How I Practice

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FOOD AS METAPHOR IN GROUP PSYCHOTHERAPY FOR EATING DISORDERS

Food and the way in which it is gathered, prepared, consumed, and expelled, among other things, are common topics in eating disorder psychotherapy groups. Food talk is particularly pronounced in the early stages of the group, as members grapple with finding similarities in a way that minimizes shame and alienation, and maximizes normalization and universality. Food talk also appears in later stages of the group when members are under stress. Usually this stress is interpersonal in nature, involves strong affects or needs whose expression historically has been forbidden, and may be in response to troublesome events occurring within the context of the group and/or members' everyday lives.

Traditionally, some group psychotherapists have only considered the discussion of food important for symptom assessment, treatment planning, and/or outcome evaluation. For instance, food talk is encouraged by many clinicians in order to determine symptom severity and suitability for group treatment, problem areas and avenues for behavioral treatment strategies (e.g., contracting, goal setting, menu planning), and patient progress and program evaluation. While this approach to food talk is appropriate at times, it is also too narrow if one hopes to better understand the intra/interpsychic functions such behavior serves for members.

In my work with eating-disordered persons in group during the past eight years, I have found that discussions of food serve as useful metaphors for the myopia often found in the object relational world of my patients. Food talk, in other words, provides a wonderful window to the troubled intra/interpersonal life of group members, and illuminates various ways in which eating-disordered behavior is symbolic of unwanted thoughts, feelings,

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and needs. Exploration and interpretation of these metaphors by the therapist, consequently, help members "put words to" forbidden intra/interpsychic and group processes that otherwise get acted out symbolically in eating-disordered and other seemingly superfluous behavior.

The following four vignettes are offered as brief illustrations of psychodynamic alternatives to approaching food talk in the eating disorders group.

Vignette #1

One evening we announced to our eating disorders group we would be adding two new patients—the group would increase from six to eight members. Over the next several weeks, members continued to discuss issues predominant at the time of this disclosure. In the first meeting with the new members, the veterans of the group proceeded with an unusually lively and cohesive repartee. After a while, however, the mood of the group flattened, and at one point our discussion was punctuated by a particularly pregnant pause. When we asked our charges what the silence might mean, one member exclaimed, "It's like there's eight mouths and only two hamburgers in here!" My co-leader and I suggested members were afraid they would not be able to get their needs met with "two more mouths to feed" in the group. Members concurred, and proceeded with a productive discussion of the frustration, shame, and guilt associated with their profound sense of dependency.

Vignette #2

At the end of a meeting, I interrupted a painful disclosure by a member in order to give the group time to "check-out," or summarize their experience of that evening's session. After a long silence, another patient commented, "I just had an image of a wiener in a croissant." Since the group regularly referred to me as a "wienie" whenever they disagreed with my behavior, I suggested this woman had some feelings about my interruption. Needless to say, she did, and proceeded to lambast me for my "insensitivity, selfishness, and greediness." This was a real achievement for an obese woman who historically stuffed her anger with food.

Vignette #3

Alice described how isolated and alienated she felt in her family-of-origin. She described both of her parents as extremely self-absorbed and perfectionistic. Her mother's preoccupation with appearance, and the toll it took on Alice, was made painfully clear when she described how her mother made her lunch. Alice liked "thick and juicy" peanut butter and jelly sandwiches, but got "dry and thin mess-less" ones instead. Alice commented that her mother seemed to care more about how the sandwich looked than what was inside. I said that perhaps that is how Alice's mother felt about her as

well. Alice began to cry, and then sob, an emotional feast for this chronically underweight woman who was as restricted with her feelings as she was with food.

Vignette #4

Dawn was a high-class prostitute with a long history of bulimia and other distasteful experiences, including early childhood sexual abuse. Her participation in group was sporadic, and her ability to identify what she thought, felt, and needed was exquisitely poor. When it was her turn to read her "autobiography" in group (something the group chose to do following its inception), she disclosed she hadn't completed the exercise. She added that "right after I began writing things down I got spacey and found myself thinking of Snickers bars instead." Unfortunately, my co-leader and I did not interpret or explore this comment further, and the group proceeded to the next person. Retrospectively, I wish one of us had asked, "How did you feel before you began thinking of candy?" or "If you hadn't thought of candy, what do you think you would have written?" After her response, we could have interpreted "thinking of candy is sweeter than the bitterness you feel when thinking of your past." With these interventions, we might have made more of an opportunity to aid this young woman in putting words to feelings that she otherwise avoided with thoughts of food.

To conclude, I have found that food and symptom talk in the eating disorders group have much more to offer therapists than simply an understanding of patient suitability for treatment or patient progress. Specifically, food talk by the group may indicate not only how well (or poorly) patients are proceeding, but also how members are feeling about themselves and others in ways that underlie their symptomatology. While some food talk lends itself to behavioral interventions for symptom control, the same or other types of such talk may be metaphors conducive to evaluating and treating self and object relational disturbances masked by eating disorder symptoms. In my experience, therefore, part of the art of working with these patients in group is knowing when it is most prudent to attend to the symptom, the metaphor, or both.