SIGNIFICANT EVENTS IN A PSYCHODYNAMIC PSYCHOTHERAPY GROUP FOR EATING DISORDERS

J. Kelly Moreno, Ph.D.
Addie Fuhriman, Ph.D.
Emmie Hileman, M.A.

This qualitative pilot study was designed to identify and explain significant events for patients participating in a psychodynamic psychotherapy group for eating disorders. Specifically, seven members of a mixed (i.e., anorectic, bulimic, obese) eating disorders group recorded what they perceived as the three most "significant events" in group meetings for 14 weeks. In addition, group members were instructed to record why each event was significant. Manifest and latent content analyses of the data revealed that members found feedback and observing others the two most common types of significant events, and emotional experience, insight, and relationship the reasons these events had such impact. The implications of these results for working with the eating-disordered patient in group, as well as their implication for general group theory and practice, are discussed.

Group therapy is a common feature in the treatment plans of eating-disordered persons (Oesterheld et al., 1987). Its popularity is based on the assumption that it is more economical than individual therapy, and offers opportunities for growth less pronounced in other treatment modalities. The literature on group therapy with this population is replete with case (e.g., Roy-Byrne et al., 1984), multiple baseline (e.g., Connors et al., 1984), quasi-experimental (e.g., Dixon & Kiecolt-Glaser, 1984), and experimental (e.g., Mitchell et al., 1990) studies designed to validate these and other treatment assumptions. In a recent review of this literature, Moreno (1994) concluded that group psychotherapy was a clinically and statistically significant treatment of eating disorders

J. Kelly Moreno, Ph.D., is at the Department of Psychology, California Polytechnic State University, San Luis Obispo, CA 93407. Addie Fuhriman, Ph.D., is at Brigham Young University. Emmie Hileman, M.A., is in private practice in Santa Barbara, CA.

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compared to no treatment, but comparative studies failed to demonstrate the superiority of one therapeutic approach over another. Moreno noted, however, that retrospective observations included in many studies suggest that universality, cohesion, insight, and the development of socialization techniques were group features that appeared to help eating-disordered patients the most.

On the other hand, Moreno noted that few of the aforementioned observations were provided by the patients themselves—most of them were made by the therapists or investigators in the study. Moreover, the few studies that questioned eating-disordered members about their experience in group therapy tended to ask closed-ended questions about what was most therapeutic or helpful (e.g., Hobbs et al., 1989). Although there are some advantages to this approach, it is also disadvantageous insofar as it limits the respondent to areas of content selected by the investigator and does not allow members to state what is unhelpful about participating in group therapy, a common oversight in group psychotherapy research.

With these things in mind, the purpose of this pilot study was to explore what eating-disordered persons experienced as significant events in psychodynamic group psychotherapy. Using a relatively open-ended and unstructured approach to identifying and explaining these events in group, we hoped to better understand what eating-disordered members themselves find to be helpful or unhelpful about this modality of treatment.

METHOD

Subjects

Seven women, ages 26–50, with a diagnosis of anorexia (2), bulimia (3), and obesity (2) served as subjects in this study. One member of the group was black; the rest were white. Each patient had been previously hospitalized (three of them many times) for an eating disorder at a West Coast treatment facility where this outpatient group was conducted. Depressive, anxiety, and somatoform features were evident in all group members, with two members also demonstrating substance abuse and multiple personality disorder features, respectively. In addition, members showed borderline personality organization (2), histrionic personality traits (2), dependent personality features (2), and schizoid personality characteristics (1). Eating and other disordered behaviors in this group were chronic, with the exception of one member who had bulimia less than one year.

Medically, two members were diagnosed with diabetes, and another had been treated for breast cancer. Nearly all members complained of long-standing family, social, marital, occupational, and other life stressors, and only three members of the group were gainfully employed. One patient was a member of a religious order (whose work therein was frequently interrupted by numerous inpatient, day patient, and outpatient therapies), another was a full-time housewife, and two were on welfare. Despite their collective difficulties in functioning, all the members of this group were highly intelligent, as evidenced by their education (four had college degrees, including one master's), vocabulary, fund of knowledge, short- and long-term memory, capacity for abstraction (e.g., metaphors were common and effective vehicles for communication in this group), and an appetite for elective reading. Four of the women had been in the group for one year, two others for nine months, and the other for six months when this investigation began.

Therapists

A male psychologist and a female marriage, family, and child counselor co-led the group. One leader was an experienced group therapist, and had worked clinically with this population for several years. The other leader was relatively new to the area of group treatment with this population. Both therapists were psychodynamically oriented and, for the most part, conceptualized eating and other disordered behaviors as functional solutions to underlying difficulties with identifying, containing, and expressing thoughts, feelings, and needs. Consequently, the therapists used questions, clarifications, here-and-now, and genetic interpretations, confrontations, empathy, and acceptance in order to promote the self-cohesion and ego strength necessary to deal directly with intra/interpsychic phenomena that otherwise are acted out symbolically in eating and other disordered behavior.

Instruments

Significant Events Form (SEF). The SEF is a three-item self-report questionnaire designed to elicit information about what members find significant in group therapy and why. Specifically, in the left-hand column of the SEF, the respondent is asked to list the three most significant events (e.g., thoughts, feelings, memories, fantasies, behaviors, or interactions) that occurred for her in a particular group. In the right-hand column of the instrument, the patient is instructed to explain why each event was significant. The SEF was constructed specifically for use in this study, and psychometric data on the measure have yet to be collected. The SEF takes anywhere from one to 15 minutes to complete, depending on the content to be disclosed and, equally important, the character of the respondent.

Procedure

The patients described above were invited by their therapists to participate in a 14-week investigation of "significant events" in group therapy. After some discussion of concerns about confidentiality, being used as "guinea pigs," and the dispensation of results, all members agreed to participate. Members were reassured that participation was completely voluntary, however, and that their tenure and treatment in the group were in no way contingent upon their compliance. Consequently, during the 13th, 14th, and 15th months of this group, members completed the SEF after each group meeting. (The therapists also completed an SEF on each member, after each group, over the same period. A comparison of therapist and patient perceptions of significant events in group will be presented in a subsequent paper.) The forms were stored in a locked clinical/research file and remained unexamined by the therapists until data collection was completed.

Analysis

Typed transcripts of the data were sent to an independent observer with extensive experience in group practice and research. The observer entered all the data into a computer, and conducted a manifest content analysis by computing a frequency distribution for all words mentioned by group members over the 14-week period. The observer also conducted a latent content analysis of the data by sorting every statement made in group during this time according to her (subjective) interpretation of its thematic content. One of the cotherapists

TABLE 1
Frequencies of Significant Events and Reasons for Their Significance in the Eating Disorder Group

	Freqency
Significant Event	
Feedback	39
Observation of other	33
Group talk	23
Openness/sharing	22
Action/change	18
Emotional expression	10
Work	6
Attention	3
Reasons	
Emotional experience	57
Insight	47
Relationship	36
Identification	16
Acceptance	12
Universality	6
Understanding	6

then examined these themes and the extent to which statements contained therein fell into the category of "significant events" or "reasons why an event was significant." Interrater reliability data on the sorting of statements with respect to content and meaning were not secured.

RESULTS

Attendance, Compliance, and Attrition

Average attendance during the 14 weeks of this study was six members per meeting. The average number of SEFs completed during this time was five per group; one member declined to participate after the second week. There was no attrition of members from the group during this period.

Significant Events

The events noted most often as significant by members are listed in Table 1. Feedback (e.g., "When Kit shared with me how I come across") and observation of others (e.g., "When Dawn talked about her fear of anger") were the most common catalytic events in the eating disorders group. In addition, the feedback and exchanges between members were largely interpersonal—there was very little discussion of "topics," including food, symptom, body, and other eating disorder talk.

Also included in Table 1 are the reasons for the significance of the events as noted by the members. Insight (e.g., "I realized I'm desperate for support"; "I can see I need structure, too") and relationship (e.g., "I felt more connected with her") were reasons commonly given by members why events were meaningful or important to them. If acceptance (e.g., "I felt accepted by her"), group talk (e.g., "I appreciate the sensitivity of the group"), attention (e.g., "It felt

good to be paid attention to"), and relationship frequencies are combined, we might have an additional, more pronounced factor of cohesion (i.e., belonging, attraction, unifying force). Likewise, if identification (e.g., "I could identify with her") and universality (e.g., "Joan's feeling made me feel not so alone") are combined, universality as a reason for significance is also stronger.

The most commonly cited reason events were significant, however, was emotional experience. In other words, the members of this group regularly thought events were important *because they made them feel a certain way* (e.g, "I felt angry"; "I felt vulnerable"; "I was afraid she would withdraw from me"; "I felt depressed"; "I felt excited"). The prominence of emotional experience in this group is also suggested by the number of times affective words were mentioned. For example, the word "feeling" (or variations of it, such as "feel" or "felt") was mentioned by members 227 times over 14 meetings. For purposes of comparison, the words "and," "the," and "to" were mentioned 181, 198, and 254 times over the same period, respectively. Additionally, with the exception of three sessions (one with more feelings and two with less), feeling words were fairly evenly distributed over the 14 sessions. Negative emotions (e.g., anger, fear, depression, frustration, irritation) were noted more often, and in greater variety, by members than positive ones (e.g., excitement). Negative emotions also were equally distributed across groups and had a greater impact on members than positive emotions.

DISCUSSION

To summarize, it appears that feedback provided, received, or observed in group stimulates emotional experiences, insights, and interpersonal connections that are meaningful to eating-disordered members. There are several interesting aspects of these findings. First, the pronounced presence of emotion in this group is surprising, since, as has been reported elsewhere (e.g., Hall, 1985), eating disorder groups are notoriously flat. One reason for this discrepancy, however, is that studies have typically examined catharsis, or emotional expression, among their group members. In this pilot study, emotional *experience* was noted as significant by members nearly six times more often than emotional *expression*. This suggests that noting the expression of catharsis may be too narrow a methodological tool to capture another important therapeutic feature in group with this population, namely, emotional experience.

Another reason emotions may have been more pronounced in this group than has been observed in other eating disorder groups was that data collection was by patient self-report rather than therapist or rater observations. With this methodology, a window may have been opened to the inner life of the group in a way that illustrated that emotions are important to members even if they are not necessarily expressed. Given that eating-disordered persons commonly present with alexithymia and other disturbances in self-awareness (Bruch, 1973), it is not surprising that the ability to experience a feeling was significant to the members of this group. Moreover, it is likely that these emotional experiences promoted the insights, identifications, and feedback also valued by group members.

Yet another reason emotions were so evident in this group is the emphasis placed on their identification and expression in the here-and-now by the leaders. Moreover, this pilot study was conducted during the beginning of the second year of the group, and the tenure of its members ranged from 6 to 12 months when the recording of significant events began. This is in contrast to other studies on group therapy for eating disorders, where there was more

emphasis on psychoeducation, cognitive modification, or behavioral self-control over a much shorter period of time (Connors et al., 1984; Gray & Hoage, 1990; Lee & Rush, 1986). Consequently, the pronounced presence of emotions—particularly negative ones—in this group may not be unlike psychodynamic group psychotherapy with other populations where the emotional experiences of members are measured in the advanced stages of group development.

The frequency with which the observation of others, or vicarious learning, was listed as a significant event in this group is also noteworthy. As with affective expression, eating disorder patients frequently have been found to be silent, withholding, restricted, or, at best, inconsistent with respect to self-disclosure in group (Hall, 1985; Maher, 1984). These results suggest, however, that there may be more subterranean participation in the eating disorder group than meets the eye. Moreover, since emotional expression and insight were the most common reasons given why an event was significant, we can assume that silence is not incompatible with affect and self-awareness in group.

Also of note was the dominance of feedback over topical eating disorder discussions as significant events in group. Group members clearly made more meaning out of their personal responses to, and interactions with, one another than any other type of event. This corroborates the observation of Shisslak, Crago, Schnaps, and Swain (1986) that a focus on the here-and-now in the eating disorder group may be the most potent vehicle for correcting the interoceptive deficits, alienation, and denial so often seen in these patients. Once again, however, these events and their reasons for significance may be the logical response to a psychodynamically (i.e., intra/interpersonal) oriented approach to group treatment. Perhaps a cognitive-behavioral approach by the leaders would have generated events and reasoning that resonated more with imparting information, socialization techniques, or other therapeutic factors less pronounced in this group.

Indeed, the relative absence of universality, hope, imparting information, and socialization techniques, among other therapeutic factors, is curious. It is particularly surprising given the isolation, hopelessness, misinformation about food/body/weight, and social discomfort commonly reported by these patients. On the other hand, it is worth repeating that this was a year-old group of chronic eating-disordered patients who had sat through scores of psychoeducational, nutritional, and other skills-oriented groups in the past. Moroever, it is not uncommon to find eating disorder patients who know more about food, nutrition, and physiology than their therapists. Consequently, it may be that these factors noted above have more impact in the earlier stages of a psychotherapy group with less chronically disturbed patients. Indeed, there is preliminary evidence to suggest that universality and imparting information are particularly potent features of the nascent eating disorder group (Moreno, 1994). Universality and identification were not absent in this group, however, as some comfort was still being derived from feeling less alone with negative feelings as well as shameful or ego-dystonic thoughts and needs.

Finally, it is interesting to note that none of the "significant events" found in this study were distasteful to group members. This is not to say that members of the group did not experience things that were painful for them. Rather, members seemed to describe unpleasant as well as pleasant experiences in ways that ultimately were helpful. This could be because of the obsequious nature of the participants, or because the measurement instrument pulled for favorable disclosures despite the intent of its developers. It could also be that

the data analysts reframed unhelpful experiences of the patients in a "therapeutic" light or, as noted above, that group members were able to make use of events that initially were felt to be undesirable. Given the ambiguity here, perhaps a better way to distinguish helpful and unhelpful ingredients of the eating disorder group would be to create an instrument with instructions for noting these things.

CONCLUSION

The purpose of this pilot study was to describe, explore, and explain significant events in a psychodynamically oriented group for eating-disordered women. Group therapy studies with this population thus far have largely ignored what the eating-disordered patient has to say about her participation in group. The results of this pilot study suggest that feedback received, provided, and observed in group promotes emotional, intellectual, and relational connections that are important to individuals whose disorder has been associated with intra- and interpersonal deficits. This may be particularly true for more recalcitrant patients in group over time, and for a treatment approach that embraces questions, clarifications, empathic responses, confrontations, and interpretations of extragroup content mirrored within the social milieu of the group. It is important to note, however, that the lack of comparison groups to control for time, leader orientation, leader technique, and process features of other clinical populations render these findings exploratory. An unvalidated measure, recalcitrant membership, lack of interrater reliability, and a very small sample size also limit the validity of these results. Future investigations that control for these limitations will significantly enhance our understanding of helpfulness in eating disorder and other psychotherapy groups.

REFERENCES

Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa and the person within.* New York: Basic Books.

Connors, M. E., Johnson, C. L., & Stuckey, M. K. (1984). Treatment of bulimia with brief psychoeducational group therapy. *American Journal of Psychiatry, 141,* 1512–1516.

Dixon, K. N., & Kiecolt-Glaser, J. (1984). Group therapy for bulimia. *Hillsdale Journal of Clinical Psychiatry, 6,* 156–170.

Gray, J. J., & Hoage, C. M. (1990). Bulimia nervosa: Group behavior therapy with exposure plus response prevention. *Psychological Reports, 66,* 667–674.

Hall, A. (1985). Group therapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia.* New York: Guilford.

Hobbs, M., Birtchnell, S., Harte, A., & Lacey, H. (1989). Therapeutic factors in short-term group therapy for women with bulimia. *International Journal of Eating Disorders, 8,* 623–633.

Lee, N. F., & Rush, A. J. (1986). Cognitive-behavioral group therapy for bulimia. *International Journal of Eating Disorders, 5,* 599–615.

Maher, M. S. (1984). Group therapy for anorexia nervosa. In P. S. Powers & R. C. Fernandez (Eds.), *Current treatment of anorexia nervosa and bulimia.* New York: Karger.

Mitchell, J. E., Pyle, R. L., Eckert, E. D., Hatsukami, D., Pomeroy, C., & Zimmerman, R. (1990). A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nerovsa. *Archives of General Psychiatry, 47,* 149–157.

Moreno, J. K. (1994). Group treatment for eating disorders. In A. Fuhriman & G. Burlingame (Eds.), *Handbook of group psychotherapy: An empirical and clinical synthesis.* New York: John Wiley.

Oesterheld, J. R., McKenna, M. S., & Gould, N. B. (1987). Group psychotherapy of bulimia: A critical review. *International Journal of Group Psychotherapy, 37,* 163–184.

Roy-Byrne, P., Lee-Benner, K., & Yager, J. (1984). Group therapy for bulimia: A year's experience. *International Journal of Eating Disorders, 3,* 97–116.

Shisslak, C. M., Crago, M., Schnaps, L., & Swain, B. (1986). Interactional group therapy for anorexic and bulimic women. *Psychotherapy, 23,* 598–606.