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Fat Lady

THE WORLD'S finest tennis players train five hours a day to eliminate weaknesses in their game. Zen masters endlessly aspire to quiescence of the mind, the ballerina to consummate balance; and the priest forever examines his conscience. Every profession has within it a realm of possibility wherein the practitioner may seek perfection. For the psychotherapist that realm, that inexhaustible curriculum of self-improvement from which one never graduates, is referred to in the trade as countertransference. Where *transference* refers to feelings that the patient erroneously attaches ("transfers") to the therapist but that in fact originated out of earlier relationships, *countertransference* is the reverse—similar irrational feelings the therapist has toward the patient. Sometimes countertransference is dramatic and makes deep therapy impossible: imagine a Jew treating a Nazi, or a woman who has once been sexually assaulted treating a rapist. But, in milder form, countertransference insinuates itself into every course of psychotherapy.

The day Betty entered my office, the instant I saw her steering her ponderous two-hundred-fifty-pound, five-foot-two-inch frame toward my trim, high-tech office chair, I knew that a great trial of countertransference was in store for me.

I have always been repelled by fat women. I find them disgusting:

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their absurd sidewise waddle, their absence of body contour—breasts, laps, buttocks, shoulders, jawlines, cheekbones, *everything*, everything I like to see in a woman, obscured in an avalanche of flesh. And I hate their clothes—the shapeless, baggy dresses or, worse, the stiff elephantine blue jeans with the barrel thighs. How dare they impose that body on the rest of us?

The origins of these sorry feelings? I had never thought to inquire. So deep do they run that I never considered them prejudice. But were an explanation demanded of me, I suppose I could point to the family of fat, controlling women, including—featuring—my mother, who peopled my early life. Obesity, endemic in my family, was a part of what I had to leave behind when I, a driven, ambitious, first-generation American-born, decided to shake forever from my feet the dust of the Russian shtetl.

I can take other guesses. I have always admired, perhaps more than many men, the woman's body. No, not just admired: I have elevated, idealized, ecstaticized it to a level and a goal that exceeds all reason. Do I resent the fat woman for her desecration of my desire, for bloating and profaning each lovely feature that I cherish? For stripping away my sweet illusion and revealing its base of flesh—flesh on the rampage?

I grew up in racially segregated Washington, D.C., the only son of the only white family in the midst of a black neighborhood. In the streets, the black attacked me for my whiteness, and in school, the white attacked me for my Jewishness. But there was always fatness, the fat kids, the big asses, the butts of jokes, those last chosen for athletic teams, those unable to run the circle of the athletic track. I needed someone to hate, too. Maybe that was where I learned it.

Of course, I am not alone in my bias. Cultural reinforcement is everywhere. Who ever has a kind word for the fat lady? But my contempt surpasses all cultural norms. Early in my career, I worked in a maximum security prison where the *least* heinous offense committed by any of my patients was a simple, single murder. Yet I had little difficulty accepting those patients, attempting to understand them, and finding ways to be supportive.

But when I see a fat lady eat, I move down a couple of rungs on the ladder of human understanding. I want to tear the food away. To push

her face into the ice cream. "Stop stuffing yourself! Haven't you had enough, for Chrissakes?" I'd like to wire her jaws shut!

Poor Betty—thank God, thank God—knew none of this as she innocently continued her course toward my chair, slowly lowered her body, arranged her folds and, with her feet not quite reaching the floor, looked up at me expectantly.

Now why, thought I, do her feet not reach the ground? She's not that short. She sat high in the chair, as though she were sitting in her own lap. Could it be that her thighs and buttocks are so inflated that her feet have to go farther to reach the floor? I quickly swept this conundrum from my mind—after all, this person had come to seek help from me. A moment later, I found myself thinking of the little fat woman cartoon figure in the movie *Mary Poppins*—the one who sings "Supercalifragilisticexpialidocious"—for that was who Betty reminded me of. With an effort I swept that away as well. And so it went: the entire hour with her was an exercise of my sweeping from my mind one derogatory thought after another in order to offer her my full attention. I fantasized Mickey Mouse, the sorcerer's apprentice in *Fantasia*, sweeping away my distracting thoughts until I had to sweep away that image, too, in order to attend to Betty.

As usual, I began to orient myself with demographic questions. Betty informed me that she was twenty-seven and single, that she worked in public relations for a large New York-based retail chain which, three months ago, had transferred her to California for eighteen months to assist in the opening of a new franchise.

She had grown up, an only child, on a small, poor ranch in Texas where her mother has lived alone since her father's death fifteen years ago. Betty was a good student, attended the state university, went to work for a department store in Texas, and after two years was transferred to the central office in New York. Always overweight, she became markedly obese in late adolescence. Aside from two or three brief periods when she lost forty to fifty pounds on crash diets, she had hovered between two hundred and two hundred fifty since she was twenty-one.

I got down to business and asked my standard opening question: "What ails?"

"Everything," Betty replied. Nothing was going right in her life. In fact, she said, she had no life. She worked sixty hours a week, had no

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friends, no social life, no activities in California. Her life, such as it was, she said, was in New York, but to request a transfer now would doom her career, which was already in jeopardy because of her unpopularity with co-workers. Her company had originally trained her, along with eight other novices, in a three-month intensive course. Betty was preoccupied that she was neither performing nor progressing through promotions as well as her eight classmates. She lived in a furnished suburban apartment doing nothing, she said, but working and eating and chalking off the days till her eighteen months were up.

A psychiatrist in New York, Dr. Farber, whom she saw for approximately four months, had treated her with antidepressant medication. Though she continued to take it, it had not helped her: she was deeply depressed, cried every evening, wished she were dead, slept fitfully, and always awoke by four or five A.M. She moped around the house and on Sundays, her day off, never dressed and spent the day eating sweets in front of the television set. The week before, she had phoned Dr. Farber, who gave her my name and suggested she call for a consultation.

"Tell me more about what you're struggling with in your life," I asked.

"My eating is out of control," Betty said, chuckling, and added, "You could say my eating is always out of control, but now it is *really* out of control. I've gained around twenty pounds in the past three months, and I can't get into most of my clothes."

That surprised me, her clothes seeming so formless, so infinitely expandable, that I couldn't imagine them being outdistanced.

"Other reasons why you decided to come in just now?"

"I saw a medical doctor last week for headaches, and he told me that my blood pressure is dangerously high, around 220 over 110, and that I've got to begin to lose weight. He seemed upset. I don't know how seriously to take him—everyone in California is such a health nut. He wears jeans and running shoes in his office."

She uttered all these things in a gay chatty tone, as though she were talking about someone else, or as though she and I were college sophomores swapping stories in a dorm some rainy Sunday afternoon. She tried to poke me into joining the fun. She told jokes. She had a gift for imitating accents and mimicked her laid-back Marin County physician,

her Chinese customers, and her Midwestern boss. She must have laughed twenty times during the session, her high spirits apparently in no way dampened by my stern refusal to be coerced into laughing with her.

I always take very seriously the business of entering into a treatment contract with a patient. Once I accept someone for treatment, I commit myself to stand by that person: to spend all the time and all the energy that proves necessary for the patient's improvement; and most of all, to relate to the patient in an intimate, authentic manner.

But could I relate to Betty? To be frank, she revolted me. It was an effort for me to locate her face, so layered and swathed in flesh as it was. Her silly commentary was equally offputting. By the end of our first hour, I felt irritated and bored. Could I be intimate with her? I could scarcely think of a single person with whom I *less* wished to be intimate. But this was *my* problem, not Betty's. It was time, after twenty-five years of practice, for me to change. Betty represented the ultimate countertransference challenge—and, for that very reason, I offered then and there to be her therapist.

Surely no one can be critical of a therapist striving to improve his technique. But what, I wondered uneasily, about the rights of the patient? Is there not a difference between a therapist scrubbing away unseemly countertransference stains and a dancer or a Zen master striving for perfection in each of those disciplines? It is one thing to improve one's backhand service return but quite another to sharpen one's skills at the expense of some fragile, troubled person.

These thoughts all occurred to me but I found them dismissible. It was true that Betty offered an opportunity to improve my personal skills as a therapist. It was, however, also true that my future patients would benefit from whatever growth I would attain. Besides, human service professionals have always practiced on the living patient. There is no alternative. How could medical education, to take one example, survive without student clinical clerkships? Furthermore, I have always found that responsible neophyte therapists who convey their sense of curiosity and enthusiasm often form excellent therapeutic relationships and can be as effective as a seasoned professional.

It's the relationship that heals, the relationship that heals, the relationship that heals—my professional rosary. I say that often to students. And

say other things as well, about the way to relate to a patient—positive unconditional regard, nonjudgmental acceptance, authentic engagement, empathic understanding. How was I going to be able to heal Betty through our relationship? How authentic, empathic, or accepting could I be? How honest? How would I respond when she asked about my feelings toward her? It was my hope that I would change as Betty and I progressed in her (our) therapy. For the time being, it seemed to me that Betty's social interactions were so primitive and superficial that no penetrating therapist-patient relationship analysis would be necessary.

I had secretly hoped that her appearance would be offset in some way by her interpersonal characteristics—that is, by the sheer vivacity or mental agility I have found in a few fat women—but that, alas, was not to be. The better I knew her, the more boring and superficial she seemed.

During the first few sessions, Betty described, in endless detail, problems she encountered at work with customers, co-workers, and bosses. She often, despite my inner groans, described some particularly banal conversation by playing several of the roles—I've always hated that. She described, again in tedious detail, all the attractive men at work and the minute, pathetic machinations she'd go through to exchange a few sentences with them. She resisted every effort on my part to dip beneath the surface.

Not only was our initial, tentative "cocktail chatter" indefinitely prolonged, but I had a strong sense that, even when we got past this stage, we would remain fused to the surface of things—that as long as Betty and I met, we were doomed to talk about pounds, diets, petty work grievances, and the reasons she did not join an aerobics class. Good Lord, what had I gotten myself into?

Every one of my notes of these early sessions contains phrases such as: "Another boring session"; "Looked at the clock about every three minutes today"; "The most boring patient I have ever seen"; "Almost fell asleep today—had to sit up in my chair to stay awake"; "Almost fell off my chair today."

While I was considering shifting to a hard, uncomfortable chair, it suddenly occurred to me that when I was in therapy with Rollo May, he used to sit in a straight-backed wooden chair. He said he had a bad back,

but I knew him well for many years afterward and never heard him mention back trouble. Could it be that he found *me*——?

Betty mentioned that she hadn't liked Dr. Farber because he often fell asleep during their hour. Now I knew why! When I spoke to Dr. Farber on the phone, he did not mention his naps, of course, but he did volunteer that Betty had not been able to learn how to use therapy. It was not hard to understand why he had started her on medication; we psychiatrists so often resort to that when we cannot get anything going in therapy.

Where to start? How to start? I struggled to find some handhold. It was pointless to begin by addressing her weight. Betty made it clear immediately that she hoped therapy would help her get to the point where she could seriously consider weight reduction, but she was a long way from that at this time. "When I'm this depressed, eating is the only thing that keeps me going."

But when I focused on her depression, she presented a persuasive case that depression was an appropriate response to her life situation. Who wouldn't feel depressed holed up in a small furnished apartment in an impersonal California suburb for eighteen months, torn away from one's real life—one's home, social activities, friends?

So I then attempted to help her work on her life situation, but I could make little headway. She had plenty of daunting explanations. She didn't make friends easily, she pointed out: no obese woman does. (On that point I needed no persuasion.) People in California had their own tight cliques and did not welcome strangers. Her only social contacts were at work, where most of her co-workers resented her supervisory role. Besides, like all Californians, they were jocks—into surfing and skydiving. Could I see her doing that? I swept away a fantasy of her slowly sinking on a surfboard and acknowledged she had a point—those did not seem to be her sports.

What other options were there? she asked. The singles world is impossible for obese people. To prove that point, she described a desperation date she had had the month before—her only date in years. She answered an ad in the personal section of *The Bay Guardian*, a local newspaper. Although most of the ads placed by men explicitly specified a

“slim” woman, one did not. She called and arranged to go out to dinner with a man named George, who asked her to wear a rose in her hair and to meet him in the bar of a local restaurant.

His face fell, she reported, when he first caught sight of her, but, to his everlasting credit, he acknowledged that he was indeed George and then behaved like a gentleman throughout dinner. Though Betty never again heard from George, she often thought about him. On several other such attempts in the past, she had been stood up by men who probably spotted her from afar and left without speaking to her.

In some desperation, I stretched for ways to be helpful to Betty. Perhaps (in an effort to conceal my negative feelings) I tried too hard, and I made the beginner's mistake of suggesting other options. Had she considered the Sierra Club? No, she lacked the stamina for hiking. Or Overeaters Anonymous, which might provide some social network. No, she hated groups. Other suggestions met a similar fate. There had to be some other way.

The first step in all therapeutic change is responsibility assumption. If one feels in no way responsible for one's predicament, then how can one change it? That was precisely the situation with Betty: she completely externalized the problem. It was not *her* doing: it was the work transfer, or the sterile California culture, or the absence of cultural events, or the jock social scene, or society's miserable attitude toward obese people. Despite my best efforts, Betty denied any personal contribution to her unhappy life situation.

Oh yes, she could, on an intellectual level, agree that, if she stopped eating and lost weight, the world might treat her differently. But that was too far removed from her, too long term, and her eating seemed too much out of her control. Besides she marshaled other responsibility-absolving arguments: the genetic component (there was considerable obesity on both sides of her family); and the new research demonstrating physiological abnormalities in the obese, ranging from lower basal metabolic rates to a preset, programmed, relatively unfluencible body weight. No, that would not work. Ultimately I would have to help her assume responsibility for her appearance—but saw no leverage for achieving that at this time. I had to start with something more immediate. I knew a way.

The psychotherapist's single most valuable practical tool is the "process" focus. Think of *process* as opposed to *content*. In a conversation, the content consists of the actual words uttered, the substantive issues discussed; the process, however, is *how* the content is expressed and especially what this mode of expression reveals about the relationship between the participating individuals.

What I had to do was to get away from the content—to stop, for example, attempting to provide simplistic solutions to Betty—and to focus on process—on how we were relating to each other. And there was one outstanding characteristic of our relationship—*boredom*. And that is precisely where countertransference complicates things: I had to be clear about how much of the boredom was *my* problem, about how bored I would be with *any* fat woman.

So I proceeded cautiously—too cautiously. My negative feelings slowed me down. I was too afraid of making my aversion visible. I would never have waited so long with a patient I liked more. I spurred myself to get moving. If I were going to be helpful to Betty, I had to sort out, to trust, and to act upon my feelings.

The truth was that this was a very boring lady, and I needed to confront her with that in some acceptable way. She could deny responsibility for anything else—the absence of friends in her current life, the tough singles scene, the horrors of suburbia—but I was *not* going to let her deny responsibility for boring me.

I dared not utter the word *boring*—far too vague and too pejorative. I needed to be precise and constructive. I asked myself what, exactly, was boring about Betty, and identified two obvious characteristics. First of all, she never revealed anything intimate about herself. Second, there was her damned giggling, her forced gaiety, her reluctance to be appropriately serious.

It would be difficult to make her aware of these characteristics without hurting her. I decided upon a general strategy: my basic position would be that I wanted to get closer to her but that her behavioral traits got in the way. I thought it would be difficult for her to take offense with any criticism of her behavior when framed in that context. She could only be pleased at my wanting to know her better. I decided to start with her lack of self-revelation and, toward the end of a particularly soporific session, took the plunge.

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“Betty, I’ll explain later why I’m asking you this, but I’d like you to try something new today. Would you give yourself a score from one to ten on how much revealing about yourself you’ve done during our hour together today? Consider ten to be the most significant revealing you can imagine and one to be the type of revealing you might do, let’s say, with strangers in a line at the movies.”

A mistake. Betty spent several minutes explaining why she wouldn’t go to the movies alone. She imagined people pitied her for having no friends. She sensed their dread that she might crowd them by sitting next to them. She saw the curiosity, the bemusement in their faces as they watched to see whether she could squeeze into a single narrow movie seat. When she began to digress further—extending the discussion to airline seats and how seated passengers’ faces grew white with fear when she started down the aisle searching for her seat—I interrupted her, repeated my request, and defined “one” as “casual conversation at work.”

Betty responded by giving herself a “ten.” I was astonished (I had expected a “two” or “three”) and told her so. She defended her rating on the basis that she had told me things she had never shared before: that, for example, she had once stolen a magazine from a drugstore and was fearful about going alone to a restaurant or to the movies.

We repeated that same scenario several times. Betty insisted she was taking huge risks, yet, as I said to her, “Betty, you rate yourself ‘ten,’ yet it didn’t *feel* that way to me. It didn’t feel that you were taking a real risk with me.”

“I have never told anybody else these things. Not Dr. Farber, for example.”

“How do you feel telling me these things?”

“I feel fine doing it.”

“Can you use other words than *fine*? It must be scary or liberating to say these things for the first time!”

“I feel O.K. doing it. I know you’re listening professionally. It’s O.K. I feel O.K. I don’t know what you want.”

“How can you be so sure I’m listening professionally? You have no doubts?”

Careful, careful! I couldn’t promise more honesty than I was willing to

give. There was no way that she could deal with my revelation of negative feelings. Betty denied any doubts—and at this point told me about Dr. Farber's falling asleep on her and added that I seemed much more interested than he.

What *did* I want from her? From *her* standpoint she was revealing much. I had to be sure I really knew. What was there about her revealing that left me unmoved? It struck me that she was always revealing something that occurred elsewhere—another time, another place. She was incapable, or unwilling, to reveal herself in the immediate present that we two were sharing. Hence, her evasive response of “O.K.” or “Fine” whenever I asked about her here-and-now feelings.

That was the first important discovery I made about Betty: she was desperately isolated, and she survived this isolation only by virtue of the sustaining myth that her intimate life was being lived elsewhere. Her friends, her circle of acquaintances, were not here, but elsewhere, in New York, in Texas, in the past. In fact, everything of importance was elsewhere. It was at this time that I first began to suspect that for Betty there was no “here” there.

Another thing: if she was revealing more of herself to me than to anyone before, then what was the nature of her close relationships? Betty responded that she had a reputation for being easy to talk to. She and I, she said, were in the same business: she was everyone's therapist. She added that she had a lot of friends, but no one knew *her*. Her trademark was that she listened well and was entertaining. She hated the thought, but the stereotype was true: she was the jolly fat woman.

This led naturally into the other primary reason I found Betty so boring: she was acting in bad faith with me—in our face-to-face talks she was never real, she was all pretense and false gaiety.

“I'm really interested in what you said about being, or rather pretending to be, jolly. I think you are determined, absolutely committed, to be jolly with me.”

“Hmmm, interesting theory, Dr. Watson.”

“You've done this since our first meeting. You tell me about a life that is full of despair, but you do it in a bouncy ‘aren't-we-having-a-good-time?’ way.”

“That's the way I am.”

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"When you stay jolly like that, I lose sight of how much pain you're having."

"That's better than wallowing in it."

"But you come here for help. Why is it so necessary for you to entertain me?"

Betty flushed. She seemed staggered by my confrontation and retreated by sinking into her body. Wiping her brow with a tiny handkerchief, she stalled for time.

"Zee suspect takes zee fifth."

"Betty, I'm going to be persistent today. What would happen if you stopped trying to entertain me?"

"I don't see anything wrong with having some fun. Why take everything so . . . so . . . I don't know— You're always so serious. Besides, this is me, this is the way I am. I'm not sure I know what you're talking about. What do you mean by my entertaining you?"

"Betty, this is important, the most important stuff we've gotten into so far. But you're right. First, you've got to know exactly what I mean. Would it be O.K. with you if, from now on in our future sessions, I interrupt and point out when you're entertaining me—the moment it occurs?"

Betty agreed—she could hardly refuse me; and I now had at my disposal an enormously liberating device. I was now permitted to interrupt her instantaneously (reminding her, of course, of our new agreement) whenever she giggled, adopted a silly accent, or attempted to amuse me or to make light of things in any distracting way.

Within three or four sessions, her "entertaining" behavior disappeared as she, for the first time, began to speak of her life with the seriousness it deserved. She reflected that she had to be entertaining to keep others interested in her. I commented that, in this office, the opposite was true: the more she tried to entertain me, the more distant and less interested I felt.

But Betty said she didn't know how else to be: I was asking her to dump her entire social repertoire. Reveal herself? If she were to reveal herself, what would she show? There was nothing there inside. She was empty. (The word *empty* was to arise more and more frequently as

therapy proceeded. Psychological “emptiness” is a common concept in the treatment of those with eating disorders.)

I supported her as much as possible at this point. Now, I pointed out to Betty, she was taking risks. Now she was up to eight or nine on the revealing scale. Could she feel the difference? She got the point quickly. She said she felt frightened, like jumping out of a plane without a parachute.

I was less bored now. I looked at the clock less frequently and once in a while checked the time during Betty’s hour not, as before, to count the number of minutes I had yet to endure, but to see whether sufficient time remained to open up a new issue.

Nor was it necessary to sweep from my mind derogatory thoughts about her appearance. I no longer noticed her body and, instead, looked into her eyes. In fact, I noted with surprise the first stirrings of empathy within me. When Betty told me about going to a western bar where two rednecks sidled up behind her and mocked her by mooing like a cow, I felt outraged for her and told her so.

My new feelings toward Betty caused me to recall, and to be ashamed of, my initial response to her. I cringed when I reflected on all the other obese women whom I had related to in an intolerant and dehumanized fashion.

These changes all signified that we were making progress: we were successfully addressing Betty’s isolation and her hunger for closeness. I hoped to show her that another person could know her fully and still care for her.

Betty now felt definitely engaged in therapy. She thought about our discussions between sessions, had long imaginary conversations with me during the week, looked forward to our meetings, and felt angry and disappointed when business travel caused her to miss meetings.

But at the same time she became unaccountably more distressed and reported more sadness and more anxiety. I pounced at the opportunity to understand this development. Whenever the patient begins to develop symptoms in respect to the relationship with the therapist, therapy has really begun, and inquiry into these symptoms will open the path to the central issues.

Her anxiety had to do with her fear of getting too dependent or addicted to therapy. Our sessions had become the most important thing in her life. She didn't know what would happen to her if she didn't have her weekly "fix." It seemed to me she was still resisting closeness by referring to a "fix" rather than to me, and I gradually confronted her on that point.

"Betty, what's the danger in letting me matter to you?"

"I'm not sure. It feels scary, like I'll need you too much. I'm not sure you'll be there for me. I'm going to have to leave California in a year, remember."

"A year's a long time. So you avoid me now because you won't always have me?"

"I know it doesn't make sense. But I do the same thing with California. I like New York and I don't want to like California. I'm afraid that, if I form friends here and start to like it, I might not want to leave. The other thing is that I start to feel, 'Why bother?' I'm here for such a short time. Who wants temporary friendships?"

"The problem with that attitude is you end up with an unpeopled life. Maybe that's part of the reason you feel empty inside. One way or another, every relationship must end. There's no such thing as a lifetime guarantee. It's like refusing to enjoy watching the sun rise because you hate to see it set."

"It sounds crazy when you put it like that, but that's what I do. When I meet a new person whom I like, I start right away to imagine what it will be like to say goodbye to them."

I knew this was an important issue, and that we would return to it. Otto Rank described this life stance with a wonderful phrase: "Refusing the loan of life in order to avoid the debt of death."

Betty now entered into a depression which was short-lived and had a curious, paradoxical twist. She was enlivened by the closeness and the openness of our interaction; but, rather than allow herself the enjoyment of that feeling, she was saddened by the realization that her life heretofore had been so devoid of intimacy.

I was reminded of another patient I had treated the year before, a forty-four-year-old excessively responsible, conscientious physician. One

evening in the midst of a marital dispute, she uncharacteristically drank too much, went out of control, threw plates against the wall, and narrowly missed her husband with a lemon pie. When I saw her two days later, she seemed guilty and depressed. In an effort to console her, I tried to suggest that losing control is not always a catastrophe. But she interrupted and told me I had misunderstood: she felt no guilt but was instead overcome with regret that she had waited until she was forty-four to relinquish her controls and let some real feelings out.

Despite her two hundred and fifty pounds, Betty and I had rarely discussed her eating and her weight. She had often talked about epic (and invariably unproductive) struggles she had had with her mother and with other friends who tried to help her control her eating. I was determined to avoid that role; instead, I placed my faith in the assumption that, if I could help remove the obstacles that lay in her path, Betty would, on her own, take the initiative to care for her body.

So far, by addressing her isolation, I had already cleared away major obstacles: Betty's depression had lifted; and, having established a social life for herself, she no longer regarded food as her sole source of satisfaction. But it was not until she stumbled upon an extraordinary revelation about the dangers of losing weight that she could make the decision to begin her diet. It came about in this way.

When she had been in therapy for a few months, I decided that her progress would be accelerated if she worked in a therapy group as well as in individual therapy. For one thing, I was certain it would be wise to establish a supportive community to help sustain her in the difficult diet days yet to come. Furthermore, a therapy group would provide Betty an opportunity to explore the interpersonal issues we had opened up in our therapy—the concealment, the need to entertain, the feeling she had nothing to offer. Though Betty was very frightened and initially resisted my suggestion, she gamely agreed and entered a therapy group led by two psychiatric residents.

One of her first group meetings happened to be a highly unusual session in which Carlos, also in individual therapy with me (see "If Rape Were Legal . . ."), informed the group of his incurable cancer. Betty's father had died of cancer when she was twelve, and since then she had

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been terrified of the disease. In college she had initially elected a pre-medical curriculum but gave it up for fear of being in contact with cancer patients.

Over the next few weeks, the contact with Carlos generated so much anxiety in Betty that I had to see her in several emergency sessions and had difficulty persuading her to continue in the group. She developed distressing physical symptoms—including headaches (her father died of brain cancer), backaches, and shortness of breath—and was tormented with the obsessive thought that she, too, had cancer. Since she was phobic about seeing doctors (because of her shame about her body, she rarely permitted a physical exam and had never had a pelvic exam), it was hard to reassure her about her health.

Witnessing Carlos's alarming weight loss reminded Betty of how, over a twelve-month period, she had watched her father shrink from an obese man to a skeleton wrapped in great folds of spare skin. Though she acknowledged that it was an irrational thought, Betty realized that since her father's death she had believed that weight loss would make her susceptible to cancer.

She had strong feelings about hair loss as well. When she first joined the group, Carlos (who had lost his hair as a result of chemotherapy) was wearing a toupee, but the day he informed the group about his cancer, he came bald to the meeting. Betty was horrified, and visions of her father's baldness—he had been shaven for his brain surgery—returned to her. She remembered also how frightened she had been when, on previous strenuous diets, she herself had suffered considerable hair loss.

These disturbing feelings had vastly compounded Betty's weight problems. Not only did food represent her sole form of gratification, not only was it a method of assuaging her feeling of emptiness, not only did thinness evoke the pain of her father's death, but she felt, unconsciously, that losing weight would result in *her* death.

Gradually Betty's acute anxiety subsided. She had never before talked openly about these issues: perhaps the sheer catharsis helped; perhaps it was useful for her to recognize the magical nature of her thinking; perhaps some of her horrifying thoughts were simply desensitized by talking about them in the daylight in a calm, rational manner.

During this time, Carlos was particularly helpful. Betty's parents had,

until the very end, denied the seriousness of her father's illness. Such massive denial always plays havoc with the survivors, and Betty had neither been prepared for his death nor had the opportunity to say goodbye. But Carlos modeled a very different approach to his fate: he was courageous, rational, and open with his feelings about his illness and his approaching death. Furthermore, he was especially kind to Betty—perhaps it was that he knew she was my patient, perhaps that she came along when he was in a generous (“everybody has got a heart”) state of mind, perhaps simply that he always had a fondness for fat women (which, I regret to say, I had always considered further proof of his perversity).

Betty must have felt that the obstructions to losing weight had been sufficiently removed because she gave unmistakable evidence that a major campaign was about to be launched. I was astonished by the scope and complexity of the preparatory arrangements.

First, she enrolled in an eating-disorder program at the clinic where I worked and completed their demanding protocol, which included a complex physical workup (she still refused a pelvic exam) and a battery of psychological tests. She then cleared her apartment of food—every can, every package, every bottle. She made plans for alternative social activities: she pointed out to me that eliminating lunches and dinners puts a crimp into one's social calendar. To my surprise, she joined a square-dancing group (this lady's got guts, I thought) and a weekly bowling league—her father had often taken her bowling when she was a child, she explained. She bought a used stationary bicycle and set it up in front of her TV set. She then said her goodbyes to old friends—her last Granny Goose Hawaiian-style potato chip, her last Mrs. Fields chocolate chip cookie, and, toughest of all, her last honey-glazed doughnut.

There was considerable internal preparation as well, which Betty found difficult to describe other than to say she was “gathering inner resolve” and waiting for the right moment to commence the diet. I grew impatient and amused myself with a vision of an enormous Japanese sumo wrestler pacing, posturing, and grunting himself into readiness.

Suddenly she was off! She went on a liquid Optifast diet, ate no solid food, bicycled forty minutes every morning, walked three miles every afternoon, and bowled and square-danced once a week. Her fatty casing

began to disintegrate. She began to shed bulk. Great chunks of overhanging flesh broke off and were washed away. Soon the pounds flowed off in rivulets—two, three, four, sometimes five pounds a week.

Betty started each hour with a progress report: ten pounds lost, then twenty, twenty-five, thirty. She was down to two hundred forty pounds, then two hundred thirty, and two hundred twenty. It seemed astonishingly fast and easy. I was delighted for her and commended her strongly each week on her efforts. But in those first weeks I was also aware of an uncharitable voice within me, a voice saying, "Good God, if she's losing it that fast, think of how much food she must have been putting away!"

The weeks passed, the campaign continued. After three months, she weighed in at two hundred ten. Then two hundred, a fifty-pound loss! Then one hundred ninety. The opposition stiffened. Sometimes she came into my office in tears after a week without food and no compensating weight loss. Every pound put up a fight, but Betty stayed on the diet.

Those were ghastly months. She hated everything. Her life was a torment—the disgusting liquid food, the stationary bicycle, the hunger pangs, the diabolic McDonald's hamburger ads on television, and the smells, the ubiquitous smells: popcorn in the movies, pizza in the bowling alley, croissants in the shopping center, crab at Fisherman's Wharf. Was there nowhere in the world an odor-free place?

Every day was a bad day. Nothing in her life gave her pleasure. Others in the eating-disorder clinic's weight-reduction group gave up—but Betty hung tough. My respect for her grew.

I like to eat, too. Often I look forward all day to a special meal; and, when the craving strikes, no obstacle can block my way to the dim sum restaurant or the gelato stand. But as Betty's ordeal continued, I began to feel guilty eating—as though I were acting in bad faith toward her. Whenever I sat down to eat pizza or pasta al pesto or enchiladas con salsa verde or German-chocolate-cake ice cream, or any other special treat I knew Betty liked, I thought of her. I shuddered when I thought of her dining, can opener in hand, on Optifast liquid. Sometimes I passed up seconds in her honor.

It happened that, during this period, I passed the upper weight limit I allow myself, and went on a three-week diet. Since my diets consist

primarily of eliminating ice cream and French fries, I could hardly say to Betty that I was joining hands with her in a sympathy fast. Nonetheless, during these three weeks I felt her deprivation more keenly. I was moved now when she told me how she cried herself to sleep. I ached for her when she described the starving child within her howling, "Feed me! Feed me!"

One hundred eighty. One hundred seventy. An eighty-pound weight loss! Betty's mood now fluctuated wildly, and I grew increasingly concerned for her. She had occasional brief periods of pride and exhilaration (especially when she went shopping for slimmer clothing), but mainly she experienced such deep despondency that it was all she could do to get herself to work each morning.

At times she grew irritable and raised several old grievances with me. Had I referred her to a therapy group as a way of dumping her or, at least, sharing the load and getting her partly off my hands? Why had I not asked her more about her eating habits? After all, eating was her life. Love her, love her eating. (Careful, careful, she's getting close.) Why had I agreed with her when she listed the reasons that medical school was not possible for her (her age, lack of stamina, laziness, having taken few of the prerequisite courses, and lack of funds)? She viewed, she told me now, my suggestion about a possible career in nursing as a putdown, and accused me of saying, "The girl's not smart enough for medical school—so let her be a nurse!"

At times, she was petulant and regressed. Once, for example, when I inquired about why she had become inactive in her therapy group, she simply glared and refused to answer. When I pressed her to say exactly what was on her mind, she said in a singsong child's voice, "If I can't have a cookie, I won't do anything for you."

During one of her depressed periods, she had a vivid dream.

I was in a place like Mecca where people go to commit suicide legally. I was with a close friend but I don't remember who. She was going to commit suicide by jumping down a deep tunnel. I promised her I'd retrieve her body but, later, I realized that to do this I'd have to crawl down this terrible tunnel with all sorts of dead and decaying bodies around and I didn't think I could do it.

In associating to this dream Betty said that, earlier the day of the dream, she had been thinking that she had shed a whole body: she had lost eighty pounds, and there was a woman in her office who weighed only eighty pounds. At the time she had imagined granting an autopsy and holding a funeral for the "body" she had shed. This macabre thought, Betty suspected, was echoed in the dream image of retrieving her friend's dead body from the tunnel.

The imagery and depth of the dream brought home to me how far she had come. It was hard to remember the giggling, superficial woman of a few months before. Betty had my full attention for every minute of every session now. Who could have imagined that, out of that woman whose vacuous chatter had so bored me and her previous psychiatrist, this thoughtful, spontaneous, and sensitive person could have emerged?

One hundred sixty-five. Another kind of emergence was taking place. One day in my office I looked over at Betty and noticed, for the first time, that she had a lap. I looked again. Had it always been there? Maybe I was paying more attention to her now. I didn't think so: her body contour, from chin to toes, had always been smoothly globular. A couple of weeks later, I saw definite signs of a breast, two breasts. A week later, a jawline, then a chin, an elbow. It was all there—there had been a person, a handsome woman, buried in there all the time.

Others, especially men, had noticed the change, and now touched and poked her during conversations. A man at the office walked her out to her car. Her hairdresser, gratuitously, gave her a scalp massage. She was certain her boss was eyeing her breasts.

One day Betty announced, "one hundred fifty-nine," and added that this was "virgin territory"—that is, she hadn't weighed in the one hundred fifties since high school. Though my response—asking whether she worried about entering "nonvirgin territory"—was a sorry joke, it nonetheless initiated an important discussion about sex.

Though she had an active sexual fantasy life, she had never had any physical contact with a man—not a hug, not a kiss, not even a lascivious grab. She had always craved sex and was angry that society's attitude toward the obese sentenced her to sexual frustration. Only now, when she was approaching a weight when sexual invitations might materialize, only now when her dreams teemed with menacing male figures (a

masked doctor plunging a large hypodermic needle into her abdomen, a leering man peeling the scab off a large abdominal wound), did she recognize that she was very frightened of sex.

These discussions released a flood of painful memories about a lifetime of rejection by males. She had never been asked on a date and never attended a school dance or party. She played the confidante role very well and had helped many friends plan their weddings. They were just about all married off now, and she could no longer conceal from herself that she would forever play the role of the unchosen observer.

We soon moved from sex into the deeper waters of her basic sexual identity. Betty had heard that her father had really wanted a son and been silently disappointed when she was born. One night she had two dreams about a lost twin brother. In one dream she and he wore identification badges and kept switching them with each other. She finished him off in another dream: he squeezed into a crowded elevator into which she couldn't fit (because of her size). Then the elevator crashed, killing all the passengers, and she was left sifting through his remains.

In another dream, her father gave her a horse called "She's a Lady." She had always wanted a horse from him, and in the dream not only was that childhood wish fulfilled but her father officially christened her a lady.

Our discussions about sexual practice and her sexual identity generated so much anxiety and such an agonizing sense of emptiness that, on several occasions, she binged on cookies and doughnuts. By now Betty was permitted some solid food—one diet TV dinner a day—but found this more difficult to follow than the liquid-only diet.

Looming ahead was an important symbolic marker—the loss of the one-hundredth pound. This specific goal, never to be attained, had powerful sexual connotations. For one thing Carlos had, months before, only half jokingly told Betty he was going to take her to Hawaii for a weekend when she had lost a hundred pounds. Furthermore, as part of her pre-diet mental preparation, Betty had vowed herself that when she lost a hundred pounds she was going to contact George, the man whose personal ad she had answered, to surprise him with her new body and reward his gentlemanly behavior with her sexual favors.

In an effort to reduce her anxiety, I urged moderation and suggested

she approach sex with less drastic steps: for example, by spending time talking to men; by educating herself about such topics as sexual anatomy, sexual mechanics, and masturbation. I recommended reading material and urged her to visit a female gynecologist and to explore these issues with her girlfriends and her therapy group.

Throughout this period of rapid weight loss, another extraordinary phenomenon was taking place. Betty experienced emotional flashbacks and would spend much of a therapy hour tearfully discussing startlingly vivid memories, such as the day she left Texas to move to New York, or her college graduation, or her anger at her mother for being too timid and fearful to attend her high school graduation.

At first it seemed that these flashbacks, as well as the accompanying extreme mood swings, were chaotic, random occurrences; but after several weeks, Betty realized that they were following a coherent pattern: as she lost weight she *re-experienced the major traumatic or unresolved events of her life that had occurred when she was at a particular weight*. Thus her descent from two hundred fifty pounds set her spinning backward in time through the emotionally charged events of her life: leaving Texas for New York (210 pounds), her college graduation (190 pounds), her decision to drop the pre-med curriculum (and to give up the dream of discovering the cure for the cancer that killed her father) (180 pounds), her loneliness at her high school graduation—her envy of other daughters and fathers, her inability to get a date for the senior prom (170 pounds), her junior high graduation and how much she missed her father at that graduation (155 pounds). What a wonderful proof of the unconscious realm! Betty's body had remembered what her mind had long forgotten.

Memories of her father permeated these flashbacks. The closer we looked, the more apparent it was that everything led back to him, to his death, and to the one hundred fifty pounds Betty weighed at that time. The closer she approached that weight, the more depressed she grew and the more her mind swarmed with feelings and recollections of her father.

Soon we spent entire sessions talking about her father. The time had come to unearth everything. I plunged her into reminiscence and encouraged her to express everything she could remember about his illness, his dying, his appearance in the hospital the last time she saw him, the

details of his funeral, the clothes she wore, the minister's speech, the people who attended.

Betty and I had talked about her father before but never with such intensity and depth. She felt her loss as never before and, over a two-week period, wept almost continuously. We met thrice weekly during this time, and I attempted to help her understand the source of her tears. In part she cried because of her loss, but in large part because she considered her father's life to have been such a tragedy: he never obtained the education he wanted (or that she wanted for him), and he died just before he retired and never enjoyed the years of leisure for which he had longed. Yet, as I pointed out to her, her description of his life's activities—his large extended family, his wide social circle, his daily bull sessions with friends, his love of the land, his youth in the navy, his afternoons fishing—was a picture of a full life in which her father was immersed in a community of people who knew and loved him.

When I urged her to compare his life with her own, she realized that some of her grief was misplaced: it was her own life, not her father's, that was tragically unfulfilled. How much of her grief, then, was for all her unrealized hopes? This question was particularly painful for Betty who, by that time, had visited a gynecologist and been told that she had an endocrine disorder that would make it impossible for her to have children.

I felt cruel during these weeks because of the pain our therapy was uncovering. Every session was an ordeal, and Betty often left my office badly shaken. She began to have acute panic attacks and many disturbing dreams, and, as she put it, she died at least three times a night. She could not remember the dreams except for two recurrent ones that had begun in adolescence, shortly after her father's death. In one dream, she lay paralyzed in a small closet which was being bricked up. In the other, she was lying in a hospital bed with a candle, which represented her soul, burning at the head of the bed. She knew that when the flame went out she would die, and she felt helpless as she watched it get smaller and smaller.

Discussing her father's death obviously evoked fears of her own death. I asked Betty to talk about her first experiences and early conceptions of death. Living on a ranch, she was no stranger to death. She watched her

mother kill chickens and heard the squeal of hogs being slaughtered. Betty was extremely unsettled by her grandfather's death when she was nine. According to her mother (Betty told me she had no recollection of this), she was reassured by her parents that only old people die, but then she pestered them for weeks by chanting she didn't want to grow old and by repeatedly asking her parents how old they were. But it was not until shortly after her father died that Betty grasped the truth about the inevitability of her own death. She remembered the precise moment.

"It was a couple days after the funeral, I was still taking off from school. The teacher said I should return when I felt ready. I could have gone back earlier, but it didn't seem right to go back so soon. I was worried that people wouldn't think I was sad enough. I was walking in the fields behind the house. It was cold out—I could see my breath, and it was hard to walk because the earth was clumped and the plow ridges were frozen. I was thinking of my father lying beneath the ground and how cold he must have been, and I suddenly heard a voice from above saying to me, 'You're next!'"

Betty stopped and looked at me. "You think I'm crazy?"

"No, I told you before, you don't have the knack for it."

She smiled. "I've never told that story to anyone. In fact I'd forgotten it, forgotten it for years until this week."

"I feel good you're willing to trust me with it. It sounds important. Say some more about being 'next.'"

"It's like my father was no longer there to protect me. In a way he stood between me and the grave. Without him there, I was next in line." Betty hunched up her shoulders and shuddered. "Can you believe I still feel spooky when I think about this?"

"Your mother? Where was she in all this?"

"Like I've told you before—way, way in the background. She cooked and she fed me—she was real good at that—but she was weak—I was the one protecting her. Can you believe a Texan who can't drive? I started driving at twelve when my father got sick, because she was afraid to learn."

"So there was no one shielding you?"

"That's when I started having nightmares. That dream about the candle—I must have had it twenty times."

“That dream makes me think of what you said before about your fear of losing weight, about having to stay heavy to avoid dying of cancer like your father. If the candle flame stays fat, you live.”

“Maybe, but sounds farfetched.”

Another good example, I thought, of the pointlessness of the therapist rushing in with an interpretation, even a good one like this. Patients, like everyone else, profit most from a truth they, themselves, discover.

Betty continued, “And somewhere in that year I got the idea I was going to die before I was thirty. You know, I think I still believe that.”

These discussions undermined her denial of death. Betty began to feel unsafe. She was always on guard against injury—when driving, bicycling, crossing the street. She became preoccupied with the capriciousness of death. “It could come at any instant,” she said, “when I least expect it.” For years her father had saved money and planned a family trip to Europe only to develop a brain tumor shortly before the departure date. She, I, anyone, can be struck down at any time. How does anyone, how do I, cope with that thought?

Now committed to being entirely “present” with Betty, I tried not to flinch from any of her questions. I told her of my own difficulties in coming to terms with death; that, though the fact of death cannot be altered, one’s attitude toward it can be vastly influenced. From both my personal and my professional experience, I have come to believe that the fear of death is always greatest in those who feel that they have not lived their life fully. A good working formula is: the more un-lived life, or unrealized potential, the greater one’s death anxiety.

My hunch was, I told Betty, that when she entered more fully into life, she would lose her terror of death—some, not all of it. (We are all stuck with some anxiousness about death. It’s the price of admission to self-awareness.)

At other times Betty expressed anger at my forcing her to think about morbid topics. “Why think about death? We can’t do anything about it!” I tried to help her understand that, though the *fact* of death destroys us, the *idea* of death can save us. In other words, our awareness of death can throw a different perspective on life and incite us to rearrange our priorities. Carlos had learned that lesson—it was what he meant on his deathbed when he talked about his life having been saved.

It seemed to me that an important lesson Betty could learn from an awareness of death was that life had to be lived *now*; it could not be indefinitely postponed. It was not difficult to lay out before her the ways she avoided life: her reluctance to engage others (because she dreaded separation); her overeating and obesity, which had resulted in her being left out of so much life; her avoidance of the present moment by slipping quickly into the past or the future. It was also not difficult to argue that it was within her power to change these patterns—in fact she had already begun: consider how she was engaging me that very day!

I encouraged her to plunge into her grief; I wanted her to explore and express every facet of it. Again and again, I asked the same question: “Who, what, are you grieving for?”

Betty responded, “I think I’m grieving for love. My daddy was the only man who ever held me in his arms. He was the only man, the only person, who told me he loved me. I’m not sure that will come my way again.”

I knew we were entering an area where once I would never have dared to go. It was hard to remember that less than a year before it had been difficult for me even to look at Betty. Today I felt positively tender toward her. I stretched to find a way to respond, but still it was less than I wanted to give.

“Betty, being loved is not sheer chance or fate. You can influence it—more than you think. You are much more available for love now than you were a few months ago. I can see, I can feel the difference. You look better, you relate better, you are so much more approachable and available now.”

Betty was more open with her positive feelings toward me and shared long daydreams in which she became a physician or a psychologist and she and I worked together side by side on a research project. Her wish that I could have been her father led us into one final aspect of her grief that had always caused her much torment. Alongside her love for her father, she also had negative feelings: she felt ashamed of him, of his appearance (he was extremely obese), of his lack of ambition and education, of his ignorance of social amenities. As she said this, Betty broke down and sobbed. It was so hard to talk about this, she said, because she was so ashamed of being ashamed of her own father.

As I searched for a reply, I remembered something my first analyst, Olive Smith, said to me over thirty years before. (I remember it well, I think, because it was the only remotely personal—and the most helpful—thing she said in my six hundred hours with her.) I had been badly shaken by having expressed some monstrous feelings about my mother, and Olive Smith leaned over the couch and said gently, “That just seems to be the way we’re built.”

I cherished those words; and now, thirty years later, I passed along the gift and said them to Betty. The decades had eroded none of their restorative powers: she exhaled deeply, calmed herself, and sat back in her chair. I added that I knew personally how difficult it is for highly educated adults to relate to uneducated blue-collar parents.

Betty’s year-and-a-half assignment in California was now drawing to a close. She did not want to stop therapy and asked her company to extend her time in California. When that failed, she considered searching for a job in California but ultimately decided to return to New York.

What a time to stop—in the midst of work on important issues and with Betty still camped outside the one-hundred-fifty-pound roadblock! At first I thought that the timing could not have been worse. Yet, in a more reflective moment, I realized that Betty may have plunged so deeply into therapy *because of*, not despite, our limited time frame. There is a long tradition in psychotherapy going back to Carl Rogers and, before him, to Otto Rank, which understood that a pre-set termination date often increases the efficiency of therapy. Had Betty not known that her time in therapy was limited, she might, for example, have taken far longer to achieve the inner resolve she needed to begin her weight loss.

Besides, it was by no means clear that we could have gone much further. In our last months of therapy, Betty seemed interested more in resolving the issues we had already opened than in uncovering new ones. When I recommended that she continue therapy in New York and offered her the name of a suitable therapist, she was noncommittal, stating that she wasn’t sure whether she would continue, that maybe she had done enough.

There were other signs as well that Betty might go no further. Though not bingeing, she was no longer dieting. We agreed to concentrate on

maintaining her new weight of one hundred sixty and, to that end, Betty bought a whole new wardrobe.

A dream illuminated this juncture in therapy:

I dreamed that the painters were supposed to paint the outside trim on my house. They were soon all over the house. There was a man at every window with a spray gun. I got dressed quickly and tried to stop them. They were painting the whole outside of the house. There were wisps of smoke coming up all over the house from between the floorboards. I saw a painter with a stocking over his face spraying inside the house. I told him I just wanted the trim painted. He said he had orders to paint everything, inside and out. "What is the smoke?" I asked. He said it was bacteria and added they had been in the kitchen culturing deadly bacteria. I got scared and kept saying over and over, "I only wanted the trim painted."

At the onset of therapy, Betty had indeed wanted only the trim painted but had been drawn inexorably into reconstructive work on the deep interior of her house. Moreover, the painter-therapist had sprayed death—her father's death, her own death—into her house. Now she was saying she had gone far enough; it was time to stop.

As we neared our final session, I felt a mounting relief and exhilaration—as though I had gotten away with something. One of the axioms of psychotherapy is that the important feelings one has for another *always* get communicated through one channel or another—if not verbally, then nonverbally. For as long as I can remember, I have taught my students that if something big in a relationship is not being talked about (by either patient or therapist), then nothing else of importance will be discussed either.

Yet I had started therapy with intense negative feelings about Betty—feelings I had never discussed with her and that she had never recognized. Nevertheless, without doubt, we had discussed important issues. Without doubt, we had made progress in therapy. Had I disproven the catechism? Are there no "absolutes" in psychotherapy?

Our final three hours were devoted to work on Betty's distress at our impending separation. What she had feared at the very onset of treatment had come to pass: she had allowed herself to feel deeply about me

and was now going to lose me. What was the point of having trusted me at all? It was as she had said at first: "No involvement, no separation."

I was not dismayed by the re-emergence of these old feelings. First, as termination approaches, patients are bound to regress temporarily. (*There is an absolute.*) Second, issues are never resolved once and for all in therapy. Instead, therapist and patient inevitably return again and again to adjust and to reinforce the learning—indeed, for this very reason, psychotherapy has often been dubbed "cyclotherapy."

I attempted to address Betty's despair, and her belief that once she left me all our work would come to naught, by reminding her that her growth resided neither in me nor in any outside object, but was a part of her, a part she would take with her. If, for example, she was able to trust and to reveal herself to me more than to anyone previously, then she contained within herself that experience as well as the ability to do it again. To drive my point home, I attempted, in our final session, to use myself as an example.

"It's the same with me, Betty. I'll miss our meetings. But I'm changed as a result of knowing you——"

She had been crying, her eyes downcast, but at my words she stopped sobbing and looked toward me, expectantly.

"And, even though we won't meet again, I'll still retain that change."

"What change?"

"Well, as I mentioned to you, I hadn't had much professional experience with . . . er . . . with the problem of obesity——" I noted Betty's eyes drop with disappointment and silently berated myself for being so impersonal.

"Well, what I mean is that I hadn't worked before with heavy patients, and I've gotten a new appreciation for the problems of——" I could see from her expression that she was sinking even deeper into disappointment. "What I mean is that my attitude about obesity has changed a lot. When we started I personally didn't feel comfortable with obese people——"

In unusually feisty terms, Betty interrupted me. "Ho! ho! ho! 'Didn't feel comfortable'—that's putting it mildly. Do you know that for the first six months you hardly ever looked at me? And in a whole year and a half you've never—not once—touched me? Not even for a handshake!"

My heart sank. My God, she's right! *I have* never touched her. I

LOVE'S EXECUTIONER

simply hadn't realized it. And I guess I didn't look at her very often, either. I hadn't expected her to notice!

I stammered, "You know, psychiatrists don't ordinarily touch their——"

"Let me interrupt you before you tell any more fibs and your nose gets longer and longer like Pinocchio." Betty seemed amused at my squirming. "I'll give you a hint. Remember, I'm in the same group with Carlos and we often chat after the group about you."

Uh-oh, I knew I was cornered now. I hadn't anticipated this. Carlos, with his incurable cancer, was so isolated and felt so shunned that I had decided to support him by going out of my way to touch him. I shook his hand before and after each hour and usually put my hand on his shoulder as he left the office. Once, when he learned about the spread of his cancer to his brain, I held him in my arms while he wept.

I didn't know what to say. I couldn't point out to Betty that Carlos was a special case, that he needed it. God knows she had needed it, too. I felt myself flushing. I saw I had no choice but to own up.

"Well, you're pointing out one of my blind spots! It is true—or, rather, was true—that, when we first began to meet, I was put off by your body."

"I know. I know. It wasn't too subtle."

"Tell me, Betty, knowing this—seeing that I didn't look at you or was uncomfortable with you—why did you stay? Why didn't you stop seeing me and find someone else? Plenty of other shrinks around." (Nothing like a question to get off the hot seat!)

"Well, I can think of at least two reasons. First, remember that I'm used to it. It's not like I expect anything more. Everyone treats me that way. People hate my looks. No one *ever* touches me. That's why I was surprised, remember, when my hairdresser massaged my scalp. And, even though you wouldn't look at me, you at least seemed interested in what I had to say—no, no, that's not right—you were interested in what I *could* or *might* say if I stopped being so jolly. Actually, that was helpful. Also, you didn't fall asleep. That was an improvement on Dr. Farber."

"You said there were two reasons."

"The second reason is that I could understand how you felt. You and I are very much alike—in one way, at least. Remember when you were

Fat Lady

pushing me to go to Overeaters Anonymous? To meet other obese people—make some friends, get some dates?”

“Yeah, I remember. You said you hated groups.”

“Well, that’s true. I do hate groups. But it wasn’t the whole truth. The *real* reason is that I can’t stand fat people. They turn my stomach. I don’t want to be seen with them. So how can I get down on you for feeling the same way?”

We were both on the edge of our chairs when the clock said we had to finish. Our exchange had taken my breath away, and I hated to end. I didn’t want to stop seeing Betty. I wanted to keep on talking to her, to keep on knowing her.

We got up to leave, and I offered her my hand, both hands.

“Oh no! Oh no, I want a hug! That’s the only way you can redeem yourself.”

When we embraced, I was surprised to find that I could get my arms all the way around her.