or understanding from permeating the psyche (no-entry) the patient also redirects 'the missile' into the object at the same time and thereby dismantles the therapeutic armamentaria simultaneously.

Based on the tenets of developmental theory and studies of survivors of trauma, this phenomenon occurs because the patient blocks contact with an inadequate caretaker or perpetrator of abuse as a survival mechanism. The original caretaker used their infant to contain and metabolize their needs, anxieties, and traumatic histories; the infant (our patient-to-be) was not only left to metabolize their own feelings but also had to erect an impermeable barrier to survive what was psychologically foisted upon them, that is, protection from a substantially emotive force from the caretaker. It is reasonable to wonder if laying down layers of adipose tissue are somatic mechanisms that can serve more than a physiological function in times of negative energy balance. Might one 'fear of being thin' (Castelnuovo-Tedesco and Reiser 1988) in some individuals like Anton arise from the 'no-entry' defense, wherein the perception of possible weight loss leaves one vulnerable and privy to invasion by a needful, invasive object and every layer of adiposity serves a definitive protective function that requires psychodynamic deconstruction over time?

I wish to emphasize that although statements like Anton's may temporarily derail us in our work, they deserve deeper scrutiny enabling them to be transformed in the fullness of time. In particular, when we clinicians feel countertransference shame, guilt, or prejudice about the habits and intractability of a symptom such as binging and its residual effects on the patient's body, consideration should be given to how we may have fallen victim to a massive projection on the patient's part that is totally out of their awareness. We must avoid the temptation to offer more "good food" by way of giving what may seem to us salient and lifesaving advice, patient education, behavioral tools, and psychodynamic interpretation. Understanding that a developmental deficit in mental functioning has been encountered, we must be prepared to play a very slow game of containment with our patient and to stay close to the bone of emotional experience. We must also pay attention to what our own body is telling us in the process to offer back to the patient meaningful reframing and affective attunement that is palatable to them.

As noted, working with remarks such as Anton's can make me feel defensive and angry, especially because I cannot use my countertransference in the typical manner of registering it and interpreting the projection by saying something like, "Anton, you seem to be telling me that I am not useful to you today. You must be angry. I wonder if it is about …" Rather, I must silently process my "bad analyst feeling" (Epstein 1987) in the room by emotional containment alone. Here I find the free association process most helpful and let my mind wander; I gently guide it to quietly hypothesize what I know about Anton's development that resulted in his 'no-entry' defense. This work, in contemporary parlance known as mentalization or reflective function, is the first essential step because it was what the original caretakers were not able to do and, in the case of traumatic experience, is derailed or cordoned off in another sector of the mind.

I have also found, however, that the processing of the no-entry defense cannot and does not end with reflection alone for most psychoanalysts and psychodynamic therapists who deal with eating and body issues. We must find other methods to work out what we contain in our practice through our bodies. Little is written about this in the professional psychoanalytic journals even though many practitioners make a point of talking about their exercise, yoga, barre, meditation, and physical activity routines privately or in passing to colleagues. Notice also how often a conversation or an email ends with the closure 'Take care' or a similar veiled reference to the body as well as psychological wellbeing. This is a curious phenomena in and of itself given how much 'the body' has made its way into contemporary discourse in psychoanalysis and because practitioners since the time of Freud have affirmed how important it is to consider every aspect of life as a portal for understanding more about the unconscious and the self.

Physical regimens help us to feel less trapped by what has been deposited into our bodies and are as essential to psychological wellbeing as they are to physical health. Deserving of further psychodynamic understanding is why clinicians have thought or written relatively little about the psychological meaning behind our own dietary, exercise, and health rituals that is beyond the scope of this communication. Might we consider that we all suffer from a bit of our own 'no-entry' defense when it comes to imagining what these forms of engagement in life mean beyond the manifest? Are we more comfortable in the realm of being 'talking heads' who idealize words and devalue corporality even as we simultaneously affirm the importance of physical action and health status in our lives by what we surreptitiously insinuate between the lines in our daily discourse and assignations?

When working in psychotherapy with an individual such as Anton, consider also that one must do more than contain and silently process affect (Barth 2014; Zerbe 1993a, b, 2008) when the resistance to take in the nourishing

interventions or interpretations of the therapist is virulently resisted. Consider instead the powerful force emanating from the no-entry defense that reverberates into psyche and soma of the therapist, creating in part some of the physiological countertransference phenomena discussed in the vignettes of Anais and Anton. Think of the no-entry defense as a kind of 'projective identification plus' phenomena. While an appreciation of the early attachment and later developmental dynamics help clinicians to make intellectual sense of what is happening between the patient and us, we must take particular care to also look after our own bodies. This includes, but is not limited to, paying attention to our health and making room for rest, periods of rejuvenation, and exercise in our daily lives as one facet of metabolizing the aggression, rejection, and violence we encounter daily.

Healthful care of one's body is done in moderation, however, and does not evanesce to preoccupation as in the 'false body' defense discussed below. Paying attention to one's own body thoughtfully is also a powerful source of positive identification for our patient who, for reasons related to the individual dynamic constellation of their primary caretakers, need models of regulation and self care. Patients with the 'no entry' defense are highly attuned to others' needs for their 'help' in regulating or coping and defensively try to turn the tables on the therapist by challenging boundaries. They are more comfortable in the role of helper than the one being helped. When the therapist demonstrates that she/he cares for physical and psychological needs of our own, it frees the patient to look after himself and, most crucially, whittle away at their 'no entry' defenses that preclude natural give and take in relationships and the 'learning from experience' (Bion 1962) that occurs daily when one can permit it to happen.

Another Family Secret Emerges

Anton's racial heritage was ambiguous. He shared in our first meetings that his parents' 'mixed marriage' had not created any manifest problems in his academic or personal life, had actually opened some opportunities for him in his art, and had not been a subject that we took up in the treatment until his niece needed a bone marrow donation for a ravaging cancer. Anton vehemently refused to be genetically tested despite his adoration and grave concern for this little girl. When I probed for his rationale, surmising that it had more to do with apprehension about the anticipated pain involved in the procedure (which could easily be controlled by medication and therefore quickly remediated with education) or finding out that he would not be suitable and therefore need to work through feelings of guilt and failure (obviously more sticky psychological concerns), he said, "My siblings and I don't have the same dad. They don't know that. I won't be the person to tell them. The genetic test will confirm the different fathers. Everyone will be a mess. Imagine the fallout after all these years, especially now when so much is about life and death."

Anton had not consciously withheld this information from himself or from me. It was neither repressed and therefore rendered unconscious, nor dissociated and split off as in another sector of his mind. Rather, it was held in abeyance, in what I have come to think of as a psychological 'netherworld' where family and other personal secrets may spontaneously and unpredictably emerge. Holding secrets may take untoward effects on a patient's psyche and soma with which neither the treating clinician nor the patient have suspected, let alone reckoned. In Anton's case, we were able to begin to wonder together if each layer of adipose tissue that he wanted desperately to be rid of on a conscious level served an unconscious function of encasing concealed knowledge that he knew would disrupt the family nexus when shared. His 'no-entry' defense could be then grasped on yet another level, as if to say, "I cannot allow myself to be truly penetrated by therapeutic zeal that will rob me of essential protections for the people I love and myself. I hold this secret knowledge at my own cost and will continue to build barriers to protect it even as I act as if I want to defeat my binging and problems created by being overweight."

Finding the True Self and Grappling with a False Body

One can think of Anton's dilemma as one of having a false self, shrouding his private knowledge about his background in order to protect others and himself from full autonomous functioning. Secrets and no-entry defenses work in a syncopated rhythm to "protect against archaic threats of disintegration due to self-loss and/or object loss and tend to emerge in those moments when an individual's distinctiveness might otherwise become most apparent" (Brandchaft et al. 2010, p. 194). Small wonder Anton chafed and then erupted by telling me that he knew everything he needed to know about weight reduction and binge alleviation. In fact, he did. He simply could not put the suggestions to use because they would disrupt the internal mechanisms essential for psychological survival. The false self always wins a pyric victory over the emergent True Self of the child or adult who believes, often based on idiosyncratic developmental history, that vital relationships and resources are at risk if one grows and becomes autonomous.

Following Freud's (1923) observation that the "ego is first and foremost a bodily ego" (p. 26), pediatrician and psychoanalyst D. W. Winnicott acknowledged that his concept of the True Self (Winnicott 1965) was also rooted in the body (Miller 2014; Zerbe 1993b, 2008). The child's

inherent tendency toward forward psychological and physical development only occurs when ongoing, nurturing exchanges with the mother are mutual, reliable, and lively. Inevitable disruptions, such as when the child becomes overwhelmed, frustrated or angry, are repaired when the primary caretakers have the internal capacity to understand the child's developmental needs and are available to emotionally contain and transform them through words and soothing gestures. I have also been impressed clinically with how adult figures of attachment who are important to the patient may also impinge on the body and self image, quickly eroding confidence and leading to demoralization. As psychotherapists, we must look more broadly at figures in the adult life cycle of our patients, and not just their earliest relationships, to fully comprehend their suffering (see also Barth 2014). In Anton's case, protectiveness and important attachment toward siblings and a beloved niece precluded the True Self from emerging and kept a family secret underground.

The concept of true and false self (Winnicott 1965) have been applied to understanding many different kinds of psychopathology in the late 20th and early twenty-first century. Splitting and dissociative phenomena that develop after trauma or deprivation and result in psychophysiological illnesses, self-harm syndromes or addictions, are somatic manifestations of the false self (Farber 2000; Farber et al. 2007; Zerbe 1993a, b, c, 2008). Binge eating problems are another case in point. These eating disorder symptoms are kept under raps from the therapist despite multiple attempts to welcome them into the clinical encounter because they are syntonic yet ultimately destructive to the body and sense of personal integrity.

One may conceptualize that the false self morphs to become also a 'false body' in conditions where the body plays a major role in heralding inner anguish and psychological catastrophe. Symptoms such as Anton's transmute to become actual false body phenomena. When speaking about aspects of the false self or false body in this way, we are actually veering away from seeing the concept as a useful metaphor of the mind or explanation for faulty psychological functioning alone and extending the concept to the soma (Miller 2014). Note that Anton's biracial identity was one aspect of his 'false body' experience because he would not acknowledge that he and his siblings had different fathers, let alone fathers of obviously varying racial lineages, even though it was obvious. Another 'secret, hidden but in plain view' complicated his perception of his body and fueled unconscious body hatred. Body image disturbance such as Anton's also fits into contemporary phenomenological understanding of binge eating where overvaluation of the shape and weight proves to be clinically significant phenomena but are not yet a diagnostic specifier (Smolak and Levine 2015; Kearney-Cooke and Tieger 2015). Patients who binge eat and have body image disturbance such as Anton are known to have a poorer prognosis than binge eating patients who do not (Eshkevari et al. 2014).

Sometimes even participating in seemingly healthy exercise regimes, maintaining a so-called healthy diet, and strict self-care rituals may be manifestations of the false body (Goldberg 2004). When these adaptations to life are disrupted what ensues is psychological breakdown or a return to more overt and potentially lethal symptoms (Zerbe 1992). Such persons may deny the need for the other when they inhabit a false body and can appear exceedingly independent superficially. These patients are actually exceedingly anxious about making emotional contact with others and experiencing normal human dependency needs (Sands 2003). On the other hand, patients with a false body can glom on to the therapist in a symbiotic, enmeshed fashion and are experienced by the therapist as intrusive and demanding. All the while, the patient may make limited progress yet treat the therapist as if essential to that patient's life. A parasitic relationship develops in which the therapist must actively work with intense countertransference feelings, especially related to maintaining appropriate therapeutic boundaries.

In summary, patients who inhabit a false body have significant difficulty in negotiating the inevitable tension between autonomy and mutuality in relationships. The therapist must help the patient to normalize the yearning for relationship and integrate this with a separate sense of self. In this way, the false body may gradually give way over time, and the patient can establish a sustained sense of separateness in the presence of another person. Consider that the false body may be a shroud for a sense of death in life that is responsible for countertransference reactions of ennui, despair, deadness, and psychophysiological reactions. One psychodynamic caveat for treating the false body is to focus on eating disorder symptoms and the sequels of poor self care. As Sands (2003, p. 108) has poignantly commented, "Because the patient's deepest needs are sequestered in her body, the therapist must remember the body. If we forget the patient's body, we forget the child in the patient."

Conclusion

Attending to the impact of shame, secrets, no-entry, and false body defenses provides another portal to understanding and helping patients with binge eating problems to gain ground in their recovery. Clinicians who work with these issues by creating a safe haven for listening to personal history will, over time, be rewarded with compelling lessons about the human experience. Secrets long withheld

but 'hidden in plain view,' as well as feelings of shame surface when the clinician begins to wonder with the patient why some symptoms have improved while others appear refractory to behavioral and pharmacologic intervention. Prompted by countertransference reactions that are lodged in the body, the therapist may first notice that something has gone awry or unspoken in the psychotherapeutic work because of physical sensations, gestures, postures, or aches and pains that occur during the patient's treatment hours or when the therapist reflects on a particular patient. The affects of disgust, depression, and guilt that are descriptive in the diagnosis of BED thus warrant greater psychodynamic scrutiny because they are unbearable to the patient and become scotomized, dissociated, or projected onto others. Taking into account the no-entry defense and the experience of having a 'false body' also attunes therapists to the difficulties some patients with binge eating have in allowing themselves to be healthfully dependent on others while inhabiting their own body.

Problems with binge eating superficially appear to be about regulation of intake and mood. A psychodynamic perspective takes into account that this disorder of psyche and soma is difficult to remediate until the patient can embrace a fuller sense of self, including one's own bodily self. This process necessitates that the individual acknowledge heretofore secret aspects of her/his historical past, including yearnings for a decidedly different life; confront extraordinary difficulties that she/he may have in accepting help (no-entry defense) and in warding off shame; and embrace a truer sense of her/his body and psychological self. This paper makes the case that the therapist must also wrestle with similar issues and that these concerns are often split off from clinician awareness to our detriment. Incorporating psychodynamic perspectives into an integrated treatment plan for BED has the potential to yield unique rewards for both patient and mental health clinician over time and to further enlighten health care professionals about why this problem so often becomes chronic despite a fuller contemporary diagnostic appreciation and therapeutic reservoir for recovery.

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