PRACTICE

Long-Term Psychodynamic Group Psychotherapy for Eating Disorders: A Descriptive Case Report

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Fifteen women with long-standing histories of eating and other disordered behavior participated in a psychodynamically oriented psychotherapy group over a 3-year period. This article provides a number of observations on this group and describes how a variety of organizational, patient, therapist, and treatment variables combined to help as well as hinder favorable outcome in group members. The implications of these findings for assessment, preparation, selection, and intervention are discussed, and recommendations are offered for working with more recalcitrant eating disordered people in group in the future.

Anorexia nervosa is characterized by abnormal body weight, fear of fat, body-image distortion, and amenorrhea (American Psychiatric Association [APA], 1994). Bulimia nervosa is evidenced by binge eating, purging, body and weight preoccupation, and out-of-control feelings while eating (APA, 1994). Obesity is characterized by supernormal body weight and, in some cases, concomitant abnormalities in eating behavior (e.g., binge eating) (Logue, 1991).

Group therapy for people with anorexia nervosa and bulimia nervosa has increased considerably in the past two decades, as has research on its clinical utility. In a recent review of the literature, Moreno (1994b) found that over a hundred papers have been presented or published on the subject since 1967, when Lafeber and Lansen described the first group treatment for anorexia. Most of these reports are psychoeducational, cognitive, and/or behavioral in nature (Connors, Johnson, & Stuckey, 1984; Gray & Hoage, 1990; Lee & Rush, 1986; Leitenberg,

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Rosen, Gross, Nudelman, & Vara, 1988; Mitchell et al., 1990; White & Boskind-White, 1981; Wolchik, Weiss, & Katzman, 1986). There is a dearth of descriptive or controlled research on psychodynamic approaches to group therapy with people suffering from anorexia and bulimia (Moreno, 1994b).

This article describes a psychodynamic psychotherapy group for eating disordered women over a 3-year period. First, a brief description of the psychodynamic approach to treating anorexic, bulimic, and obese people in group is described. Next, the history of the group under investigation is chronicled, and retrospective outcome observations made by the therapists are provided on the 15 women who participated. A variety of institutional, patient, therapist, and treatment variables affecting the course of the group are also discussed. Recommendations for group treatment of anorexic and bulimic people in the future are offered, particularly in light of other research on group therapy with this population.

PSYCHODYNAMIC GROUP THERAPY FOR EATING DISORDERS

Eating disordered people are notorious for their deficits in self-awareness, self-acceptance, self-expression, and containment, particularly with respect to affects and needs that arise in relation to others (Aronson, 1993). The psychodynamic function of binge eating, purging, and restricting is to help patients deny, anesthetize, and discharge unwanted internal states preceding, coinciding with, or following interpersonal exchanges. The goal of the psychodynamic psychotherapy group is to help members identify, tolerate, and put words to troublesome experiences previously acted out in eating and other disordered behavior.

The dynamically oriented group leader selects interventions from the same menu as other group therapists to accomplish this goal. Three interventions, however, differentiate the dynamically oriented group therapist most from other leaders: empathy, confrontation, and interpretation.

Empathy is a soothing function the leader provides for the group, an understanding of internal states that otherwise get acted out through the manipulation of food, body, and weight (Barth & Wurman, 1986). Consequently, leader empathy models a more benign approach to forbidden or unwanted experiences, thereby promoting self-acceptance among members. On the other hand, leaders make mistakes (empathic failures), therein helping members to integrate imperfection in the valued leader and, therefore, themselves. Empathic failures by leaders also allow other members to soothe the person speaking, thus promoting altruism in the group and self-esteem in the empathic patient in particular.

Confrontation is the identification of discrepancies in group (Yalom, 1995). It is not an aggressive intervention made popular by some aspects of the self-help movement but simply the observation that the member experiences two or more competing features within oneself or others. For eating disordered people, confrontation is especially helpful in decreasing splitting and promoting integration. Specifically, members see that neither side of their experience is right or wrong; growth comes with their ability to hold opposing feelings about themselves and others simultaneously.

What most differentiates the dynamically oriented group leader from others, however, is interpretation, or the translation of one communication into another. The eating disorder itself may be seen as a symbolic communication of underlying difficulties with autonomy, impulse control, and dependency, among other things. Interpretations by the leader help members put words to these struggles so that they may be understood and dealt with directly instead of acted out with eating or other symptomatic behavior (Moreno, 1994a).

IN THE BEGINNING: MONTHS 1 TO 3

Selection and Composition

Initially, this group was open to people participating in a multifaceted aftercare program following inpatient treatment for an eating disorder. As per hospital protocol, the group was free for the first 12 weeks of participation and cost $10 per meeting thereafter. Prospective members were accepted on a first-come, first-served basis and could come and go as they pleased.

Overall, 15 women participated in this group over a 3-year period. Fourteen of the members had been treated earlier at the inpatient eating disorder unit of the hospital, and many had been hospitalized for eating and other disorders more than once. All members were female, the youngest being 15 and the oldest 50. One member was Black; the rest were White. Three members were obese, 10 were bulimic, and 2 were anorexic. Nearly all members evidenced anxiety and affective disorders, and many of them demonstrated personality disordered features, especially of a dependent, narcissistic, and/or borderline nature. Several women showed dissociative and substance abuse patterns. Eight of the 15 were fully employed, 1 was employed part-time and later

went on welfare, 2 were housewives, 1 was a student, and 3 were completely dependent on welfare. The group began with 11 members.

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 group work as well as eating disorders. Both therapists were psychodynamically oriented and conceptualized eating and other disordered behavior as functional solutions to underlying difficulties with identifying, containing, and expressing thoughts, feelings, and needs.

Attendance and Attrition

During the first 3 months of the group, attendance was very poor—a few members were absent each week due to work and school conflicts, illness, vacation, and other sudden events. Patients also spoke regularly of quitting the group. By the end of 3 months, membership in the group fell from 11 to 5 participants.

Affect

The first several meetings of the group were characterized by an unusual amount of overt anxiety and hostility compared to other groups run by the leaders, eating disorder focused or otherwise. Specifically, members seemed frightened by the size of the group and the anticipated persecution and rejection it suggested. Members also attacked one another regularly, despite repeated attempts by the leaders to resolve a conflict or to explore the unwarranted intensity of member responses. The display of other feelings was nearly nonexistent as members regularly expressed their preference to avoid feelings (e.g., sadness) they could not identify, tolerate, or fix in themselves or others. This was particularly pronounced in the group's resistance to writing and reading their autobiographies, an informal activity they agreed to do in the second meeting. As one member put it, "I didn't do it [the autobiography] because I don't want to deal with depressing stuff. I hate depressing stuff."

Structure

Initially, there were very few ground rules for the group (e.g., no [illegible] fee, no exclusion criteria), and the leaders

concluded this was significantly related to its poor start. Consequently, to preclude further disintegration, the leaders negotiated several changes in group policies and procedures with the hospital administration. First, group membership would be limited to eight patients. In addition, future members would be individually assessed, prepared, and screened for group suitability, and all participants would be required to commit and contract to attend for 3 months at a time. New patients would begin payment for services immediately on commencement of group, and all members would pay $15 per session 1 month in advance. Members would not be reimbursed for absences, with the exception of extended vacations or work leaves disclosed 1 month ahead of time, and patients were asked to report all extragroup contact in the following group meeting. The impact of these changes was immediate, as described below.

IN THE MIDDLE: MONTHS 4 TO 32

Attendance and Attrition

In contrast to the experience of the first 3 months, it took 29 more months for the group to lose another six members. Moreover, the shortest length of stay during this period was 7 months, with all other members participating for a year or more. Attendance also improved, with only one person, on the average, absent each week. Likewise, members began to disclose, emote, and respond to one another more deeply—albeit slowly, inconsistently, and with difficulty—as the following descriptions indicate.

Affect

Interestingly, as the group matured, the most immediate change in affect was in the direction and intensity of hostility—instead of attacking one another, group members began attacking the male leader. For example, for about 6 months, the male leader was routinely described as being "in left field," "a wienie," "insensitive," and "unempathic," among other things. Following this collision with him, members returned to confronting one another, only this time, more constructively. One woman seemed to begin to untangle her association between anger and aggression, a significant achievement for someone who earlier in life was convicted for stabbing (nearly fatally) her physically abusive husband. Another patient appeared to contain or appropriately express anger, instead of acting it out vis à vis silence, tardiness, mid-meeting

exits, and absenteeism. A third member seemed to see how her hostility toward others was her way of defending against unwanted feelings and needs in herself. All members continued to confront the leaders, only now with more anger, less hostility, and increased curiosity about what their feelings said about themselves as well as the therapists. The therapists' ability to contain the hostility (e.g., by not retaliating against, being crushed by, or abandoning the group), and interpret and empathize with the underlying vulnerabilities it defended against is what promoted this evolution of affect modulation in the members over time.

Dependency

Another feature of this group that became quite pronounced in the middle of its course was dependency. Members, for instance, expressed resentment toward new patients for fear they would become invisible to the leaders. One woman even exclaimed, "It's like there's 8 mouths and only two hamburgers in here!" when membership increased from 6 to 8 members. Members also were acutely aware of the emotional and physical condition of the leaders. When this was explored, it became clear that if the leaders weren't healthy, there would be no one to care for them. One woman, in particular, was furious with the male leader for smoking and worried terribly about the female leader when she discontinued wearing her wedding ring. Group members also expressed considerable conflict around being dependent and the opportunities it afforded for being rejected and abandoned. Finally, and perhaps most important, the members of this group expressed shame at the gravity of their needs, as well as anxiety and guilt whenever they were met. Sometimes, in fact, members of the group would reject assistance from others because the shame, guilt, and vulnerability that followed was too overwhelming.

Competition

Unmet dependency and narcissistic needs seemed to spawn competition and attempts to be special in group. For instance, one patient acknowledged that she frequently tried to confuse the group, especially the male leader, to stand out from the others. She added she felt angry that a former physician in the hospital, under investigation at the time for sexual misconduct with patients, abused others and not her. The group also was threatened when one member began seeing the female leader in individual therapy and when another member entertained the idea of seeing another member's psychiatrist. The wish to be special was

particularly evident one evening when a patient shared her fear that the male leader might pay less attention to her in group because a new member "was prettier." Another patient then became angry with the speaker for assuming that she and the new member were the only two who could compete for the leader's affection. A third member was then angry with both of them for leaving her out of the equation "just because I'm obese." This woman, in fact, commonly complained that the leaders paid more attention to the anorexics and bulimics because she was fat and they weren't.

Boundaries

Poor ego boundaries among members were evident throughout the tenure of this group. For example, several members expressed anxiety whenever their perceptions of group events were not shared by others, especially the leaders. They feared if they entertained alternative perspectives, they might take in something "bad" due to a distortion someone was unaware of or unwilling to admit. Another member was virtually silent her first several meetings in group, only to disclose one day that she had stabbed her first husband 19 times because of his abuse. She was relatively quiet thereafter. This "binge/starve" cycle of participation was not uncommon in this group. Another member was reluctant to disclose things to the group lest we "take them away from her," as her mother had done. As a group, members periodically confessed that they were reluctant to ask one another questions for fear of being intrusive or invasive. The group seemed to believe that one's limits were determined by others rather than oneself.

Sexuality

Group members were very conflicted about sexual impulses because of the frustration, vulnerability, and shame they engendered. Discussion of sex, in fact, was nearly nonexistent during the first year of this group. By the second year, however, members began to disclose a variety of thoughts, memories, feelings, and wishes regarding sexual orientation and behavior. A number of these sexual issues eventually found their way into the here and now of the group, particularly with respect to ways members related to the male therapist. One woman, for instance, disclosed her fear that if she couldn't attract the male leader with seductive comments, dress, and behavior, he wouldn't pay attention to her. Another patient asked him to "warn" her if he ever decided to get married. And yet another member was terrified of losing weight lest the male therapist become interested in her, deny it, and "make her crazy."

This woman also was afraid that if she lost weight, she would threaten the others in the group and lose their support.

Countertransference

This was a very difficult group to conduct, largely because of the myriad of unpleasant feelings the leaders experienced during its course. In the beginning of the group, the therapists were frustrated and stumped by the hostility among members and their reluctance to take advantage of so many resources (e.g., universality) members had to offer one another. Later, the male therapist felt increasingly inadequate and confused as the group rejected, ridiculed, or ignored his comments. Similar interventions made by his partner were taken seriously by the group, thereby adding to his frustration. Throughout the course of the group, both leaders continued to struggle with feelings of disappointment and confusion, because group interaction, affective expression, engagement, responsiveness, feedback, and support seemed so irregular. Repeatedly, they left group thinking that the members had finally "turned the corner" with respect to cohesion and commitment to the therapy, only to return to what seemed like a bowlful of strangers a week later. Finally, their frustration also was a function of their observation that improvement seemed painfully slow, and often, they wondered whether the group was of much value to its members.

Cotherapy

The leaders used one another in a way that enabled them to make sense of, tolerate, and contain the plethora of countertransference feelings throughout the tenure of the group. For instance, they routinely took about an hour following each meeting to ventilate, ask questions, test reality, provide feedback, problem-solve, and support one another. During the middle of the group, however, several problems surfaced and created tension between the leaders. Competition for the group's acceptance and respect, poor communication, and the projection of personal concerns onto one another were some of the more common difficulties they experienced. But the most frequent and troublesome issue between the leaders was their difference in orientation and related activity level. Specifically, one of the leaders was more intrapersonally oriented, whereas the other was more interpersonally and group oriented. Consequently, one leader would get frustrated with the other for working too long on an individual at the expense of the group, whereas the other leader argued that deeper individual work was compromised by a larger group focus. Over time, the leaders were able to integrate their approaches, but they still struggled with the timing of individual, interpersonal, and group interventions.

Therapeutic Factors

What appears to have been most therapeutic for members is evident in a "significant events" study conducted by the leaders during months 13 to 15 of this group (Moreno, Fuhriman, & Hileman, 1995). In the study, members were asked to record the three most significant events in group each night and why each one was significant. Manifest and latent content analyses of the data indicated that simply having emotional experiences (e.g., anger, sadness, fear) was why certain events were so significant to members. Other events were significant to members because they promoted self-awareness, universality, and relationships with others in the group. Feedback, particularly emotionally laden feedback, and observation of others were the most commonly cited events in group that yielded the insight and connectedness noted above. As Moreno et al. (1995) summarized, "it appears that feedback provided, received, or observed in group stimulates emotional experiences, insights, and interpersonal connections that are meaningful to eating disordered members" (p. 60).

These findings surprised the leaders—had they not conducted this study, they never would have guessed that there was as much emoting, learning, and engaging as the aforementioned results suggest. In fact, in an earlier article (Moreno & Hileman, 1991) summarizing their impressions of this group after 1 year, they observed that universality, cohesion, insight, and catharsis were marginal, at best. They concluded that high levels of dependency and narcissism, among other things, greatly interfered with members' ability to attend, respond, and attach to one another in group. Although this conclusion may remain true to some extent, it also may have been overstated, given the results of the significant events research.

Finally, some other observations made regarding curativeness in this group involved the modeling of cooperation, conflict, and affection between the therapists. Despite the cotherapy difficulties noted earlier, members seemed to benefit from the observation of exchanges between the group leaders. Most of all, members noted that it was very helpful to them to see a female stand up to, and effectively conflict and negotiate with, a male. In addition, group members admitted to being acutely attuned to the way in which the leaders "played" (e.g., teased) with one another, and that it was particularly comforting to see that this could occur between men and women without anyone being abused, exploited, or minimized.

IN THE END: MONTHS 33 TO 37

Size

This group seemed to function best with five to six members. At this size, members seemed to be able to get their needs met for attention and mirroring without undue frustration or injury. Likewise, at this size, the group seemed to feel safer and less threatened by anticipated attacks from others. When the group was larger (8 to 11 members), persecutory anxiety, frustration with time sharing, and injuries to the need to be special seemed to significantly impair self-disclosure and emotional engagement. Interestingly, however, when the group census was very low (two to three members), performance anxiety ran high, and the group clamored for new members.

Outcome

As per patient self-report and therapist observations, by the end of the group, 3 of the 15 members were no longer eating disordered. The remaining 12 women remained eating disordered on termination, but it is important to note that 5 of them quit group in the beginning when it remained relatively unstructured (and unproductive). Another person participated for 2 years but frequently took long leaves from the group to meet her religious obligations. The other 6 members participated in group from 7 months to 2.5 years but failed to demonstrate any sustained improvement in eating disordered behavior. Six of the 15 women seemed to improve their ability to identify, contain, and express egodystonic thoughts, feelings, and needs. Four of these patients showed some improvement in their interpersonal relationships, as evidenced by less indiscriminate investment in others and greater assertiveness with members, family, friends, and coworkers. Self-esteem seemed to improve somewhat in these 4 members as well.

SUMMARY

To summarize, 15 women participated in a 3-year psychotherapy group for eating disorders. Initially, there was marginal institutional support for the group, and participation, attendance, and commitment to the group were poor. In addition, anxiety and hostility among members were high, and other expressions of affect were avoided. Subsequent changes in the assessment, preparation, selection, and structure of the group were associated with lower attrition and more consistent attendance and interaction in the future.

During the middle phase of the group, hostility was directed first at the leaders, especially the male. After several months, anger replaced hostility, and constructive expressions of aggression among members began to emerge. Other affective displays remained limited, but emotional experience in members ran high. Unmet dependency and mirroring needs were particularly pronounced during the middle of the group and were made visible by food metaphors, hostility toward new members, attunement to the welfare of the therapists, and competition for favored status with the leaders and group as a whole. Boundary disturbances were prominent in the group, as members reported feeling torn between their wish to connect and their fear of engulfment, abandonment, or feelings of shame if they did so. Sexuality was avoided for well over a year in the group but began to surface as some members disclosed memories of molestation and sexual feelings for the male therapist.

Over time, limited emotional expression, minimal feedback, and slow improvement in members created some frustration and self-doubt in the leaders, but they were buoyed by their support of one another when they weren't divided over how to run the group. Moreover, the therapists seemed to underestimate the gains made by the group: The patients reported benefiting considerably from the insights, emotions, and relationships they experienced while interacting with or observing one another. By the end of the group, however, only three members had improved with respect to eating disordered behavior.

DISCUSSION

The eating disorder group therapy literature is replete with case (e.g., Roy-Berne, Lee-Benner, & Yager, 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 demonstrating the utility of this treatment modality with this population. The results of this study conflict somewhat with those above, particularly with respect to outcome. This discrepancy may best be explained by a host of institutional, patient, treatment, and therapist factors.

To begin with, participation and outcome in this study were initially compromised by failure to adequately assess, prepare, and select appropriate patients for group. Had there been hospital support to do this earlier, four patients would have been excluded from the group because of young age, symptom severity, unbridled hostility, and an imminent

time conflict due to school. Moreover, the remaining seven members would have been educated about group rules, roles, and rationale and required to commit to attend for a specified period before terminating. Along with payment in advance, these pregroup procedures might have softened group tensions that prompted absenteeism, attrition, and poor outcome early in the group. The favorable effect of such pregroup procedures on attendance and interaction later in this group is testimony to this hypothesis. Others (Hall, 1985; Roy-Berne et al., 1984) have suggested that such procedures promote participation and desirable outcome as well.

Favorable outcome among the members of this group also was limited because of the chronicity of the disorder in most of the patients. As noted earlier, most of the women in the group had suffered from an eating disorder for many years and remained acutely disturbed despite one or more earlier hospitalizations. Many other studies in the literature, on the other hand, were conducted with eating disordered college students without such acute and long-standing difficulties. Moreover, these women, unlike the patients in other studies, presented with a number of other severe clinical syndromes and character disturbances that consistently interfered with their maximization of the therapeutic factors available to them in group. Specifically, extreme self-absorption, unmet dependency needs, fears of engulfment, and an allergy to affect were just some of the features observed among members that inhibited them from interacting in ways that potentiate universality, cohesion, catharsis, interpersonal learning, hope, altruism, and other benefits of talking in a group.

Marginal outcome among some group members also may have been a function of the unidimensional treatment approach taken by the therapists. First, only seven of the patients in this group also were in individual therapy, and only one of them with one of the group leaders. This is in contrast to case evidence (Hall, 1985) suggesting that more severely disturbed eating disordered people do better in individual and group therapy, particularly when provided by the same therapist (Scheuble, Dixon, Levy, & Kagan-Moore, 1987). Hence, perhaps outcome among the members of this group might have been more favorable, had the participants been in individual treatment with one of the group leaders as well.

Second, the leaders of this group worked almost exclusively within a psychoanalytic psychotherapeutic approach integrating contemporary self, object, and ego approaches to group treatment. One leader emphasized the use of questions, clarifications, empathy, and acceptance to help individuals in the group explore, identify, express, and contain forbidden thoughts, feelings, needs, and impulses. The other leader

emphasized confrontations (of discrepancies) and interpretations of individual, interpersonal, and group phenomena. Both leaders were especially curious about indirect or symbolic expressions of feelings and needs and used their respective approaches to help patients "put words to" behaviors (e.g., silence, tardiness, absenteeism, bingeing, purging, restricting, intoxication, self-mutilation, food-talk, "there-then" talk), that heretofore they had been unable or not encouraged to do.

On the other hand, the leaders rarely used other cognitive, behavioral, and educational techniques (e.g., goal setting, role playing, information sharing, identification of behavioral alternatives to bingeing, purging, and restricting) found to promote symptom management in group members (Connors et al., 1984; Mitchell et al., 1990). Consequently, this may explain why the patients in this group improved in various areas of psychosocial functioning but not with respect to specific eating disordered behavior. Psychotherapeutic techniques designed to promote self-awareness, self-expression, and self-esteem, in other words, still may not be enough to affect long-standing and deeply entrenched patterns of eating disordered behavior. This is consistent with Garner and Garfinkel's (1985) observation that multidimensional as well as multimodal approaches to the treatment of eating disordered people are indicated.

Finally, marginal outcome in some members also may be a function of some therapist variables that interfered with the treatment. First, although both therapists had some experience conducting groups with eating disordered people when the group began, neither of them were experts. Recent empirical evidence by Yager, Landsverk, and Edelstein (1989), however, suggests that experts promote more symptom improvement in their eating disordered charges than inexperienced ones. Moreover, as the leaders struggled at times with one another and the group, they were unable to secure adequate consultation, because no one on staff knew any more about groups with this population than they did. This is in contrast to MacKenzie and Harper-Giuffre's (1992) claim that even the seasoned veteran is wise to make provisions for supervision when conducting groups with this population.

Second, the leaders had their own perfectionistic tendencies and fears of making mistakes, which could have contributed to the very careful and guarded way in which members self-disclosed and interacted in group. Also, the frequency and intensity of the therapists' negative countertransference might have been less problematic had they begun with lower expectations of these patients compared to other populations they had worked with in group. Finally, it took a long time for the leaders to negotiate a palatable blend of individual, interpersonal, and group interventions. Consequently, limited responsiveness and "turn taking"

among group members might have been encouraged by the therapists' oversupply of intrapsychic procedures, thereby interfering with universality, cohesion, and interpersonal learning. On the other hand, an overemphasis on interpersonal and group interventions by the therapists seemed to stimulate member fears of abandonment. Perhaps a more balanced diet of personal, intermember, and collective interventions might have expedited and intensified the factors known to be therapeutic when members talk to one another, as well as the therapists, in group.

RECOMMENDATIONS

The results of this study lend themselves to several recommendations for group work with eating disordered patients, especially chronically disturbed ones, in the future. First, the importance of thoroughly assessing and preparing patients cannot be overstated—such procedures may do much to minimize attrition and maximize participation in group. Second, a multidimensional group approach incorporating psychodynamic, cognitive, and behavioral procedures is suggested to ameliorate eating disordered behavior as well as other deficits in psychosocial functioning. With mildly disturbed patients, this may be best accomplished with weekly group psychotherapy. For more moderate-to-severely disturbed patients, individual as well as group psychotherapy is recommended, because neither modality alone is likely to contain the bevy of needs present in these patients. If the resources are available, another option is intensive outpatient group psychotherapy, where more severely disturbed patients participate in several nutritional, educational, behavioral, and interpersonal groups per week (Mitchell et al., 1985). Third, group psychotherapy with chronic eating disordered people is not easy, and therapists—even seasoned ones—are not advised to work alone. A male-female cotherapy team is ideal and provides members with opportunities to work through unresolved conflicts with both genders. Cotherapists also should meet after group and arrange for third-party consultation.

CONCLUSION

Group therapy for anorectic, bulimic, and obese people is an effective, albeit challenging, approach to treatment. This report describes some process features of a long-term psychotherapy group for eating disordered people. Also included in this discussion are observations on how various selection, patient, treatment, and therapist variables affected outcome for group members. Some suggestions for improving participation and outcome for eating disordered patients in group therapy in the future are offered.

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Group Work as Facilitation of Spiritual Development for Drug and Alcohol Abusers

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Group work designed to promote the spiritual development is described and applied to therapy groups conducted for drug and alcohol abusers. A definition of spirituality is given that can be used to show how spiritual development can be fostered in therapy groups. Research that relates to the spiritual development of the members of drug and alcohol groups is discussed. Comparisons are made between the ways that group work and Alcoholics Anonymous promote the spiritual development of drug and alcohol abusers.

Group therapy is a commonly used treatment for people who have drug and alcohol problems. Group approaches are often used in treatment centers and other therapeutic settings because these clients often have problems communicating effectively with others and forming healthy interpersonal relationships (Heath & McCormich, 1977; Lewis, Dana, & Blevins, 1994). In addition, drug and alcohol abusers are likely to have serious personal problems, such as family problems and problems in sexual and romantic relationships. These problems contribute directly to or exacerbate drug and/or alcohol dependency (Doweiko, 1993; Platt & Labate, 1976).

Group therapy can help drug and alcohol abusers to develop the ability to cope with problems associated with their addictions. These include (a) providing a climate that supports members who attempt to identify and deal more effectively with personal problems and (b) helping members to develop more healthy interpersonal relationships by interacting with others in the group (Page & Berkow, 1994).

The Twelve-Step Approach developed by Alcoholics Anonymous (AA) has had a major influence on the treatment of drug and alcohol abuse in the United States and other countries. The core of the AA program is the Twelve Steps of AA; these steps provide guidelines about how addicts can cope with their addictions (Le, Ingvarson, & Page, 1995). The Twelve

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