

The Group Treatment of Bulimia: Assumptions and Recommendations

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The authors discuss the use of group approaches when treating bulimia and outline recommendations for more efficacious group treatment.

Based on the prevalence of bulimia as well as on characteristics inherent to this disorder, it seems that group treatment may offer clients distinct advantages over individual treatment alone. The bulimic client might benefit from Yalom's (1985) curative factors of group therapy: instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, and group cohesiveness.

Bulimic clients typically feel a sense of loneliness and isolation (Abraham & Beumont, 1982). The secretiveness of the bulimic's behavior results in the self-perception of being the only person in the world who binges or purges. Group treatment gives clients a sense of universality and support. Many of our clients report a sense of relief after their first session because they find out they are not alone. The cohesiveness that develops in the group reduces the client's sense of isolation and allows the bulimic client to develop trust, which often is an issue. Usually, bulimic clients are caretakers who do not receive a reciprocal amount of nurturance themselves. Paradoxically, bulimic clients are caretakers in an egocentric or narcissistic way. The group allows them to learn to give altruistically, yet learn to care for themselves. Within the group modality, they have the opportunity to give support to other group members and to receive the support of the group as well. This contributes to their ability to establish more reciprocal

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relationships in which they are able to validate their own needs and feelings.

Frequently, bulimic clients have family histories that include obesity, depression, and alcoholism (Caruthers, 1986; Herzog, 1982; Merrill, 1986; Pyle, Mitchell, & Eckert, 1981; Strober, Salkin, Burroughs, & Morrell, 1982), disorders that tend to inhibit reciprocity in relationships. This history, plus the bulimics' social learning in their families, may have contributed to limitations in their coping skills. Group treatment provides an opportunity for the bulimic to recapitulate the family of origin and to learn new ways of interacting. Because of the prevalence of other types of dysfunctional relationships (Norman & Herzog, 1984), bulimics might also benefit from groups that provide training in developing interpersonal skills and use social reinforcement for enhancing change.

REVIEW OF THE LITERATURE

Recent studies support observations suggesting that bulimic clients can improve as a result of being in group therapy (Connors, Johnson, & Stuckey, 1984; Stevens & Salisbury, 1984). In this article we review such studies and offer recommendations for conducting therapy with bulimic clients.

Lacey (1983) reported using an eclectic treatment that included behavioral, cognitive, and psychodynamic approaches when treating bulimic clients. His program lasted ½ day each week for 10 weeks and combined ½ hour of individual therapy with 1½ hours of group therapy. Treatment strategies included a structured program, use of the transference relationship, a dietary diary, a prescribed diet that controlled carbohydrate intake, and a weekly weigh-in. Individual and group sessions provided support as well as an opportunity to identify emotional and social factors associated with the binge-purge episodes. Of the 30 clients who were involved, 24 (80%) stopped binge eating and vomiting by the end of the 10 sessions, and 4 additional clients stopped within 4 weeks after treatment ended. Twenty clients had no bulimic episodes during a 2-year follow-up period.

Weiss and Katzman (1984), in contrast, reported on a didactic experiential group program for five bulimic clients. Their group met for 1½ hours weekly for 7 weeks and included reading materials, exercises, and homework to maintain improvement following termination. Clients were also required to keep a binge-purge diary in which they recorded what they ate and related thoughts, feelings, and alternative coping skills. Of the five clients involved, four improved and one became worse. Overall, there was a two-thirds decrease in the group's binge-

purge frequencies and improvement in body image, self-esteem, and level of depression. These changes were maintained 10 weeks after treatment ended.

Stevens and Salisbury (1984) reported similar results when using a group program that combined behavioral and psychodynamic principles to treat eight female, bulimic clients. Their group met for 1½ hours weekly, with the exception of one extended session that lasted for 5 hours. During the initial 4 to 6 weeks, clients were asked to keep food journals and were given specific behavioral prescriptions to decrease binge-purge episodes. During the second phase of treatment, clients focused on discovering, labeling, and managing their feelings. The researchers found that clients typically used denial to deal with anger, resentment, and frustration. After treatment, five of the eight clients reduced binge-purge episodes and were free of symptoms at a 10-month follow-up.

Connors et al. (1984) reported comparable results when offering a multidimensional group program to 26 female, bulimic clients. Treatment consisted of 2-hour sessions twice a week for 3 weeks, followed by weekly 2-hour sessions for an additional 6 weeks. This program was also divided into three phases. Phase 1 consisted of education and self-monitoring. Phase 2 involved clients setting short-term goals and expressing their feelings. Phase 3 was spent teaching clients such alternative coping strategies as relaxation training and cognitive restructuring. Of the 20 clients who completed treatment in the two groups offered, there was an overall reduction of 70% in binge-purge episodes at a 10-week follow-up.

Unlike the investigators discussed so far, Kirkley, Schneider, Agras, and Bachman (1985) compared a prescriptive cognitive-behavioral treatment to a more nondirective cognitive-behavioral treatment. Two groups of 7 clients each were assigned to two treatment conditions ($N = 28$). The two groups met for 1½ hours weekly for 16 weeks. Both included group interaction and self-monitoring. Results suggested, however, that the group that provided specific behavioral prescriptions had fewer dropouts and that group's members had fewer binge-purge episodes following treatment. At a 3-month follow-up, 38% of the cognitive-behavioral group and only 11% of the nondirective group had abstained from bingeing and purging. Additionally, 23% of the cognitive-behavioral group and 11% of the nondirective group had relapsed to its pretreatment binge-purge frequencies.

Kirkley et al. (1985) compared the effectiveness of two forms of cognitive-behavioral group treatment, whereas researchers at the University of Denver assessed the effectiveness of a traditional interpersonal approach (Kelly & Liter, 1984), a feminist approach (Lindsey, Gauchat, & Ricker, 1984), and a cognitive-behavioral group approach (Mines,

1984a) when treating the behavior of bulimic women. All three groups met weekly for 1½ hours. The traditional interpersonal group was an unstructured group that focused on relationships, whereas the feminist support group used Orbach's (1982) structured exercises. In this group, attention was placed on cultural pressure for women to be thin, the meaning of thinness and of food, and the manner in which participants received emotional nurturance. The cognitive-behavioral group, in contrast, taught clients delayed bingeing, identification and refutation of irrational thoughts, mental rehearsal, relaxation techniques, and behavioral techniques to manage eating. Although binge-purge behavior was reduced or eliminated for individuals in all three groups, it seemed that the participants in the cognitive behavioral group were better able to stop their purging. This finding was upheld at 4- and 12-month follow-ups as well.

Based on these results, two additional cognitive-behavioral group programs were implemented. In the first (Caruthers, 1986), two groups of five clients met for 1½ hours weekly for 23 weeks. These groups used 3 weeks of self-monitoring and group building, 18 weeks of exposure with response prevention, and 2 weeks for consolidation of improvement and termination. Clients were asked to eat during the first 30 minutes of their group in the exposure and response prevention period. Clients also made a verbal contract not to purge and to engage in identification and refutation of irrational beliefs during the last hour of group treatment. During the 18 weeks of exposure with response prevention, roast beef dinners were served for 6 weeks, pizza for 6 weeks, and sugar cookies for 6 weeks.

Results indicated that eight clients had decreased their binge-purge behavior by the end of the 23 weeks of treatment. At the 3-month follow-up, seven of the eight clients maintained improvement and four of the total number of clients who completed the program reported no binge-purge episodes.

In the second cognitive-behavioral group program (Merrill, 1986), one group of five clients and one group of six clients met for 1½ hours weekly for 23 weeks. These groups used 3 weeks of self-monitoring and group building, 9 weeks of identifying and disputing irrational beliefs, 9 weeks of developing problem-solving skills, and 2 weeks for consolidation of improvement and termination (Merrill, 1984, 1986).

Results of this program suggested that of the eight clients who completed the treatment, bingeing behavior decreased moderately for two (50% to 74% reduction), markedly for three (more than 75% reduction), and completely for three (100% reduction). Purging behavior also changed, with one client demonstrating slight improvement; one, moderate improvement; three, marked improvement; and three, total improvement. In general, follow-up at 3 months supported these changes in behavior.

CONCLUSION

At this time the application of group approaches to the treatment of bulimia warrants cautious optimism. The length and intensity of treatment seems to be associated with positive change. Groups that are longer, more intense, and structured seem related to positive outcomes.

Despite the various group treatment techniques used, it seems that most include self-monitoring and behavioral techniques to manage eating behavior, identifying and refuting dysfunctional thoughts, and the development of better coping and problem-solving skills. Additionally, most provided members with support, trust, social learning, universality, cohesiveness, and, probably, catharsis.

Although it seems that the group programs described were effective when treating bulimia, there are several limitations in the research presented. First, few studies used adequate control groups. Second, none of the studies (with two exceptions: Merrill, 1986, and Caruthers, 1986) demonstrated a replication of the procedure across therapists and clients. Third, none of the studies was designed to adequately address individual differences in potential success rates at pretesting. Fourth, in some of the studies, individual therapy and group therapy were confounded. And fifth, the results of many of these studies may have been biased by the fact that short-term, time-limited groups may be inadequate to treat bulimic clients who need a longer, intensive, and more comprehensive form of treatment.

RECOMMENDATIONS

Given these limitations, we now present some guidelines for conducting group treatment with bulimic clients, particularly cognitive-behavioral treatment. First, it seems that not all bulimic clients benefit from group treatment, and some do, in fact, become worse. For this reason, a comprehensive approach to assessment and treatment is indicated. In screening clients for group membership, it is important that counselors are aware of any differences among the clients being considered. Clients who are currently dependent on drugs or alcohol or who have severe character disorders are typically not appropriate for time-limited group treatment (Merrill, 1986; Mines, 1984). In addition to needing more intensive individual treatment, such clients are frequently disruptive to the group and tend to drop out of treatment prematurely (Merrill, Mines, & Starkey, in press).

Next, there are numerous interventions that can have an impact on the behavioral or cognitive components maintaining the bulimic cycle. Self-monitoring seems to help clients become more aware of their in-

dividual binge-purge patterns, as well as their cognitive and emotional cues for bingeing and purging. Food logs should include the date and time of bingeing; foods eaten; where they were eaten; how subjectively anxious the client became after eating; on a scale of 1 to 10, how full the client felt after eating; and the clients' thoughts, physical sensations, and emotions. Sharing food logs in the group provides a sense of universality as well as a way for clients to identify dysfunctional patterns that maintain their binge-purge behaviors.

Exposure with response prevention as a group intervention also seems important and requires that clients engage in in vivo eating experiences in the group. There are several possible approaches to implementing this technique. Food may be provided by the group leaders, clients, or by eating at a restaurant. Clients should be asked to eat until they approach a desire to purge, but this urge should not be carried out. Over time, the clients' anxiety about what they have eaten should decrease.

Although the initial goal for each group member may be to obtain control of binge-purge behaviors, behavioral change alone seems insufficient. To prevent relapse, cognitive and affective change seem necessary (Marlatt & Gordon, 1985; Winstead, 1984). Bulimic clients typically share a set of irrational beliefs related to perfectionism, self-deprecation, and the importance of approval (Butterfield, 1982; Merrill, 1984), as well as irrational beliefs about food and eating, the effectiveness of vomiting, and susceptibility to weight gain (Rosen & Leitenberg, 1984). Given these difficulties, it seems helpful to target these specific beliefs and to refute them in the group setting.

In considering our data and observations, we find that it is easier for clients to identify other group members' irrational beliefs and negative self-talk than their own. This is in opposition to Fairburn's (1985) position that cognitive restructuring and refuting beliefs should not be done in a group format. Gentle humor along with psychoeducational interventions can be useful when beginning to identify and refute these beliefs. For example, giving clients basic information regarding physiology, water retention, menstrual cycles, and nutrition can be effective in helping them refute irrational beliefs about weight gain and the effectiveness of purging.

After the identification and refutation of irrational beliefs, it seems that clients could profit from problem-solving training that focuses on the development of new coping skills to combat negative affect. It seems that bulimic clients have excellent skills for generating alternatives to solve problems, but this process may break down when they are dealing with their own negative affect (Merrill, 1986). The group format may be helpful because members who are not emotionally involved with a problem may help generate alternatives to that problem. During the

problem-solving component of treatment it may also be helpful to teach alternative activities to compulsive eating and to purging as a weight-control technique. Assertiveness, communication, social skills, and stress-management training may be relevant. During the final phase of group treatment, the termination phase, it seems important to help group members consolidate improvement, plan for the future, and learn ways to terminate from the group.

A cognitive-behavioral approach to treating bulimia seems viable and efficacious. Additional research is needed, however, to ascertain which techniques are most efficient and effective for the various subtypes of bulimic clients seen.

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