

## *chapter eight*

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# *Sacred Circles*

## Feminist-Oriented Group Therapy for Adolescents With Eating Disorders

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### *Introduction*

Feminist-oriented group therapy for eating-disordered adolescents attempts to identify, address, and eradicate the embodiment of oppressive physical, social, and political forces by providing sacred healing grounds within which self-awareness and transformation can occur. Unlearning of silence, starvation, and solitude, the sanctioned developmental milestones in Western girls' adolescence, is fostered by creating "alternative relational and dialogical spaces" (Piran, Jasper, & Pinhas, 2004). Communication and creative resilience strengthen when safety and respect are experienced in the context of the therapeutic group relationship.

Group therapy emerged as a mainstream therapeutic medium in the 1940s, and its practice has undergone radical transformations while its benefits have been widely applauded. Significant changes in group practices have mostly occurred in "front characteristics," such as the structure, membership, content, leadership style, duration, setting, and theoretical orientation, whereas the core elements of group therapy, the "bare-boned mechanics of change" have demonstrated remarkable constancy (Yalom & Leszcz, 2005, p. xiii). This chapter highlights these essential group elements, provides a brief overview of fundamental feminist-oriented therapeutic concepts and illustrates the integration of these core features within the "lived experiences" of adolescent girls in an eating disorders recovery group.

## *Overview of Group Therapy*

The distinct advantages and therapeutic possibilities group treatment confers have been well documented (Bloch & Crouch, 1985; MacKenzie, 1990; Yalom & Leszcz, 2005). In general, the potential benefits of group treatment include the eradication of shame and isolation of individual members; improved social support; opportunities to improve communication skills (listening, articulation, and reflection); leadership modeling and training; vicarious and experiential learning; and experiencing healing and growth in connection (Yalom & Leszcz, 2005). Feminist-oriented group therapy borrows from these general benefits while also providing a process for group interaction sensitive to issues of gender, agency, and social oppression (Butler & Wintram, 1991; DeChant 1996; Lakin, 1991; Seu & Heenan, 1998). The invaluable therapeutic benefits, relative cost-effectiveness, and short-term duration of many groups arguably distinguish this healing modality as a critical and primary source of therapeutic intervention (Yalom & Leszcz, 2005).

Provide Lakin, 1991, reference.

The global, economic, and diverse applications of group psychotherapy also render it vulnerable to misapplications and mismanagement. This introduction will focus on three fundamental aspects of group therapy vital for clinical effectiveness: patient assessment and preparation for group; group cohesion; and core group therapeutic factors (Harper-Giuffre & MacKenzie, 1992; Yalom & Leszcz, 2005).

## *Assessment and Preparation for Group*

Establishing a patient's appropriateness and readiness for group may be the single most predictive factor of therapeutic outcome. Patients need to clearly demonstrate the interest, willingness, and initiative to attend meetings on time, as scheduled, and to their completion. Most dropouts occur in the first few weeks of a group because one of the above criteria was not met (Harper-Giuffre & MacKenzie, 1992). Given these criteria, group therapists can use a treatment contract delineating these requirements, allowing patients to make informed commitments and holding them accountable to their peers and group facilitators. Psychoeducational and didactic groups provide a more topic-oriented focus and can be an ideal stepping stone for patients pursuing more subjectively oriented process groups. A brief, introductory didactic group meeting explaining therapeutic principles would be an ideal primer for these purposes.

New members should be indoctrinated into the concept of the group relational process as the "source" for, and "container" of, therapeutic changes, as well as be informed about the themes, issues, and dynamics likely to emerge over the course of group therapy. If possible, offering new

members the opportunity to talk to a current or previous group member may greatly enhance their “buy-in,” improve readiness for group treatment, demystify common fears, and clarify misunderstandings regarding its process (e.g., not fitting in or being judged).

Another critical group assessment variable involves establishing that patients have the intellectual, cognitive, and emotional capacity to effectively integrate and utilize the rich and often-provocative material generated in a process-oriented group. As noted in this chapter, eating-disordered patients who are critically emaciated, malnourished, metabolically unstable, or profoundly depressed will not be able to make effective use of group therapy. Similarly, patients with certain personality features (e.g., borderline, paranoid, or narcissistic) or erratic, impulsive behaviors that preclude their ability to resonate with, receive feedback from, or consistently attend to the group process will unlikely benefit from group therapy and may potentially compromise it.

### *Group Cohesion*

Group cohesion, or developing feelings of “groupness,” is the first critical task of an emerging group. Through this sense of community, members derive the initiative, conviction, and accountability essential for therapeutic change to occur. Once consolidated, the healing ties that bind group members are synergistic, and the sacred space created within their circle ideally percolates with a powerful restorative potential. To the degree members operate with integrity, honoring the defined structures of the group (i.e., attendance, confidentiality, consistency) while thoughtfully indulging the boundless properties of their union (i.e., self-disclosure, risk taking, authentic presence), profound growth and change can occur.

As a rule, traditional models of group leadership are more autocratic in the sense that leaders are presumed to be the experts and to function much like conductors, tasked with orchestrating, if not actively directing, the rhythm and flow of the group process. Extra group social contact is thus generally discouraged because the facilitator is not present to “manage” or observe the interactions and because of concerns that issues such as enmeshment, competition, or conflict could develop outside the group context that could dilute the working relationships of members within it (Harper-Giuffre & MacKenzie, 1992). In contrast, feminist-oriented groups view power and leadership as being shared among members and facilitators who are all considered to be experts of their own experience (Butler & Wintram, 1991; DeChant 1996; Enns, 2004; Seu & Heenan, 1998). Relationships are considered a potent resource for therapeutic experimentation

and change, thus extra group contact is supported, even encouraged as a vital healing tool.

### *Core Therapeutic Factors*

Drawing from the extensive body of literature provided by Yalom and Leszcz (2005) and Bloch and Crouch (1985), Harper-Giuffre and MacKenzie (1992) suggested clustering curative group therapy factors into four categories: supportive factors, self-revelation factors, learning from others factors, and psychological work factors. Metaphorically considered, these are the kindling elements that provide the source of the healing energy group therapists are challenged to ignite, stoke, and tend to cultivate the group's ultimate curative potential. It is through the vibrant, energetic exchange of these elements—the rub of a dynamic membership and the breadth of new considerations—that therapeutic combustion occurs.

#### *Supportive Factors*

Supportive factors include the instillation of hope, acceptance, universality, and altruism. Joyce Carol Oates (personal communication, 2007) is credited with saying that, “Hope is the healer that helps us survive when our soul is as thin as a playing card.” Healing without hope is like wet matches: Devoid of the spark of possibility, however slight, even the most resilient of us cowers in the dark. Groups have the added healing property of exposing members to hope's healing in action by witnessing and participating in other member's growth processes. Experiencing empathy while observing other's dysfunctional thought and behavioral dynamics can diminish internal derision while instilling motivation for personal change. Conversely, as with engendering hope, experiencing other's acceptance, despite self-loathing, can eradicate the shame and social isolation pervasive in this client culture. As Yalom and Leszcz (2005) poignantly described, “The phenomenon (of universality) finds expression in the cliché ‘we're all in the same boat’—or perhaps more cynically, ‘misery loves company’” (p. 6). In fact, empathic resonance appears to be neurochemically mediated. Recent research on mirror cells in the anterior cingulate demonstrated that the brain cannot distinguish real from perceived pain, suggesting that “feeling another's pain” is indeed not just a metaphor. Dubbed the “Dalai Lama” cells, this discovery reveals we are literally wired for connection (Ramachandran, 2006).

Last, altruism functions in group therapy by way of redirecting clients' exhausting and deriding self-focus, providing opportunities for making meaningful contributions in others' lives. Shifting seamlessly between

Use square brackets if parenthetical material added.

roles as help receivers and providers, group members expand their sense of self, effectiveness, and interpersonal worth.

### *Self-Revelation Factors*

These factors include the therapeutic benefits of self-disclosure and catharsis. Timing of self-disclosure is key, and group leaders are charged with assisting members to share judiciously with regard to their own and the group's capacity to emotionally integrate and to make effective use of shared material. Catharsis, the expression of highly charged emotions, must be paired with cognitive learning to reap its therapeutic rewards (Yalom & Leszcz, 2005). Simply stated, insight is not curative. Clients must translate, integrate, and channel their insights and abreactions into directed, persistent behaviors to achieve sustained improvement and meaningful change.

### *Learning From Others*

Interpersonal instruction factors, most vital early in the group process, include modeling and vicarious learning (Harper-Giuffre & MacKenzie, 1992). Members will mimic and follow therapists' lead when it comes to risk taking, such as self-disclosure and interpersonal support (Yalom & Leszcz, 2005). Developing the skills and willingness to contend with fear and anxiety, the twin torments of contemporary culture, may also be facilitated through group interaction. Group members learn vicariously as others describe their successful recovery efforts as well as their responses to relapse. "Confronting traumatic anxieties with active coping (for instance, engaging in life, speaking openly, and providing mutual support), as opposed to withdrawing in demoralized avoidance, is enormously helpful" at the interpersonal, intrapsychic, and neurochemical levels (Yalom & Leszcz, 2005, p.11).

Use square brackets if parenthetical material added.

### *Psychological Work Factors*

Receiving feedback, trying out new behaviors, developing insight, and experiencing corrective emotional experience are core factors in long-term, process-oriented groups (Harper-Giuffre & MacKenzie, 1992). Establishing the proper balance of structure and spaciousness provides a fertile environment for members to experiment with new manners of understanding and "innerstanding" (Kimura, 2004). The variety of membership and shared vulnerability offer extensive opportunities for members to practice new behaviors; receive immediate, constructive feedback; and experience and offer validation of perceptions. Groups become both a social microcosm and a kaleidoscopic panorama of one's family constellations. Herein lies one of its unique advantages. Members eventually "show up," relating and exhibiting the same maladaptive patterns,

insecurities, and unfinished business learned in their families and their broader social contexts. In Yalom and Leszcz's (2005) terms, "there is no need for them to describe or give a detailed history of their pathology: *they will sooner or later enact it before the other group members' eyes*" (p. 32). Processing these dynamics is the harbinger of insight and the foundation for corrective emotional experiences. Through well-informed and thoughtfully directed interactions (e.g., Gestalt techniques), groups can effectively challenge members to rework and release their hold on inhibiting or destructive vestiges of the past.

Indicate if italics added.

### *Feminist Theory and Therapy*

The infusion of feminist theory into clinical practice has radically contradicted, if not altered, both fundamental principles of human development and functioning and theoretical models of change on which the foundations of clinical practice were informed. Central, organizing shifts in perspective include reformulations of adolescent female development; relocating concepts of pathology from the individual into the cultural context; and revitalizing the power and necessity of connection and mutuality while diminishing patriarchal emphasis on competition and individualism, presumed to be the "natural" and necessary dynamics of male development (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller, 1976). Key feminist concepts of particular relevance to therapy with eating-disordered adolescents include (a) recognition that gender and gender roles are socially constructed (Smolak & Murnen, 2004); (b) conceptualization of power as intrinsically relational, incorporating a dramatic shift from a "power over" to a "power with" model in the treatment relationship (Surrey, 1991); (c) helping women to find their own "voice," speak it, and in so doing legitimize their personal authority (Gilligan, 1982); (d) reconceptualizing adolescent development as occurring in connection with and through relationship (i.e., self-in-relation theory; Jordan et al., 1991); and (e) exposing the traumatizing effects of the objectification and commodification of the female body (Anderson-Fye & Becker, 2004; Kilbourne, 1999; Maine, 2000; McGilley, 2004; Wolf, 1991).

### *Feminist-Oriented Group Therapy for Adolescents With Eating Disorders*

Group therapy for eating-disordered adolescents provides opportunities to be "response-able to self and others, attend to one's own and collective well-being" (Brabeck & Brown, 1997). For 21 years, I have been the primary therapist for an adolescent eating disorder group. The group also

serves as a training opportunity for new therapists. Uniquely, my current cotherapist is a former member of this group who went on to complete her graduate training in marriage and family therapy. Both of us have recovered from an eating disorder (neither a prerequisite nor an inherent advantage or detriment for group leadership). The issues of self-disclosure and personal recovery from an eating disorder have been previously discussed in the literature (Johnson & Costin, 2002; McGilley, 2000).

Group candidates are carefully screened for their readiness and capacity to benefit from the group experience. Patients are expected to be able to manage their eating disorder symptoms such that they are *relatively* medically and nutritionally stable. Given the variable course of recovery, it is common that members will go through bouts of physical or psychiatric instability. Members can maintain their group status as long as their compromise does not impair their ability to provide to, and profit from, the group process. Group readiness also requires that patients have overcome denial and view their eating disorder as a problem. If and when a member is unable, by virtue of relapse, resistance, or loss of conviction, to uphold the defining admission criteria, she will be asked to take a “time-out” until she and the group feel she has restored her commitment to recovery.

### *Group Format and Demographics*

The group is open ended and process oriented, comprised of up to eight high school and college-aged youth, with a blend of eating disorder diagnoses. Weekly meetings are 2 hours, and confidentiality is strictly observed. Aside from my initial decisions on whom and when to refer to group, virtually all subsequent decisions involving the size, timing of adding members, and the process of the group are made by the group collective. Members are viewed as their own experts, emphasizing that “truth” does not rest in any external therapeutic authority. Group facilitators serve as guides and collaborators in healing. Members are encouraged to think and, literally, sit in circles instead of lines as a way to diffuse unnecessary competition, thus 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 one of many healing mantras members use to source their recoveries (McGilley, 2006).

### *Group Process*

Group begins with a “go around” the circle in which each member takes 5 minutes to update her symptom status (e.g., whether she is maintaining weight, self-harming, bingeing, purging, overexercising, without indulg-

ing specifics), followed by identifying whatever issue, theme, or circumstance she would like to further address in the group. For example, a member might state that she restricted over the weekend and wanted to work on confronting the friends whose behavior had triggered hurt and anger, feelings she elected to cope with by starving.

Following the go around, I review each member's request for help to set the agenda. The group is then open for the girls to direct their focus and energy as they see fit. This nondirective process allows members to practice their assertiveness, test out expressing their needs, and vie for their rightful place at the table. Since this is an open-ended group, there is always a blended membership of "newbies" and "croners." Croners inevitably assume leadership roles and tend to the kindling process of the group. For example, modeling the therapeutic tasks of finding their voice, negotiating self-in-relation, and risking conflict in connection, croners encourage newbies, who are apt to minimize their needs for group time, or confront members who overutilize group time in a manipulative or ineffective manner. Last, the content of group discussion is generally open, except with regard to member's weight and specific symptom management issues. These issues are relegated to individual therapy because of their potential iatrogenic and contagion effects.

### *Between-Group Contacts*

The bonds that form between members, especially in these times of e-speak, Facebook, and MySpace, readily begin to extend beyond the confines of the therapy circle. It is distinctly through having new experiences inside and outside the group that they begin to see themselves in a different, redemptive light. One of our healing mantras, borrowed from Dr. Maureen Walker (2002), speaks directly to this: "Do not go out acting as if you don't have people!" The group understands this as a measure of their accountability to one another as much as a message of shared community.

It is completely unrealistic, in my experience, to assume group members (at least adolescents) will not have outside contact, so it is in the best interests of the group facilitator to help members effectively and appropriately tap into these connections. Members are invited at the outset to join a group e-mail list—none have refused. Inactive members (e.g., those away for college) often e-mail their updates to instill a sense of their "virtual" presence and continued investment in the group. Rather than diluting the connections between members, as cautioned by Yalom and Leszcz (2005), I have found that between-group exchanges, even when conflictual, can significantly deepen what occurs in a group or provide grist for the "therapeutic mill" in subsequent ones. Members are held to the honor system and are encouraged to bring e-mail interactions back



into the circle for discussion. It is deeply embedded in our concept of a healing circle that our “Word” is ultimately all and everything we have to bring to our relationships. I have been heartened by the degree to which group members embrace and protect this covenant. A crone summed it up by writing:

This is what GROUP therapy is about! Using each other as resources is the best way to stay grounded and sane during the week. These e-mails are like little booster shots of therapy for me.

Scheduling group outings and celebrations are other ways for therapists to capitalize on between-group contacts, further fostering cohesion and growth in environments otherwise commonly riddled with symptom triggers or emotional land mines. Playing laser tag, for example, can give members permission to practice spontaneity, competition, fear management, and rampant silliness while also allowing them to witness and relate to their group facilitators in alternative learning contexts. Last, the therapeutic benefits of group meals have been long practiced and well documented in the literature. Our group abides by three rules for group meals: no diet foods, no salads without protein, and no solo trips to the bathroom.

### *Group Duration and Graduation*

Group members’ attendance varies from months to years, with 3 years an estimated average length of stay. College-aged members attending school out of state often resume membership during summer breaks, even if this extends the group size limits. Graduation from group is discussed in advance, and members are encouraged to give candid feedback about the departing member’s readiness to leave and indicators for relapse, as well as to honor her growth and contributions to the group. Importantly, graduations are also potent therapeutic junctures in which issues of loss, abandonment, and unresolved grief and conflict can be acknowledged and reworked. Graduations are celebrated in a manner of the member’s choosing, such as the exchange of symbolic gifts or a “dress-up” dinner. Graduates are welcome to return for visits (e.g., over Christmas break) or if they have later need for treatment support (although this has been extremely rare).

### *Group in Action*

From its inception, this group has been almost as much about educating new therapists as it has been about fostering patients' recoveries. For a workshop on the blessings and pitfalls of psychotherapy, I enlisted the group's help in providing true and intimate reflections on their experiences of the treatment process. The following dialogue is from the group enactment of the improvisation game called the Good, Bad, and the Ugly.

Improv exercises are intended to invoke the dramatic, and in this exercise, three people are given theatrical license to expound on the good, bad, and the ugly qualities of whatever subject is chosen. What ensued in this group incorporates a blend of exaggerated "truths" about the best and worst of what happens behind therapy's closed doors. Rather than the improvisational nature of the exercise obscuring the virtues and pitfalls of therapy and recovery, it served to expose and highlight these aspects. This exercise can become intense and demoralizing for those in the "bad" and "ugly" roles. To close the experience from a position of true congruence, I eventually shifted the process and engaged them in a frank discussion of their current status in recovery and how it felt to "defend the illness" after working so hard to defeat it. Ultimately, the experience has proven itself to be humbling and gratifying, exposing the enormous efforts required to achieve the redemptive benefits of recovery. The following excerpts from the improv exercise have been chosen to illustrate various group and feminist concepts discussed in the previous sections. Dialogue has been edited for brevity and clarity if necessary.

#### *Improvisation Reflecting Oppressive Social Contexts*

In this exchange, centered on the theme of "recovery," three members adopted good, bad, and ugly perspectives as they spontaneously debated the liberating promise of healing vis-à-vis a hegemonic culture promising acceptance through compromise:

*Good: "In recovery, you are finally living your life. You aren't living the eating disorders life."*

*Ugly: "Who cares what anyone says about recovery. Being thin and being pretty and having control—that's the only thing."*

*Good: "What about your personality and your experiences? Don't you want to do more with your life than be thin and pretty? There is so much more to you."*

*Bad: "The thing is I know how to do the eating disorder. It's easy, simple and convenient. Why not stay there?"*

Ugly: *"It makes me special. Everyone else has these needs [for recovery] but I know I don't need it. I'm stronger than them."*

Good: *"Are you really stronger than anyone when you are 90 pounds and can barely walk around?"*

Ugly: *"Absolutely! And I'm the best at it."*

Good: *"So you are the best at being sick? Don't you want to be remembered for helping others or being an amazing presence in a room?"*

Bad: *"Do people really look at those things? Let's be honest with ourselves."*

Good: *"I think so. I think your personality is way more important than your outward appearance."*

Ugly: *"Have you looked at a magazine lately?"*

Good: *"You can't live to the world's standards. You have to have higher standards. And that's what recovery teaches you—to have higher standards than the world."*

At this point in the discussion, I jumped in to support the member promoting the good aspects of recovery:

Therapist: *"The good thing about recovery is, if you achieve it, it's the only way you are ever going to live real again."*

Ugly: *"Reality sucks. Who cares if you are not living real?"*

Therapist: *"It is the only chance you've got."*

Ugly: *"To do what?"*

Therapist: *"To be real! With your eating disorder, you have to be willing to risk that the only chance you've got is the one you never took ... that's what recovery gives you back."*

Ugly: *"It's too much time, too much effort, too much consistency. Consistently changing everything. You're going to screw up sooner or later. ..."*

Good: *"But how much effort do you put into your eating disorder?"*

Ugly: *"Tons!"*

Good: *"So why not change the direction of that effort to recovery?"*

*Improvisation Reflecting Issues of Empowerment*

Empowerment is often an ambivalent achievement for eating-disordered patients, particularly those still wrangling with the “tyranny of nice and kind,” who find unfortunate solace in acquiescence and conflict avoidance (Gilligan, 1982). It is a true marker of both a group’s maturity, and an individual’s recovery, when patients become decisive, risk taking, and contrary. The theme for this discussion was “therapists.” Even as far along in recovery as most were in this group, the idea of valuing their health and restoration remained a troublesome dilemma:

*Ugly:* “I think it’s just a stupid job. Seriously, I listen to my friends all the time, and I don’t have a degree and I don’t get paid.”

*Good:* “*But what if they have lived through it and have the degree?*”

*Ugly:* “*I’ve lived through stuff and give my friends advice, and I don’t get paid.*”

*Good:* “*Don’t you think they are a little more knowledgeable?*”

*Ugly:* “*I can get the same information from somethingfishy.com for free!*”

*Good:* “*I think the point is that connection, talking it out, it’s so candid.*”

*Bad:* “*Well there might be a connection, but how does that make it easier to change? You can talk, but if you don’t want to change, you are not going to.*”

*Good:* “*Right! Therapy changed my life because I was ready to change.*”

Supporting clients to find their own voice, trust their own perspective, and source their own experience for direction is another aspect of empowerment. There is no mistaking the longing in some, especially those earlier in the recovery process, to be “freed” from the bittersweet responsibilities and demands of being fully functioning and wholly present in their lives.

*Good:* “*My therapist says the right things at the right time. She lets me talk and cry, offers me advice that gives me the nudge I need to have the confidence to say, ‘Hey, I figured that out on my own!’*”

*Ugly:* “*She probably read it in a book somewhere!*”

*Bad:* “*I hate the silence part!*”

Good: *"Maybe silence is good? Letting you have your own space to figure some things out? God knows it isn't silent anywhere else in our lives!"*

Bad: *"Why do they have to talk in such secret code? Why can't they just come out and say it? Why do I have to figure it out for myself? Obviously, I don't know what I am doing wrong."*

Ugly: *"I totally agree. They use secret talk! 'How do you feel when that happens?' Okay. I'm obviously sick and I'm coming to you so why don't you tell me what I'm doing wrong? Don't let me figure it out for myself. Why stretch it out for weeks when you can tell me in 1 day what to do or what I'm doing wrong?"*

#### *Improvisation Reflecting Issues of Voice and Self-in-Relation*

The dialogue around the theme of "group therapy" revealed sentiments regarding the challenges and potential mixed blessing of a communal healing environment, including the potential lack of mutual empathy and the risks of resorting to the "underground" for shelter (Brown & Gilligan, 1992). Yalom and Leszcz's (2005) supportive factors (e.g., universality, instillation of hope, altruism); learning from others (e.g., modeling, vicarious learning); and psychological work factors (e.g., developing insight, receiving feedback) are also clearly reflected in this interaction:

Good: *"The best part of group therapy is that it shows you that you're not the only one feeling the way you are."*

Bad: *"The worst is that everyone takes up your time. Everyone has their own agenda."*

Ugly: *"Are you joking me? Blah blah blah! Let's get to me for once!"*

Good: *"Isn't that a little self-centered? I mean you can learn so much from others."*

Bad: *"Yeah, everything to do wrong!"*

Good: *"You also see how other people have stumbled and how to avoid their mistakes."*

Bad: *"Or you can be better at being the worst!"*

Ugly: *"Yeah—how about the competition? Every single girl in the room has the same disease. Let's just put it out on the table—everyone's in competition."*

Good: *"But everyone is working toward the same goal. We all want to get better!"*

Bad: *"One of the bad things is that everyone isn't on the same page. We say we have the same agenda, but we don't. Then we get bogged down and lost!"*

Ugly: *"And what about the liars? They come in here, tell half the story, half the truth. Some are working their program, and others are totally holding back, not speaking the truth. They don't even want to get better."*

Good: *"How do you know they aren't telling the truth?"*

Ugly: *"Through their behaviors. They come in weekly with the same symptoms, same excuses. Their words and actions don't line up."*

Good: *"Shouldn't we be understanding? We have all been in their position. It takes more than just deciding to get better; it's a process."*

#### *Improvisation Reflecting Objectification and Commodification of Women's Bodies*

Sadly, regardless of what topic the group was addressing, issues of body disparagement were replete in the discussion. Fortunately, despite their facility in promoting the "virtues" of seeking bodily perfection, its hollow victory was no longer lost on them. This exchange was about the pros and cons of "recovery":

Ugly: *"I like my eating disorder. It's gotten me attention from modeling agencies. Why would I change that? My strengths and talents lie in my beauty."*

Good: *"Recovery would argue that you're worth more than a price tag. In the end, do you want people at your funeral to say you were a million-dollar model?"*

Bad: *"Least I got my 5 minutes of fame. When I'm thin, the modeling agencies want me."*

Good: *"You have to decide if you're going to play your life to an audience that values you as an object. They've [objectifying culture] got plenty of ways to make sure you're for sale. How do you want to distinguish yourself, be remembered; what's the difference you want to make? There are huge industries invested in keeping us at war within and between ourselves. Our challenge is to decide: What do we want to buy with our attention today?"*

Several group members joined in the discussion advocating for the benefits of recovery and embodiment:

*Good: "What if you recover and get 5 years of fame instead of 5 minutes? You'll never know if you don't try. The type of attention you get when you are recovered is much more meaningful than what you get from a modeling agency. It's more satisfying if someone looks at your heart and personality than your face or jean size."*

*Bad: "What if I don't get attention either way?"*

*Good: "What if you keep living 'what if'? That's the whole deal. Recovery gives you a way to stay out of that suspended place. Eating disorders offer excuses and keep you from being fully present. Decide if you're going to live a suspended life, or if you are willing to soar AND willing to crash. Are you willing to live into a full range of your experience? An eating disorder will only allow you to experience a fraction of what you're fully capable of. Remember our mantra? 'As long as we're going to be alive, we might as well be amazing!'"*

### *A Path to Fullfillment*

Navigating the tumultuous and potentially treacherous terrain of recovery is a hearty challenge for both therapists and their patients. As with any therapeutic encounter, there are countless quagmires and counter-transferential impasses. The group setting, with all of its equanimous and liberating potential, can also foster compromising collusions, resentments, and scapegoating dynamics. Even the most seasoned therapists will benefit from supervision to maintain rigorous and conscientious regard for their role in sustaining the sacred space that fosters a group's curative elements. Feminist-oriented therapy embraces the inevitability of conflict as further opportunity to teach new models of strength through vulnerability and growth through authentic connection.

In closing, the following quotation from my cotherapist summarizes the multiplicitous benefits of group for all those sharing in the process:

*A feminist oriented process group has been transformative for me on two dimensions; first as an adolescent waning in the throes of my own eating disorder, then years later as a young recovered therapist just out of graduate school. Working as*

a co-therapist in this group afforded me renewed opportunities to experience the strength of shared power, to overcome fears associated with not being good enough, and to rediscover my voice and what it means to use it therapeutically. As I contemplate the life mantras of the group and the principles that drive therapeutic change, I am reminded of a quote by James Berrie: "Those who bring sunshine to the lives of others cannot keep it from themselves."

Group therapy for eating disorders, at its radiant best, sheds redemptive light on the path to recovery for those seeking its fulfillment.

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