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Group Therapy Research with Eating Disorders: A Summary for Clinicians

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Group therapy for eating disorders has increased dramatically in the past two decades. This is because group is believed to be more cost effective than other eating disorder approaches, and to offer opportunities for universality, cohesion, and interpersonal and observational learning less pronounced in other treatment modalities. Recent research on group therapy for eating disorders has attempted to validate empirically these and other treatment assumptions. In Fuhriman and Burlingame's (Eds.) Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis I reviewed this body of literature, and summarize it here for clinicians interested in perusing what's been reported so far about group work with this population.

Ninety-seven reports on group therapy for anorexia and bulimia nervosa published or presented through 1991 were reviewed and critiqued. Most of these reports were empirical in nature, including case as well as controlled investigations. Global outcome data suggested that roughly one-third of members improved dramatically following group treatment for an eating disorder, with another third evidencing mild-moderate improvement. Remaining patients showed little or no improvement and, in some cases, got worse.

With respect to treatment modality, group therapy was statistically and clinically significantly superior to no treatment. Consistent differences between group therapy, and individual, family, and drug therapy, however, were not found. Nonsignificant differences notwithstanding, consensus remained that group therapy is more cost-effective than other treatment formats with this population.

Regarding theoretical orientation, statistically significant differences between psychodynamic, cognitive, behavioral, psychoeducational, and eclectic approaches were few. In other words, the aforementioned treatment approaches appeared to yield similar outcomes for anorexic and bulimic patients in group. A review of retrospective observations made by patients, therapists, and investigators following group treatment, however, suggested that a smorgasborg of psychodynamic (eg, interpretation), cognitive (eg, confrontation of distortions within as well as outside of group), behavioral (eg, self-monitoring, goal setting, identification of alternatives to binging/purging/restricting), and psychoeducational (eg, information about food and dieting) approaches promoted symptom control and healthier forms of psychosocial adaptation. Therapist warmth, gentle probing, empathy, and acceptance, however, seemed to be the tray upon which all other interventions were best served.

Eating disorder patients referred to group by other health care professionals were generally more severely disturbed than patients recruited through various forms of public announcements or advertisements. Referred patients also evidenced higher attrition rates, but better outcomes, than recruited ones. Members participating in three or more forms of assessment (eg, clinical interviews, psychological testing, collateral reporting, behavioral observation, medical evaluation) also demonstrated lower attrition and more favorable outcome than those required to participate in two or fewer evaluation procedures prior to commencement of group treatment. Interestingly, larger groups (eg, 8-10 members) showed higher attrition rates, yet better outcomes, than smaller ones, and there was virtually no evidence to suggest that mixing anorexic and bulimic patients in group is contraindicated. In fact, attrition rates across studies were considerably lower in mixed eating disorder groups than homogenous ones consisting of anorexics or bulimics. Age and developmental level of the patient appear to be more important considerations in the composition of an eating disorder group than subtypes therein.

The literature on patient and therapist variables suggested that borderline personality disorder and precariously low body weight were associated with higher attrition and poorer outcome in group. Experienced therapists evidenced lower attrition rates and more favorable outcomes than inexperienced ones, and male/female cotherapy teams appeared to be particularly useful to group members starving for more palatable internal representations of cooperation and conflict between the sexes. There was also considerable consensus that cotherapy attenuates some of the powerful countertransference reactions commonly reported by therapists in conducting group therapy with this particularly difficult patient population.

Some of the more often noted process features of eating disorder groups were that members engaged in a considerable amount of "food talk", particularly in the early stages of treatment or later when under stress. The eating disorder group also tends to be less interactive and affectively charged than other types of groups. Universality, cohesion, insight, and development of socialization techniques were the most frequently mentioned therapeutic factors in group, and the development of the eating disorder group in general appears to be more protracted than is usually found in other types of groups. Longer eating disorder groups evidenced more favorable outcomes than shorter ones, although there was some evidence to suggest that brief intensive outpatient group therapy may be equally as effective as treatment over time.

To conclude, research to date suggests that group therapy is a clinically indicated and cost effective treatment for persons with anorexia and/or bulimia. A bevy of methodological bruises on the body of this research, however, greatly limits the validity of these findings, particularly with respect

to what it is *precisely* about talking in a group that attenuates eating and other disordered behavior. As the old saying goes, may future research provide the answer to this and remaining clinical questions.