1995

The efficacy of group treatment for bulimia

Jeanne R. Weakland
University of Northern Iowa

The efficacy of group treatment for bulimia

Abstract

Bulimia is ultimately a life threatening behavior which involves eliminating food or calories through self-induced vomiting, enamas, laxatives, diuretics, diet pills, and/or compulsive exercise (Beasley & Knightly, 1994). These methods can result in serious or fatal health risks such as dental problems, tearing and bleeding of the throat, kidney damage, muscle weakness, and cardiac malfunction (Tannenhaus, 1992).

THE EFFICACY OF GROUP TREATMENT FOR BULIMIA

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

---

by

Jeanne R. Weakland

May 1995

This Research Paper by: Jeanne R. Weakland

Entitled: THE EFFICACY OF GROUP TREATMENT FOR BULIMIA

has been approved as meeting the research paper requirements for the Degree of Master of Arts.

Jeffrey S. Ashby

3/30/95
Date Approved

Advisor/Director of Research Paper

Terry T. Kottman

3-30-95
Date Approved

Second Reader of Research Paper

Michael D. Waggoner

3.30.95
Date Received

Head, Department of Educational Administration and Counseling

The Efficacy of Group Treatment Methods for Bulimia

Rationale

Bulimia is ultimately a life threatening behavior which involves eliminating food or calories through self-induced vomiting, enamas, laxatives, diuretics, diet pills, and/or compulsive exercise (Beasley & Knightly, 1994). These methods can result in serious or fatal health risks such as dental problems, tearing and bleeding of the throat, kidney damage, muscle weakness, and cardiac malfunction (Tannenhaus, 1992).

There are a variety of mental and emotional problems which are closely associated with the pattern of bulimia. Some of these include depression, alcohol and drug abuse, personality disorders, family issues, low self-esteem, and a general loss of control over behaviors. Research also supports a significant association between a history of sexual abuse and the onset of bulimia (Mitchell, 1990). It is difficult to determine the prevalence of bulimia among the general population, as most studies have been targeted toward specific populations. Estimates vary from study to study depending on the population and the criteria utilized to measure bulimic behaviors. The majority of studies have focused on college-aged students, as this population is highly accessible to research studies. The average age of onset for bulimic behaviors is 18. This age is frequently a

time of upheaval and change, which is believed to precipitate the onset of bulimia. In some studies, 20% of college-aged females meet DSM-III-R criteria for bulimia (Mitchell, 1990).

A definite need exists for the effective treatment for bulimia. Numerous treatment approaches have been implemented and researched in the past two decades. Group treatment is the focus of many of these studies.

Group treatment has many advantages. It can be utilized instead of, or as an adjunct to, individual therapy. Thus, a major benefit is the cost effectiveness of group treatment. The structure of a group offers a safe atmosphere in which bulimics can share feelings such as guilt, shame, and fear (Capuzzi & Gross, 1989). Group approaches are also helpful in assisting bulimics with the isolation and emptiness often experienced in interpersonal relationships. The group becomes a safe place to test and model new behaviors before making changes in the "real" world. Group work is also helpful in terms of assisting with body image distortion. Members are able to observe distorted thinking in others. As a result, they are more likely to internalize an awareness of their own distorted body images. The positive feedback, encouragement, and confrontation offered through groups can pave the road for recovery from bulimia (Capuzzi & Gross, 1989).

The purpose of this paper is to examine the efficacy of various group treatment methods. Group methods can often offer superior advantages to other types of treatment. However, there are cases which may benefit from a more individualized method of treatment.

Group Characteristics

Several group characteristics play a role in the efficacy of group treatment. A study by Hendren, Atkins, Sumner, and Barber (1987) explored several group treatment characteristics such as duration, composition, and leadership styles. Interestingly, this exploration supported the idea that groups have fewer limitations in the treatment of bulimia than previously believed. In this study, Hendren et al. (1987) thoroughly examined the experiences of 121 patients in 5 ongoing, open groups for a period of 4 years in an eating disorder program at two hospitals. One conclusion of the researchers (Hendren et al., 1987) was that anorexic and bulimic patients can benefit from the same group. Although distinct differences between these two disorders do exist, cohesiveness does not appear to be sabotaged by combining treatment applications and group composition.

Hendren et al. (1987) also found that age and development of group members had more of an impact than the severity of symptomatic behaviors in terms

of group placement. In this study, groups were divided into the categories of girls in middle school, girls in high school, women of college-age, and women older than college-age. These categories appeared to facilitate more age appropriate discussions of issues and provide peer support. Those patients who were further along in their treatment served as role models by providing encouragement and hope.

Another conclusion from this study was that the longer the duration of group participation, the better the treatment outcome of the patient. The researchers observed that the majority of patients who displayed no change in their behaviors attended less than 10 sessions of a group. Those who reached recovery and resumed social relations attended over 25 sessions (Hendren et al., 1987).

A final finding of this study (Hendren et al., 1987) was the importance of a directive therapist or team of co-therapists. Due to the fact that eating disorder patients can be a difficult population to treat, it is important for the therapists to take an active role. Tasks such as asking questions, encouraging feedback, and gentle confrontation appeared to facilitate the group process in a more effective manner than a more client-centered, passive approach.

To summarize this extensive study, the results appear to give credence to the idea that groups do

not have to be limited. Despite the cost effectiveness of brief group treatment, the results of this study suggests that long term treatment may be significantly more effective and hence, worth the cost. This study did not offer any data in terms of long-term efficacy. It is clear that follow-up is an essential need in order to establish the effects of long-term groups. It is also clear that important questions still exist in terms of a variety of other treatment variables.

Treatment Response and Patient Variables

There are many factors which lead to bulimic behaviors. There are also a wide variety of factors which contribute to the efficacy of treatment. Although this may seem evident, there is a surprising lack of research on the relationship between treatment response and patient variables.

As a direct result of this lack of research, Maddocks and Kaplan (1991) conducted a study and examined a wide range of treatment variables. The population of this study consisted of 86 female clients admitted to a day-hospital eating disorder program at Toronto General Hospital. Those who met the criteria for bulimia according to the Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (DSM-III-R, American Psychiatric Association, 1987) were the focus of this multi-modal, intensive group therapy program of approximately six

weeks.

The researchers (Maddocks & Kaplan, 1991) divided patients and the response to treatment into three separate categories. That is, a "good" response equaled abstinence from bulimic behaviors during the final four weeks of the program, a "moderate" response indicated one episode or less during the final four weeks of the program, and a "poor" response meant that a patient experienced more than one bulimic episode in the final four weeks of the program.

Initially, ten variables were established to discriminate between the three previously mentioned categories. However, researchers used only five variables in the final analysis which provided the most information and accounted for 44% of the variance between groups. These variables included the Beck Depression Inventory, a history of anorexia prior to bulimia, the dieting and bulimia scales of the Eating Attitudes Test-26, and the body dissatisfaction scale of the Eating Disorder Inventory.

It is interesting to note that the BDI score independently accounted for 26% of the 44% variance between groups. In fact, patients who were found to be in the "poor" category reported greater levels of depression than the other two groups at admission.

It is significant to note that in this study, a history of anorexia did not appear to have a negative

effect in terms of treatment efficacy. In fact, patients in the "poor" category were actually more likely to have been heavier in the past. One possible explanation is that a history of a higher weight encouraged this category of patients to stay invested in bulimic behaviors in order to maintain a lower weight (Maddocks & Kaplan, 1991).

A finding in this study was that the frequency of bulimic behavior prior to treatment was not a factor in the efficacy of treatment. That is, patients' treatment outcome was not related to the severity of their behaviors (Maddocks & Kaplan, 1991).

Abstinence as a Criterion Outcome

Within the existing research on bulimia, there are inconsistent and unclear criteria for treatment outcomes. The most commonly used criterion has been the percentage reduction of bulimic behaviors rather than abstinent behaviors. This can be problematic, as several studies suggested that bulimia is often an ongoing battle which often results in high relapse rates. A trend appears to exist in which short-term abstinence appears common, but relapse often occurs within two to three years (Keller, Herzog, Lavori, Ott, Bradburn, & Mahoney, 1989).

Maddocks, Kaplan, Woodside, Langdon, and Piran (1992) have found percentage reduction as a criterion for treatment outcome problematic. As a result, they

conducted a two year follow up of the previously discussed day hospital program (Maddocks & Kaplan, 1991). The purpose of this follow-up study was to examine abstinence rather than percent reduction as a criterion outcome for the treatment of bulimia. While 86 female patients initially entered the program, 43 were available for a 2 year follow-up study.

Following a thorough investigation, Maddocks et al. (1992) determined that 46% of the follow-up patients were abstinent from bulimic behaviors. Additionally, 26% were classified as having a moderate response, while 28% were classified as having a poor response. Overall, these researchers (Maddocks & Kaplan, 1991) found that abstinent responders reported a decreased concentration on weight and body shape, fewer difficulties with relationships, and lower scores on the tests described in the previous study by Maddocks and Kaplan (1991). Additionally, they also reported fewer feelings of depression and greater feelings of self-esteem (Maddocks et al., 1992).

These findings suggest that percentage reduction was not accurate in terms of measuring actual progress. This seems to indicate that the criterion outcome in studies needs to be stricter. This is essential, as patients with quite mild symptoms of bulimia appear to be equivalent to "poor" responders in this study in terms of overall mental health. This suggests

that only abstinence can be considered in terms of recovery from bulimia, which poses important implications for future studies. This factor needs to be considered in terms of evaluating the efficacy of group treatment.

Dropout Relationship to Treatment Efficacy

Another important aspect to focus on in terms of groups is the effect of dropouts on the group. As with any group, members who leave the group prior to termination, also referred to as dropouts, have an effect on the dynamics of the group. This is particularly evident in treatment groups for bulimia due to the unique issues which may be present. The tendency to isolate and mistrust others can lead to a negative outcome when a trusted member breaks group cohesion by leaving the group. Additionally, dropouts can instigate the "wave-phenomenon" in which a chain reaction of dropouts occur due to the low group morale and lack of trust (Stone, Blaze, & Bozzuto, 1980).

Merrill, Mines, and Starkey (1987) conducted a study of six groups in which dropout variables were examined. The procedure included 53 women who were divided into various types of groups which ran from 30 to 40 weeks. The researchers used the 20th week to distinguish dropouts from persisters. Within the six groups, 33 members persisted, while 20 dropped out.

At the conclusion of the groups, some patterns became evident. One pattern was that groups who had relatively inexperienced leaders had 50% dropout rates, whereas groups who had relatively experienced leaders had 16% dropout rates (Merrill et al., 1987).

Another pattern was that several demographic factors appeared to separate dropouts from persisters. Dropouts were less likely to be employed, less likely to be sexually active or married, and more likely to be younger than persisters. Some other variables which emerged as a pattern were that dropouts were less likely to have trouble falling asleep at night and less likely to have cardiovascular and gastrointestinal tension. One final pattern noted in this study was that dropouts were less likely to engage in negative thinking (Merrill et al., 1987).

The researchers (Merrill et al., 1987) hypothesized several conclusions from these observations. One hypothesis is that drop-outs tend to be less mature and more socially isolated than persisters. This may contribute to the tendency not to commit to the group's duration. The observation that dropouts appear to have fewer physical complications from stress lead these researchers to hypothesize that dropouts may be less motivated to invest their time and energy in group treatment. In line with this perspective, it follows that

persisters may be in more turmoil as a result of their bulimic behaviors and are therefore more willing to invest in the group process. In short, members need to have a motivation for committing to the group (Grotjahn, 1982).

These researchers (Merrill et al., 1987) followed up on the dropouts with a questionnaire. Although the feedback received through these questionnaires was varied, two of the most frequent rationales for termination were feeling as though the group could not assist them and feeling a lack of belonging to the group. These researchers concluded that it is essential to offer hope and cohesiveness within the group process (Merrill et al., 1987).

It is important to reflect on the effects which dropouts may have on group treatment with bulimics in order to gain some insight into the dynamics at work in a group. It is also essential to explore types of populations which would benefit most from the group process.

Suburban Adolescent Females At Risk

Suburban adolescent females are an example a population at risk. Faust (1983) found adolescent females from middle to upper class families are more likely to develop eating disorders than adolescent females from lower class families. Additionally, suburban adolescent females are more often raised

in a double bind environment of achievement versus compliance than are urban adolescent females. Often girls in suburban environments receive the message that they should achieve specific high standards while simultaneously remaining compliant and passive. Harper and Shillito (1991) suggested that such a contradiction in expectations may be derived from an enmeshed upbringing in which the child is subject to the control needs of the parent figures. In short, suburban families tend to be achievement-focused, status-sensitive, and appearance-conscious. Females in this type of environment are more likely to internalize these characteristics, thus becoming overly sensitive to external approval. It becomes clear how this process can provide the foundation for perfectionism, control needs, and ultimately bulimic behaviors (Harper & Shillito, 1991).

Out of an awareness of suburban adolescent females' susceptibility to bulimia, Harper and Shillito (1991) designed a support group model of treatment. This group was implemented from the perspective of bulimia as a cognitive-behavioral disorder rather than a personality disorder. As a result, this eight week, semi-closed group focused on education, cognitive restructuring, and providing support for suburban girls in one of Ohio's major metropolitan areas. The focus of the group included activities such as

drawing a self-portrait, maintaining a daily food diary, educating members on the set-point theory which suggests that the body will maintain a biologically determined weight, and assisting members in becoming aware of the dangers associated with bulimic behaviors. Additionally, it was continually stressed that caloric deprivation naturally leads the body into a binge response, as well as a lowered metabolism. Therefore, it was emphasized that once normal eating is resumed, binge urges and episodes will naturally decrease (Harper & Shillito, 1991).

Although no empirical results were offered by Harper and Shillito (1991), a specific purpose for such a group was given. The authors held that enmeshed environments facilitate an isolation which makes it very difficult for bulimics to seek assistance outside of the family boundaries. In an attempt to break this barrier, Harper and Shillito (1991) targeted suburban adolescents through schools with widely distributed educational literature.

According to Harper and Shillito (1991), the group provides a positive trusting atmosphere in which members can identify and disclose bulimic behaviors perhaps for the first time. The group can also prevent escalation of bulimic behaviors, while simultaneously providing the education and support necessary to eventually cease the behaviors completely. A final

reason for the group is to help members to begin the process of healing by overcoming their own issues in order to eventually reach out and provide assistance for others (Harper & Shillito, 1991).

Group Psychotherapy

It is also important to focus on specific types of groups in terms of their efficacy. Oesterheld, McKenna, and Gould (1987) conducted a critical review of the literature on group psychotherapy in the treatment of bulimia. In this comprehensive review Oesterheld et al. (1987), examined 18 groups in which a wide variety of treatment methods were implemented. In several different models the percent reduction in the binging and purging cycle fell between 52% to 97% following a treatment method (Oesterheld et al., 1987). It is important to note that these positive results refer only to short-term evaluations.

Due to the lack of follow up in these studies, possible long-term benefits of the groups are unknown. Five groups reported good results in the follow-up (Oesterheld et al., 1987). This difficulty is a representation of the various problems the researchers identified in the studies they reviewed. Other difficulties included trusting the reliability of patients in terms of self-report responses, establishing a baseline from which to measure progress, eliminating dropout statistics in the final results,

and lacking clearly defined treatments.

One conclusion from this examination was that active behavioral and affect-focused groups seem to be most effective in treating bulimia (Oesterheld et al., 1987). Treatment is most beneficial when it includes techniques such as journal writing, cognitive restructuring, and emotional support. Additionally, groups which are established for a minimum of three to four months appear to be highly beneficial (Oesterheld et al., 1987).

The researchers (Oesterheld et al., 1987) also concluded that the advantages of group treatment are rooted in beliefs rather than actual facts. The goals of decreasing isolation, implementing reality testing with peers, and developing strong relationships are not specifically found to be efficacious reasons for implementing group treatment in any of the 18 studies which they examined. As a result, this examination appeared to emphasize the need for a closer examination of the dynamics which are at work in group treatment for bulimia (Oesterheld et al., 1987).

Recent literature suggests there is an underlying idea that the treatment of bulimia needs to be multi-modal in nature (Oesterheld et al., 1991). However, this assumption has not been thoroughly tested. Although treatment outcomes for bulimia appear favorable in the literature, the specific treatment

techniques are not identified.

Cognitive-Behavioral Versus Psychoeducational Groups

It is important to explore the characteristics of a variety of group interventions. Psychoeducational interventions are often the initial techniques which are integrated into cognitive-behavioral approaches. Education appears to set the stage for rational thought processes. Some specific cognitive-behavioral strategies include self-monitoring, cognitive restructuring, learning coping skills, and problem solving strategies (Garner, Fairburn, & Davis, 1987).

In one study (Olmstead, Davis, Rockert, Irvine, Eagle, & Garner, 1991), the efficacy of a brief, 5 session, psychoeducational group was compared to that of a 19 session, individual, cognitive-behavioral and educational intervention. The cognitive-behavioral treatment had greater efficacy than the short-term educational intervention only for those who were assessed as pathological in various areas. That is, for patients who were vomiting more than 42 times per month, cognitive-behavioral treatment combined with educational elements appeared more efficacious. For patients who were vomiting less frequently, the treatment methods appeared to make no difference in terms of efficacy. This finding is important because of the implication that educational interventions can be used with the majority of bulimic patients,

offering a more cost-effective and time efficient approach. This study found that psychoeducational techniques are more practical than cognitive-behavioral techniques, with the exception of more severe cases of bulimia.

An Educational Group

Another educational group treatment program for bulimia was implemented at Clemson University (Connor-Greene, 1987). This six week program educated a small population of six bulimic students on various aspects of bulimia, as well as normal eating patterns. Some of these areas included effects of bulimic behaviors, binge eating as the body's natural response to starvation, and alternative coping strategies. This type of information was included in the group with the purpose of motivating subjects to change. It is also important to note that this group was designed to supplement the individual treatment the students received (Connor-Greene, 1987).

The results of this study (Connor-Greene, 1987) are encouraging in terms of an overall reduction in bulimic behaviors. With the exception of one drop-out, four out of the five subjects reported a normalization in their eating habits. These subjects reported a greater consistency with eating three meals a day, a decrease in binge episodes, as well as a decrease in self-induced vomiting after completing this six

week educational program. All members reported feeling in greater control of their eating at the conclusion of the group with a decreased emphasis on utilizing the scale (Connor-Greene, 1987).

It is clear that further research needs to be done to determine the efficacy of this approach. However, this limited data does suggest that a brief educational group may be an effective supplement in the normalization and re-education of bulimic individuals.

A Cognitive Behavioral Group

In another study (Kettlewell, Mizes, & Wasylyshyn, 1992) on the cognitive behavioral group treatment of bulimia, three baseline periods of two, six, and ten weeks were established. This provided a broader base from which to draw conclusions regarding the efficacy of cognitive-behavioral treatment. There was a small sample of 13 female participants in this study who were assigned to one of the previously mentioned baselines. The techniques of treatment utilized in this study included focusing on the consequences of bulimic behaviors, exploring realistic goal setting, recognizing faulty cognitions, reviewing the set point theory, and learning new coping strategies.

The results of this study (Kettlewell et al., 1992) indicated that 69% of the 13 subjects were free

from binging, hence these subjects experienced 100% reduction rate. Although initially this may appear to be a very significant outcome, the three month follow-up found that only 15% of the 13 subjects remained abstinent from bulimic behaviors. However, 62% reported having two or fewer binges per week. This is a significant improvement when compared to the pre-treatment mean of 9.9 binge episodes per week. These results support the value of a cognitive-behavioral approach in terms of reducing bulimic behaviors.

Systems-Centered Group Psychotherapy

Another group treatment which appears to be beneficial is systems-centered group psychotherapy. According to Post (1992), systems-centered groups offer many advantages which may not exist in other treatment approaches. Post (1992) believed that groups address the unique needs of bulimics. Some of these needs include dealing with low self-esteem and a lack of a clear identity, coping with feelings of shame, examining the tendency to isolate, exploring fears of abandonment, and dealing with perfectionistic tendencies (Post, 1992). Post suggested that systems-centered groups provide bulimics with the possibility of forming meaningful interpersonal relationships and therefore, gaining much needed support.

Post (1992) has been involved with various other forms of treatment such as cognitive-behavioral, self-help, and artistic-focused groups. This exposure has supported her belief in the efficacy of systems-centered groups, also referred to as interpersonal groups. Systems-centered groups appear to offer the opportunity for members to focus on developing here-and-now relationships. Additionally, systems-centered groups provide the opportunity for growth and awareness. Members may be more likely to generalize this growth to everyday living.

Several components are potentially important in systems-centered groups. These elements include, but are not limited to, the need for clear boundary setting among group members, the essential ability of the therapist to develop a balance in his or her therapeutic style which will help met the variety of needs in the group, and the ability to continually place the responsibility for change on the group members (Post, 1992).

Spiritual Groups

Spiritual groups may also offer important treatment benefits. Although no research was found to support the efficacy of spiritual groups, Phillips and Levine (1993) suggested that spiritual groups offer components which may not be included in basic psychotherapuetic groups. Phillips and Levine (1993)

have explored the importance of assisting bulimics in examining their spiritual lives through a supportive group environment. One spiritual group, which is part of an overall treatment program at the Renfrew Center in Philadelphia, provides bulimic patients with the opportunity to explore their spiritual selves. The authors believe that spirituality is often a hunger which can be satisfied most successfully through the group experience. Additionally, the group can serve as a chance to unload emotional baggage which often underlies bulimic behaviors. On a final note, it is essential that these types of groups are conducted in a way which fosters a very non-judgmental atmosphere for the members. As a result, open exploration can be safe and beneficial (Phillips & Levine, 1993).

Conclusion

Although over 40 studies investigating the efficacy of group treatment for bulimia have been conducted, Fettes and Peters (1992) suggested that, "The overall magnitude of group treatment efficacy, and the influence of various treatment characteristics on outcome, have not been adequately examined" (p.62). These authors believe that important questions regarding group treatment and bulimia are currently unanswered and in need of further, more precise research. Fettes and Peters (1992) conducted a meta-analysis of the current literature. This analysis

of 40 studies concluded several results, while also raising a variety of questions. One finding was that group therapy in the treatment of bulimia is moderately efficacious at post-treatment and in the year following treatment. That is, short-term results appear more positive than long-term results (Fettes & Peters, 1992).

Another finding was that treatments which included a greater number of hours were more effective than those with fewer hours. Specifically, more intense groups appear more efficacious than brief groups (Fettes & Peters, 1992).

Also, group treatment which included additional interventions such as individual therapy, evidenced better than group treatment alone. A possible implication of this could be that providing more hours of group counseling could improve treatment results. However, while group treatment has proven effective for a moderate amount of bulimics, there are some individuals with who group treatment or group treatment as an adjunct is not helpful. Therefore, two essential factors are that multiple treatments are costly and may also have negative effects on individuals who may not need treatment beyond the scope of a group intervention (Fettes & Peters, 1992).

Fettes and Peters (1992) suggested that research needs to be directed towards determining a single

criterion which characterizes group treatment responders from non-responders. Within this classification, it could be assessed whether the addition, substitution, or elimination of group treatment would be most valuable.

There is a lack of extensive research on treatment types and treatment outcomes for bulimia. Although some information is available, it is very limited in the sense that research on types of group treatment is either behavioral or cognitive behavioral with some insight-oriented or educational components (Fettes & Peters, 1992). Additionally, abstinence as a criterion outcome is utilized less frequently than percentage reductions of behavior.

There is a lack of research on the number and gender of therapists and treatment outcomes. While it is obvious that group treatment is cost effective, Fettes and Peters (1992) are interested in determining any negative effects of group leaders in terms of "burn-out." After all, such an effect would eventually decrease the efficacy of group treatment. The other suggestions for further treatment include utilizing a broader range of dependent measures in the treatment studies, incorporating methods which better predict reliability and validity of self-report measures, conducting more extensive research, and researching larger population samples (Fettes & Peters, 1992).

Research on the efficacy of group treatment for bulimia has only been in the forefront for the last two decades. The need for extensive and specific research is clearly evident. Several essential questions regarding group treatment remain unanswered. Future research will need to address questions and issues such as which types of group treatment are most efficacious with which types of clients, which criterion needs to be used to determine efficacy of group treatment, and which type of client benefits from group treatment, individual treatment, or a combination of these.

These questions are difficult to answer because there are a variety of variables and factors present. For example, recovery or the efficacy of group treatment may have many differing definitions. In some studies, a group may be considered efficacious if the majority of members experienced a percentage reduction in behavior. However, this indicates that the group was not efficacious for some members and that reducing bulimic behaviors is equivalent to a cessation of these behaviors. It is clear that this is not an accurate indication. In other studies, abstinence may be used to determine the success of group treatment. Bulimics tend to have a relatively high relapse rate which suggests that abstinence as

a criterion outcome may not be realistic. It appears that future research will need to be tailored to address the specific concerns and questions related to the efficacy of group treatment for bulimia.

References

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed, revised) (DSM-III-R). Washington, DC: American Psychiatric Association.

Beasley, J. D., & Knightly, S. (1994). Food for recovery. New York, NY: Dell Publishing.

Beck, A. T. (1978). Depression inventory. Philadelphia: Center for Cognitive Therapy.

Capuzzi, D., & Gross, D. R. (1989). Youth at risk: A resource for counselors, teachers, and parents. Alexandria, VA: American Association for Counseling and Development.

Connor-Greene, P. A. (1987). An educational group treatment program for bulimia. College Health, 35, 229-231.

Faust, J. (1987). Correlates of the drive for thinness in young female adolescents. Journal of Clinical Child Psychology, 16, 313-319.

Fettes, P. A., & Peters, J. M. (1992). A meta-analysis of group treatments for bulimia nervosa. International Journal of Eating Disorders, 11, 97-110.

Garner, D. M. (1987). Psychotherapy outcome research with bulimia nervosa. Psychotherapy and Psychosomatics, 48, 129-140.

Garner, D. M., Fairburn, C. G., & Davis, R. (1987). Cognitive-behavioral treatment of bulimia nervosa: A critical appraisal. Behavior Modification, 11, 398-431.

Grotjahn, M. (1982). Learning from dropout patients: A clinical review of patients who discontinue group psychotherapy. International Journal of Group Psychotherapy, 22, 306-319.

Harper, K. V., & Shillito, L. S. (1991). Group work with suburbia. Columbus, OH: The Hayworth Press.

Hendren, R. L., Atkins, D. M., Sumner, C. R., & Barber, J. K. (1987). Model for the group treatment of eating disorders. International Journal of Group Psychotherapy, 37, 589-602.

Keller, M. B., Herzog, D. B., Lavori, P. W., Ott, I. L., Bradburn, I. S., & Mahoney, E. M. (1989). High rates of chronicity and rapidity of relapse in patients with bulimia nervosa and depression. Archives of General Psychiatry, 46, 480-481.

Kettlewell, P. W., Mizes, J. S., & Wasylyshyn, N. A. (1992). A cognitive-behavioral group treatment of bulimia. Behavior Therapy, 23, 657-67.

Maddocks, S. E., & Kaplan, A. S. (1991). The prediction of treatment response in bulimia nervosa: A study of patient variables. British Journal of Psychiatry, 159, 846-849.

Maddocks, S. E., Kaplan, A. S., Woodside, D. B., Langdon, L., & Piran, N. (1992). Two year follow-up of bulimia nervosa: The importance of abstinence as the criterion outcome. International Journal of Eating Disorders, 12, 133-141.

Merrill, C. A., Mines, R. A., & Starkey, M. A. (1987). The premature dropout in the group treatment of bulimia. International Journal of Eating Disorders, 6, 293-300.

Mitchell, J. E. (1990). Bulimia nervosa. Minneapolis, MN: University of Minnesota Press.

Oesterheld, J. R., McKenna, M. S., & Gould, N. B. (1987). Group psychotherapy of bulimia: A critical review. International Journal of Group Psychotherapy, 37, 163184.

Olmstead, M. P., Davis, R., Rockert, W., Irvine, M. J., Eagle, M., & Garner, D. M. (1991). Efficacy of a brief group psychoeducational intervention for bulimia nervosa. Behavior Research Therapy, 29(1), 71-83.

Phillips, B. W., & Levine, P. (1993). Exploring our spirituality. The Renfrew Perspective, 2.

Post, G. (1992). Systems-centered group therapy. The Renfrew Perspective, 4.

Stone, W. M., Blaze, M., & Bozzuto, J. (1980). Late dropouts from group psychotherapy. American Journal of Psychotherapy, 34, 401-413.

Tannenhaus, N. (1992). What you can do about eating disorders. New York, NY: Dell Publishing.