A Substance Called Food: Long-Term Psychodynamic Group Treatment for Compulsive Overeating

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ABSTRACT

Obesity has proven difficult to treat. Many approaches neglect to address the deep-rooted underlying psychological issues. This paper describes a psychodynamically oriented approach to treating compulsive overeating as an addiction. Common to all addictions is a compulsion to consume a substance or engage in a behavior, a preoccupation with using behavior and rituals, and a lifestyle marked by an inability to manage the behavior and its harmful consequences. The approach represents a shift away from primarily medical models of intervention to integrated models focusing on the psychological underpinnings of obesity. Long-term psychodynamic group psychotherapy is recommended as a primary treatment.

A monumental problem, obesity has reached alarming rates. More than one-third of U.S. adults are obese (Ogden, Carroll, Kit, & Flegal, 2012). Medicine has taken a disjointed perspective

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in categorizing eating disturbances. While anorexia (AN) and bulimia nervosa (BN) are classified as psychiatric disorders, obesity is viewed as a metabolic disorder (World Health Organization, 1992), with medical and surgical treatments commonly recommended.

Traditionally, obesity researchers have downplayed, even denigrated, theories emphasizing processes of compulsive overeating (Devlin, 2007). Today, researchers increasingly view eating disorders as rooted in early-life experiences. Parallels between compulsive eating and addiction are increasingly recognized by both the public sector and the scientific community (Davis & Carter, 2009; Davis & Claridge, 1998; Davis et al., 2011; Volkow & O'Brien, 2007; Volkow & Wise, 2005). Notably, the May 1, 2013, issue of *Biological Psychiatry* was entirely devoted to food addiction.

In the 1980s, the first two authors of this article began developing a group treatment approach addressing eating disorders simultaneously with the full spectrum of addictive disorders. Both authors have conducted psychodynamically oriented groups at agencies, addiction treatment centers, eating disorder programs, and halfway houses. Presently, they lead (between them) 25 long-term, weekly psychotherapy groups in their private practices in Vancouver and Chicago. The groups have been ongoing for as long as 12 years. In the Vancouver groups, compulsive overeating is heavily targeted in admission criteria, while the Chicago groups draw people recovering from a wide array of addictive disorders. In the case illustrations presented, names and other identifying features are changed to protect patient confidentiality. Where details are retained, permission has been obtained from the patients.

Our highly integrative, psychodynamically oriented model, Group Relations-Informed Addiction Treatment (GRAT), builds on attachment theory and integrates 12-step principles to help compulsive overeaters "attach" to a culture of recovery. Long accepted as a primary treatment modality for substance abuse (Flores, 2004; Khantzian, 2006; Khantzian & Albanese, 2008), group psychotherapy is also well suited for treating people whose "drug of choice" is food. With progressive recovery, overeaters develop healthy, emotionally regulatory relationships and use food to nourish the body rather than to suppress painful affects.

Embedded in our approach is a focus on challenging negative self-schemas and exploring affective cognitive structures, namely shame. Behavioral interventions, such as healthy eating guidelines and social support, are incorporated.

A primary goal of long-term group therapy is to help patients develop trust in others so that they gradually attach to people instead of chemicals or processes. Group members are encouraged to work through family-of-origin issues as entrenched family dynamics and traumatic experiences are reenacted in group. Group leaders attend to each member's optimal level of autonomic and emotional arousal and guide members toward therapeutic work at the upper edge of their "window of tolerance" (Siegel, 1999, p. 253). Breakthroughs can then occur without destabilization.

In the therapeutic environment of group, members are encouraged to make speakable the various manifestations of their addictive disease and support one another in a lifelong recovery process. Members learn to invest in intimate relationships rather than seek relief, escape, or pleasure while burying overwhelming feelings.

> The longer traumatized people rely on external substances to regulate their internal worlds, the weaker those inner worlds become....Emotional muscles atrophy....Authentic, honest connection slowly erodes.... (Dayton, 2000, pp. xvi-xvii)

ADDICTION AS A DISEASE WITH MULTIPLE EXPRESSIONS

Addiction is slowly gaining recognition as a "syndrome" not specific to any substance or behavior (Holden, 2001; Shaffer et al., 2004). The concept of addiction as a dynamic disease with multiple manifestations was detailed in a manual on group treatment of process addictions published by the American Group Psychotherapy Association (Korshak, Nickow, & Straus, 2014). Obesity may be understood as a consequence of the addictive process of compulsive overeating, much as cirrhosis of the liver frequently results from alcoholism. Interventions for obesity that do not address the processes leading to it are as futile as "treating" a compulsive gambler's debt without recognizing the gambling behavior.

The term "process addictions" refers to out-of-control behavioral processes such as gambling, sex addiction, relationship addiction, Internet and other technology addictions, and workaholism. Eating disturbances have components of both chemical and process addictions. Awareness of the interplay among eating disorders, substance abuse, and process addictions is critical to successful treatment outcomes: As patients progress in recovery from one addiction, other addictions often magnify or surface. In a lifetime, a person may practice more than one addiction at a time, with patterns often driven by efforts to manage adverse consequences. Importantly, a person may give up one addiction, such as overeating, and subsequently engage in others, such as alcoholic drinking, compulsive spending, or work addiction.

Obesity has been defined by such indices as weight, body mass index, and fat composition (Lau & Obesity Canada Clinical Practice Guidelines Steering Committee and Expert Panel, 2007; Thompson, Cook, Clark, Bardia, & Levine, 2007). Static measures do not account for compensatory behaviors or offer insight into eating patterns or internal struggles. Using weight or body mass index to assess compulsive eating is equivalent to diagnosing alcoholism based on blood-alcohol level.

We define compulsive overeating as a chronic pervasive pattern of self-destructive use of food. An individual may overeat only healthy nutritious foods. A person may overeat at meals, all day, only in the evening, snack frequently, graze throughout the day, or binge once or multiple times per day or week (Ma et al., 2003; Tanofsky-Kraff & Yanovski, 2004). The tendency to eat little or nothing during the day and then overeat at night parallels the alcoholic's resolve to drink only after five o'clock.

Emerging research suggests that certain foods may powerfully activate compulsive overeating patterns in some people (Ifland et al., 2009; Spring et al., 2008; Volkow & Wise, 2005). Triggering foods often include those high in fat, sugar, or carbohydrates as well as those containing white flour or wheat. High-carbohydrate and high-fat palatable foods have been shown to have a "priming effect" on the brain reward system, akin to the effect of the first drink for an alcoholic.

Although the science of food addiction is in its infancy, Overeaters Anonymous (OA), a 12-step program founded in 1960, has

always recognized food as a substance of abuse. Illuminating the overeater's struggles, OA literature states:

> [N]ormal eaters will sometimes find pleasure and escape from life's problems in excess food. Compulsive overeaters, however, often have an abnormal reaction when we overindulge. We can't quit. A normal eater gets full and loses interest in food. We compulsive overeaters crave more. Some of us even have a strange reaction to particular foods: While others can comfortably eat single portions of these foods, we feel compelled to eat another serving after we finish the first...and then another...and another. (Overeaters Anonymous, 1990, p. 2)

Understanding compulsive overeating as a disease, and not a failure of will power or weakness of character, helps many overcome barriers to recovery.

A DIAGNOSTIC DILEMMA

Each successive edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) has failed to recognize compulsive overeating as a disease. Some associated compulsive overeating behaviors are listed as criteria of Binge Eating Disorder (BED), Bulimia Nervosa (BN), Anorexia Nervosa (AN)-restricting and binge eating/purging subtypes, and Eating Disorder Not Otherwise Specified (ED NOS). Compensatory behaviors common among compulsive overeaters include excessive exercise and abuse of laxatives, diuretics, psychostimulants, and thyroid medication.

Diagnostic ambiguity has created a dilemma wherein overweight individuals often go undiagnosed and are denied vital services. Resources are largely directed toward individuals with BN and AN. Further, whether an obese person's eating issues will be addressed may depend on the evaluating clinician's personal biases. For example, a therapist who equates obesity with laziness or lethargy is not likely to recommend eating disorder treatment. Similarly, a clinician who is overweight or obsessed with food and weight but is unaware of the underlying psychological issues may not recognize a patient's need for treatment.

We conceptualize eating disorders on a continuum in varying degrees of severity. At one end are normative dieting and weight

concerns; at the other are morbid obesity secondary to compulsive overeating and dangerously low weights due to the severe restricting in anorexia. The continuity model emerged in research based on subclinical and clinical populations (Futch, Wingard, & Felice, 1988; Gleaves, Brown, & Warren, 2004).

The *DSM-5* conceptualization of Substance-Related and Addictive Disorders parallels our understanding of eating disorders. It combines substance abuse and substance dependence into one category, describing a “single disorder measured on a continuum from mild to severe” (American Psychiatric Association, 2013). Behavioral addictions are captured as a new category; however, only gambling disorder is mentioned (American Psychiatric Publishing, n.d.).

Psychological studies of obesity treatment tend to be short-term, with inadequate follow-up (Agras et al., 1995; Berkman et al., 2006; Brownley et al., 2007; Ciano et al., 2002; Cognolato et al., 1996; Minniti et al., 2007; Riess, 2002; Renjilian et al., 2001; Seamoore, Buckroyd, & Stott, 2006; Wilfley et al., 2002; Wiser & Telch, 1999). Most studies are based on BED. Tasca and colleagues (2012) are among the few who take a psychodynamic approach; most research is based on cognitive-behavioral and highly structured, manualized treatments. The lack of sophisticated, qualitative, longitudinal studies presents challenges in evaluating outcomes. Longer-term psychodynamic group psychotherapy is a vastly underutilized and understudied modality despite its significant potential for the overweight/obese populations (Weiss, 2006).

TRAUMA AT THE ROOT OF COMPULSIVE OVEREATING

Psychological trauma is often overlooked by treating professionals as a key element in the etiology and treatment of obesity. Many of our patients with compulsive overeating histories meet full or partial *DSM-5* criteria for post-traumatic stress disorder (PTSD). Most present with “developmental trauma” (van der Kolk, 2009). That term captures the clinical presentation of children and adolescents exposed to chronic interpersonal trauma, such as physical, sexual, or emotional abuse, rageful behavior or other violence, family alcohol and drug abuse, neglect, and inad-

equate caregiving. Our clinical observations are consistent with the findings of the Adverse Childhood Experiences (ACE) study. The research by Kaiser Permanente and the Centers for Disease Control found that traumatic childhood experiences negatively impact adult health, increasing vulnerability for obesity as well as alcoholism, drug abuse, cigarette smoking, depression, suicide attempts, sexual promiscuity, and domestic violence (Felitti et al., 1998).

Compulsive overeaters commonly first discover, reveal, or process trauma histories during group therapy, recognizing their own stories in others' narratives (Harris, 1998; Herman, 1992). Trauma's connection with addiction (Hien, Cohen, & Campbell, 2005) and eating disorders (Brewerton, 2007; Grilo et al., 2006; Gunstad et al., 2006; Gustafson & Sarwer, 2004; Hirth, Rahman, & Berenson, 2011; Noll, Zeller, Trickett, & Putnam, 2007) has been documented. In practice, trauma is often unrecognized, although studies have linked PTSD and obesity (Vieweg et al., 2006). Many clinicians diagnose borderline personality and other character disorders, although the patients' dysfunctional interactional styles developed as an adaptive, self-protective response to early life trauma and to subsequent traumatic reenactments.

TREATMENT AND RECOVERY

Obesity treatments traditionally target diet and exercise, creating a power struggle, explicit or implicit, between clinician and patient. While "physical recovery," our preferred term for weight loss, is critical, we encourage patients to develop a strong recovery support network, focus on emotional healing, "surrender" to healthy eating, and "let go" of obsessive weight monitoring. The primary task of recovery is abstinence from compulsive overeating, "one day at a time," leading to weight loss, improved health, and more gratifying relationships, work, and leisure. (The terms "surrender," "letting go," and "one day at a time" are part of 12-step nomenclature.)

If uneducated about addictive processes associated with overeating, clinicians may intervene in ways that intensify shame. Treating professionals may even badger the overweight patient to lose weight. When efforts fail, they may give up on addressing

eating, or they may collude with the disease by not confronting patients for fear of hurting feelings. Not addressing overeating condemns the individual to emotional isolation and perhaps early death.

Abstinence from compulsive overeating may be defined as eliminating compulsive eating behaviors while working toward or maintaining a healthy body weight. Individualized guidelines may be determined by examination of a patient's behavior patterns, eating history, nutritional needs, and level of physical activity. Guidelines may change as a person learns by trial and error, with clinical and peer support, what works best. Perfectionism is a common dynamic in eating disorders. Perfectionism and all-or-nothing thinking may produce a "good/bad" food dichotomy and encourage the so-called diet mentality often ingrained in a compulsive overeater's psyche from early in life. Thus the tendency could be to abandon a meal plan entirely after one deviation. By contrast, recovery means getting back on track as quickly as possible. If an overeater veers from a recovery plan, she or he is encouraged to share honestly with peers in recovery and seek support.

Personal abstinence for a compulsive overeater may include avoiding "trigger" foods, eating prescribed portions of food spaced throughout the day, avoiding obsessive use of scales and mirrors, and reporting meals and snacks daily to a group member or clinician. Refraining from eating in secret, in the car, at the kitchen counter, or out of the garbage and avoiding compulsive behaviors associated with body image disturbances (such as body-checking) may also be part of an abstinence plan.

Typically, compulsive eaters berate themselves (Dennis & Wickstrom, 2010), engaging in an internal self-critical dialogue. They delude themselves and others to reduce shame and feelings of loss of control. During clinical assessment, compulsive eaters commonly underreport food intake (Sallé, Ryan, & Ritz, 2006). They may also lie about weight and clothing sizes. Honesty, accountability, and transparency are critical to recovery.

Groups are pivotal in healing shame associated with addiction (Brook & Spitz, 2002; Flores, 2013; Roth, 2004) and underlying trauma (Dayton, 2000; Harris, 1998; Korshak et al., 2014). Members are more likely to reveal disease behaviors when they hear

others' accounts. Furthermore, members often challenge one another to face difficult truths.

> Kelly disclosed with humor covering embarrassment that she missed the prior week's group because she rushed home to shower after ingesting 24 laxatives. Miscalculating when she would need the bathroom, she had defecated in her clothes while shopping. While some group members laughed, one interjected that she did not find the episode funny, given the medical consequences of laxative abuse.
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> Rita related that she once worked for an escort service. Other members then shared their histories of sexual promiscuity, one of the sequelae of sexual trauma. One member quipped, "At least you got paid for it."

Such interactions lighten the burden of shameful secrets.

It is almost impossible for a compulsive overeater in early recovery to entirely avoid a return to active eating disorder behaviors. The concept of "relapse forward" is critical to abstinence. Individuals are encouraged to use any relapses as a growth opportunity. For example, a person may gain insight into dynamics that trigger disease behavior or discover that new coping strategies are needed to achieve back-to-back abstinence.

A GROUP RELATIONS-INFORMED ADDICTION TREATMENT MODEL (GRAT)

Our group treatment model, GRAT, draws from psychodynamic theory, Bowlby's theory on attachment and loss as adapted by Flores for addicted populations (Flores, 2004, 2013), Bion's group relations theory as adapted by Roth for addicted family systems (Roth, 1988, 1991, 2004), and the spiritual principles of 12-step recovery. We understand eating disorder recovery as a process of working through underlying family-of-origin dynamics and trauma while gradually letting go of behaviors by relying on recovery networks. Resiliencies develop from facing life's challenges with ongoing support. Central to the recovery process is an understanding that the compulsive overeater cannot recover alone.

Resistance, in our view, is a healthy part of the recovery process, allowing for mistrust in authority to be made speakable and processed in a safe therapeutic environment. Many overeaters struggle with authority issues stemming from dysfunctional parent/caregiver relationships (Dayton, 2000; Roth, 2004). As Dayton puts it, "If someone has experienced a rupture in a 'survival bond,' subsequent bonds may be harder to form and subsequent ruptures may be more devastating because they return us to the pain of the original one" (2000, p. xix). Caregiver relationships are often reenacted with teachers, bosses, doctors, therapists, and even clergy and police. GRAT addresses symptoms, provides opportunities to work through authority and peer conflicts, and promotes lifelong recovery.

Groups are conducted weekly for 90-minute sessions. Standard composition is eight or nine members. Patients may remain in a group for years, even decades. However, shorter-term group participation often produces significant therapeutic benefits, such as physical recovery and healthier attachments. When one member leaves, another member joins after appropriate group processing of termination issues. Most groups have long-term stability. When turnover occurs, members process grief, loss, change, and healthy adaptation to life transitions.

In group life, family and traumatic reenactments regularly emerge, creating powerful opportunities for corrective emotional experiences. Cohesion develops as group members find that they may clash with certain members and also at times intimately join with those members. The term "reenactment" has been defined as "the unconscious re-experiencing and behavioral recreating of past events in the current therapy setting and in the person's daily life" (Tyson & Goodman, 1996, p. 536). Groups can promote the "decoding" of dissociated experiences as long as therapists "model exploration and acceptance of whatever feelings or expectations a patient brings" (Hegeman & Wohl, 2000, pp. 66-67).

Reenactments lead to new insights about one's struggles, strengths, self-defeating patterns, and dysfunctional roles arising from unresolved early-life experiences.

> Helena would leave the room, shake incessantly, or dissociate during any hint of conflict. Eventually, with group support, she tolerated intense conflict. She learned that her fear of conflict evolved from traumatic childhood witnessing of violence. Memories surfaced of her father brutally beating her, her mother, and her siblings. Her trauma history, which unfolded in fragments over months, included severe physical abuse by father from age four; incest; rape; witnessing her father beat a co-worker to death; and experiencing the death of a much loved older sister who had endangered herself to protect her from her father's rage.
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> Helena came to understand that her compulsive eating behaviors and substance abuse were efforts to gain a sense of control over her life and medicate painful feelings. Lost was a sense of connection and a sense of meaning. She discovered that her traumas had rendered her helpless and voiceless. Through mirroring and validation from others, she found compassion for herself, began to overcome barriers to intimacy, and gradually let go of eating disorder behaviors and alcohol.

Informed by group relations perspectives, the therapist conceptualizes the "group-as-a-whole" to enrich members' personal and collective insight. Underlying group-as-a-whole theory is the understanding that groups are systems, and the whole is qualitatively different than the sum of the parts. Experiential learning in group leads to interpretations, which in turn spur further "self-exploration, self-discovery and self-expression" among members (Harkins, Bair, & Korshak, 2013, p. 403). Interpretations are based on data available in and outside a group, with the assumption that a group "elects" one or more members to represent the group consensus. No comment made or behavior exhibited by any group member is unrelated to the flow of the group. GRAT therapists make these connections explicit when interpreting group process.

In traditional group psychotherapy models, contact outside group is discouraged (Yalom & Leszcz, 2005). New members often are asked to sign a contract agreeing to no outside contact, sometimes for months or years after a member's termination. By contrast, the GRAT model encourages members to interact in their outside lives. Group leaders and group culture promote

transparency. Members bring back to group for examination and processing interactions that occur outside. Members often strengthen attachments in group by working through their outside conflicts. Additionally, they may support one another's recovery outside group, such as by accompanying a member to a stressful family function. Members also may attend one another's graduations, weddings, funerals, and other significant events. Outside contact often evolves into larger overlapping networks, creating "extended families" that enhance the recovery process.

The expression "an elephant in the room" refers to a blatant, looming, or sometimes less obvious truth hidden, ignored, or unaddressed. Many compulsive overeaters come from addicted family systems where important truths have been covered up. Healthy recovery networks allow for matters once unspeakable to be shared openly, not only in the therapy group but in the larger extended recovery family.

> Christopher described an emotionally neglectful childhood, although he didn't consider his experience "traumatic." His mother was overwhelmed and depressed; his alcoholic father was distant. Christopher came into one session highly upset but hesitant to speak. Prompted by the therapist, he revealed that he felt overlooked and abandoned by her. The therapist, who was also his treating psychiatrist, had forgotten to return a pharmacist's phone call to renew his prescription. Christopher initially feared expressing his feelings, thinking that he might alienate the therapist, that others might judge him for unrealistic expectations, and that he might be undeserving of care and attention. So Christopher was shocked when the leader emphatically apologized. He was not accustomed to authority figures owning their mistakes. The healing interaction with the leader, along with group validation for Christopher's assertion of his needs, engendered trust.
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> When Christopher first started in group nine years ago in his late 20s, he carried 80 extra pounds, had been in and out of treatment for alcohol and cocaine abuse, and engaged in sexually promiscuous behavior. His eating disorder history included severe restricting, overeating, and exercise bulimia. Socially reticent, he rarely spoke in group for the first few years. Now maintaining a healthy weight for more than five years and stable in his recovery from alcohol and drugs, he has close friends and is beginning to date.

> Once hopeless about finding a meaningful career, he recently returned to college and is excelling in his studies.

To relieve obsessions and change behavior around food, patients must ultimately let go of control. Although traditional treatment approaches are based on control of eating behaviors, it is countertherapeutic for a clinician to exert control over a patient's behavior. Experiences of disempowerment contribute heavily to the etiology of an eating disorder; individuals often use eating behaviors because it is the one thing they believe they can control. Further, patients may become ashamed if they perceive that they have failed to meet authority expectations.

In the GRAT model, group members are encouraged to meet successive challenges and achieve what we call "progressive recovery." For example, a person may share honestly about food struggles in group yet not stop overeating. Similarly, a person may give up "binge foods," such as desserts or chips, but not surrender to a meal plan. As therapists, we do not engage in power struggles with patients. While some patients more readily accept a therapist's suggestions, others rebel against authority and are more receptive to help from peers. Thus, role modeling by group members may greatly impact another member's willingness. The notion of "attraction rather than promotion," one of the 12-step program traditions, is also relevant to therapy.

Examination of self-destructive patterns in group may become a means of breaking through denial. In GRAT groups, members strengthen their foundation and build their self-esteem by observing others' resiliencies and contributing to others' healing. Newcomers to 12-step fellowships are told, "Let us love you until you learn to love yourself." Establishing trusting bonds leads members to seek out affirming relationships in 12-step fellowships and in the outside world. Group therapy thereby functions as an "ecological bridge to new community" (Mendelsohn, Zachary, & Harney, 2007, p. 227).

To set and maintain effective group boundaries, GRAT leaders apply group relations principles relevant to small groups (up to 12 individuals) within social systems. They also draw on guidelines of Al-Anon Family groups, a 12-step program focusing on codependency recovery. Adherence to boundaries does not

mean therapists are rigid. In fact, skillful boundary management allows for flexibility in the group leadership role. For example, the leader may adopt a more traditional psychodynamic role to help intensify a member's parental or other authority transference reaction. Alternatively, the leader may take on a supportive, nurturing role when a member experiences a reenactment of childhood bullying. GRAT therapists may at times assume a mentorship role or even self-disclose to model recovery behavior, normalize struggles, or celebrate resilience. Therapists' transparency and vulnerability help diminish patient idealization of the therapist, minimizing the power differential and making possible a more egalitarian culture. New and healthier relationships with authority in group often lead to transformed relationships with authority in the outside world.

Unlike in traditional group therapy models, physical contact among members is often part of GRAT group culture. Members who are initially uncomfortable with touch, or conversely, those inclined to be effusive with touch, practice healthier physical boundaries, respecting personal needs and preferences. It is not unusual for a member to grasp another member's hand for support while disclosing a painful experience. Warm embraces, given and received respectfully, support healthy attachments.

A mainstay of the group therapist's work is facilitating willingness to engage in the recovery process. The mere act of joining a group constitutes motivation for recovery. Commitments may be tenuous, however. GRAT group therapists are compassionate supporters of a gradual recovery process. Long-term group therapy allows for layers of work to be accomplished, along with supportive interventions during stressful times. Individuals at all levels of recovery may experience a re-emergence of symptoms. Some group members may lose their resolve and interrupt or terminate treatment. Some are unable to imagine life without excess food; others struggle with facing the severity and consequences of their disease, while still others fear confronting trauma. Many who leave treatment later return with greater resolve, usually after more adverse consequences.

A cornerstone of the GRAT approach, clinical supervision focuses not only on patients' progress but also on therapists' growth personally and professionally. Therapists are encouraged to ex-

plore countertransference reactions while also examining their own relationships with food, body image, and other addictive or dysfunctional behaviors. Just as many addiction professionals have personal or family histories of chemical dependency (Vannicelli, 1989), many group therapists working with eating-disordered patients have grown up in families with disordered eating, other addictions, and trauma. Clinicians impacted in their personal lives by eating and weight issues may have blind spots, distortions, or extreme reactions to aspects of patients' presenting symptoms and behavioral patterns. They may also have culturally embedded "fat" biases and prejudices (Drell, 1988). Additionally, judgments about eating disorder behaviors may arise from societal misconceptions. Professional schools rarely or minimally address countertransference issues in the context of eating and other addictive disorders.

INTEGRATION OF GROUP PSYCHOTHERAPY AND 12-STEP RECOVERY

Language of 12-step recovery is common in GRAT groups. The culture and leaders of GRAT groups encourage OA attendance as an adjunct to group treatment. Phone and on-line meetings are also available. Participation in OA offers group members the chance to be in a larger community with others who have similar struggles and histories. Listening to recovery successes at 12-step meetings engenders hope.

Therapy groups are professionally facilitated, whereas 12-step meetings are led by lay people in recovery. Another distinction is that 12-step culture discourages "crosstalk" (direct member-to-member interaction), whereas spontaneous exchanges are the essence of group therapy. Fearing judgmental feedback, people new to recovery sometimes prefer 12-step meetings to group therapy. However, recovering compulsive eaters who might feel disconnected in a meeting, or who are inclined to deeper levels of self-disclosure, often prefer group therapy, where they may receive prompts or probing questions from the leader or members.

Historically in the clinical community, 12-step meetings have been controversial. Antipathy has been noted between group therapists supportive of 12-step philosophy and others, with

"subtle and at times overt denigration of one another" (Yalom & Leszcz, 2005, p. 440). The gulf narrows as more clinicians learn from patients and others about the benefits of 12-step participation. Among myths identified by Yalom and Leszcz are that the 12-step program discourages psychotherapy and medication, enables members to avoid personal responsibility, and devalues emotional expression (2005, pp. 440-442).

A myth we repeatedly encounter is that a person must be religious to benefit from 12-step recovery. Importantly, broad references to a higher power of one's own understanding are prominent in program literature. Individuals may choose their own spiritual path. Since motivation and will power are insufficient to overcome addictive behavior, a source outside oneself is critical to recovery. Resistance to the higher power concept is not uncommon among newcomers. Trauma survivors, in particular, often have difficulty believing that a higher being could exist. Recovering people learn that their power source could be a therapy group, a 12-step meeting, the universe, nature, or any entity outside themselves. For many, 12-step fellowships are the primary spiritual community. Some also engage in other meditative, spiritual, or religious practices.

Origins of 12-step spirituality are rooted in Swiss psychoanalyst Carl Jung's clinical work. Jung told a desperate patient that, in rare instances, alcoholics have miraculously recovered through spiritual experiences. The patient began a spiritual practice and enlightened Bill Wilson, who subsequently co-founded AA (Alcoholics Anonymous, 2013). In Overeaters Anonymous, eating disorders are seen as "cunning, baffling and powerful," much like alcoholism (Alcoholics Anonymous, 2013, pp. 58-59). In GRAT groups, members commonly explore spirituality themes.

DISCUSSION: GRAT GROUPS AS CULTURES OF RESILIENCE

Traumatic childhoods and emotionally impoverished home environments are frequently reported by compulsive overeaters. Many have been abused, neglected, or psychologically "starved." GRAT groups provide emotional nurturance, support, mirroring, and validation. The "holding environment" (Winnicott, 1960) of the group offers emotionally corrective caregiving by the leader and

group members, opportunities to develop trust, and a safe setting in which to negotiate social relationships.

Groups provide a therapeutic milieu with peer support for resolving conflicts within and outside the group. Members often face intense feelings, experience pleasure and joy, and celebrate milestones in recovery. Traumatic reenactments in the here-and-now richness of group process often lead to cathartic breakthroughs. GRAT groups facilitate discovery of unconscious themes fueling unhealthy, sometimes toxic, relationship patterns. Insights and experiences in group deepen commitment to personal growth and provide impetus for action. Changes unfold over time. Compulsive overeating and other addictive behaviors gradually diminish as recovery networks solidify. GRAT groups come to represent "cultures of resilience" (Nickow, 2005) offering abundance—abundance of support, camaraderie, intimacy, and connection.

GRAT groups provide for transformative experiences impacting generations. They often interrupt transgenerational, self-perpetuating cycles of abuse, neglect, and emotional impoverishment. Often family and extended family observe the changes in loved ones and embark on their own recovery journeys. Regardless, reverberations from one person's growth are frequently felt throughout the family system.

Diagnostic classification presents a major barrier in eating disorder recovery. Classification of obesity as a metabolic or medical disorder has drastically limited understanding in the psychiatric and psychological communities. Conceptualizing obesity as a complex problem resulting from addiction allows for meaningful interventions. The professional community has been slow to embrace eating disorders as addictions. It is commonplace for alcoholics to be turned away from alcohol treatment programs if they disclose that they have active eating disorders. It is commonplace for people in treatment for eating disorders to be denied admission if substance abuse co-occurs. While honesty is a foundation of recovery from all addictions, individuals often face the choice of concealing certain addictions or being denied treatment. Such "catch 22s" are familiar in the history of mental health treatment. Even today, despite advances, a dual-disordered patient seeking treatment may find that psychiatric programs insist that the ad-

diction be treated first, while addiction programs mandate psychiatric treatment first.

In our clinical practice, we have seen tremendous short- and long-term therapeutic benefits of GRAT groups in treating a wide spectrum of eating disorders and addictions. Research has yet to substantiate the efficacy of long-term group psychotherapy as a critical component of treatment. Currently, we are developing research methodology to document the long-term dramatic results we have witnessed in our patient populations. Ultimately, our research will yield longitudinal data. We also continue to gather anecdotal and experiential data on the benefits of the GRAT model. It is our deep conviction that collegial consultation and collaboration, as well as experiential learning in here-and-now process groups (such as those offered at AGPA conferences), are at the heart of training and supervision for group psychotherapists. In the spirit of egalitarianism, we champion parallel growth and development processes for GRAT group members and leaders.

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