

## Chapter 41

# Group Psychotherapy for Anorexia Nervosa and Bulimia

Katharine N. Dixon

### INTRODUCTION

**F**ew other psychiatric disorders have spawned a sizable patient population as rapidly as did anorexia nervosa and bulimia during the 1970s and 1980s. Feminism, unisex fashions, emphasis on youthfulness, and a culture of narcissism contributed to women's increasing focus on their bodies and need for a feeling of control in their lives. These culturally fueled syndromes were further fanned by the media through advertising trends for women's products, descriptions of celebrity dieting and bulimia, and a proliferation of medically unsound diets in women's magazines.

The mental health profession was largely unprepared for the numbers of eating disordered women who often needed extensive diagnostic and treatment services. The professional community's lack of understanding or inexperience with these usually difficult and complex disorders further hampered effective delivery of treatment services. Over time, the trend for specialized eating disorders centers has increased the number of qualified professionals through clinical and training programs. Nevertheless, a group-therapy approach came to be frequently used, in part to ration experienced therapists. It appeared to be at least a cost-effective modality, if not also treatment-effective.

Group therapy has been used widely in the treatment of psychosomatic illness [1] and other specific problems, eg, alcoholism, gambling, weight control, and smoking [2]. Prior to the recent increase in reports describing

group treatment of eating disorders, self-help and support organizations already had begun to offer group meetings for individuals with eating disorders and their family members or friends [3]. Moreover, because bulimic patients often are spontaneous, outgoing, gregarious, and socially adept, it is not surprising that group treatments would be readily considered for patients with these particular personality traits and that these patients would be attracted to a group setting.

Therapy in groups offers unique opportunities for altruism, social skills practice, peer reinforcement, and peer feedback and advice that are unavailable in an individual therapy setting. Further, the homogenous format of eating disorder groups provides a potentially powerful framework within which the patient's behavioral symptoms and associated distress can receive maximal attention, both through shared experiences with other group members and a concrete focus on the problems that brought the group together.

### GROUP THERAPY WITH BULIMIC PATIENTS

The current interest in group treatment of bulimia is reflected in the increase in published studies over the past three to four years. In early reports, only Boskind-Lodahl and White [4] and White and Boskind-White [5] had described experience treating bulimic women in a group setting. Since 1983, more than 20 reports, including five controlled studies, have related the effects of group treatment on bulimic behavior and associated

symptoms in these patients. By far, the majority of studies report experience with time-limited, closed-membership groups using an eclectic combination of treatment techniques. Thirteen studies [5-17] include follow-up data on maintenance of change.

### Group Orientation and Strategies

A few group treatment studies use primarily a psychodynamic approach [18-20], but the majority of groups report using a combination of strategies, with [4,8,9,17,21-24] or without [6,10-16,25,26] a psychodynamic or experiential component (table 1). Most frequently, group studies reported in the literature employ a combination of cognitive, behavioral, and educational methods. The trend toward a cognitive-behavioral-educational orientation in the group treatment of bulimia has been created by a number of influences. Clinicians became aware early that traditional insight-oriented psychotherapy with bulimic patients either avoided the issue of eating behavior or was insufficient to bring about significant symptom change and elimination of bulimic behaviors in many patients [27]. Prior research in the treatment of obesity showed that behavior modification techniques effectively shaped eating behavior and could be applied in group settings [28]. Similarities in problems with eating control between bulimic patients and some patients with obesity, thus, led to the application of techniques used for eating restraint in the obese population to the bulimic population. Likewise, the major role played by cognition in allowing unrestrained eating to occur in bulimia led to an interest in cognitive therapy techniques for these patients.

Cognitive-behavioral techniques focus on current problematic behavior and underlying faulty cognitions, actively changing the bulimic behavior and introducing new, more adaptable behaviors and thinking. Treatment tends to be relatively brief, progress measurable, and the methods potentially applicable by a more inexperienced therapist than would be required for more traditional methods.

Fairburn [29] first described the systematic application of cognitive-behavioral techniques in the individual treatment of 11 bulimic patients, with remission of symptoms in nine patients after 28 weeks of treatment and maintenance of change in most patients over one year. While a number of studies include cognitive-behavioral techniques as one of several methods, only three studies [11,13,14] have examined the effects of cognitive-behavioral treatment of bulimic patients. Schneider and Agras [14] reported symptom remission in 7 of 13 women with 16 weeks of cognitive-behavioral group treatment based on Fairburn's model. Five patients (38%) in this study continued to be symptom

free at six-month follow-up. Kirkley et al [13] compared cognitive-behavioral and nondirective approaches during 12 weeks of group treatment and found a greater change in bulimic symptoms and lower dropout rate in the cognitive-behavioral group. Yates and Sambraio [11] examined the differences between two groups, both of which were cognitive-behavioral, but only one included specific behavioral recommendations, over a treatment interval of six weeks. Both groups with and without specific instruction had a 33% dropout rate, no patients were abstinent in the group without specific instruction, and only two of eight patients in the cognitive-behavioral with instructions group were abstinent at six month follow-up. Whether cognitive-behavioral techniques as the only or primary approach in group treatment, particularly brief treatment, will uphold the promise of Fairburn's work remains to be seen and has not been supported by evidence to date. Indeed, Fairburn [30] questions whether the patient-therapist relationship and interaction necessary for the success of cognitive restructuring can occur in a group setting. To date, no study of cognitive-behavioral group treatment for bulimia has approached the four to six month duration of Fairburn's individual treatment of 82% post-treatment remission of symptoms. Clearly, symptom outcome in bulimic groups may be related not only to treatment approach but also to other variables, such as treatment length and format.

Behavioral principles used in bulimic groups are similar to those shown to be effective in the treatment of obesity, ie, record-keeping, identification of stimuli leading to binge-eating, techniques to gain control of eating, and development of alternate strategies. Relaxation and assertiveness training are sometimes included in bulimic group strategies to address the problems of anxiety and low self-assertion commonly seen in bulimic patients. No group studies report the use of behavior modification techniques alone in the treatment of bulimic patients, although nearly every study, other than those from primarily psychodynamic groups, indicates incorporation of behavior techniques in the group approach.

The educational component of most groups furnishes information about bulimia, medical consequences, nutrition, set-point theory, and sociocultural influences through the use of lectures, handouts, and structured discussions. Even Fairburn's [29] model for individual cognitive-behavioral treatment of bulimia incorporates education in the initial weeks. Although a valuable addition and perhaps therapeutic, education about bulimia cannot be construed as therapy and is always combined with other therapy techniques.

A psychodynamic or experiential approach used

Table 41.1 Group treatment studies in bulimia

Study	Subjects		Treatment Length	Group Approaches
	Entered	Completed		
<i>Psychodynamic</i>				
Weinstein & Richman (1984)	32	7 (10 wks) 16 (20 weeks)	10 & 20 weeks	Psychodynamic
Reed & Sech (1985)	5	4	26 weeks	Psychodynamic
Barth & Wurman (1986)	40	not reported	3 years	Psychodynamic
<i>Eclectic with psychodynamics or experiential component</i>				
Boskind-Lodahl & White (1978)	13	12	11 weeks, including 6 hr marathon	Experiential
Hornak (1983)	8	8	6 months	Encounter/peer support Behavioral/cognitive
Dixon & Kiecolt-Glaser (1984)	30	11	10 weeks	Psychodynamic/behavioral
Roy-Byrne et al. (1984)	19	9	1 year	Psychodynamic/educational/ cognitive/behavioral
Stevens & Salisbury (1984)	8	6	16 weeks	Psychodynamic/behavioral
Fernandez (1984)	6	6	12 weeks	Psychodynamic/educational/ cognitive/behavioral
Freeman et al. (1986)	--	--	15 weeks	Psychodynamic/behavioral
Johnson et al. (1983)	13	10	12 sessions/ 9 wks	Educational/ cognitive/behavioral
Connors et al. (1983)	26	20	12 sessions/ 9 wks	Educational/ cognitive/behavioral
Weiss & Katzman (1984)	5	5	7 wks	Educational/behavioral/ experiential
Yates & Sambrailo (1984)	24	16	6 wks	Cognitive/behavioral, directive and non-directive
Wolchik et al. (1986)	13	11	7 wks	Educational/behavioral/ experiential
Huon & Brown (1985)	45	40	12 sessions/ 6 and 12 wks	Educational/structured discussion/relaxation and assertion training
Kirkley et al. (1985)	28	22	16 wks	Cognitive/behavioral, directive & non-directive
Schneider & Agras (1985)	13	13	16 wks	Cognitive/behavioral
Lee & Rush (1986)	15	11	12 sessions/ 6 wks	Cognitive/ behavioral/educational
<i>Intensive and combined modality treatment with group emphasis</i>				
White & Boskind-White (1981)	14	14	5 hrs daily/ 5 days	Experiential/behavioral
Lacey (1983)	30	30	10 weeks	Psychodynamic/behavioral
Mitchell et al. (1985)	104	86	8 weeks	cognitive/behavioral/ educational/self-help
Brisman & Siegel (1985)	114	114	15 weeks	Behavioral/educational/ self-help
Wooley & Kearney-Cooke (1986)	18	18	3.5 weeks	Psychodynamic/experiential/ educational/behavioral

alone or with other treatment orientations is described by several authors [4,18-20,22,31]. Various levels of "insight" occur in a group setting [32]: (1) how group members are seen by other people (interpersonal), (2) what they are doing to and with other people (behavioral), (3) why they do what they do to other people (motivational), and (4) how they got to be the way they are (genetic). Since persistent psychosocial factors play a role in the

etiology and perpetuation of bulimia, it could be hoped that durable treatment effects would come about through the patient's increased understanding of the intrapsychic and interpersonal contribution to symptomatic behavior and maladaptive coping and, further, that group interaction would augment opportunities for such insight to occur.

### Combined and Intensive Treatment Modalities

Multicomponent and multidimensional treatment programs are commonly used in the treatment of anorexia nervosa. Although bulimia group therapy studies report the process, content, or outcome of a group format, in reality patients often receive other concurrent treatment modalities. That multimodal and intensive treatment is increasingly described for bulimic patients reflects an improved understanding of the complex, difficult, and enduring problems these patients present. The role, value, and intensity of each component varies among clinical settings, so that individual, group, family, or drug treatment modalities may each be considered as primary or adjunctive in the patient's treatment depending on therapist or treatment setting orientation. Five combined or intensive outpatient treatment programs with emphasis on group treatment have been described in published studies [5,15,27,31,33]. That concurrent outpatient modalities are beginning to be combined into a larger unit of treatment rather than used in parallel fashion marks a step forward in the treatment of bulimia.

White and Boskind-White [5] first reported an intensive group treatment format using an experiential/behavioral approach with 14 bulimic women five hours daily for five days. Follow-up at six months showed three women binge-free, seven improved, and four unchanged. Mitchell et al [27] describe an eight-week intensive outpatient group treatment program conducted during evening hours at the University of Minnesota. Groups meet three hours nightly in the first week, diminishing to weekly meetings in the second month. Lectures, group therapy, and eating together are supplemented with three individual sessions and regular support group meetings. The Minnesota intensive program evolved to treat patients with severe eating problems following the observation that these patients often failed to maintain change after hospitalization. Reported results indicate that 47% of these patients with severe disturbance are able to be abstinent from the onset of the program [34]. Brisman and Siegel [15] initiate treatment with a 15-hour weekend marathon followed by six bimonthly group meetings and support groups on alternate weeks. Thirty-three percent of 114 women attending the marathon weekend were symptom free at follow-up, which ranged from one month to two years.

Lacey [7] used a combined individual and group format over a ten-week period in a controlled treatment study of 30 bulimic women, 28 of whom had symptom remission at the end of treatment and 24 of whom remained symptom-free over two years. Patients were seen by the same therapist for a weekly 1/2-hour be-

haviorally-oriented individual session and a 1 1/2-hour five-member, insight-oriented group session held on the same half-day.

Wooley and Wooley [31] describe a unique 3 1/2-week intensive treatment program with special emphasis on body image. Following a two-day evaluation, patients receive six to eight hours of therapy daily while housed in a nearby hotel. While an emphasis is placed on the group modality, treatment intensity approximates or exceeds that of inpatient treatment. Patients are involved in educational seminars and body image therapy as well as individual, group, and family therapy. Patients are urged to continue treatment after completion of the intensive program. A one-year follow-up of 18 patients showed 39% symptom-free and 44% with maintenance of at least 50% symptom reduction [17].

### Prescription of Group Therapy

While homogenous for problem and usually gender, the bulimic patient population is heterogenous for age, psychopathology, psychodynamics, and severity of impairment. It goes without saying, then, that the prescription and timing of treatment modalities should take into consideration various aspects of the patient's presentation.

Mitchell et al [27] have outlined guidelines for prescription of treatment modalities within the University of Minnesota program following a detailed clinical assessment of the bulimic patient. Those with mild eating problems are referred to weekly psychotherapy groups, those with more severe problems to an intensive outpatient group program, and those with medical or psychiatric instability to the inpatient program. Individual psychotherapy and antidepressant medication are used sparingly.

The Eating Disorders Program at Ohio State University has seen an evolution in timing and orientation of individual and group treatment modalities. After observing the apparent ineffectiveness of traditional individual insight-oriented psychotherapy with bulimic patients early in the development of clinical services, patients were assigned in the initial phases of their treatment to groups using a cognitive-behavioral orientation to address the problems with eating control. The high attrition rate from these groups led to re-evaluation of the prescription and timing of the components of the patient's treatment plan. Following a clinical assessment, bulimic outpatients in our program presently begin treatment in individual psychotherapy. Vigorous efforts are made by individual therapists to recapture patients who miss appointments or fail to show. Individual sessions have an initial cognitive-behavioral emphasis to bring the eating behavior under control,

followed by a gradual transition to a more psychodynamically oriented approach to help the patient gain awareness of associated interpersonal and intrapsychic issues. Assignment to group psychotherapy is reserved for those patients who have been engaged in the psychotherapeutic process and would further benefit from the interaction of a treatment group. Since substantial education and cognitive-behavioral work has already been accomplished in individual sessions, groups tend to be primarily insight-oriented in approach. Whenever possible, patients are assigned to groups led by their individual therapist.

A number of group treatment studies conducted with patients solicited through articles or newspaper advertisements [4,5,11-13,16,26] have improved knowledge about the applicability of treatment techniques in a group setting for bulimics. However, even though careful screening of respondents eliminates unqualified subjects, the use of solicited subjects for a group treatment study does not substantially increase our understanding of the prescription of group treatment within a comprehensive treatment plan. Moreover, the effectiveness of the group treatment modality may be underestimated unless the timing of entry into specific treatment modalities is done under clinical conditions and as part of an overall clinical plan.

#### GROUP THERAPY WITH ANOREXIA NERVOSA PATIENTS

There are far fewer reports in the literature of group psychotherapy with anorexia nervosa patients than with bulimia patients, and all reports are largely descriptive. Individual and family psychotherapy and, in the very low-weight patient, hospitalization have been the main interventions used to bring about weight restoration and repair of the developmental and psychological deficits in the anorexia nervosa patient. Even though successful weight restoration may be accomplished through behavioral methods or hospitalization, the anorexia nervosa patient's recovery occurs within the context of the patient-therapist relationship. What, then, is the role of group psychotherapy in the treatment of the patient with anorexia nervosa?

Several authors relate experience with outpatient groups for anorexia nervosa [35-40] as an adjunct to the patient's primary treatment method. Group therapists, as a rule, are different from therapists working with the individual or family, except for Hall [38], who was at least the family therapist for all her group patients. One group [36] used a recovered anorexic as a group cotherapist, a practice generally reserved for self-help groups.

The anorexia nervosa patient is likely to have an initial group psychotherapy experience during an acute

hospitalization, more so since the development of eating disorder units in many general and psychiatric hospitals over the last decade. Inpatient groups may include all anorexic patients on the ward, or they may allow the low-weight patient to attend only after significant nutrition restoration. Such groups are also more likely to include both anorexia nervosa and bulimia patients, whereas outpatient groups almost always segregate by present diagnosis. Only Lieb and Thompson [41] describe experience with a group composed solely of inpatients, a closed-ended group of four adolescents on a medical ward. Polivy [35] and Piazza et al [36] report experience with mixed inpatient/outpatient groups for anorexia nervosa patients.

Whether inpatient or outpatient, the anorexia nervosa patient will not be able to participate meaningfully in group therapy until the starvation process is reversed. Inpatient settings with separate treatment modalities for insuring adequate nutrition and weight restoration are thus better able to accommodate low-weight patients in group therapy than can outpatient groups. Too, the captive nature of inpatient settings eliminates the problem of sporadic attendance and premature termination frequently seen with anorexia nervosa patients in outpatient settings.

With weight loss and progression of the disorder, the anorexic becomes increasingly withdrawn from relationships, bodily preoccupied, and constricted in outside interest. Even with weight restoration, many patients continue to have significant problems with self-esteem, assertiveness, independence, and expressiveness compounded by a set of distorted thoughts and beliefs. While these issues are addressed in individual and family therapy, the group setting has advantages of peer feedback, support, and social interaction under the direction of a psychotherapist, an opportunity not available within other modalities.

Goals in group therapy for anorexia nervosa patients are generally directed toward the psychological and social aspects of the illness, ie, issues of self-worth, adequacy, control, family relationships, intimacy, and expression of feelings. In some instances, secondary motives may be to decrease social isolation and treatment resistance [41], provide a forum for discussion of common concerns [37], and to extend treatment options when individual and family therapy modalities have been insufficient to reverse chronicity [38]. Most reports emphasize the supportive role of group therapy for these patients. Although food and weight concerns are reported as issues for discussion, no groups for anorexia nervosa report using cognitive-behavioral techniques or focus on weight gain or maintenance as a group therapy goal. Inbody and Ellis [40] indicate that all group members attained normal body weight over the eight-month

life of the group, although the group was psychodynamically oriented and weight gain was not a primary focus of the group. Outpatient groups for anorexia nervosa tend, in fact, to require that the anorexia nervosa patient be within at least 20% of normal body weight before entry into group therapy [35,39].

Although group therapy is preferred by many group therapists as the sole treatment modality for many psychiatric problems and problems of living, other prior or concurrent treatment modalities are prerequisites for anorexia nervosa patients due to the complex and chronic nature of the disorder. Thus, it is not surprising that most reports to date used group treatment as an adjunctive modality, including that of Lieb and Thompson [35], who treated four adolescents on a medical ward.

#### MIXED ANOREXIC AND BULIMIC GROUPS

Eating disorder groups in an outpatient setting tend to be homogenous for current diagnosis, ie, anorexia nervosa or bulimia. A poorer outcome for currently bulimic patients with a past history of anorexia nervosa has been noted in several outpatient bulimia group therapy studies [7,9,23]. Inbody and Ellis [40] discuss the eight-month group treatment of seven anorexia nervosa patients, five of whom also had bulimic behavior. In this psychodynamically oriented group, all patients gained to a pre-agreed weight and those five patients who were binge-vomiting had a decrease in bulimic behavior over the course of eight months.

Mixed-composition groups are more likely to be conducted in an inpatient setting and, as such, are more likely to have a greater degree of individual psychopathology. The open-ended nature of hospital groups prevents the use of structured sessions found to be useful in short-term, closed outpatient groups for bulimics. Nevertheless, the mixed composition of inpatient groups presents the opportunity for patients to understand the similarities in underlying psychological and social issues associated with anorexia nervosa and bulimia.

#### SPECIAL PROBLEMS IN EATING DISORDERS GROUPS

##### Coexisting Psychiatric Disturbance

Personality disorder features and depressive symptoms are common among anorexia nervosa and bulimia patients. The relationship between eating disorders and other psychiatric syndromes has not had sufficient systematic study to warrant classification of anorexia nervosa or bulimia as variants of other psychiatric disorders or co-existing illnesses in some patients. However, sub-

groups of eating disorder patients may fulfill diagnostic criteria for coexisting psychiatric disorders. For example, Levin and Hyler [42] noted that 63% of bulimic patients enrolled in a drug study met DSM-III criteria for histrionic or borderline personality disorder.

Several authors [7,22,38-40] have noted that patients with serious characterological or affective disturbance often do poorly in outpatient eating disorder groups. Roy-Byrne et al [22] recommend limiting the number of patients with borderline personality organization to no more than three per group. Prior or concurrent individual psychotherapy should be a strong consideration for the borderline patient whose impulsivity, low frustration tolerance, hostility, and shifting alliances are particular liabilities in a group setting. These patients may be able to benefit from a short-term, structured group directed specifically toward eating control, but even under these conditions, strict limits for attendance, punctuality, and compliance often need to be enforced. Maher [39] describes an outpatient group experience with anorexia nervosa patients in which the depression and despair within the group substantially interfered with the group process, even though most patients were within a normal weight range.

Pregroup assessment for coexisting personality or affective disorder in eating disorder patients is important to determine whether the patient may need longer or more intense treatment than the group therapy alone can provide. Adequate screening and planning for these patients will increase their chance of effective utilization of group treatment and the group's chance for constructive work.

##### Noncompliance

Noncompliance with group rules, including erratic attendance, has been noted as a problem in eating disorder groups [18,22,26,27]. Late arrivals in one group [22] led to establishment of firm ground rules, including locking the door five minutes after start of the group and loss of membership after two unexplained absences. Missing sessions and failing to complete homework assignments results in dismissal from the University of Minnesota program, and approximately 6% of entering group patients are asked to leave the program before completion [27].

##### Premature Termination

Patients who drop out from group treatment both fail to benefit from the group and have a negative effect on group morale and cohesiveness. Premature termination from group therapy is a common occurrence in many types of groups, usually in the early phase of treatment [32]. Failure to complete group treatment has

been reported as a problem in both anorexic and bulimic groups [8,22,24,27,35,39].

A number of factors have been reported to be associated with premature termination in eating disorder groups. Polivy [35] found that dropouts from an anorexia nervosa group were younger and more likely to be still living in their family of origin than group completers. In a comparison study of individual and group therapy for bulimic patients, Freeman [24] observed a dropout rate twice as high in group therapy as individual therapy, noting that reasons for premature termination from group seemed related to lack of improvement or dissatisfaction with the group treatment modality. Kirkley et al [13] found a higher dropout rate in a bulimic group using a nondirective approach than in a cognitive behavioral group; and dropouts tended to be younger, more angry and depressed, and have a shorter duration of bulimia than completers. At least two of the six dropouts in bulimic groups studied by Connors et al [10] had problems with alcohol abuse. Dixon and Kiecolt-Glaser [8] also found that patients with alcohol or substance abuse did poorly in bulimic groups or dropped out prematurely. Further, this study reported that premature terminators had higher social desirability scores on the Marlowe-Crowne Social Desirability scale than did group completers. In an eclectic group treatment for bulimics described by Lee and Rush [26], dropouts had higher hostility scores on the SCL-90 and more depression at follow-up than did completers.

One hundred percent completion of group therapy was accomplished by Fernandez [23] with a requirement for prepayment of the entire fee to cover the 12-session group treatment, a strategy used in behavioral groups for obese patients. All members attended all sessions and were punctual.

In a previous study in which group therapy was offered to bulimic patients without a requirement for concurrent or substantial prior individual treatment [8], we found that 63% of group members failed to complete ten sessions in a group using both behavioral and insight-oriented techniques. The group was open-ended, and pregroup preparation did not emphasize the importance of attending a specified number of sessions. Some group members left because of external factors (geographic distance, end of school year). However, we were impressed that reasons for premature termination seemed related to the inadequacy of group treatment alone to provide the time or opportunity to address adequately both behavioral change and the complex underlying intrapsychic and interpersonal issues associated with anorexia nervosa and bulimia.

This led, then, to a patient selection process that required that the patient be referred for group therapy by an individual therapist who felt the patient was ready for

and would benefit from group treatment. Since our groups by this time were primarily insight-oriented and ongoing, patients were considered to be completers after they successfully met treatment objectives determined by the patient's individual therapist before beginning group therapy. An effort was made to assign patients to a group led or co-led by their individual therapist.

In a study of 38 eating disorder patients (34 bulimic, 4 anorexic) who were seen in insight-oriented group therapy under conditions providing pregroup preparation and requiring concurrent individual therapy [Scheuble, 46], the overall premature termination rate dropped to 44%, considerably less than our experience with open-membership groups not requiring concurrent individual therapy. Premature terminators were most likely to leave group treatment within the first five sessions. Four of five patients with alcohol or substance abuse left group prematurely, even though they were concurrently in individual treatment. Only one of four patients with a diagnosis of anorexia nervosa left group therapy prematurely. Interestingly, of the 19 patients who participated in a group led or co-led by their individual therapist (combined psychotherapy), only four patients (21%) dropped out early, while 68% of patients in a group led by a therapist other than their individual therapist (conjoint psychotherapy) left prematurely. It appears, then, that the establishment of a working alliance with an individual psychotherapist enables some eating disorder patients to persist in a group treatment setting, more so if the individual and group therapists are the same. Similar findings have been described by Wong [43] and Slavinska-Holy [44] in the treatment of patients with borderline personality organization.

Only Lee and Rush [26] have attempted to obtain follow-up information on patients who left group therapy prematurely. These investigators found that premature terminators reported more depressive symptoms before group entry and had a higher binge frequency at three to four month follow-up than did group completers.

Patients who discontinue group therapy prematurely not only do not benefit from the brief exposure to the group, but they also may be harmed by the treatment failure [32]. In addition, irregular attendance and early dropouts interfere with cohesiveness and motivation among the remaining group members. For these reasons, pregroup identification of factors that are related to the patient's likelihood of successful or failure in group therapy are important, both to the individual patient and the group.

Selection of patients and pregroup preparation are two factors within the control of the group therapist that can mitigate the high drop-out rates associated with eat-

ing disorder groups. In addition to the usual exclusionary criteria for entry into a group, specific factors may need to be considered before placing an eating disorder patient in group therapy. Patients with alcohol and substance abuse appear to fare poorly in eating disorder groups, even with concurrent individual treatment. Indeed, the current trend is to exclude patients with alcohol and substance abuse from bulimic groups. Hostile, angry, and depressed patients may have difficulty with a group setting until these problems are moderated through other modes of treatment. Patients with a high need for social approval may experience difficulty in open or goal-directed groups that require honesty and self-disclosure for optimal benefit. Since many bulimic groups are time-limited and rely heavily on completion of homework assignments, patients with chaotic interpersonal relationships, uneven school or employment histories, or other indications of unreliability may need to demonstrate evidence of regular attendance in individual sessions before placement in a group.

At least three group-related factors may influence group completion for some patients and warrant further systematic study. These include (1) the use of structured, directive techniques in brief, time-limited groups; (2) incorporation of cognitive-behavioral techniques in individual psychotherapy sessions before or concurrent with assignment to a group whose orientation is psychodynamic or experiential, and (3) placement of the patient in a group led or co-led by the patient's individual therapist.

#### **Maintenance of Change**

The literature on bulimia treatment is replete with studies demonstrating the short-term effectiveness of cognitive-behavioral techniques in a group setting. Both symptom reduction and remission occurs immediately post-group in the majority of patients completing a course of group therapy. It is not surprising to find those aspects of the patient's distress related to demoralization—eg, feelings of low self-esteem, hopelessness, or inadequacy—improved along with a decrease or elimination of bulimic behaviors. However, long-term post-group outcome is less favorable and indicates that some patients lose the progress obtained during the group treatment period.

The final treatment phase in Fairburn's model for individual cognitive therapy includes specific strategies for relapse prevention. Varying degrees of attention are given to the issue of relapse prevention in reports of time-limited bulimic groups. Except for two reports [23,34] indicating inclusion of relapse prevention strategies within the group format, minimal time seems to be devoted to anticipating post-group problems. Further,

except for reports from intensive or combined treatment programs, little or no information is provided on how recommendations for additional, ongoing treatment are made.

#### **CONTROLLED STUDIES**

Five studies [4,7,16,24,26] using waiting-list controls have been reported. Boskind-Lodahl and White [4] nonrandomly assigned advertisement respondents to experimental and control groups. Few significant effects of group treatment as assessed by psychological measures were noted between experimental and no-treatment groups, and differences were even less at follow-up. Comparisons of bulimic behaviors between the treatment and non-treatment groups were not reported. In another study [7], however, 15 patients alternately assigned to a waiting-list control group had no significant change in bulimic frequency compared with an overall remission rate of 80% (93% by four weeks later) at the end of ten weeks of combined group and individual treatment for the 30 subjects in the study. Wolchik et al [16] reported that 11 women who were in a behavioral/educational/experiential group program, including two individual sessions, for ten weeks had a greater decrease in bulimic behaviors and improvement in depression and self-esteem post-group than did seven women who received no treatment. Patients were nonrandomly assigned to treatment or no-treatment groups, however, based on scheduling conflicts or time of response to news announcements. Thirty respondents to a newspaper advertisement were randomly assigned to treatment or a waiting-list control group by Lee and Rush [26]. Seventy-one percent of patients who received twice weekly cognitive-behavioral group therapy for six weeks had greater than 50% decrease in binge frequency post-group compared with 21% of no-treatment subjects. However, only half of treated patients had a 50% decrease in vomiting, suggesting that vomiting behavior may be more resistant to treatment than binge-eating. Freeman [24] outlines a comparison study with random assignment of subjects to cognitive-behavioral individual psychotherapy, educational, insight-directed group therapy, and a no-treatment group. Preliminary results indicated that all treatment conditions produced significant changes in bulimic behaviors, that cognitive therapy produced greater change in depression, and that patients were more likely to drop out of group therapy than individual therapy.

Although aggregate data of these four studies reporting individual outcomes immediately post-group [4,7,16,26] show that 54% of patients were symptom

free and 28% had 50% or greater improvement, the largest study [7] combined individual and group treatment modalities, and the study by Wolchik et al [16] included two individual sessions. Thus, whether group or individual treatment primarily accounted for symptom improvement cannot be determined. Nevertheless, in these controlled studies in which the only treatment condition was psychosocial, 82% of bulimic patients had 50% or greater improvement in bulimic behavior in the immediate post-group period.

### OUTCOME

Few patients with anorexia nervosa or bulimia receive only group therapy as treatment of their eating disorder. On the contrary, many patients receive other concurrent and/or post-group treatment. In this light, most immediate outcome reports are contaminated by other concurrent treatment. Thus, long-term follow-up of group treatment more accurately reflects the outcome of a treated eating disorder rather than the efficacy of the group treatment modality itself.

#### Bulimia

Composite results from 13 studies of group therapy for bulimics [4,6-9,11,12,14,16,18,22,26,34] that provide individual immediate outcome data (N = 201), indicate that 62% of patients were symptom-free post-group, 18% had at least 50% symptom reduction, and 20% were less than 50% improved or had no change. Follow-up information at intervals ranging from one month to two years is also available on 338 individual patients in the reports of 13 studies (table 2). Of these 338 patients, 36% were symptom free, 36% were at least 50% improved, and 28% had less than 50% improvement, no change, or were unavailable for follow-up. It should be noted that outcome data is reported only on patients who are group completers, thus excluding dropouts, who are likely to continue to be symptomatic [26].

From available information in the bulimia group therapy literature, then, it appears that fewer patients are symptom-free at follow-up (36%) than immediately post-group (62%), with a substantial number of patients resuming bulimic behavior. Nevertheless, 72% of bulimic patients who met requirements for completion of group therapy, usually time-based, continue to be at least 50% improved over time.

All group therapy studies with bulimic patients reporting either immediate or follow-up data, regardless of orientation or treatment duration, can demonstrate a significant reduction in binge-purging frequency for the study sample post-group and over time, albeit to varying degrees. For many patients, maintenance of

change poses a greater problem. Indeed, Mitchell et al [45] describe a fluctuating, chronic course of illness for many bulimic patients. While a single outcome variable is insufficient to gauge the efficacy of treatment, it is disturbing that many patients have continued bulimic symptoms, sometimes unchanged, even with specific and/or intensive treatment.

#### Anorexia Nervosa

No systematic outcome measures, immediate or long-term, are available in the literature of group psychotherapy for anorexia nervosa. The multimodal nature of the treatment plan of most anorexia nervosa patients is an obstacle in the objective assessment of the relative values of each component of the treatment plan. Subjective impressions of six of seven authors [35-38,40,41], however, support the usefulness of group therapy as an adjunctive treatment modality for some patients with anorexia nervosa. Hall [38] reported that six of ten chronic anorexia nervosa patients were able to gain and maintain close to a target weight, and three resumed menstruation by the end of 13 months of group therapy. Lieb and Thompson [41] found that all four anorexics in group therapy during a medical hospitalization maintained their discharge weight at follow-up several months later.

Maher [39], however, felt that group therapy had little or no usefulness in the anorexia nervosa patient's treatment. Unrelenting despair, dependency on the group therapists, inability to reach out to other group members, and a high dropout rate were problems encountered during the nine-month period of Maher's outpatient group. That 75% of the group members also had a diagnosis of borderline personality disorder was recognized as a potential source of difficulty for this group.

Since group therapy for anorexia nervosa is adjunctive in nature and has primarily psychodynamic, experiential, or supportive orientations, its efficacy and role in the treatment of these patients is difficult to determine. Six of seven descriptive reports [35-37,39-41] indicate positive treatment effects, mostly psychosocial, for some anorexia nervosa patients in group treatment after acute starvation has been reversed. One report [39], however, indicates negative effects from outpatient group treatment. Most reports suffer from limited descriptions of the patient population, unspecified or vague objectives of the group modality, and absence of outcome measures relevant to the type of group. Before generalizations can be made regarding the efficacy or nonefficacy of group therapy for anorexia nervosa patients, more systematic research is needed to identify better the relationship between specific group interventions and specific effects with specific sub-

Table 41.2 Outcome in Group Treatment of Bulimia

Study	% Dropout	# Completers	Follow-up Interval	Follow-Up Outcome		
				Symptom free	Improved 50+%	No change or no data
<i>Eclectic approach with psychodynamic/experiential component</i>						
Dixon & Kiecolt-Glaser (1981)	63%	11	1 yr	45%	55%	0%
Stevens & Salisbury (1984)	25%	6	10 mo	83%	17%	0%
<i>Eclectic approach without psychodynamic component</i>						
Johnson et al. (1983)	23%	10	8 wks	10%	70%	20%
Connors et al. (1983)	23%	20	10 wks	15%	40%	45%
Yates & Sambrailo (1984)						
Directive approach	33%	8	6 wks	25%	25%	50%
Non-directive	33%	8		0%	50%	50%
Kirkley et al. (1985)						
Directive approach	7%	13	12 wks	38%	39%	23%
Non-directive	35%			11%	69%	21%
Huon & Brown (1985)	12.5%	40	6,12, & 18 mo	68%	22%	5%
Schneider & Agras (1985)	0%	13	6 mo	38%	31%	15%
Wolchik et al. (1986)	15%	11	10 wks	9%	45%	45%
<i>Intensive or combined treatment modalities</i>						
White & Boskind-White (1981)	0%	14	6 mo	21%	50%	29%
Lacey (1983)	0%	30	1 mo, 3 mo and q 3 mo for 2 yrs	67%	27%	6%
Brisman & Siegel (1985)	0%	114	1 mo-2yrs	33%	38%	29%
Wooley & Kearney-Cooke (1986)	0%	18	1 yr	39%	44%	17%

groups of these patients.

### CONCLUSION

Although no systematic investigations of group therapy for anorexia nervosa patients have been published, the few available descriptive reports give evidence of limited benefit for some patients. On the other hand, the group treatment of bulimia has a high level of patient acceptance and permits high-volume delivery of service, with a short-term, cognitive-behavioral approach, which seems to be the emerging trend. Whether this trend is representative overall of the group psychotherapy practice for bulimia patients is unclear since behavioral psychotherapy is more conducive to systematic research than psychodynamic or experiential psychotherapy.

In spite of the apparent effectiveness of brief, behaviorally oriented psychotherapy as an initial intervention, high attrition and relapse rates continue to be significant problems for the bulimic patient in group therapy. Future research needs to identify the concurrent or sequential combinations of different formats optimal for specific patients, develop screening and intervention techniques to prevent premature termination from treatment, and address the issue of durability of change in these potentially persistent, disabling psychiatric disorders.

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