Group Psychotherapy with Obese Disordered-Eating Adults with Body-Image Disturbances: An Integrated Model

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Body-image disturbances and body-image misperceptions are common phenomena in the adult obese or disordered eating population, but they have received scant notice in group psychotherapy literature. This paper integrates an important missing conceptual link of body-image development and offers a group psychotherapy treatment model. This paper does not address the eating disorders, i.e., bulimia and anorexia nervosa. The integrated concept described here will show how a group psychotherapy model can effectively treat body image disturbances which often stem from developmental deficits. It also addresses problems with those patients, who, after weight loss, continue to have misperceptions of their size and shape, and experience shame and self-loathing as a result.

INTRODUCTION

The disordered eating population consists of those struggling with weight regulation—from the moderately obese to the morbidly obese and those diagnosed with binge eating disorders. Many in the U.S. population suffer from body image disturbances, body image misperceptions, body dissatisfaction and weight concerns. Those who come for treatment for body image problems are adults who have both childhood or adult onset of obesity, or who have struggled with weight regulation for a long time. Patients with childhood and juvenile onset of obesity often present as adults with developmental delays and deficits. Excluded are those with anorexia and bulimia nervosa.

To treat body-image disturbances within this population, one must have an understanding of the development of body image. According to Krueger, "The absence of a developmental model of the body self—its formation, maturational evolution, the integration of body and psyche, and

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related psycho pathologies—has led clinicians in psychotherapy and psychoanalysis to focus nearly exclusively on the psychological self without sufficient regard for the body self as container and foundation of the psychological self. The body image and sensory awareness/integration of these individuals had been subjected to the same process of developmental arrest as their psyches" (1). I suggest that this applies to the disordered eating or obese population depending upon age of onset. Krueger further notes that although Freud recognized the body ego as the foundation for subsequent ego development, the body and its evolving mental representation have been largely omitted from developmental and psychoanalytic theory (1). The absence of a developmental model of the body self has, perhaps, limited our knowledge of treatment oriented therapies to alter body image disturbances. This paper is intended to integrate this important missing conceptual link of body image development of the disordered eating population to formulate a group psychotherapy treatment model to effectively treat body image disturbances. It is my opinion that body image disturbances with the obese disordered-eating (ODE) adults are best treated by a combined multi-modal approach.

DEFINITIONS

While the medical community describes obesity according to body mass index, to further understand the psychiatric implications of obesity and disordered eating, one must first understand the language of the field. Obesity is classified into constitutional and symptomatic obesity (developmental and childhood onset), and reactive obesity (adult onset).

Constitutional obesity starts in childhood, frequently in infancy, and is often familial. These youngsters usually have good social, school, and emotional adjustment. They usually do not eat more than slim people, although they may be less active. It is postulated that constitutionally obese individuals may have a high physiological set point to which the body returns even after dieting, and that attempts to lose weight may result in a chronic state of starvation.

Symptomatic obesity refers to developmental or childhood onset of obesity associated with emotional problems that begin in childhood. Reactive obesity is associated with eating problems that begin in reaction to a major trauma in adulthood (2).

Body self refers to the full range of kinesthetic experiences on the body's surface and in its interior, and the body's functions (1). "The developments of a body self can be conceptualized as a continuum of three stages, the first of which is the early psychic experience of the body. The

second stage is the early awareness of a body image, with an integration of inner and outer experience. This process forms body surface boundaries and internal state definition. The final stage is the integration of the body self as a container of the psychological self, the point at which the two merge to form a cohesive sense of identity" (3).

Body image (BI) refers to the physical, emotional, and interpersonal view of one's body—the inner mental picture and sum of emotional attitudes towards it. This picture represents the physical perimeter of one's body as a whole, as well as the size, shape, and spatial relationships of its parts. The emotional feelings and attitudes are the major components of body image and can influence the accuracy of the inner mental blueprint (2). The linkage between body and mind takes shape during the formative, developmental stages of the individual.

Body image disturbance (BID) is the over- or underestimation of the body's actual size and shape, coupled with derogatory attitudes of the self. Derogatory attitudes consist of shame and self-loathing about girth, real or fantasized. These attitudes develop from continuous negative attitudes and criticism towards the child about appearance. The parent, in essence, rejects the child as he or she is. The child becomes the container for which the parent projects his or her own negative unresolved issues. This empathic misalignment between parent and child can give rise to developmental deficits and body-image and self-image pathology as seen in childhood and juvenile onset of obesity. Cultural influences have an impact, but less so than family of origin. The body-image problems of adult onset obesity arise out of having a "thin memory" (4). Such patients retained a "normal" weight in childhood while traversing developmental milestones and then gained weight in adulthood. Their self perception is thin, not fat, what I call the "fat, thin" people (4). Conversely, "thin, fat people," (5) are those who were fat as children and who got stuck developmentally then lost weight as adults and continue to see themselves as fat. Bruch refers to them as carrying an image of their former size like a "phantom" within them (5). Bruch also refers to the "thin fat people" (5) in her population of anorexics, who see themselves as grotesquely fat. Their concept of body image is fixed in childhood, thus their view of their BI today, as adults, remains as if it were then, in their childhood.

Body-oriented therapy (BOT) includes all forms of psychotherapy that focus on the body to improve psychic functioning. In this approach, patients are faced with primarily nonverbal experiences, which can be discussed later in treatment. BOT is usually connected to existing psychotherapeutic schools of thought. BOT has been applied to eating disordered

patients under different names: body-image groups, body-image therapy, body-movement therapy, dance-movement therapy, physiotherapy, and psychomotor therapy (6) (7) (8).

Body experience refers to the neurophysiological aspect—body scheme, body orientation, body size estimation, body knowledge—as well as to the psychologic phenomenological aspect—body image, body awareness, body boundary, and body attitude. Body experience comprises all individual and social experiences: the affective and the cognitive, the conscious and the subconscious. Thus the concept of body experience is multi-dimensional (9,10).

BI AND BID IN OBESITY LITERATURE: A HISTORICAL PERSPECTIVE

There are three opposing theoretical models and treatment approaches in the literature regarding obesity: the medical and medical surgical, the cognitive-behavioral and the somatic psychodynamic/psychoanalytic. A prevalent view in the medical world is that obesity is a medical condition, not a psychiatric disorder (11). Some practitioners believe that obesity is psychiatrically relevant only because some obese patients have concurrent psychiatric issues of importance to their medical treatment. Psychotherapy, therefore, is not considered a primary treatment for obesity (12). However, this view is too narrow where body-image disturbances are present and especially for those with developmental deficits.

Both cognitive-behavioral therapy and interpersonal therapy have been found to be effective in normalizing eating and reducing distress in obese patients with binge-eating disorders, although neither intervention is associated with significant weight loss (12). In these therapies, the behavior of disordered eating is the therapeutic focus. By not acknowledging a psychiatric (psychosomatic) component to obesity, the underlying dynamic is not addressed, and therapeutic changes realized by addressing only the behavior of the disordered eating manner are superficial (5) (13). Body image disturbances among the obese are not body dysmorphic disorders (14). Rosen further provides a cognitive-behavioral model of working with obese women (15). Thompson et al. have concluded that body image disturbance results from too much teasing in early ages (16). While Grillo et al. rates teasing as a risk factor for the development of a negative BI (17).

The literature claims that cognitive-behavioral therapy is the only treatment modality that has any effect on body image and is empirically tested (16). Some credence is given to feminist therapies for promoting change in body image (16). This being the case, it would seem that the

profession has not made full use of an important body of clinical knowledge, which is the power of group psychotherapy in dislodging BIDs.

The majority of the literature on body image (BI) has focused on anorexics and bulimics. Much of this literature measures and assesses BI and BID of anorexics and bulimics (18). Some parallels can be drawn between this population and that of the obese disordered eating population.

The question of whether or not obesity is a psychiatric problem is debated in the literature (19). Some believe obesity is a complex symptom that indicates a disorder of impulse control and occurs in a variety of character disorders (13). Current thinking suggests that overeating is often an effort to regulate affect or to achieve self-soothing so far not attained through nonfood objects. Attachment theory gives insight into the problems many of these patients have in the interpersonal realm.

A landmark study, conducted under the auspices of the American Academy of Psychoanalysis, "demonstrated the value of psychoanalytic treatment in the overweight population and validated the improvement of body image in these patients" (20). The researchers also found that through identifying specific psychodynamic issues associated with weight gain or loss and different deviant eating patterns, obese individuals could lose weight and maintain the loss. Psychotherapy also improved patients' self-esteem and social adaptation by reducing their tendency to disparage their bodies. While giving attribution to the role that genetics, metabolism, and fat cell morphology play in obesity, the study clearly documented a relationship between compulsive eating, weight fluctuations, emotions, body image, self-representation, and specific psychodynamic issues (20).

Devlin says that "psychotherapy may be helpful in enhancing self-acceptance in obese patients who have learned to feel ashamed about their weight and may help patients to cope with the effects of prejudice and 'weightism' that are pervasive in our culture" (12). This reference seems to deal with those patients who do not lose weight and it focuses on the patients acceptance.

The literature on body image includes very little on treatment. The early literature of the 1970s and 1980s focused on the anorexia and bulimia nervosa population of eating disorders. In an attempt to validate its authenticity, the literature largely contained charts and graphs about assessment and measurement techniques of body image disturbance (18).

Some literature did present the psychosomatic nature of obesity (21) (22) (23) (13). Bruch stands out as the early maverick in the field, pointing to the underlying emotional mechanism of eating disorders and psycho-

therapeutic approaches to treatment. Of central interest to her was body image and development of the self. Bruch gives us insight about thin fat people. "We cannot consider a fat person cured, even though he has lost his weight, unless all the other functional symptoms have also disappeared. Loss of weight alone represents a pseudo cure" (5). Her position was that prognosis for these patients was guarded unless their body image disturbance was corrected. It has been my clinical observation that Bruch's theoretical position underscores the main reason why weight programs don't work in the long run.

Other literature on body image and body-image disturbance contains contradictory information. There is disagreement on the definition of body image; how body image is formulated; the relationship of body movement to body image; the development of body-image disturbance; the effect of weight loss on body-image disturbance; whether all populations—normal weight, obese, anorexics—overestimate or underestimate their body. If everyone is suffering a body image disturbance, can it be pathologic (4)?

During the late 1970s in *Fat is a Feminist Issue* the feminist and revolutionary writer Orbach wrote that the culture is to blame for the negative focus on fat for women and the ensuing distorted body images that women have (24). The literature of the feminist psychotherapists in the 1980s and 1990s suggest that body image disturbance is in the eyes of the beholder, primarily the result of women reacting to a male dominated culture (25,26). They focused on women "reclaiming their bodies." Garner and Wooley challenged the medical establishment, suggesting that traditional weight programs just didn't work and that traditional medicine needed to be honest with patients at the onset, advising them that weight loss programs had poor outcomes and that more damage could be done going on endless diets (27, 28). Was it good to have women work so hard to lose hundreds of pounds of weight only to regain them and then some? Rodin addressed some of the confusion that this author had originally noted in the literature in 1986, i.e., all women in American and Western culture were discontented with their bodies, the "normative discontent" (29).

Historically, the feminist summation of body image in women was that women primarily saw their bodies as commodities, their physical appearance serving as interpersonal currency. Beauty was a central asset that helped women gain access to a man's resources. Men saw their bodies as actively functional tools that need to be in shape and ready for use. The feminist psychotherapists tried to "empower women," utilizing the more creative rather than the traditional psychoanalytic therapies. These expe-

riential therapies, both for individuals and in group, included dance, art, poetry, psychodrama, music therapies and family sculpting. This is the first place where one begins to see the use of group psychotherapy in treating body image disturbances.

In the 1990s, society's unrelenting emphasis on physical appearance drove many people, both male and female, to pursue physical perfection. Cash and Pruzinsky (30) discussed body image as it affected the entire population. Through cognitive-behavioral therapy, they introduced the idea that perhaps body-image disturbance could be changed by reframing the thinking about the body. They later looked at the eating disordered and obese population. In the latter part of the 1990s, Rosen introduced work in body dysmorphic disorders and cognitive-behavioral schema to work with obese women to help diminish their self-loathing without weight loss (15).

Thompson tried to standardize the definition of body image through empirically tested models for measuring and assessing body image and body image disorders. He has been working to develop a related DSM diagnosis for body image disturbance in the obese population. His theory, as is Rosen's, is ongoing and consistent teasing at an early age can bring about a body-image disturbance (16).

DEVELOPMENT OF BODY IMAGE AND BODY-IMAGE DISTURBANCES

Nonpathological development of body image is well described in Krueger's work. He suggests that: "psychotherapy and psychoanalysis focuses nearly exclusively on the psychological self without sufficient regard for the body self as the container and foundation of the psychological self. The body image and sensory awareness/integration of those with eating disorders has been subjected to the same process of developmental arrest as their psyches" (1). He further observes: "Their body images were disrupted, blurred, distorted, incomplete, or infantile, and often fluctuated with emotional state. Those with severe narcissistic and borderline pathology may not experience the distinctness of their bodies or their body boundaries. Lacking this consistent and accurate internal image of their bodies and sense of self, such patients necessarily rely on other people and external feedback and referents to mirror their worth and adequacy. Object and internal image constancy are missing" (1). The psychodynamic literature suggests that children who have eating issues, who encounter negative input from family and others that extends through adolescence, are susceptible to developing a body-image disturbance.

Bruch wrote about the families that produce persons with eating disorders and body image disturbances. The roots of difficulty lie in the disturbed relationship with mother at a very early preverbal level. The type of mothering experienced by these patients is that they were used as an object to fulfill the needs of one or both parents and to compensate for failure and frustration in the parent's own life. "Since feeding is often a response to the parent's emotional needs rather than to the child's hunger, these patients grow up confused about their own body urges and are unable to distinguish hunger from anxiety or other emotional states. The pathological bond between parent and child results in feelings of helplessness and inadequacy, resulting in a deficient sense of separateness" (5). The Kaplans (31) and later Herzog (32) support this theory. Winnicott (33) eloquently describes the elements of difficulties with individuation from an object relation point of view.

Wilson suggests that the selection of a child for the development of obesity occurs by process of parental neglect rather than over concern as in the anorexia and bulimia nervosa (13). Conversely, the cognitive behavioral literature depicts that teasing is the culprit for instigating BID and suggests that the treatment for negative BI is the cognitive desensitization and restructuring of thinking beginning with the focus of restructuring negative self-talk. Krueger's work provides the missing theoretical explanation for the development of distorted body image. He explains that those at risk have early developmental pathological sequelae, which fall into three groups. Although not mutually exclusive, the types of interactions can be described as: 1. parental over intrusiveness; over stimulation; 2. parental empathic unavailability; and 3. parental inconsistency or selectivity of response (1). Thus a more sophisticated understanding of the development of body image disturbances is laid out. Although teasing can be a contributing factor, BID mostly stems from developmental deficits.

THE INTEGRATED GROUP PSYCHOTHERAPY MODEL —AN OVERVIEW

The Integrated Model for Group Psychotherapy is an integrated clinical approach that makes use of elements of psychoanalytic and psychodynamic theory, object relations theory, self psychology, gestalt therapy, attachment theories, experiential, body oriented and sensory motor therapies within the context of group psychotherapy. The group creates a holding environment where patients can deconstruct the evolution of their body image and distorted view of self and eventually reconstruct a healthier internal model. The long-range goal of the Group is Yalom's

transfer of learning function, (43) i.e., that this healthier model will be integrated into the patients' internal schema/structure enabling them to transfer it to their life outside of the group.

Historical Overview: Evolution of the Group Model from The Body Image Workshop

In the late 1980s, a group model called The Body Image Workshop was developed to work with obese patients having body image problems stemming from developmental deficits. Originally the term workshop was used since there was less resistance to this term in medical clinics where the culture might not be geared to the psychosomatic understanding of obesity. However, contracting with patients clearly spelled out a psychotherapeutic agenda. The workshop model evolved into a group psychotherapy model. This allowed me to form a psychotherapy contract with patients. The half-day workshop was in fact an introduction to group psychotherapy. My goal was to create a group therapy model, short and/or long-term which could correct impaired object relations and address developmental deficits and self-representation with ODE adults having BID's. The population included were child and juvenile as well as adult onset of obesity.

The Group Model: Introducing Movement

The Integrated Group Psychotherapy Model explored integration of mind and body through the use of movement. Movement, which is central in the development of body image had been neglected in the treatment of body-image problems. Selected movements of T'ai Chi were modified and selected for this population. T'ai Chi was chosen since it centers awareness of self within the body. T'ai Chi, an ancient form of Chinese movement art, is used as a nonintrusive and nonthreatening form of body-oriented therapy because it allows patients to have a body experience and accurate mirroring, i.e., using movement to experience inner and outer body images that are necessary for body-image development (34). My colleague, who co-led this group, is a trained dance performer, a T'ai Chi instructor, and a certified teacher of the Alexander technique.

Incorporated into the group process, was a tactile exercise called "body sculpting" which made use of patient's guided self-touch (4). In this process, the therapist, through verbal guidance, mimics a parent "holding" a child positively. The patient, through self-touch, reexplores his or her body boundaries. The mirroring comes through the transference with the therapist and from the modified movements of the T'ai Chi instructor. The sculpting exercise grew out of the literature on childhood development in

which body movement and touch have been shown to shape body image (34).

TREATMENT AND THE USE OF MOVEMENT IN BODY IMAGE LITERATURE

Schilder underscores the importance of motility in his 1935 study of body image. "We would not know much about our bodies unless we moved them. Sensations stemming from multiple perceptual and muscular feedback are integrated into a dynamically developing body image, thus motility plays an essential role, not only in defining the boundaries of the self, but in differentiating one's self from the total perceptual environment." The inactivity so characteristic of obese people thus appears to be related to their often disturbed body concept (36) (37).

There is little indication in the obesity literature, however, that body awareness, movement, and tactile techniques are used in the treatment of obese adults (35). Overweight patients often have difficulty moving. Even walking can be a chore. Full-length mirrors are avoided. In addition to avoidance and denial, obese adults reported that they had anesthetized their bodies. This was especially true in the sexual arena. Dissociation was central to their pathology. It became apparent that perception of one's body image could not change from merely talk therapy. It seemed that incorporating movement into the therapeutic work was a natural progression in treatment. Current work in trauma helps us better understand the mind-body connection (38–41). Krueger wrote about treatment through movement with anorexics and bulimics (42). He suggested that there is no "authentic" movement for anorexics and bulimics. Because of the missed early experience of accurate mirroring as children, these patients have not experienced any internally directed autonomous communication of feeling. Their bodies are not seen as vehicles for their own expression, but rather as mirrors for the feelings of others. His model of treatment focuses on accurate mirroring, utilizing dance movement, designed to integrate the mind and body as this basic body awareness has never been completely established. The dance movement parallels a normal developmental sequence.

Pre-Group Screening

In evaluating potential patients for The Integrated Group Psychotherapy Model, I focused on body-image disturbances and followed the inclusion and exclusion guidelines for groups recommended by Yalom

(43). In addition, understanding the meaning of eating and fat for these patients was essential. Thus, an evaluation that is specific to disordered eating, with a focus on ego functioning and developmental deficits, was required. Developmental deficits were determined by examining age of onset of obesity, combined with psychostructural organization and integration.

The degree of psychostructural integration, loosely interpreted, can be understood in four categories—psychotic, borderline, narcissistic, and neurotic. First, the level of functioning was determined. Once a patient's psychostructural organization and developmental achievements have been ascertained, the question remains: Where do eating, body image, and self-pathology fit into his or her character structure? Secondly, it was important to determine the place weight and eating play in the patient's family dynamics. (1, 44) (See Table I for Criteria of Inclusion/Exclusion in group.)

Patient Selection

The Integrated Group Psychotherapy Model was developed as a three-, six- or twelve-month protocol. Groups met weekly for two hours. Membership consisted of men and women from their mid 20's to mid 50's who were self-referred. They were already in psychotherapy and were self-identified as having problems with disordered eating. They were encountering problems with their self-perceptions. Usually there were more women than men. The maximum in any given Group were 12 participants. Some had lost a significant amount of weight, while others were ambivalent about putting their desire to lose weight into action. All wanted to explore the particular meaning of their relationship to food, weight, and eating issues from a psychodynamic perspective and to explore their distorted feelings about self. They complained of having a distorted body image. They had lost weight, but did not "feel" thin. Or they were overweight and felt and saw themselves as thin. They complained that their "fat" and self-image prevented them from having the kind of lives they wanted. The big complaints were in the realm of interpersonal life. Many had lost weight but had experienced a hollow victory. Weight loss had not gotten to the root of their misery. "Men or women don't want me because I'm overweight." "I'm a 35 year old man or woman and I'm a virgin." "I'm a 7th grade teacher and the kids I teach know more about dating and sex than I do."

Following the patient selection phase the actual group work begins.

Table I. (1) (44) THE MEANING OF EATING AND FAT

	Ego Functioning	Milestone Problems	The Meaning of Eating and Fat	Body Image Group Inclusion/Exclusion
Psychotic	major ego impairment	infantile fear of annihilation	soothing mechanism	No for group
Borderline	low to high functioning	life's ups & downs experienced with extreme difficulty. Fear of annihilation.	Managing separation fusion anxiety. Unconscious fantasy engulfing the other. Fear of being controlled by the other. Defensively destroying the other. Helps deny importance of other people. Helps deny depression. Has no choice but to eat or scream. Weight loss efforts will result in frustration. Have not developed techniques of self soothing. In danger of developing bulimarexia patterns & destabilizing metabolic rates. Only as ego develops can these patients give up food. Body Image disturbances rampant.	Higher functioning may be eligible for group. Recommend individual work.
Narcissistic Personality Deficient	Immature egos, more developed than borderlines	People won't be interested if they really know them. Present "false self" to others. Pursuit of thinness is an attempt at definition of self & a wish to be desired. Present as entitled. Eat what they want to eat & wish to be thin at the same time. Life has no limits.	Presenting a socially acceptable thin physical self. Maintaining the attention of others on the superficial, physical aspects of the self. Finding somatic compensation for narcissistic tensions. Fear of humiliation. Interest in physical attractiveness isn't necessarily connected to sexual or competitive feelings, but to self esteem needs. If they lose wt. Lose excuse "the reason I can't have a relationship is because I am fat."	Yes for group, but highly recommend individual work.
Neurotic adult functioning	High ego functioning	Will present eating out of control when injured, faced with life's stressor's-job loss, death, divorce. When faced with stressors will regress to earlier developmental stage. Postulates these pts. Didn't obtain appropriate oral gratification and might regress to oral level behavior.	Anxiety over sexual/romantic involvement and achievement; managing conflicts over sexuality, gender related issues, denying homosexual fears-by maintaining sexually unappealing body type and denying sexuality. If they stop eating, they lose the excuse being overweight gives them to avoid relationships. Fearful of addiction to "love choice."	Yes to group, but recommend ongoing individual work.

The Method: Five Phases

Traditional cotherapy preparation work followed. Cotherapists met several times in advance of the first meeting and discussed the group format and their role definitions. Since the T'ai Chi instructor was not a psychotherapist, clear boundaries were defined as to the level of her verbal input. The author ran the sessions. The T'ai Chi instructor was introduced as an expert in movement and body work. Although the T'ai Chi instructor did not interpret emotional material, she could and did share her reactions with group members in reference to movement.

Movement is central throughout all five phases. All sessions began or ended with thirty minutes of movement. Sometimes movement was used during the sessions in order to highlight a point.

PHASE I—Introduction and Evaluation

The contract and therapeutic agenda were introduced. (Patients were given handouts (Tables IV, V) and asked to bring them to group the following week. The goal of Phase I was to develop a therapeutic alliance, foster self-disclosure, destigmatize weight and size, and to get baseline drawings (as discussed below). The T'ai Chi expert was introduced and a contract about movement and touch was set. All instructions regarding movement were done verbally and through demonstration. If a physical position was to be corrected, the instructor asked permission to "put hands on the patient." The patient could deny permission. Thirty minutes of each session either began or ended with several T'ai Chi movements. The group language was purposely modified to focus on metaphors for eating. Food was translated into a language of emotions, i.e. feelings and relationships. Eating was put into a different frame, i.e., problems of self soothing and connection with the love object.

The initial phase of the group (Weeks one to four) was spent diagnosing the problem, not just in words and description, but through a series of drawings. In my original work in the Body Image Workshop I had developed a series of 12 Projective Drawings (Table II) (4) which could quickly get to unconscious material and identify roadblocks to weight loss and the genesis of negative Body Image. These 12 projective drawings are used throughout the five phases.

In the first session it was important to get a base line of these drawings (Drawings 1, 2, 3, and the sculpting exercise) (4) before patients began deconstructing their story and began the treatment process. These drawings later would be used for comparison in Phase V.

In the first group they discussed: 1. Why they were participating in the

Table II. PROJECTIVE DRAWINGS OF HOW WEIGHT AFFECTS PATIENTS' SELF-IMAGES

1. How do you perceive yourself today? (The patient should write down actual weight on the drawing.)

2. How would you like to look when you lose weight? (Patients should write down their ideal weight.) Assure the patient that this is only a "dream-come-true" rendition. The patient should be encouraged to fantasize.

3. How do you think you will really look when you lose the weight? (Have the patient indicate that weight on drawing.) In this picture patients should produce a realistic picture of how they will look. There must be no fantasizing here.

4. How do you think people with a positive influence in your life (e.g., a friend) see you? (If patients wish to name that person they can do so. The patient should identify the relationship.)

5. How do you think people with a negative influence in your life (e.g., a friend, parent that the patient does not get along with) see you? (Again, the patient can name that person and identify the relationship.)

6. How do women perceive you?

7. How do men perceive you?

8. How does your lover, significant other, companion, or spouse perceive you? (If these people are different, draw a separate picture for each.) If there is no lover, spouse, or significant person, how do you want your fantasy lover to see you? How do you really perceive your fantasy lover would see you? (This last drawing must be "stark reality.")

8a. Draw a picture of your fantasy lover.

The next two drawings are concerned with parents' perception. If the parents are deceased, patients would provide drawings of how their parents saw them as children; then, how the patients think parents would see them as adults. (The parents' age, weight, and height during a patients' childhood and at the times of the parents' deaths should be indicated.)

9. How do you perceive your mother sees you: (Have the patient indicate the mother's age, weight, and height.)

10. How do you perceive your father sees you? (Have the patient indicate the father's age, weight, and height.)

Occasionally patients describe their parents as being thin while they may actually be obese. If you suspect this is the case, have the patient draw pictures of the parents.

11. How do you perceive your therapist sees you?

12. The Sculpting Exercise. Guided by the therapist's specific verbal instruction, the patient is guided through a relaxation sequence. (Using Jaffe's breathing exercise, patients concentrate on relaxing specific body parts in a sequential fashion, which results in a relaxed state.) Again guided by the therapist's verbal instruction, then patients are instructed to "sculpt" themselves, imagining that they are sculptor's clay. The therapist guides them through a sequence to literally feel the contours of their body three dimensionally from head to toe. After this, they are asked to draw what their body felt like.

Workshop. 2. When their problem began. (Table V) 3. The need to eat; distinguishing eating out of hunger or out of the need to be soothed emotionally. 4. How the legacy of parental over or under stimulation and/or involvement left them with a legacy of defective self-regulation. 5. How eating was a primitive connection with their mother, and how they never learned to soothe themselves adequately. 6. Their struggle against

the so called "food addictions." 7. Becoming familiar with information about the latest research in obesity.

In Phase I an assessment was made regarding the patients motivation to change as well as their personal meaning of eating. These were assessed through a series of questions: Why are you interested in exploring your body image now? Are you satisfied with your current weight? Why is your weight and/or body image a problem? What made you want to come to treatment? What, apart from your weight/body image do you want to change about yourself? What are the advantages and disadvantages to being fat and thin? How does your weight get in the way of your daily life and in the way of your relations with men and women? Has your weight always affected you in this way? What is the personal meaning of eating? What is your fantasy life? What would life be like for you if you could manage to do what you say you want to do? When you last lost weight, what happened? Did your concept of self change? Thus, the patient's perception of self through a group psychotherapy dynamic evolved.

As well as motivation, Patient's "Weight Zones" are defined (Table III) (4). The concept of "Weight Zones" offers a structure to think about one's weight. Patients are offered the option to return to any level or zone of weight where they feel safe in order to do the developmental work needed at any one given time. This could literally mean gaining weight until they felt safe. This working definition of weight sets a frame of control and safety.

PHASE II—Externalized Objects

The goal of this phase is to 1. Deconstruct and discuss one's perception of self in reference to externalized objects through drawings and 2. to further explore one's body perimeters through body sculpting, i.e., guided touch, along with the specific T'ai Chi movements. The T'ai Chi instructor

Table III. DETERMINING WEIGHT ZONE

Name
Safe Weight
Panic Weight (panic at being "too thin" or "too fat")
Getting "too thin"
Getting "too fat"
Death Weight
Attractive and Available Weight
Dating and Sexual Weight?
Naked Body and "I can allow myself to have sex weight"

Table IV. DEMOGRAPHIC INFORMATION

Name Age
Current Weight
Highest Weight (as an adult)
Lowest Weight (as an adult)
How much weight have you lost?
How many times have you gone from high to low weight?
At what age did you start trying to lose weight? (Go on diets.)
At what age did you begin to have eating problems?

demonstrates guided visualization and guided movement with a focus to anatomy and body stance. The analysis of externalized objects in group members lives is derived from Drawings 4, 5, 6, 7, 8. Group-as-a-whole methods are used, integrating the progressive use of the 12 projective drawings through group process. The use of discussion of the drawings and the specific movements taught by the T'ai Chi instructor create the mainframe and boundary of the work of the group.

In the short model, Phase II is three-to-four-weeks-long. In the long model, this is the middle part of the group which can go on for weeks depending upon patient response. The T'ai Chi instructor introduces anatomical instruction demonstrated on a skeletal model. I review for the group normal development of body image; understanding the development of their body image distortion in their family of origin, and developmental milestones of separation and individuation. During this phase members are very interactive with each other in the group process. Members are encouraged to comment on each others drawings and to discuss the feelings that arise from seeing and experiencing the drawings.

The timing of the introduction of new material was geared according to patient response. Appropriate timing for each group was always a challenge. The goal was not to flood patients with too much interpretation and

Table V. AGE OF ONSET OF OBESITY

Identify the age you were told you had a problem with your eating and your weight. Now, identify when you felt you were beginning to have problems with your eating and your weight.

	Told	**Felt**
Childhood Onset (age)		
Juvenile Onset (age)		
Adolescent Onset (age)		
Adult Onset (age)		

too much new material. This required the sophistication of a trained group therapy professional. The first or last 30 minutes of each group session during Phase II was devoted to a form of movement. We reviewed what their experiences were out in the world. Why is body image so important to them? What is it that they hope to achieve? Why are eating and looks so important to them? What is their goal in social life? Where are they regarding others? Did they have hopes of attachment? Why hasn't that happened?

During this phase the following were reviewed and discussed: 1. The psychoeducational piece starting with anatomical instruction. 2. The view of normative discontent in society-at-large. 3. Concepts of body image and body image development were explored, as well as the concept of eating as a primitive connection with mother. 4. Fat described as a symptom of emotional conflict. 5. It was suggested that the goal of eating may not be to get fat. Fat may be the result of a complicated process. 6. Eating may be part and partial of a primitive method of soothing and incorporating the love object. 7. Eating is a defense mechanism which is caloric and leads to being overweight or "fat." Eating may be in response to feelings that they feel they could not contain, i.e., emptiness, fear, anxiety, sadness. 8. The need to eat is very complicated, if one takes into account the biological mechanisms behind it, i.e., fat cell morphology and the physiological set up. 9. Normal growth and developmental factors in family life are discussed. Similarly, cultural mandates, fears about growing up, separation and individuation, and differentiating one's self from others are also focal points of discussion.

PHASE III—Internalized Objects

The goal of Phase III is to study the interaction between the patient and their parents. Movement therapy is continued to correct their view of their actual size, weight, and attitude through relearning their body boundaries.

Phase III is an introduction to their internal world. What has been developed over time from birth through young adulthood as an internalized object/and then how has that been projected out into the world? Drawings were done of the internalized object, parents, and therapist.

For the short-term model, Phase III took place over the last four to five weeks of the group. As in Phase II, the first 30 minutes of each group session was devoted to movement. This was the most poignant and powerful phase of the group experience. It was when group members felt the most vulnerable and unsafe. It was essential that the therapist was

mindful that the group maintained strong boundaries and containment of intense emotions during this phase. A representative sampling of techniques used in this phase are guided visualizations and gestalt chair work.

Patients brought in family photos from when they were young. Group discussion consisted of 1. self assessment, i.e., a review of the reality of what each patient looked like when younger. 2. Assessment of the other's pictures. 3. Gestalt/chair work was introduced after review of the pictures. The group worked as a team, designating two people to role play the parent and the child in the pictures. The two, who represented the child, chose who they wanted on their team to shadow and coach them in responding to the person in the dyad who functioned in the role of the judgmental, negative parent. Patients then reversed roles. In the short-term model, there was time for only one or two demonstrations, but all patients got to work the dyad with the group dividing into teams.

A sample of the questions explored in this phase are: 1. What did they learn in their families about separation? Could their parents let them go? Did any one parent prevent them from being launched? 2. What did they learn about their own sexuality? 3. Were they raised so that they could "strut their stuff?" Could they beat out the parent? 4. What picture of self did their parents give them? 5. What did their parents like about them? 6. What didn't they like? Issues of competition, guilt, love, hate, and aggression were discussed. 7. Patients were asked to bring in family photos. 8. The notion of projection was introduced. What feedback do group members get when they are out in the world? 9. They were asked to imagine how life would be different when and if they lost weight. What do they want to be different? What was it like in the group?

PHASE IV—Pre-Termination

The goal of this phase is 1. Evaluate patient progress regarding the integration of the emotional material learned and its translation towards their perception of self. 2. Evaluate any change they've made in feeling more integrated in "their own skin" in size, shape, and attitude. 3. Begin entering into the Termination Phase of the group.

As the group enters into the termination phase they begin to review the shared experiences of group members. They can choose to return to any phase of the group to look again at any material they feel they need to. As they continue to work with the T'ai Chi instructor they can continue to comment on their progress as they take a more realistic view of their bodies. During this phase there was a guided meditation of a beach scene. This fantasy walked patients through their negative and ambivalent feel-

ings of their parents to negotiating with their parents and speaking up for themselves. The parent listened, or the patient grappled with the fact that the parent never listened. Patients learned that they must separate from their family of origin. The session ended with a rapprochement between the two.

PHASE V—Termination and Review

The goal of termination is to review the patient's progress and work and to give closure to group members. This phase can last for two to three weeks. In the last phase of the group patients are asked to redo all of the drawings and the sculpting exercise described in Table II, and compare their original drawings to these new drawings. Termination encompassed a review of what they learned and assessed their need for further treatment. A group follow-up meeting was planned for six months later.

DISCUSSION

The Integrated Model for Group Psychotherapy has proven to be an innovative and successful way to apply group techniques to ODE adults with BID. The advantage of a group model for working with BID's is that there are multi mirrors, i.e. multi object reflection using projection and transference. Transference involves all group participants, including the T'ai Chi instructor. I observed some of the valuable elements frequently found in homogeneous groups—more rapid emergence of transferential issues, greater level of self-disclosure, and more cross identification. The group was homogeneous by problem selection, but the members had different psychostructural organizations. In these groups the more developed patients, having a later age of onset, were able to model and give feedback of a healthier perception of self. Even those who had childhood onset of obesity and had self distortions could have great clarity when observing the size, shape, and self-loathing of someone else. Some served as parental stand-ins, both positive and negative. From a cultural standpoint, most overweight patients suffer from negative input from peers and the culture at large. As body dissatisfaction and weight concerns become increasingly normative among women in Westernized countries it becomes harder to differentiate pathological concern from cultural norms. Motivation and empathy were quickly addressed. The management of intense affect emerged as a group theme, in particular anger, a prevailing emotion, and its appropriate expression. The group allowed a greater expression of feeling than in individual therapy. The group it seemed, provided a safer

place than individual therapy. The group could hold each other's anger, process and contain it.

By the end of the Group, there was a reduction in anger and a greater ability to address separation and individuation, allowing patients to begin looking at their parents objectively. Main themes emerged: boundary issues with parents, enmeshment, and identifying the parenting child. Group members were able to address the difference between feeling compassion for their parents, which requires separateness, as opposed to being enmeshed and breathing through another's lungs. Group members were stunned by their level of rage, jealousy, and shame. The power of the group experience facilitated their awareness of what their needs were. They experienced a huge sense of relief that others had the same problems and that they weren't "crazy."

The sculpting exercise and movement addressed their body dissociation. Towards the end of the Workshop, some members expressed that they "felt thin" and had less attachment and emphasis on negativity. Some became more accepting of themselves and their bodies. They were relieved to not have to focus on having to lose weight to succeed in life. There was relief at gaining some understanding of the development of body image. They were less fearful of their bodies. There seemed to be an integration of body and mind. When determining weight zones, it became obvious to these patients that some of their belief systems were contradictory to the logic of the numbers in weight which they attached to each zone.

The exploration of "when did the problem begin?" helped patients decode their potential secondary gains for not losing weight. The family photos were a useful tool that challenged their memory of self-image. Their expression of shock in the discrepancy between their memory and the pictures was powerful. Many who thought they were fat and ugly as children were surprised at the positive feedback they had from other group members. Identification of their enmeshed family structure became central. More specifically, a pattern of intense mother-daughter relationship was noteworthy. Making use of the power of the group to find the strength to begin the process of being launched from their family of origin became a central theme.

Many came to understand that the root of their conflicts was grounded in the sexual arena. This encompassed their competition with mother, individuation and separation from mother; their being a stand in for mother with father or father with mother. The challenge was to come to terms with their sexuality and not be fearful of it. The overweight men had to come to terms with others' perception of them as androgynous, non

sexual. Group members were able to reflect a reality that demonstrated how far afield parents' perceptions of their children were. They could see themselves through others' eyes. Clearly identified were the areas of developmental arrest and parental empathic failure. Eventually some could forgive themselves for the neglect of their bodies. Some could forgive their parents and strike a more balanced appreciation for the task of parenting. The group model seemed to provide what Yalom calls the eleven primary categories of curative factors (43).

CONCLUSION

Group is an effective modality to treat body image disturbances with the disordered eating population. Throughout the process, it became clear that these patients needed to address their need to be launched from their family of origin and the group was a facilitator in this process. In essence, siblings could help each other develop and grow. Their level of self acceptance was raised. Many went on to exercise classes. Several decided that they no longer needed to lose weight and that they could be content with themselves as they were. Several continued more rigorously to lose weight. All reported that the Group had a strong impact on their lives. All remarked that they never had felt so powerful as when they followed the T'ai Chi technique. The speed of self integration was facilitated much more than solely in individual treatment. The Integrated Group Psychotherapy Model is a starting point to work with obese patients whose lives have become limited by their misperceptions of self in size and attitude. The work is based upon my many years of clinical experience in this field. My work provides an opportunity for further study which goes beyond talk therapy in the attempt to change body image and challenges traditional theoretical and practical approaches to body image disturbance.

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