she'd think. "At first they all hate [the therapeutic lunches]," Barnett says, "it's very stressful--but it helps them to know other people have the problem and can work on it."

Carol's favorite binge food is cake. Bigtime. "I could eat a whole three tiered wedding cake," she says. So she would bring in some cheesecake and talk about how she felt while eating it in front of the group. Eventually, she put food in its proper place in her life and made peace with it.

"We help people realize . . . they can eat a wide variety of foods, and that the eating disorder loses power as the feeling of deprivation is decreased," Barnett says. But for Carol, a true break with her compulsion to overeat came only when she finally admitted that her addiction to food was a sickness.

Similar underlying emotional problems bond eating disorder patients like Carol with drug and alcohol recovery patients in their joint group therapy time. Barnett says "the MICA (mentally ill, chemically addicted) patients need to stop their addiction [and] the eating disordered people need to resolve their emotional conflict, but they both use something to deal with their emotions . . . that's not healthy."

Barnett insists that the unlikely union of such disparate patients for part of the day in therapy helps both groups. "They learn to become aware of the universality of their problems," Barnett says, "and to decrease isolation." Developing empathy for others is a noble rationale for conducting mixed group sessions, but it's not without a downside.

Carol tells how the people in the MICA group, many living in half-way houses, were seemingly oblivious to the feelings of the eating disorder people. "They would sit there in class and eat candy, or talk about food," Carol says. Though it would be illegal, Carol points out, her group would never even think of smoking pot or chugging a beer in