Rethiking group therapy for anorexic patients

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Abstract
This paper presents an approach to working with groups of anorexic patients via decoding of primitive concrete language.

Key words: anorexic patients, group, concrete language, therapy

Certain assumptions about treating anorexics with group therapy have been held up as reasons for not using this mode of therapy. The characteristics of patients with anorexia nervosa are that they remain withdrawn despite restoration of body weight, anxious, rigid, egocentric, preoccupied with body weight and food and have extreme difficulty in identifying and expressing feeling. Thus the patients are likely to be silent, or so preoccupied with food that this may be the sole topic of discussion.
Using the traditional methods of psychoanalysis and group analysis, little success has been reported with this patient group. It is also difficult to construe the characteristics described above in terms of traditional psychoanalytic concepts. Bruch (1973) and Selvini-Palazzoli (1974) described early disturbances in the mother-infant relationship, which contribute to the development of the personality structure associated with anorexia nervosa. They suggest that the defective ego must be recognised and strengthened in psychotherapy in a way similar to the approaches used with borderline, narcissistic or schizophrenic patients.

This paper suggests that, due to the changes in thought and language exhibited by this patient group, essential early communication and language skills can be enhanced by group work. Attention to these tasks by the group conductor or therapist forms part of the building blocks on which later, overtly language-based therapies, depend (Lacan, 1998).
Most in-patient facilities are based around group activities and we must assume that there are sound therapeutic reasons for doing so other than economic viability. Most of these groups are not talking groups but are task orientated. The question might be, are these tasks therapeutic in their own right? Do cooking groups instil a knowledge of what constitutes appropriate amounts of food in an appropriate context, or making a collage of female figures from magazines improve perception of body image or is there an occluded task, related to early communication skills?

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Task groups are viewed as low key, non-threatening strategies by which patients both interact with other patients and staff. It is suggested here that if the communication events within the groups are monitored and given more prominence in the mind of the group leader, the therapeutic effects of so called task-orientated groups can be enhanced.
The borderline and narcissistic features of this patient group directly effect the language and communication in the therapeutic setting. The most prominent feature of borderline thinking and language is the lack of symbol and metaphor. The fact that the grammatical structure of the language remains intact often leads clinicians to believe that the patients are using language in a normal way. However, because the content is littered with concrete objects, the communications resemble Swiss cheese with holes where the thought has, due to anxiety, been reduced to a concrete non-symbolic symbol but where, it is suggested, the nascent thought resides.

For example a patient 'Anna' during an initial assessment, when asked about her relationship with her father who had suffered for many years from a depressive illness, spoke very protectively about him and denied any feelings of sadness or anger towards him 'It is just how it is'. On my exploring the subject further she suddenly interjected the question 'Do the bran flakes that I eat (her only food) damage my stomach?' This was understood to mean that probing about her feelings towards her father had provoked anxiety and threatened her idealised view of him. Thus, the 'damage' the enquiries had made to her internal world was experienced by her as possible damage to her intestines. Furthermore, bran flakes were understood to be the means by which she rid herself of her 'internal world' and reduced her anxiety of anything staying inside her mind that might cause her distress. When asked why she had spoken in this way at this time she had no explanation other than she had suddenly become preoccupied with this thought and wanted to know the answer. On being given the therapist's understanding of her question she expressed shock and recognition of the fleshed-out thought. Anna clutched her stomach and felt dizzy saying it was quite an overwhelming sensation.

Typical communications with this patient group are concrete in nature but are valid communications nevertheless, because they are communications, uttered in the hope of their being understood by an 'other'. They just happen to be couched in concrete object language where perhaps only a sliver of meaning, one aspect of the communication, represents the message. Perhaps these communications can be better understood as being closer to dream material. Dream material occurs when the conscious functions are switched off, when reality does not intrude (Solms,1999). Classically, such dream material is interpreted within the context of the analytic session. It is suggested here that such concrete utterances, by our

conscious anorexic patients, can also be understood within the therapeutic situation if the concrete object is expanded into its symbolic language form with reference to the context.

Without an internal emotional language to make links between our reaction to the world about us via our minds, we are unable to process and make sense of our reactions. Initially, emotional reactions are felt by the body as anxiety. We might understand anorexia as an anxiety reduction mechanism when faced with incomprehensible emotional demands perhaps somewhat similar to a functional autism. The control of concretely keeping something out leads to a reduction in anxiety. The internal world then feels 'better' and is in place of a resolution of the anxiety via processing in language within the mind.
The narcissistic position of our patients also leaves them with a reduced ability to relate to an 'other'. Thus our patients have borderline concrete thought processes in a primitive attempt to communicate but little sense of being heard by a sentient other. This might well be a good description of the early mother child dyad where for whatever reasons the mother is unable to attend to the meaning of her baby's communication (Fonagy & Target). This may be due to her own preoccupations, or her own difficulties in allowing herself to receive her child's projections into her at a primitive level (Klein, 1952). Gianna Williams (1997) has described the 'no entry' mother.
Willams wrote of mothers of anorexic girls who project into their babies, using them as 'containers' for their own intolerable feelings. Therefore babies not only experience a sense of their own anxiety being uncontained and mediated but also receive their mothers' anxiety. In other words they experience a double dose of anxiety without any means of processing these feelings.

Early maternal preoccupation facilitates the relationship between mother and child, encouraging close attention by the mother to the nascent communications coming from the baby towards a receptive mother. The dance between mother and child becomes established as a duet for two voices with the mother's mind as an adjunct to the baby's mind and as mediator and interpreter of the world. If the mother is not attuned to her child's communications she might respond randomly. If she cannot bear to hear her own unmet demands in those of her child she might unconsciously silence those demands. The mother's own fragility and need for reassurance in her mothering might lead her to find the separate development of her child's mind quite threatening.
Ana-Maria Rizzuto, eloquently describes in her 2002 paper the linguist Roman Jakobson's description of the constitution of the speech event. Unusually among

linguists Jakobson includes emotional contact as a factor of language which he labels Phatic.
The Phatic function serves to establish and maintain contact between interlocutors and is also the first verbal function acquired by infants before being able to send or receive informative communication.
Klein, Bion and Fairbairn concentrated on the emotive function of communication and the internal object as the addressee, while Winnicott and his adherents have been more attentive to the phatic function of establishing contact between mother and child.
It is this phatic function that I wish here to concentrate on. If the assumption is made that our patients, when under threat of impingement construct a false self, then the language used by our patients would lack the phatic function. Their aim would be to avoid contact, which might make them extremely anxious and vulnerable. If their early experience had been of the kind where their primitive communications of distress and need were met with a rigid or an inappropriate response, the essential building blocks of internal language which connect body state with anxiety reduction and satisfaction would be compromised. The result may be an impaired ability to attend appropriately to their bodily response to emotional events via appropriate mental processing, or 'mentalising' as Fonagy has described it.
If attempts at communication with an 'other' lead only to raised anxiety and primitive dread then these attempts, it might be conjectured, would soon become extinguished. A child might be met with a mother who is unable to exhibit the flexibility of mind required to 'try out' different solutions to her baby's cry. The mother may experience anxiety when her baby's cry requires her to have an image of a hungry baby in her own mind which may be intolerable. Rigidity in the mind of the mother may lead to perseveration of her responses, which may be unconnected to the child's communication.
A possible result might be an experience of ineffectuality on the part of the child who, later on in life, would have to align her thoughts with those of others especially the mother to maintain equilibrium. Attempts to communicate emotional need may be easily abandoned or emptied out or 'killed off' if it results in raising mother's uncontained anxiety.
Thus the argument presented here is that the representation in the child's mind, in language, of its feeling state remains in a primitive pre-symbolic state. Buhl (2002) Pearlman (1999)
In the borderline state of mind exhibited by eating disordered patients, external reality is eschewed and the internal world is given precedence over the external. The language, as stated above, is littered with the concrete expressions which, in this patient group, represent their real experience. If that experience can be heard,

understood, translated and expanded into its symbolic form, then a phatic exchange has been made.
The underlying assumption of this approach is, that if the patient has felt heard, understood and responded to appropriately in their concrete non-symbolic communications, then an early developmental function has been re enacted.
Although task orientated groups have been discussed the following example is taken from a long term open psychotherapy group which concentrated specifically on these primitive, pre-symbolic, concrete communications.
The patients had, of course, been faced with the reality of re-feeding. Along with other aspects of the programme the re-feeding took into account the patients borderline fears that once they had started, they might never stop eating and grow like a balloon. Acknowledging and taking seriously this state of mind was aimed at giving them confidence that their primitive fears were respected even while their physical needs were being met.

Laura was one such member of a group, which had been in existence for some three years. She had been referred at the age of seventeen after having been treated at a local hospital for one year. She had received some behaviour therapy, which had not made a great deal of impact on her symptoms or her thinking. Following assessment, where she made a good relationship with the group therapist, she entered the group.

For her first three sessions she remained quiet but on the fourth she was invited to speak by the other group members. Her discourse consisted mainly of a description of her symptoms how many times a day she binged and vomited. The group, who were all older than she and most had been with the group from its inception, acted in a protective way and allowed her to say as much as she wished. It soon became clear that the content soon gave way to the actual act of speech. It occurred to the group therapist that with so much 'talk' the possibility of other members speaking was reduced as was the opportunity for conflict. The space had been filled with anodyne content. When this was pointed out Laura agreed that she felt she was 'making things better' by helping the others to avoid an argument that had seemed to be brewing in the early weeks. She saw as the aim for therapy to make people 'feel better' that is not to feel anything upsetting. The idea of something erupting was feared and to be avoided. The movement to understanding bingeing and vomiting as ways of filling space and time and avoiding conflict followed. The group began to track when Laura tried to take over the group with her 'filling empty talk'.
As might be expected it particularly occurred when the group temperature rose. Whilst there was some talk about her fear of conflict within her family it became clearer that it was her fear of conflict in the group, that might distress her, that she

was trying to avoid. At times Laura's 'talk' focused on some aspect of her body. At one time her face became the focus. She was worried about a blemish and wanted to have some treatment on it. She worried about being seen. The therapist wondered how she was to 'face the (group) world' if there was something inside her so 'blemished'. At other times there would be a pain reported which was tracked by the group as the starting point of 'Laura Speak' to try to uncover the message of where the pain might be lurking.
The group seemed to be quite co-operative in their quest for understanding. One patient even declaring she wished to create a dictionary of Concrete Speak. Laura found the group supportive and brought her concrete utterances as a starting point in the hope that she would be able to try and understand, with the help of the group, the root thought that lay underneath.
As Laura's emotional vocabulary grew, her bingeing and vomiting subsided along with the level of generalised distress. Her 'Filling Talk' began to be more focused on events that she had found stressful; even so it was peppered with 'concrete objects' when the content out-stripped her ability to think about it.

Laura's attempts at keeping herself calm could be understood in the context of her early life. Her mother was young and had suffered post-natal depression in the context of a very chaotic wider family. Laura had several different carers and never established a secure relationship with her mother or her father who was only occasionally on the scene. Mother, who was seen by the family and group therapist along with her, by now ex-husband and son was a well meaning but histrionic and fragile woman unable to face any hint that she may have done anything untoward. This supported the picture of Laura having lacked any experience of containment of her anxieties. In the family sessions her mother was unable to hear her daughter who soon became quiet. Mother focused the session on her own needs and difficulties with her daughter. Whilst painful, these sessions illuminated Laura's dilemma and led to some healing. It was of great importance that outside witnesses should reflect how difficult it was for Laura to be heard and to begin the difficult road to maturing and understanding her own emotional world.
It is suggested that there are benefits of working with the analytic stance of curiosity, applied to the decoding of the speech event in order to uncover the 'root thought' The main benefit is the co-operative nature of the intervention. Nothing is being 'put' into the patient that they have not thought. Due to their deficit in symbolic thinking leading to an impoverished internal emotional language, classical interpretations may be experienced as intrusive and unrelated to their need state. The 'decoding' replicates the early attempts at communication which are, of course, about body states. However, the patient is also the possessor of a well functioning intellectual mind that is unable to access the information held in primitive form in

their bodies. This approach is to enable the 'joining up' of the mind, to bring to intellectual consciousness the 'root thought' only experienced in primitive anxiety.

This paper has therefore shown the benefit of approaching the treatment of anorexia from the perspective of expanding internal emotional language skills via 'fleshing out' the nascent symbolic thought which resides in the concrete expression of anxiety. It is suggested that this approach replicates early mother-child interactions where there is an hypothesised deficit due to difficulties within the mind of the mother.

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