

Group Therapy for Adolescents With Eating Disorders

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Eating disorders (ED) are complex, multidetermined illnesses. The biopsychosocial model of ED stresses the confluence of genetics, temperament, biological phenomena, and sociocultural influences as etiological in their development. Successful treatment typically requires several years and may include psychiatric medication as well as individual, group, and marital or family treatment. This article addresses the role of group therapy in the treatment of adolescents with ED. Group therapy provides a fertile environment in which adolescents can address underlying issues such as self-esteem, body image, emotions, conflict avoidance, family and interpersonal relationships, and sexuality. The emergence of group themes and healing mantras are described as curative factors in the healing process.

KEYWORDS: Eating disorders; adolescents; group therapy.

The goal is to help a patient with the cruel self-damnation that she tries to hide but which is one of the more important experiences. . . . This requires from the therapist a change in the conventional attitude. . . . The therapist needs to be a mentor, a guide who is observant and perceptive and who helps the patient develop her undeveloped aptitudes, the expression of self-initiated behavior. . . . The therapeutic task is to encourage the anorexic patient in her search for autonomy and self-directed identity in the setting of a new intimate interpersonal relationship where what she has to say is listened to and made the object of exploration.

—H. Bruch (1986, p. 332)

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OVERVIEW OF ADOLESCENTS WITH EATING DISORDERS (ED)

In the 20 years that I have specialized in the treatment of eating disorders (ED), I have witnessed a radical transformation in the etiology and treatment of these conditions. Dr. Bruch, considered the “Fore-Mother” of the field, departed from strict analytic formulations and set the therapeutic stage for the conceptualization of ED as complex, multidetermined illnesses requiring judicious and flexible care. The current biopsychosocial model of ED evolved from the original psychoanalytic view of the patient as fearing oral impregnation; to the early structural family therapy models, which blamed mothers regarded as pathogenic, symbiotic, and controlling (Minuchin, Rosman, & Baker, 1978; Selvini-Palazzoli, 1978); into one in which the confluence of genetic vulnerability, temperamental inclinations, biological phenomena, and sociocultural influences conspire in the eventual development of ED. This process has been described as “genetics loading the gun and culture pulling the trigger” (Bulik, 2005, p. 53). The cultural context refers to the extensive and persistent overobjectification of girls’ and women’s bodies and the predominantly Western attitudes about beauty equated with excessive thinness. The cash cow that is the dieting industry has thus become the manna for the industrialized masses. In its multibillion-dollar wake, one of few U.S. industries allowed to financially flourish precisely because their products fail to deliver or sustain results, the devastation is most acutely manifested in two seemingly contradictory crises in adolescents’ physical and mental health. Unprecedented rates of child and adolescent obesity are paralleling increased incidence and earlier onsets of ED (Lucas, Beard, O’Fallon, & Kurland, 1991; Rome et al., 2003). This seeming paradox is easily explained by the biopsychosocial model that promotes dieting as the gateway behavior to the eventual development of ED, especially in those biologically and genetically predisposed (Rome et al., 2003). Dieting adolescents are 7 times more likely to develop ED (Rome et al., 2003).

Just as etiological understandings of ED have dramatically evolved, so too have our approaches to treatment. Strict analytic and systemic approaches have given way to cognitive behavioral (Fairburn, 1995), family (Lock, Le Grange, Agras, & Fairburn, 2001), experiential (Hornyak & Baker, 1989), and feminist orientations (Fallon, Katzman, & Wooley, 1994), in addition to pharmacological advances (Bacaltchuk, Hay, & Mari, 2000; Treasure & Schmidt, 2002). Still, especially with regard to adolescents, we now know more about risk factors than we do about prevention or treatment, and even with state-of-the-art treatments, almost half of patients have a chronic or unremitting course (Steiner & Lock, 1998). The gold standard for ED treatment is a team approach comprising the patient; family; and medical, psychiatric, dietary, and mental health professionals (Kriepe et al., 1995). Depending on the age and circumstance of the patient, several other key individuals figure prominently in the treatment course. These may include coaches, school nurses and counselors, and clergy. Thus successful ED treatment requires the patience, persistence, and active collaboration between a host of health care professionals

dedicated to the well-being of patients and their families. The treatment course is typically arduous and time consuming; most patients will spend 5–7 years before full recovery is achieved (Strober, Freeman, & Morrell, 1997). On a more positive note, children and adolescents, especially when evaluated and treated early in the illness, appear to have slightly better outcomes than adults and shorter durations of illness (Gowers & Bryant-Waugh, 2004; Rome et al., 2003). A thorough review of issues related to general management, evidence-based treatment, and therapeutic goals of adolescent ED can be found in Gowers and Bryant-Waugh (2004).

TREATMENT FOR ADOLESCENT ED

The focus of this article is the use of group therapy in the treatment of adolescents with ED. It is perplexing that, despite a bimodal age of onset for anorexia nervosa (AN) in early and late adolescence, and in late adolescence or early adulthood for bulimia nervosa (BN), the relatively extensive research devoted to treatment approaches and outcomes completely overlooks the adolescent population (Gowers & Bryant-Waugh, 2004). There are no published controlled studies examining the effects of inpatient or cognitive behavioral treatments of AN. Family therapy (FT) approaches to AN have received slightly more attention, with four published studies. Briefly, FT has been found more effective than individual therapy for adolescents with early-onset, shorter duration illnesses (Dare & Szmulker, 1991). Le Grange, Eisler, Dare, and Russell (1992) found conjoint FT equally effective as family counseling separate from the patient with regard to weight gain, self-esteem, and eating attitudes. In a similar finding, behavioral family systems therapy was initially more effective in weight gain compared to ego-oriented individual therapy, but after 1 year, the two treatments were comparable in outcome (Robin, Siegel, Koepke, Moye, & Tice, 1994). Seeing the patient separate from the parents was as therapeutically beneficial as conjoint sessions. Last, the only published study that directly compared the effectiveness of group therapy to other modalities found that inpatient treatment, outpatient individual plus conjoint sessions, and group therapy were equal and superior to a nontreatment control condition with regard to weight gain, resumption of menses, and overall mental state (Crisp et al., 1991).

Early-onset BN is rare, and 95% of cases are effectively managed in the outpatient setting (Robin, Gilroy, & Dennis, 1998). Consequently, there is no published controlled research evaluating the benefits for either inpatient or partial treatment for adolescents with BN (Gowers & Bryant-Waugh, 2004). Cognitive behavioral treatment (CBT), considered the treatment of choice for adult BN (Fairburn & Harrison, 2003), is practiced widely but has not been exclusively studied in the adolescent population. The general perception among clinical practitioners is that older adolescents with appropriate cognitive skills may benefit from CBT similarly to adults (Gowers & Bryant-Waugh, 2004). FT in the treatment of adolescent BN has been reported in one small, uncontrolled trial that suggested modest improvement in bulimic symptoms in 6 of 8 patients (Dodge, Hodes, Eister, & Dare, 1995).

Interpersonal psychotherapy, which focuses almost exclusively on critical relationships presumed to be causative or sustaining influences in the ED (vs. focusing on methods of symptom management or eradication), consistently proves *over time* to be equally effective as and preferred by patients over CBT for adult patients with BN (Agras, Walsh, Fairburn, Wilson, & Kramer, 2000). Interpersonal psychotherapy has been effective in the treatment of adolescent depression and is believed to hold promise in its applications to adolescents with ED (Robin et al., 1998). Finally, there are no controlled studies on pharmacological approaches to adolescent ED, despite the fact that medications are routinely used with this population (Gowers & Bryant-Waugh, 2004). In sum, the available but relatively sparse scientific research on treatment approaches for adolescent ED suggests that family therapy, with or without the patient being seen conjointly, is most beneficial for adolescents with AN, whereas CBT or interpersonal psychotherapy approaches have clinical appeal and show promise for older adolescents with BN based on outcomes with the adult population (Agras et al., 2000).

GROUP THERAPY FOR ADOLESCENT ED

As earlier stated, children and adolescents with ED have demonstrated slightly better outcomes than their adult counterparts (Gowers & Bryant-Waugh, 2004), but it remains to be determined what exact recipe of treatment modalities will best serve our ED youth. There is no question that successful and responsible treatment includes a multidisciplinary team willing to tailor medical, nutritional, vocational, familial, and therapeutic interventions to the child's specific needs. Who are these at-risk youth, and what do we know about their vulnerabilities to ED? They are overwhelmingly female and representative of all ethnic and socioeconomic classes. They come from Western or industrialized cultures in which sociopolitical and economic forces serve to overemphasize a beauty ideal equated with excessive thinness and costly body maintenance products and practices (Maine, 2000; Steiner & Lock, 1998; Wolf, 1991). We know that dieting plays a critical role in ED onset and that, as early as elementary school, 37% of kids are dieting, and 45% specifically want to be thinner (Maloney, McGuire, Daniels, & Specker, 1989). Dieting and pathogenic weight control behaviors peak at 60% of U.S. high school girls (Field, Wolf, Herzog, Cheung, & Colditz, 1993). In addition to the genetic underpinnings previously noted, body image disturbance appears to be the primary and common denominator among these adolescents (Attie & Brooks-Gunn, 1989; Steiner & Lock, 1998). A host of other risk factors noted in the adolescent literature include the following:

- premorbid history of anxious attachment, picky eating, and digestive problems (Marchi & Cohen, 1990; Sharpe et al., 1998)
- deficient self-regulation (Steiner, 1990)
- affective lability and pubertal status (Killen et al., 1992)

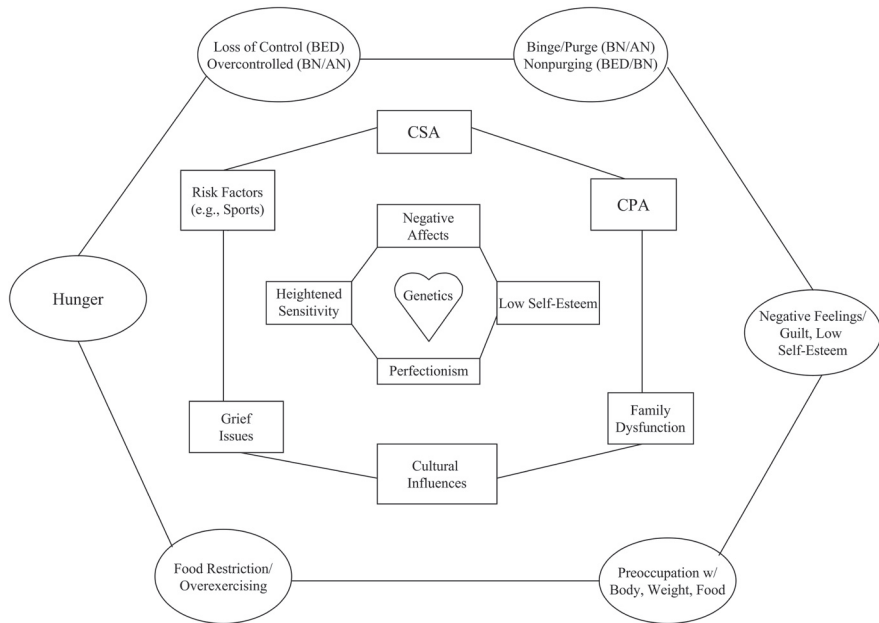


FIGURE 1. Conceptual model of etiological and risk factors associated with eating disorders. *Note:* BED = binge eating disorder; CPA = child physical abuse; CSA = child sexual abuse.

- preoccupation with body shape (Fabian & Thompson, 1989; Levine, Smolak, Moodey, Shuman, & Hessen, 1994)
- peer teasing (Fabian & Thompson, 1989)
- communication problems with parents (Larson, 1991)
- maternal preoccupation with dieting (Hill, Weaver, & Blundell, 1990)
- acculturation to Western values (Pumariega, 1986; Steinhausen, 1995)
- pear-shaped body and premorbid obesity (Radke-Sharpe, Whitney-Saltiel, & Rodin, 1990)
- personality and temperamental characteristics (AN adolescents are more anxious, inhibited, and controlled, whereas BN adolescents are affectively labile, undercontrolled, and active; Steiner & Lock, 1998)
- history of childhood physical or sexual abuse (Rorty, Yager, & Rosotto, 1994).

Figure 1 provides a conceptual model that incorporates these etiological and risk factors associated with ED.

Given the vast array of biological, temperamental, dietary, familial, and intrapsychic factors that contribute to the emergence of ED, successful therapeutic interventions must be sufficiently broad and developmentally attuned to the complexities inherent

in the recovery process. Eating or not, as it turns out, is only one of numerous therapeutic concerns. Weight gain in AN and symptom control in BN are the initial and primary treatment goals, but these adolescents, beyond the typical challenges of childhood, must also grapple with excessively low self-esteem, difficulty identifying and expressing emotions, impaired family dynamics, learning to tolerate ambiguity and ambivalence, negotiating self-in-relation, finding their voice, risking conflict in connection, and clarifying and adjusting to sexual identity. I believe group therapy is a vital and fertile healing ground for these adolescents once sufficient symptom control has been achieved.

Group therapy is widely practiced in the treatment of adults with ED with consistent positive results (Harper-Giuffre & MacKenzie, 1992) and was found in one study of adolescents to be as effective as inpatient or outpatient individual therapy (Crisp et al., 1991). In my clinical experience of running an outpatient adolescent ED group for 20 years, this modality of treatment is a productive and cherished aspect of their recovery process. A thorough description of this group follows, including descriptions from current members who were asked to share their perspectives on the relative merits and shortcomings of group therapy. I have led this group since its inception and have frequently had therapists-in-training sit in to learn about this method and the tasks of recovery from the real experts—the patients themselves. Currently, the group has two cotherapists (one is a marriage and family therapist, and the other is a master's-level social worker). Some would consider it important to know that I myself have a personal history of AN, but that is not a prerequisite for group leadership, and it is debatable whether this confers any special benefits or obstacles to the members. This issue and the topic of self-disclosure have been previously discussed and debated in the literature (McGilley, 2000). It should also be noted up front that this group benefits from certain characteristics that may limit the degree to which outcomes can be replicated or generalized. For example, the group has unusual longevity with the same primary therapist (20 years), who has extensive training and experience in the treatment of eating disorders. The group routinely has a waiting list, which tends to instill a special sense of distinction once a part of the group. Last, and perhaps most important in this regard, group candidates are patients specifically screened for their readiness and capacity to benefit from a group experience. Thus, as with all case reports, readers should bear in mind that, while much of what this group offers and lacks in terms of a model for effective treatment is applicable to groups in general (e.g., healing mantras as therapeutic tools), at least some of the outcomes are directly related to screening for motivated patients most apt to embrace and utilize group therapeutic benefits.

Group Format and Demographics

The group is open ended and process oriented, comprising up to 8 (occasionally more with the group's agreement) high school- and college-aged youth (typical age range is 15–22 years). Unlike some groups that focus exclusively on one of the ED, all

three diagnostic categories are represented in the membership (AN, BN, and eating disorders not otherwise specified). On rare occasions, highly mature children under age 14, or young adults over 22 still negotiating separation–individuation issues, will attend. The group is open to males, but in 20 years it has never had one attend. Weekly meetings are 2 hours and are held in a large, living room–like area in my office. The group abides by strict rules of confidentiality and is feminist in therapeutic design. This means that while I decide who and when to refer to group, virtually all subsequent decisions involving the size, timing of adding members, and process of the group are made from a shared power perspective. For example, several years ago, when the group comprised a highly active membership, they voted to increase the meeting time to 2 hours. A feminist orientation (as with certain other therapeutic traditions) also implies that each individual is viewed as her own expert and that the so-called truth does not rest in any external therapeutic authority. Instead, group facilitators serve as guides and collaborators in healing, working toward listening members into their own truths and supporting their natural and necessary growth in connection. For an excellent and thorough review of the feminist approach to the treatment of ED, see Fallon et al. (1994).

Group members' attendance varies from months to years, with 3 years being an estimated average length of stay. Graduation from group is discussed in advance at length, and members are encouraged to give candid feedback about the departing member's readiness to leave and indicators for relapse and to acknowledge her growth and contributions to the group. Once a member formally graduates from group (an occasion duly celebrated in a manner of the patient's choosing), she is welcome to return for visits or if she has later need for treatment support (this has been extremely rare). Visits by group graduates are typically over the holidays and are a source of great joy, inspiration, and hope for the active membership.

Criteria for Admission

Aside from the age and developmental issues highlighted previously, group members must be simultaneously seen, at least initially, in individual or family therapy and be sufficiently weight restored or in control of their symptoms such that they are able to make effective use of the group process. Discussion of weight or specific symptoms is strictly forbidden and relegated to individual therapy. The most critical factor is that the individual is dedicated to recovery and is ready to use the group in the service of healing. Competition is a common theme and characteristic of patients with ED and must be closely monitored and discussed or, as will be later noted, it risks compromising the overall group process and the well-being of members. Members are reminded of the cultural context that pits women against one another for others' financial and political gain (Wolf, 1991). Instead, they are encouraged to think and sit "in circles instead of lines" as a way of diffusing unnecessary competition as well as building healthy alliances and appreciation for individual differences and strengths. In this model, there is plenty of room at the

top for all of their gifts; perfection is seen as an unrealistic and limiting goal, and the concept that “enough is plenty” is a healing mantra of wide appeal.

Group Process

Each 2-hour session begins with a simple process involving a *go around*, followed by an open forum, in-depth discussion of issues and themes identified as needing further consideration. The go around consists of each member briefly detailing her week, including her symptom status (e.g., whether she is maintaining her weight, self-harming, or bingeing or purging, but not specifics about how and in what ways this occurs). She closes her go around by indicating if she has anything she would like to bring to the circle for further discussion. This process can take anywhere from 15 to 45 min, depending on the week and the group's preference for the amount of detail shared up front. Following the go around, all the issues raised for discussion are reviewed, and the girls are encouraged to then dive in and direct their focus and energy as they see fit. This nondirective process allows members to practice their assertiveness, to test out expressing their needs, and to “vie for their rightful place at the table.” Since this is an open-ended group, at any one time, there is almost always a blended membership of “newbies” and “cronies.” In my experience, as members come more fully into their own and more fluent in their own perspective, they are generous and supportive of newer members, who are apt to pass on or minimize their needs for group time. They are also more willing to call out members who overutilize group time in a manipulative or ineffective manner, modeling the therapeutic tasks of finding their voice, negotiating self-in-relation, and risking conflict in connection.

Considerable effort is put into preparing a new member for the group—and the group for the new member. The opportunity for group therapy is presented to all my adolescent patients when I go over the typical ED treatment process during their initial evaluation. Thus my own patients know that it is *an option* they can work toward and look forward to in their recovery efforts. For reasons I cannot explain, today's adolescents almost universally welcome the opportunity to join group, whereas 20 years ago, it was avoided or approached with much greater reluctance. Perhaps the advent of Internet chat rooms, which break down barriers of isolation while providing confidentiality, has helped these youth to feel more comfortable sharing with strangers. Referrals are also accepted from outside therapists, assuming they meet the membership criteria. Often, the group is full, and new members must await their “chair in the circle.” The group is informed well in advance about potential referrals, and they vote on their readiness and the timeliness of adding a new member.

Prior to the new member's first group, I brief her on each active member's history to give her a flavor of the group composition. Similarly, the group is briefed on the new member, such as her age, her diagnosis, and where she attends school. In our small community (300,000) the last issue is of great interest and possible concern and

is taken into consideration if it is of therapeutic relevance. For example, if two girls attend the same school but do not know the other is in treatment, I will ask both of them if they would be willing to be in group with someone from their school. If this is a problem, the new member must wait until her peer graduates from group (this is the only specialized adolescent ED group in the area). When potential members are doubtful or intimidated by the concept of group, a volunteer of the group will call or e-mail her in the hopes of addressing any fears or questions in advance.

The occasion of a new member's first group is considered sacred and is honored by each active member sharing her "herstory" and inviting the new member to do the same. She is offered the opportunity to *not* share as well and to simply join in by watching the group in process. This rarely occurs anymore, again possibly for reasons I mentioned previously. Finally, new group members are invited to join the group e-mail list (none has refused, and it is a great source of between-group support) and to give the group three sessions before electing to leave if it feels too uncomfortable. It is with curious pride and respect for the power of healing circles that in 20 years of continuous involvement I cannot think of a single time a member elected to leave for this reason. Active members have certainly dropped out after relapsing or feeling group no longer served their needs. Members have also been asked to take a sabbatical from group when their dedication to recovery was in question. But there does not seem to be a problem for these youth to take the initial plunge into the group process and give it time to consolidate into a trusted and precious part of their treatment. The initial screening for a member's readiness and interest in participating in group likely has something to do with this phenomenon.

THEMES AND HEALING MANTRAS

Yalom's (1995) astute appreciation for group themes and their curative factors has potent relevance and implications for adolescents with ED. Hotelling (1987) provided an elaborate description of these factors as they apply to bulimic women in group therapy. My clinical experience has proven that these group themes have similar applications with adolescents with ED in group therapy. Whereas dieting is patients' shared gateway behavior into ED, shame is their shared shadow inside the deadly door. Just as Yalom (1995) described the appeal of "universality" in group therapy as a combatant to the individual's inclination to feel "unique in [her] wretchedness," youth with ED are profoundly self-denigrating, steeped in shame, and dangerously confirmed that they are the unfortunate exception to every negative rule. When carefully tended and couched in a recovery orientation, ED groups for teens can become, if not the first, then a critical source of diverse, nonjudgmental acceptance. Other vital curative factors, such as imparting hope, sharing information, borrowing from others' perspectives, experiencing "we-ness," and belonging in a community of loving others, are common manifestations and benefits within the ED group. When present, they inspire the resilience, resistance to cultural biases and pressures to conform, and self-reliance that ultimately culminate in recovery.

Because symptom management issues are addressed in a member's individual therapy, the group's primary objective is to identify and address the underlying issues that the ED was originally designed to cope with or resolve as well as any sustaining factors impairing progress. By now, members clearly understand that the ED *is* the problem, not the solution, and that "fat is not a feeling" but a culturally coded projection of fear, rage, and hurt from the bodies of their lives onto their physical bodies. These essential insights, and the awareness that language, in its myriad forms, is both the source and conduit for intrapsychic and interpersonal change, are the foundation for potential and vital therapeutic shifts in the process and content of the group. My group refers to certain powerful expressions we have coined over time as *healing mantras*, a shared language and perspective that is used to quickly break down unnecessary or unhealthy defenses and cognitions and to build up hope and esteem. The full nature and subject of these mantras exceeds the confines of this article and will be the subject of a forthcoming book. However, a few of the mantras will be discussed in context to illuminate how a group, once nurtured and rooted in a healing ground, can effectively transform language in the service of transforming lives.

"Thursday Night" and Other Healing Mantras

There are moments in therapy, if attentively practiced, when a synergy develops between a client and therapist that is transcendent in potential. Because verbal language is our primary medium of communication, this phenomenon typically takes the form of finishing each other's sentences or expressing something that neither one knew or understood fully until it was expressed out loud and in connection. Some call these *aha moments*. It has long plagued me that the necessary boundaries and confidentiality requirements of therapy preclude the sharing *between* my patients of the wisdom and insights that unfold *within* them hour by hour. In response I arrived at the notion of having a dry erase board in my waiting room on which all my patients are encouraged to share their "ahas" as well as other inspiring expressions. The board quickly filled, and it has become a rich resource for stimulating growth and challenging resistances.

"Thursday Night" is the weekday the adolescent group meets, but it is also the first mantra that made it on the board. This mantra was inspired by a group member who was stalled in her recovery and could not seem to find the internal drive to take the next step. Floundering and grasping for any clues that might ignite change, I asked this 4.0 student when she began a paper that was due on Friday. "Thursday night," she said without an ounce of chagrin. That way, she explained, her "A" on the paper would feel even better compared to those who slaved over theirs for days! Divine inspiration graced our exchange, and I replied from an unanticipated place of knowing: "Well, that explains your difficulty in recovery; it's not yet Thursday night . . ." The group has since used this mantra when members are dodging responsibility or denying the toll these prolonged illnesses can take on their lives. "Thursday

Night” is a clarion call to action as well as a potent reminder that recovery requires decisiveness and is doomed by denial.

“Do the Know” is an expression I coined in an effort to translate the notion that insight is not curative. Adolescents with ED tend to be acutely bright and ever more informed about their illness (in a recent initial evaluation of a 13-year-old AN, she shared her knowledge of the newly located genetic markers for AN). However, as with most humans, *knowing* better and *doing* better are two quite separate issues. As Kay Redfield Jamison (1999) so poignantly and powerfully puts it, “The gap between what we know and what we do is lethal.” This is brutally true in the case of ED. Group members use this mantra to gently confront the feigned helplessness of others, their refusal to act on what they know, or their sense of powerlessness. They recognize they must be agents of change or risk becoming chronically or terminally ill. As they well know, ED have the highest mortality rate of all psychiatric illnesses.

“Easy Is Over-Rated” is a much repeated group mantra. Too often, patients faced with the risks and demands of recovery insist that what is being asked of them is “too hard.” Exasperation must be the mother of mantra invention because after hearing one too many times in group that “it’s easier to stay this way,” I countered with “easy is over-rated.” It struck a communal chord and went straight onto the board. It is written in permanent ink and has caught the attention of almost all my clients, regardless of why they are in therapy.

Patients with ED generally do not feel worthy of other’s love, and they lack confidence in their competence. This combination makes for a paralytic, deferential stance, which feminist writers call the “tyranny of nice and kind” (Brown & Gilligan, 1992, p. 53) and which causes patients to err on the side of pleasing others while still feeling desperately alone in their inadequacy. We use the mantra, borrowed from Dr. Maureen Walker, “don’t go out acting as if you don’t have people,” as a way of reminding each other that they are accountable and accepted members of a community and that they can source these connections beyond the weekly circle as they negotiate the vagaries and demands of healing. The bond some of these girls form is palpable and enduring, and there is no question in my mind that this sense of being a part of a healing family is instrumental in their recoveries.

CONCLUSION

In closing, the relative merits of group therapy for adolescents with ED compared to other treatment approaches has yet to be determined, but clinical experience has repeatedly demonstrated to this therapist that a group setting takes off where individual and family therapy cannot otherwise go, and the patients themselves, as illustrated in the following, can speak to these substantial blessings. The first quote is from the group’s newest member. A recovering 17-year-old AN, she waited nearly a year for her chair in the circle and has now attended several months. “Ed” in this context refers to the eating disorder personified as described in the new book *Life Without Ed* (Schaefer, 2004):

Wow! Someone understands the way I am thinking. So many times I have tried to explain [to my family] the way "Ed" can torment me and how he seems impossible to ignore. No matter how hard they try, they can never understand the disease the way I do because they have never experienced it. I am often left feeling crazy and alone. In group I hear people say the very things I have been thinking. It's comforting to know that someone is living through the same things as me. . . . It empowers me in a way, like we can survive this together. It makes me feel good to help someone else through her problems and often times helps me see mine more clearly. For a little while I don't have to worry about life, I can just go talk things through.

The second quote is from a seasoned member of the group. Initially diagnosed with AN and critically ill through high school, she is now a junior in college and has struggled with BN for the past 3 years. She is currently in her longest period of symptom recovery:

I've been in individual and group therapy for the past seven years. I must say there is a profoundly different dynamic that gets played out in group therapy. All too often eating disorders isolate us into the prisons of our minds, where we're left alone with loneliness, darkness, self-hatred, shame, guilt, and being misunderstood. A group setting allows for sharing with others who struggle with the same symptoms or haunting despair. It is truly a blessing to be humbled by another's story, or to watch someone find her own personal means and integrity to save her life! This illness has many phases and faces. In group you can attend to how people cope with their own brokenness and you can tuck away the advice that was offered and tap into it later if need be. Group is no place to compare, or to become enmeshed. You must remain vigilant and diligent in working your own program! It is a privilege to walk the road of recovery while locking hands with those who understand, relate, and cheer you on even when the crowd has gone home.

Finally, a responsible discussion of group therapy must address the caveats, pitfalls, and no-no's. As stated previously, a critical rule of group is to not discuss specific symptoms or weights. Competition between members and with the therapists must be directly addressed and reformulated into a working understanding of each other's worth and role in the group. Group therapy is demanding of the therapist, and having supervision or a coleader is highly recommended. Groups are like families in that people are not always treated the same, and frankly, they should not be. Patients can easily slip into comparing each other's treatment goals or protocols and try to engage in a power struggle over the differences. It is imperative to explain that though they may share the burden of these illnesses, each member has different personalities, resources, resilience, and resistances, all of which must be taken into account when therapeutic interventions are formulated. Fairness must not be equated with sameness. Contact outside of the group is encouraged, as long as it serves a healing purpose. This has only been a problem (to my knowledge)

with one patient in 20 years. The following is from another member who has been in this group for over 5 years and who has been in several different inpatient and residential treatment programs. She is 21 years old and has suffered with both AN and BN over the course of her illness:

Group therapy has been both the most beneficial and maybe the most detrimental part of my treatment. It is in group where I have been the most motivated to change my thinking and push myself the hardest around my recovery, but it is through group therapy that I have also been competitive around weight loss, symptoms, and just how bad things can get. I feel like group therapy can be most helpful when careful boundaries are designed to keep the focus on general healing concepts instead of specific symptoms. If the group is held to a healing standard, where general concepts, such as guilt, assertiveness, intimacy, and boundaries are discussed rather than specific behaviors, it takes away the competitive nature of the disorder, and leads us to discussions on how to live as a whole human being, not a walking eating disorder. Held to this standard of recovery, we can push each other around making our lives worth living, and someday live as healthy, whole individuals.

Recovery from ED, no matter at what age, involves coming back into a world existentially considered, a culture objectifying of women, and a heart as sure to love as it is to be broken. It is a daunting and metamorphic task that requires the informed and concerted efforts of experts and the relentless dedication of the already suffering individual. Group therapy for adolescents navigating this terrifying terrain can provide a sacred shelter where every body can be celebrated, every voice can be heard, and every spirit can be re-covered and re-newed.

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