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Paper

Good Outcome for Bulimic Patients in Long-term Group Analysis: a Single-group Study

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This study describes a modified long-term group analysis for bulimic women. In a naturalistic, prospective 'before-and-after' design the study evaluates the effects of the treatment by 'effect size' and clinical significant change. Nine out of ten bulimic patients who completed treatment obtained recovery, not only from bulimic behaviour, but also from several different areas of psychological dysfunctioning. Long-term psychoanalytic group treatment was found to be a valuable option for treatment of severely bulimic patients. The group concept holds many inherent advantages and can be combined with individual and antidepressant treatment. It is suggested that a wider range of measures is needed to evaluate treatment outcome. The Bulimics Maturation Scale constructed by the author is introduced as an outcome measure. Copyright © 2001 John Wiley & Sons, Ltd and Eating Disorders Association.

Keywords: bulimia nervosa; treatment of eating disorders; group treatment; group analysis; methods; evaluation of efficiency.

INTRODUCTION

Over the past two decades eating disorders have been a growing challenge to the health service system in most West European and North American countries. Recent studies have pointed out that bulimia nervosa is a frequent and serious disorder (Keel and Mitchell, 1997; Collings and King, 1994). Cognitive-behavioural therapy (CBT) and Interpersonal Psychotherapy (IP)

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group treatment have been extensively used and recommendations to method and format have been given for CBT (Walsh *et al*., 1997) as well as IP (Brotman *et al*., 1985). Fairburn's earlier studies suggest that bulimia nervosa patients in the long run respond well to psychological treatments that are not cognitive-behavioural in character (Fairburn *et al*., 1995). Dynamic group psychotherapy has been reported capable of symptom reduction, but drop-out from the treatment can be high (Oesterheld *et al*., 1987), and it is not clear what factors enhance or reduce effectiveness (McKisack and Waller, 1997). Although group treatment is widely recommended, few studies of long-term analytic treatments are available.

Many studies rely on measuring symptomatic change, i.e. reduction of binge eating and purging episodes, when effect is to be documented (Maddocks and Kaplan, 1991; Walsh *et al*., 1997; Huon and Brown, 1985; Herzog *et al*., 1991). It would be valuable to get beyond such a narrow range of measurement and include qualitative changes in psychological functioning.

The following study presents the results from a psychoanalytic long-term group treatment and suggests some suitable and elaborated measures for evaluation of treatment efficacy.

MATERIALS AND METHODS

Referral and assessment

The treatment took place at the Psychotherapeutic Department located at the Psychiatric Hospital in Aarhus, offering service to Aarhus County (600,000 inhabitants).

Patients were referred from general practitioners, practising psychiatrists or psychiatric hospitals in Aarhus when sufficient treatment could not be offered elsewhere. From June 1996, when a Centre for Treatment of Eating Disorders opened at the Child and Youth Psychiatric Hospital, especially difficult patients, who did not respond to a short-term (14 sessions) cognitive psycho-educational treatment, were referred from there.

The assessment began by asking the patients to write a letter about their actual problems, as they experienced them, their childhood and adolescence as they remembered it, social status, previous therapy if any and their expectations of a possible new psychotherapy.

After we received the letter, the patients were seen for one or two videotaped assessment interviews focusing on (1) the severity of the bulimia nervosa, (2) the organization of the personality according to Kernberg (1984), (3) the patient's ability to establish a therapeutic alliance (Rosenbaum *et al*., 1997), (4) finding dynamic focuses and (5) advice and information about the group therapy.

The group and the therapists

Consecutive patients were taken to start an analytic group with two therapists, a male psychiatrist (KV) and a female occupational therapist. Both were trained group analysts and had experience with individual psychotherapy as well. The group was slow open (took in new members when old members left the group), meeting $1\frac{1}{2}$ hours every week. The group had six or seven members.

Termination of therapy was a joint decision between the patient and the therapists. Patients should give notice of termination three months before.

The patients

After seven years 19 patients have been assessed. Seven patients are in treatment at the moment (all for more than one year). Two patients of the remaining 12 did not meet or maintain treatment for six months. One did not show up in the group after assessment: her mother phoned and explained that she had got a job in a shop. The other dropped out without warning in the group after 4 months during her first summer holiday.

The patients were all females. All except one met both the ICD-10 (F50.2) and the DSM-III-R criteria for bulimia nervosa, the exception met the ICD-10 (F50.3) criteria for bulimia nervosa atypica. She managed to stop binge-eating and vomiting, just before the group started, but she still needed treatment: her father had very recently and unexpectedly died.

The ten women, who maintained group attendance for more than 6 months, ranged from 20.5 to 27.3 (average 23.1) years old at the beginning of the treatment (1991-09-09). Symptom duration was on average 4.6 years (range 3.0-7.0 years).

Eight of the ten had a borderline personality organization according to Kernberg's classification and six met the criteria of a personality disorder. The personality disorder diagnoses were made after using a checklist derived from the SCID-II Questionnaire (Spitzer *et al*., 1990). Two had anorectic traits and four patients had a previous anorectic period. Three had a history of sexual abuse and five were involved in different kinds of self-destructive behaviour: drinking alcohol too often and too much (black-out), hurting oneself physically because of lack of self-care, sexual promiscuity with no contraception and involvement in masochistic relationships with men.

The treatment

The treatment was based on group analytic theory (Foulkes, 1986) modified especially in the beginning in that therapists' interventions were more

psychologically structuring, supporting and focused on interpersonal difficulties. Occasionally, 'rounds' were taken about eating management. In this way, the method was eclectic. However, the overall attitude and focus were dynamic, encouraging free, insight-oriented discussion and reflections about all that was felt to be relevant:

(1) the bulimic behaviour as a refuge and a defense;
(2) discovering and containment of feelings: sadness, grief and depression;
(3) boyfriends and other men–and trouble about them;
(4) mother and the experience of having to protect her and be responsible for her;
(5) the attempt to become independent of mother's feelings;
(6) shame, guilt and the handling of anger;
(7) jealousy and desire;
(8) loss and separation;
(9) obtaining greater self-consciousness and assertiveness;
(10) appearance, body and sexuality;
(11) making boundaries and
(12) self-care (negation of self-destructiveness)

Elements of cognitive therapy were used before and during the group treatment. Before the group the patients were sent to three counselling sessions with a dietician, concerning eating habits and meal planning. Two booklets about eating disorders (National Eating Disorder Information Centre, 1988a, 1988b) were handed out, and the group members were encouraged to read them carefully. Furthermore, another specialist gave three lectures about eating disorders within the first six months of the group.

A checklist counting weekly binge-eating episodes, purging episodes and life restrictions due to binge eating were handed out every session and collected the next, for several months in the beginning, later on special occasions (on request or before holidays and before a patient leaving the group). Besides providing the therapist with information about eating habits, it gave the patients good support in structuring outer and inner chaos.

If a patient could not reduce the number of eating episodes or vomiting episodes at all or very little within the first 6–9 months, or if the number of episodes was very high, the patient was offered an SSRI antidepressant in a high does for a period of 6(9) months (avoiding stopping the medication before a holiday break). The patients were advised that there could be a rebound effect after stopping medication.

One patient, who was referred more than a year before the group started, was in need of support before that time. She was seen for an individual session every fortnight for nine months. Another patient terminated the group after only nine months and her condition deteriorated. Five months later she continued for $3\frac{1}{2}$ years in individual supportive psychotherapy with the author. Patient G's eating pattern was almost unchanged despite several

individualized interventions in the group and a long attempt with an SSRI antidepressant. She had difficulties in getting help in the group, and the therapists found it unethical to keep her in the group and suggested she tried other treatment. She left after three years.

The duration of therapy ranged from 0.8 to 4.8 years (average 3.1 years). The average number of attended sessions was 100, ranging from 18 to 157. Although the therapists impression was that there was a good coherence in the group, the patients missed 25.3% of the sessions on average (ranging from 6 to 49%). Absence was usually announced and due to work or extension of holidays.

DESIGN AND MEASURES OF EFFECT/OUTCOME

The design was a prospective single-group study with outcome measures before and after treatment. There was no selection of patients after referral. All patients were offered the long-term group treatment.

Before and after therapy the patients were given a battery of self-rating scales. (1) *Global Life Quality (GLQ)* asked for the patient's present valuation of the quality of her life: on a ladder with seven steps (0–6) the patient should state, what kind of level was equivalent to her own life at the present time. (2) *The Registration Chart Questionnaire (RCQ)* includes the capacity to relate to family and friends, and the capacity to tolerate one's own and others' feelings. Answers to the nine questions were given on a Likert scale from 0 to 6. Average score was used. These first two scales were modifications of the outcome measures used by Husby *et al*. (1985), and further developed at the Department of Psychotherapy for the out-patient clinic. (3) *Clark's Personal and Social Adjustment Scale (CPSAS)* covers specific aspects of the patient's maladjustment: 'work', 'relations', 'social capability', 'positive mental health' and 'coping, esteem and spirit' (Frank *et al*., 1978). Average score of the 14 statements were used. (4) *Symptom Check List (SCL 90-R)* is a standard self-report symptom inventory, in which the global severity index (GSI) gives an overall measure of symptoms (Derogatis, 1992).

These self-ratings were performed just before therapy and $1\frac{1}{2}$ months after leaving the group except for one patient, who was asked one year after therapy. The patient, who was asked to terminate, did not return the post-therapy questionnaire.

Periodically during treatment the group members registered the *number of binge-eating and vomiting episodes per week*.

After therapy, the patients were asked how much on a scale from 0 to 6 they *gained from therapy*, and the therapists independently assessed each patients *benefit from therapy* as well.

The *Bulimics Maturation Scale (BMS)*, constructed by the therapists to focus on the specific problems of the bulimics, takes into account that the goal of the treatment was not only to bring the bulimic episodes to an end, but to work with deeper psychological conflicts and unconscious beliefs to achieve

psychological change (that is in the borderline structured personality). The therapists scored the patients on six scales covering (1) bulimic behaviour, (2) eating habits and attitudes and weight perceptions, (3) relations and sexuality, (4) working capacity, (5) identity and independence and (6) handling of trivial conflicts. Each subscale has scores of '0', '1' or '2', where '0' basically are unchanged bulimic behaviour and thinking and '2' equates with healthy behaviour. The scale thus has a range of 0–12 and the scale scores are annotated. A sufficient interrater reliability between the two therapists was obtained (Krippendorf's $R = 0.84$). All patients started at zero level, except the one who had stopped binge-eating just before entering the group. She started with one point.

Scores from a population of 112 same-age students late in their medical study were used as reference for the scales of GLQ, RCQ and CPSAS.

Statistical analysis

Magnitude of effect was investigated by calculating an effect size for each of the four before-and-after variables according to the formula provided by Cohen (1969): effect size (Choen's d) $= \text{mean}_{\text{after}} - \text{mean}_{\text{before}} / \text{standard deviation}_{\text{pooled}}$. Because of the small number of patients a non-parametric test (Wilcoxon matched-pairs signed-ranks test) was used to calculate the p-values.

To evaluate clinically significant change, it was decided that the level of patients' functioning subsequent to therapy should fall within the range of the functional or normal population, where range was defined as within two standard deviations of the mean of that population (Jacobson and Truax, 1991).

RESULTS

The drop-out rate will here be defined as leaving group treatment within one year, that is 2/11=18%, and if all patients are counted 3/19=16%.

The average number of vomiting episodes per week per patient was at the beginning of the group 8.5.

The binge-eating and purging episodes slowly declined to zero for nine out of 11 patients within the first two years of therapy. In three of the patients SSRI antidepressant had a striking effect both on the purging episodes and on the mood.

Table 1 shows the effect sizes of the before-and-after outcome measures and the p-values.

The effect sizes are high. An effect size > 0.70 has been considered a good result, > 1.00 a high effect in metaanalyses (Kazdin, 1994). The

Table 1. Effect sizes and Wilcoxon matched-pairs signed ranks test (exact, two tailed)

Questionnaires (n=10)	Mean before	Mean after	Pooled std dev.	Effect size (Cohen)	Z-values	p-values
RCQ	2.63	4.00	0.98	1.40	2.668	0.004
GLQ	2.1	4.2	1.02	2.06	2.682	0.004
SCL-90, GSI	1.38	0.64	0.43	−1.70*	2.666	0.004
CPSAS	2.06	2.68	0.49	1.28	2.547	0.008

*Reduction of symptoms.

negative value of GSI reflects the symptom reduction. The results are highly significant.

Table 2 shows the calculated cut-off points for the questionnaires in use and the share of patients who moved from the dysfunctional group to the functional group.

The clinical success rate is high and also higher than reported from other successful treatments: see e.g. Piper *et al*. (1998).

This can be studied further in Figure 1. The scatter plot shows for two scales as examples the positions of all ten patients.

The diagonal line ($x = y$) divides the patients into a group with positive change and a group with negative change. Patient G, who did not return the questionnaires, is located on the $x = y$ line. She was assigned the same rating 'after' (3 years therapy) as she had 'before'.

Figure 2 shows the patients' benefit from therapy.

The nine patients who returned the questionnaires after therapy were highly satisfied with the treatment. Four patients (C, F, I, J) gave the group maximum points. The therapists were more critical or modest, but still rated the patient's benefits high.

Table 2. Means and standard deviations for the 'functional groups', cut-off points for the questionnaires used and fractions of patients changed significantly and clinically

Questionnaires	N	Mean	Std dev.	Cut-off point	Patients sign. changed	Patients* clinically changed	Patients* sign. & clinically changed
RCQ	112†	4.72	0.64	3.44	7/10	6/9	6/9
GLQ	112†	4.71	0.69	3.33	9/10	8/10	8/10
SCL-90, GSI	974‡	0.31	0.31	0.93	7/10	6/8	5/8
CPSAS	112†	3.14	0.36	2.42	6/10	5/6	4/6

*Patients not in the dysfunctional area before therapy were excluded.
†Medical students.
‡Derogatis, 1992.

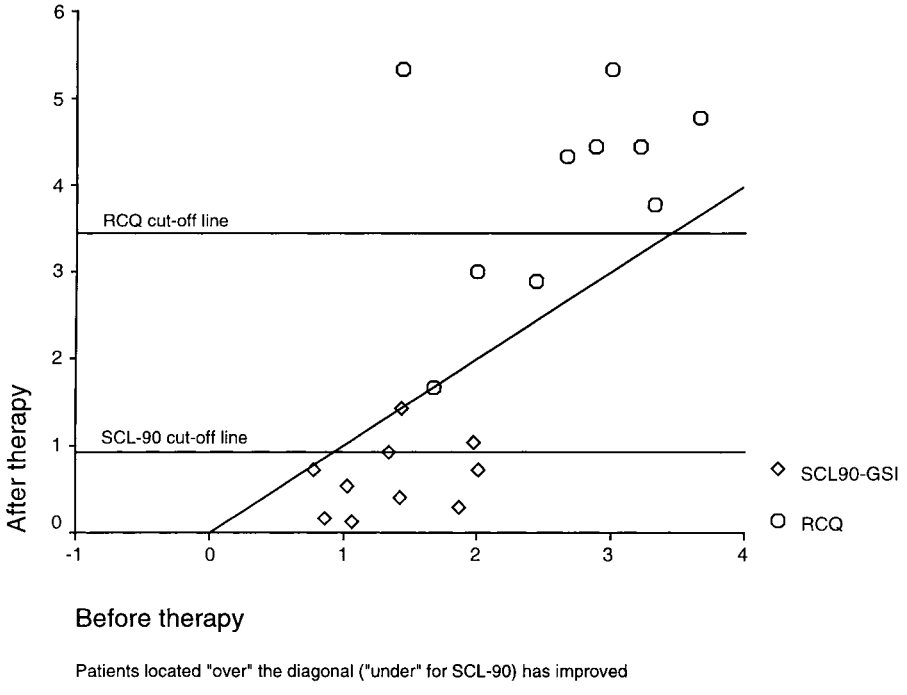

Figure 1. Outcome measures in scatterplot

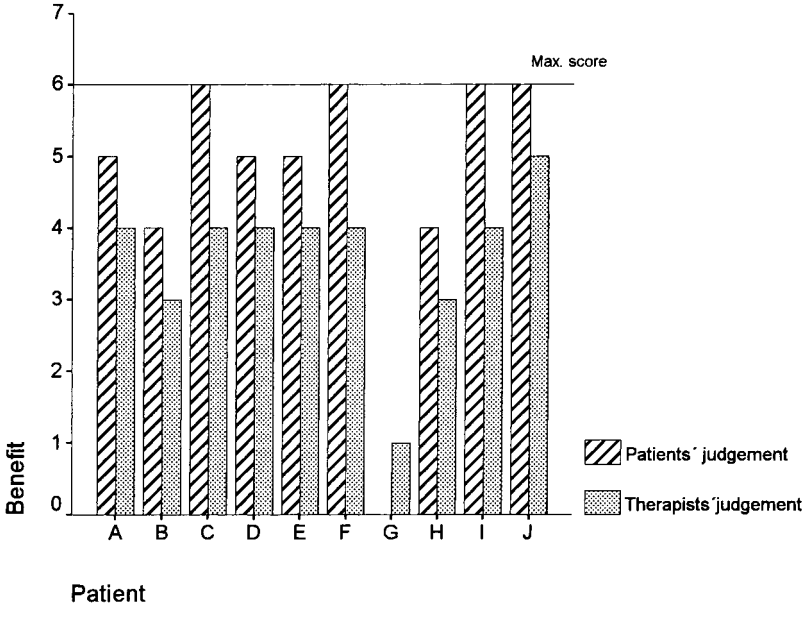

Figure 2. Evaluation of benefit from group

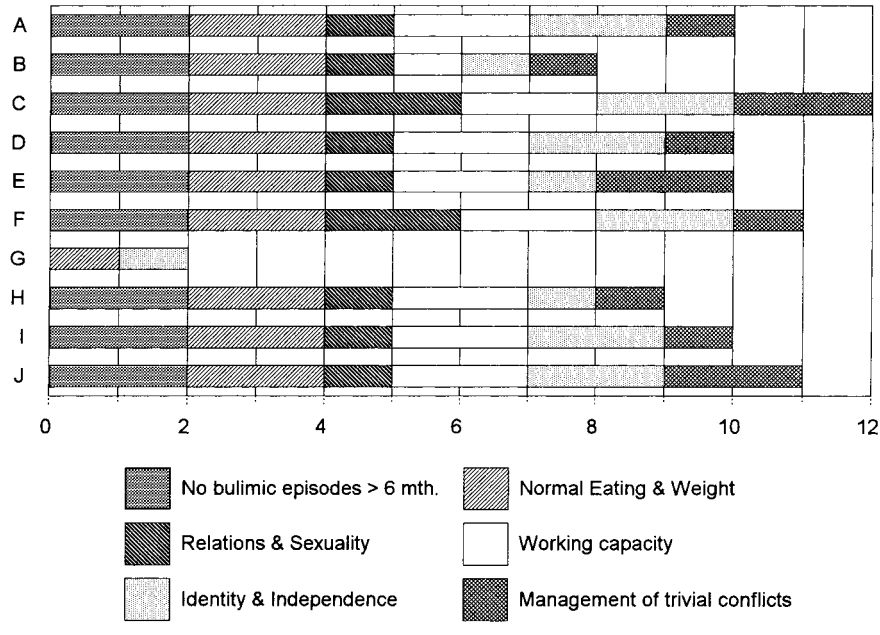

Figure 3. Bulimics Maturation Scale

Figure 3 shows accomplished goals in different defined areas in the Bulimics Maturation Scale.

At termination all patients except one (G) had had no bulimic symptoms for the last 6 months and performed well in several areas: restored normal eating behaviour and weight (C gained 10 kg of weight), but also the non-anorectic women gained weight (about 5%). They finished study, took their degrees, graduated, got a non-model job; had a long-lasting (sexual) relationship, married (I), got pregnant (C and D) and gave up borderline thinking and defence. Five stopped a self-destructive behaviour and were able to manage previous conflicts with mother and family in a mature way.

DISCUSSION

The patients were referred to special treatment after previously unsuccessful or insufficient treatment attempts. The average binge-eating and purging

episodes and the duration of symptoms before treatment are similar to what has been reported from other studies (Jäger *et al*., 1996). Furthermore, most of the patients had a personality disorder, which have been reported to be predictive of poor outcome (Herzog *et al*., 1991; Brotman *et al*., 1988).

There was no selection of the patients after the referral. Taken into account that all patients referred were offered therapy and the defined long drop-out period, the low drop-out rate is remarkable. Other studies have reported drop-out rates of up to 48% (Fairburn *et al*., 1993). In the described group only two patients (out of 11) dropped out before one year. One explanation for the low drop-out could be the intense alertness toward acting out of this type. The temptation in the patients to flee from the group at the beginning of treatment was expected and early and always addressed by the therapists. When the second patient dropped out the male therapist had announced a 5 months pause from the group. In retrospect, her leaving was interpreted as a repetition of her father leaving her and acting out of her anger towards him.

Turning to the test battery, the patients' baseline GSI was at the level of other out-patients (Derogatis, 1992), but not as high as found by Walsh *et al*. (1997). Effect size for GSI was high compared to two other naturalistic projects on psychodynamic psychotherapy. In the 'Penn' project (Luborsky *et al*., 1988) with 73 patients in long-term psychotherapy the effect size for GSI was 0.80. The research of Piper *et al*. (1998) on short-term psychotherapy up to 20 sessions achieved effect sizes of 0.78 and 0.86 for interpretive and supportive psychotherapy respectively.

The least gain in effect size was in the social adjustment area, which could reflect, that these women have some pretherapy capability to maintain working activities or study, despite their bulimic behavior.

Field *et al*. (1997) has pointed out that bulimia nervosa is an episodic disorder with episodic symptomatology, and studies have shown high relapse rates within the first 6 months after cessation of purging (Olmsted *et al*., 1994). We (the therapists) fully agree with them and have noticed that relapses occur after months of abstinence. The disappointment and coping with this have to be worked on in the group. We found it very important that the patients did not have one single binge-eating or purging episode in the last 6 months before termination, knowing that relapse is more likely to occur when this is the case. In the present study the fact that patients had no bulimic behaviour in at least 6 months before they terminated the group could say something about the durability of the restored and normalized eating habits. Actually, four of the patients did not meet the ICD-10 criteria for more than one year before termination of therapy.

In the absence of a third rater's opinion, the therapists' evaluations and calculations were performed conservatively: the ratings were consistent with the patients final remarks in the group and with letters sent to the group afterwards, and it is worth noticing that the patients rated benefit higher than the therapists. The 'normal' population of medical students was

probably going well in their daily life; they had almost finished their medical study.

A control group or comparison group was not used, leaving room for spontaneous recovery over the treatment period. However, no controlled study of long-term psychoanalytic therapy with bulimics has yet been accomplished. It is difficult, if at all possible, to apply control groups over many years. Besides, many randomized, controlled trials have problems with inclusion criteria and compliance (Treasure and Kordy, 1998). The patients included in this study were severely bulimic with a long cause of illness, and previously therapy had failed. The rate of spontaneous recovery in such patients is not high. According to the review of Keel and Mitchell, 50% had still bulimia nervosa or relapse of symptoms after 5–10 years (Keel and Mitchell, 1997).

Considering the long treatment period compared to many short-term formats, one could ask for the cost implications. It is the judgement of the author that this is a very cost-efficacious treatment. The expenses for the treatment course of every patient are about £1800 or one-fifth the cost of a 'by-pass' operation in Denmark.

It is appropriate to point out that, while the group was the all-dominating method, several other treatment modalities were used, including psycho-education, dietetics, cognitive schemes, drug therapy and some additional bilateral individual sessions, when needed. The therapists' attitude was to 'make the treatment fit the patients'.

Whether the results can be replicated is a difficult question. Could other therapists obtain the same results with the same method? How much of the result can be accounted for by the group format and how much by the therapists' general attitudes and skills?

We find the group format very valuable, if not essential, in obtaining the good result. The possibilities in the group for the new members to mirror and obtain hope and advice from others, who have made their way through the same chaotic difficulties and feelings, are invaluable. The therapists' eclectic, stepwise, individualized and borderline-attuned way of conducting the group, permitting confusion, anger and depression within the stable and firm borders, gives a climate of growth for these young women, but it requires trained therapists and takes years.

CONCLUSION

Long-term modified group analysis is a valuable option for treatment of severely bulimic patients. More elaborate measures of outcome introduced in this study–along with more traditional methods—point to a satisfactory outcome for nine out of ten patients who maturely terminated. A follow-up study is needed.

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