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ABSTRACT

Although in-depth, long-term group psychotherapy is a beneficial therapeutic experience for adolescent females suffering from anorexia nervosa, these clients are notoriously resistant to treatment and to long-term, open-ended group settings. This dissidence may stem from a motivational deficiency toward changing their eating patterns and difficulties with interrelational skills. Participating in a psychoeducational group can be a less threatening endeavor than in-depth psychotherapy. Members are not initially expected to share and process their pathological conflicts and cognitions, but to learn accurate information about the dangers of their eating disorder behavior. Because the time-limited, short-term format requires less commitment and seems more likely to result in success, members are more likely to complete the group sessions. The connections they make about the relationship between their eating behavior and underlying issues combined with the positive experiences related to group belongingness and decreased feelings of isolation may increase the likelihood that members will pursue further in-depth psychotherapy. Therefore, a short-term, psychoeducational group for weight-stabilized individuals with anorexia nervosa is an effective prelude to longer-term approaches. Participating in a psychoeducational group builds initial social and coping skills that prepares and motivates recovering clients for more intense psychotherapy. (Contains 41 references.) (GCP)

Running head: PSYCHOEDUCATIONAL GROUPS

A Psychoeducational Group Approach for Individuals Recovering from Anorexia Nervosa

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Abstract

Although in-depth, long-term group psychotherapy is a beneficial therapeutic experience for adolescent females suffering from Anorexia Nervosa, these clients are notoriously resistant to treatment and to long-term, open-ended group settings. This dissidence may stem from a motivational deficiency toward changing their eating patterns and difficulties with interrelational skills. Therefore, a short-term, psychoeducational group to provide weight-stabilized individuals with Anorexia Nervosa valuable information about their disorder, healthier eating patterns, sociocultural influences, and improved interpersonal skills is an effective prelude to longer-term approaches. Participating in a psychoeducational group builds initial social and coping skills that prepares and motivates recovering clients for more intense psychotherapy.

A Psychoeducational Group Approach for Individuals Recovering from Anorexia Nervosa

Anorexia Nervosa is a multifaceted disorder with many layers of pathology ranging from outward restrictive eating and weight control behaviors to deep-seated psychopathology underlying clients' emaciated appearance. Notoriously difficult to treat, much research has been devoted to finding an effective treatment for Anorexia Nervosa, but no one approach has been universally agreed upon (Goldner & Birmingham, 1994; Riess & Rutan, 1992). Some clinicians recommend initial educational and nutritional therapy prior to initiating intense psychotherapeutic approaches (Riess & Rutan, 1992). Therefore, a psychoeducational group that combines education with support would provide weight-stabilized adolescent females recovering from Anorexia Nervosa the information and initial coping strategies they need to explore the threatening psychopathological issues that initiated and maintained their illnesses.

An Overview of Anorexia Nervosa

Historical Overview

In the late seventeenth century, Richard Morton was the first person to document Anorexia Nervosa, which he called "a nervous consumption" caused by anxiety and sadness (Morton, 1689, as cited in Thompson, 1993). In 1874, Sir William Gull was the first to use the term Anorexia Nervosa in a paper presented to the Clinical Society of London, identifying psychological causes of the disorder and prescribing regular feedings of eggs, milk, cream, and chicken. In 1911, Pierre Janet identified obsessive and hysterical subtypes of Anorexia Nervosa. Morris Simmonds posited that pituitary gland dysfunction was the cause of Anorexia Nervosa, turning clinical attention to physical etiological factors from 1914 to 1930. In 1930, Berkman theorized that physiological effects of Anorexia were secondary to its primary psychological

causes (Silverman, 1997).

Since the assertion that Anorexia Nervosa was caused by psychological factors, many theories have emerged. In 1940, psychoanalysts proposed that Anorexia Nervosa symptoms were defenses against guilt caused by unconscious fantasies about oral insemination. Another theory asserted that the starvation inherent in Anorexia Nervosa was a struggle for control, self-respect, autonomy, and competence stemming from maternal nurturing deficiencies. Perception and body image disturbances, an inability to accurately perceive internal stimuli, and a strong sense of ineffectiveness resulted because the mother failed to recognize and confirm her child's needs for separateness and independence (Bruch, 1962, 1973, 1978 as cited in Silverman, 1997). A developmental theory posited that girls with Anorexia Nervosa were trying to avoid the psychological and biological responsibilities associated with adulthood by regressing to a pre-pubescent bodily state (Crisp, 1967, 1970, as cited in Silverman, 1997). Russell (1970, as cited in Silverman, 1997) proposed that Anorexia was caused by an intense phobia of fatness.

Definition

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association, 1994), identifies the following diagnostic criteria for Anorexia Nervosa: refusing to maintain 85% of normal body weight; fear of becoming overweight even when emaciated; body image disturbance (perception of being larger than one is in objective reality, basing one's self-worth on body weight and shape, or denying the danger of one's low body weight); and missing three consecutive menstrual periods. Subtypes of Anorexia Nervosa are the restricting-type, those who starve themselves without resorting to binge-purge behaviors, and the binge-eating/purging type, those who give in to binges periodically, then use self-induced

vomiting, laxatives, diuretics, or other medications to expel ingested calories (American Psychiatric Association, 1994). Anorexia Nervosa is a separate diagnostic category from Bulimia Nervosa, which is similar to the binge-eating/purging subtype without the severe emaciated state (American Psychiatric Association, 1994).

Physical Consequences

Anorexia Nervosa is a disorder in which an individual relentlessly pursues a slim body shape (Bruch, 1985), resulting in highly disordered restrictive eating patterns to avoid gaining weight due to the individual's fear of fatness (Hsu, 1990). Beyond normal patterns of dieting and weight loss, individuals with Anorexia Nervosa eventually embrace weight loss as exemplary of control and mastery over their lives and bodies (Garfinkel & Garner, 1982). Normal dieting spirals down to dangerously restrictive eating patterns, sometimes to 1,000 calories a day (Thompson, 1993), which can result in extreme emaciation, amenorrhea, slowed heart rate, sensitivity to cold, digestive complications, heart problems, and organ failure (American Psychiatric Association, 1994; Garfinkel & Garner, 1982; Hsu, 1990; Thompson, 1993; Treasure, 1997). Binging and purging behaviors can cause salt, water, and electrolyte imbalances, potassium deficiencies, and organ failure (Treasure, 1997).

Although many of the physical effects and medical complications of disordered eating are reversible with weight stabilization and cessation of purging behaviors, some, such as irritable bowel, digestive dysfunctions, stomach ulcers, and kidney damage, can be permanent (Treasure, 1997). If Anorexia Nervosa begins before puberty, there is a risk of stunted growth and arrested sexual development (Russell, 1983). Mortality rates of 10% (American Psychiatric Association, 1994) have been recorded for Anorexia patients.

Prevalence

Anorexia Nervosa, found in 0.5% - 1% of adolescent and young adult females, occurs most frequently in industrialized societies. Ninety percent of individuals with Anorexia are females and the disorder begins developing most commonly between the ages of 13 to 18. Bimodal onset rates have been found among 14- and 18-year-olds (American Psychiatric Association, 1994). Butler (1988) and Thompson (1993) have found the disorder to be most prevalent in females between ages 15 to 24. Anorexia rarely develops in women over 25 years (Thompson, 1993). The disorder is most common among adolescent females from higher socioeconomic groups (Bruch, 1985; Butler, 1988; Garfinkel & Garner, 1983). In a literature review, Hsu (1990) found Anorexia to be common in competitive occupations that emphasize thin bodies and dieting behavior such as gymnasts, swimmers, models, and ballet dancers.

Symptoms

Aside from the obvious emaciation, individuals with Anorexia Nervosa sometimes have head hair loss and brittle nails, a layer of soft downy lanugo hair covering arms, legs, cheeks, and neck, and blue and cold extremities (Garfinkel & Garner, 1982; Thompson, 1993). They may suffer from sleep dysfunctions, severe constipation, and can be easily bruised (Garfinkel & Garner, 1982). Although adamantly denying hunger, individuals suffering from Anorexia are often preoccupied with food and feel hungry. Some give in to the overwhelming sense of hunger, so they binge, then feel guilty and engage in purging behaviors like vomiting, laxative overuse, and diuretic abuse (Thompson, 1993).

The mental and psychological effects of starvation are notable. Individuals with Anorexia are typically socially withdrawn, indecisive, have trouble concentrating, and lose interest in

activities they engaged in prior to illness onset. They sometimes cannot identify internal emotional and physical states like hunger or satiety and report feeling hollow inside. They often do not trust their bodies, fearing weight gain with any caloric ingestion, so engage in obsessive, regimented exercise and eating rituals (Garfinkel & Garner, 1982). Individuals with Anorexia may tend to become depressed, anxious (Crisp, 1983), feel hopeless and apathetic, have difficulties with reasoning and complex thinking, and overreact easily to minor difficulties (Hsu, 1990). A famous semi-starvation study demonstrated that the same physical, behavioral, and mental characteristics of individuals diagnosed with Anorexia were seen in the 36 healthy male volunteers who participated in the study following 12 weeks of severe caloric restriction (Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950). Therefore, because many psychological features of Anorexia Nervosa are actually symptoms of dangerous nutritional deprivation, the effects of starvation need to be reversed before accurate measurement of psychological functioning can occur (Garner, 1997).

Individuals with Anorexia Nervosa, especially adolescents, can be rigid and compulsive, most often applying this personality style to school performance by getting high grades (Pryor & Wiederman, 1998). They tend to be introverted, well-behaved, intelligent, perfectionistic, obsessive, high-achieving, and conscientious (Bruch, 1985). Individuals with Anorexia often do not display emotions readily (Bruch, 1985; Pryor & Wiederman, 1998) and can have difficulty describing their feelings other than the panic and despair associated with gaining weight and the triumph in losing weight (Hsu, 1990).

Underlying perfectionistic and obsessive personality characteristics of individuals suffering from Anorexia Nervosa may be deep feelings of inadequacy and ineffectiveness (Bruch, 1985).

They tend to be mistrustful of interpersonal relationships, believing that others will reject them because they are inferior (Bruch, 1985). Their perceptions of self-worth oftentimes are associated with external standards of success and pleasing others rather than determining their own identity and separateness (Bruch, 1985; Garfinkel & Garner, 1982, 1983; Garner, Rockert, Olmsted, Johnson, & Coscina, 1985).

Researchers have identified many cognitive distortions common among individuals with Anorexia. Bruch (1985) theorized that individuals suffering from Anorexia interpret their environment and relationships based on concepts formed in early childhood. One theory is that they are stuck in Piaget's concrete operations stage and they have not progressed to the formal operations stage enabling them to evaluate complex thoughts and think abstractly (Bruch, 1985). Garner and Bemis (1985) concluded that although Anorexia may have multiple causes, the disorder boils down to a distorted belief that extreme slimness is essential. This rigid conviction is reinforced by an irrational battery of unhealthy attitudes and assumptions about body size, weight, and food. Garfinkel and Garner (1982) identified the main irrational assumptions of people suffering Anorexia to be: thinness, weight, and shape are determinants of performance and personal value; absolutistic standards of self-control are imperative; and complete certainty is needed to make decisions. Individuals with Anorexia think that weight and emotions must be predictable, social relationships cannot be attempted unless there is absolutely no possibility of rejection, dichotomous standards of right and wrong rule their world, and weight is the only measure of self-worth (Garfinkel & Garner, 1982). Roth and Ross (1988) identified the following 11 irrational beliefs commonly held by people with eating disorders: (1) thinness gives me self-worth; (2) I can restrictively diet without compromising my health; (3) I am fat and ugly; (4) I

can't control my life; (5) I am generally worthless and inadequate; (6) people are untrustworthy; (7) people want to control my life; (8) people expect me to be perfect (9) people find me to be uninteresting; (10) I need always to please other people; (11) it is wrong to directly express anger toward people (pp. 492-493).

Multiple Causes of Anorexia Nervosa

There are many theories about the etiology of Anorexia Nervosa. Genetic and biologic links have been associated with the occurrence of Anorexia Nervosa. Hsu (1990) summarized data from 42 female twin studies in which at least one twin had Anorexia. A genetic link to Anorexia was indicated as 50% of the identical twins and only 7% of the fraternal twins both had developed symptoms of the disorder. Further, Anorexia has been found to be more common among close relatives of Anorexia sufferers than in the general population. Also, affective disorders and substance abuse are common in families of individuals with Anorexia Nervosa (Marx, 1994).

Sociocultural issues. Throughout history, women have engaged in painful and physically damaging methods to improve their physical attractiveness as defined by the style of the time and culture. In a literature review, Garfinkel and Garner (1982) discovered that women in prerevolutionary China bound their feet tightly because small feet were associated with beauty, purity, and high socioeconomic status. However, this beauty ritual caused limited mobility and deformities. Further, in the 19th century Victorian era, an hourglass figure was upheld as the ideal standard of beauty, so women wore corsets to cinch in their waists. Unfortunately, the corsets caused extreme discomfort, digestive problems, and injury when the steel stays split (Garfinkel & Garner, 1982).

Researchers have associated industrialized societies (American Psychiatric Association, 1994) and Western culture with an abundance of eating disorder cases due to the emphasis on thinness (Garner, 1997). When females from less weight-conscious societies integrate into Western culture, they have been found to begin fearing fatness and to develop symptoms of eating disorders (Garner, 1997). For the past several decades in Westernized societies, fashion, publishing, and entertainment media have increasingly imposed a female glamour ideal of extreme thinness onto popular culture resulting in dieting behavior that increases vulnerability for developing eating disorders (Garner, 1997). Hsu (1990) posited that dieting provides a segue into eating disordered behavior and that the prevalence of dieting behavior in a society positively correlates with the incidence of eating disorders. A few decades ago, models' weights tended to be 8% less than the average woman. In the 1990's, models' weights have been about 23% less than the average woman's weight and the incidents of eating disorders continue to rise (Thompson, 1993). Two consecutive decade-long studies showed that the body size and weight of Playboy magazine centerfolds and Miss America beauty pageant winners steadily decreased between 1959 to 1988 while the weights of average Americans increased (Garner, 1997).

These culturally ingrained messages about thinness especially affect adolescents and children. In a literature review, Gabel and Kearney (1998) found that an overwhelming percentage of teenage girls were unsatisfied with their bodies and were on diets. Further, their review revealed this trend in elementary-aged girls as a large proportion communicated a desire to lose weight or had dieted. Dieting behaviors and fears of fatness were found to be common in 7-year-old girls which increased in intensity as they became teenagers (Edlund, Halvarsson, & Sjödén, 1995).

Developmental influences. Anorexia most commonly appears in adolescence, a time characterized by extreme turmoil in the struggle for an independent identity and adapting to rapid body changes. Female role expectations are multiple in that a woman must fulfill domestic responsibilities often while succeeding in a professional setting. The connection girls may make between female psychosexual maturity and their expanding hips and breasts with these conflicting roles can cause some adolescent girls to channel their doubts and anxieties about fulfilling multiple roles into their bodies (Scott, 1988). Bruch (1985) posited that restricting dietary intake and maintaining a low weight gives an adolescent girl control over the new expectations and challenges of establishing an identity and sense of competence that accompany puberty.

Being a teen and a female could be a risk factor for developing an eating disorder. In reviewing several research studies, Hsu (1990) found that adolescent girls were unhappier, more dissatisfied with themselves, more anxious, insecure, and depressed than boys. Depressed teens perceived themselves as overweight, even when they were not, and underweight teens as a group were less depressed than normal-weight and overweight teens. Further, a study by Patton (1988) showed that depression in teens was associated with abnormal eating patterns and attitudes. In addition, he found that introversion and social dysfunctions, characteristics of adolescent turbulence, predicted the development of eating disorders.

Family issues. Family dysfunctions have been associated with development of Anorexia Nervosa, although it is not known whether they are causes, consequences, or exacerbating factors of the disorder (Hsu, 1990). Garfinkel and Garner (1982) theorized that families may magnify cultural values of thinness and found that commonalities between parents of individuals suffering from Anorexia include having high expectations, being older, being from a high socioeconomic

class, and being concerned about eating and weight. Four common dysfunctional familial features of people suffering Anorexia include enmeshment, overprotectiveness, rigid adhesion to family rules and values, and avoidance of conflict (Minuchin, Rosman, & Baker, 1978). From a psychoanalytic standpoint, Bruch (1985) noted that although individuals with Anorexia seem very well provided for in a material and cultural sense, their emotional expressions and desires are not met. Bruch (1985) theorized that during infancy, the child's needs, especially for food, were not responded to in a consistent manner, so the child was unable to differentiate between biological, emotional, and interpersonal disturbances and separate his or her needs from the mother's.

A multifactorial view. Some researchers suggested that the onset of Anorexia Nervosa occurs in reaction to a stressful, life-changing event (American Psychiatric Association, 1994) that threatens an adolescent's self-worth and self-control, resulting in a focus on food and weight to retain a sense of competence and control (Bruch, 1985; Garfinkel & Garner, 1983). However, predispositional, causal, and maintaining factors also have been seen as multidimensional. Adolescent girls from Western cultures in families with high socioeconomic status and performance standards who have the family, cultural, and individual characteristics discussed previously, are at risk for developing an eating disorder (Garner, 1997; Garfinkel & Garner, 1982, 1983). Hsu (1990) posited that dieting behavior is used as a reaction to these cultural and familial stressors. Then, as individuals with Anorexia Nervosa start to lose weight, they receive complements on their appearance, which are positively reinforcing and serve to perpetuate dieting behavior. Also perpetuated with decreasing body size is a fat phobia, which acts as a negative reinforcer. As individuals with Anorexia become emaciated, thinness becomes a sign of mastery and power, so they deny their unhealthy state and hunger. This starvation behavior becomes

entrenched as both positive and negative reinforcers create a strong resistance to behavior change (Garfinkel & Garner, 1982).

Traditional Approaches to Treating Anorexia Nervosa

These severe psychological effects, thought disorders, and physical health risks caused by Anorexia Nervosa underscore a need for intervention. A variety of treatment approaches for Anorexia Nervosa have been proposed and studied. Psychoanalytic drive therapists attempted to bring the unconscious conflicts underlying Anorexia symptoms to the conscious and object-relations analysts became the nurturing maternal object from which the patient recovering from Anorexia learned to separate (Sayers, 1988). However, psychoanalytic approaches to treating Anorexia have not been found to be effective (Hsu, 1990). In fact, many psychoanalysts combine their methods with family, behavioral, and biological therapies (Sayers, 1988).

Behavior modification for Anorexia Nervosa has been found to be ineffective and to lead to relapse when not accompanied by changes in thought processes, attitudes, and belief systems (Buchanan, 1994). Cognitive-interpersonal (Roth & Ross, 1988) and cognitive-behavioral methods, which serve to change illogical and irrational thought processes regarding body image, food, and intra- and interpersonal interactions, have been demonstrated as effective (Garner & Bemis, 1985; Hollin & Lewis, 1988; Thompson, 1993). Garfinkel & Garner (1982, 1983) proposed a multifactorial approach to treating Anorexia based heavily upon cognitive-behavioral principles that combines drug, family, individual, and behavioral therapies. Inbody and Ellis (1985) have shown that by adapting different treatment modalities in a group setting based upon specific client need rather than adhering to one theoretical position is an effective approach to resolving each aspect of the disorder.

Although no one treatment method for Anorexia has demonstrated universal effectiveness (Riess & Rutan, 1992), clinicians agree upon some common aspects of treatment. Medically stabilizing the patient to replenish fluid, potassium, vitamin, and mineral depletions helps restore organ and body functions. Since gaining weight, an essential element of recovery, is so threatening to the fragile state of autonomy and self-control characteristics of individuals with Anorexia, a strong therapeutic alliance needs to be established for patients to effectively confront these fears and cultivate a positive recovery motivation. Ensuring healthy eating and exercise behaviors and cognitions by reversing the irrational thought patterns about body image, nutrition, and weight maintenance are essential. Family therapy is needed to address the dysfunctional patterns that exacerbate the disorder and provide support to affected family members. Finally, psychotherapy is essential in addressing and improving self-esteem, sense of self-worth, social skills, and rebuking a sense of ineffectiveness and negative irrational thought patterns (Goldner & Birmingham, 1994).

A Psychoeducational Group Approach

Rationale

A psychoeducational group can be a first step towards helping individuals suffering from Anorexia Nervosa who are weight-stabilized and have relinquished dangerous eating and behavior patterns. The multiple causes and exacerbating factors of Anorexia, namely the Western culture's pervasive emphasis on thinness and dysfunctional family environments combined with distorted thought processes regarding food, body shape, and weight can create a challenging barrier to penetrate. Therefore, the objective information provided in a psychoeducational group may give individuals suffering from Anorexia concrete challenges to cultural standards for thinness and

irrational thoughts about their bodies as well as solid grounding for future therapeutic endeavors. In fact, psychoeducation has been viewed as an essential initial part of recovering from eating disorders (Buchanan, 1994; Garfinkel & Garner, 1982; Garner, 1997; Garner et al., 1985; McFarland, 1995).

In a psychoeducational group, individuals recovering from Anorexia can learn about the dangers and ineffectiveness of eating disordered behavior, the benefits of healthy eating and weight maintenance (McFarland, 1995), and cultural and social stressors (Garner, 1997). Group participation may be an effective way to help individuals recovering from Anorexia increase their sense of self-efficacy and control over their eating disorder (McFarland, 1995) and begin to reverse the irrational thoughts about body image, food restriction, and weight (Garner, 1997).

In addition to being an efficient treatment strategy, a group experience in combination with individual and family counseling provides the mutual support and environmental structure needed to grow interpersonally (Goldner & Birmingham, 1994). Group participation reduces isolation and provides information, peer support (Hartley, 1988; Hsu, 1990), and an opportunity to challenge the thin standards of beauty and success mandated by Western culture (Garfinkel & Garner, 1982). Since many individuals with Anorexia have problems with low self-esteem, nutrition awareness, assertiveness, and isolation, a psychoeducational group can provide the education, support, validation, and feedback they need to view the disorder objectively and improve their social skills (Hartley, 1988; Lieb & Thompson, 1984). In fact, the support, peer relationships, and educational aspects of eating disorder groups have been linked with positive outcomes and relapse prevention (Hendren, Atkins, Sumner, & Barber, 1987).

The Psychoeducational Group Approach

A psychoeducational group is not designed to stand on its own as a treatment solution. Rather, combined with individual and family therapy approaches, a psychoeducational group may provide members the knowledge and intra- and interpersonal skills necessary to successfully engage in longer-term cognitive-behavioral or psychodynamic group therapy. A psychoeducational group could prepare individuals recovering from Anorexia for committing to long-term change, increasing the chance that more in-depth therapy will be successful. Riess and Rutan (1992) described a "step-wise" approach to introducing individuals recovering from Anorexia to the psychodynamic group experience that will eventually enable them to explore and resolve the deep-seated developmental conflicts and make connections between past events and present internal and intra-personal relationships. Short-term cognitively based or psychoeducational groups have been shown to effectively demystify, prepare, and educate individuals recovering from Anorexia for the longer-term open-ended therapy that has been found helpful in resolving these deeply rooted conflicts (Hall, 1985; Hendren et al., 1987; Riess & Rutan, 1992; Roth & Ross, 1988).

Specifically, a psychoeducational group provides accurate information about the biological and behavioral effects of dieting and starvation, the advantages of healthy eating and exercise habits, examines sociocultural factors that make women vulnerable to eating disorders (Garner, 1997), and explores personal strengths and coping strategies of members. Participation in a psychoeducational group can help members abandon the myths they adhere to surrounding food, weight, and body issues, realize connections between their eating behaviors and internal conflicts, and become increasingly motivated and open to more in-depth therapy (Riess & Rutan, 1992).

Psychoeducational Structure

Because women with eating disorders respond well to a structured format (Shisslak, Crago, Schnaps, and Swain, 1986) which helps to lessen the psychological chaos that individuals with Anorexia experience (Riess & Rutan, 1992), a pre-planned agenda may be an effective way to make members feel more comfortable. To orient new group members, a 30-minute preparation meeting prior to group session commencement (Hall, 1985, Marx, 1991) conducted individually with each member describes expectations of group, the rewards and challenges of group membership, the importance of attendance, and answers any questions group members have.

To begin each session, group members who feel comfortable doing so might participate in a go-around. Each member would mention something good they did for themselves, an accomplishment, or insight they experienced that week. This exercise could help introverted members alleviate anxiety (Shisslak et al., 1986) and build feelings of trust and security (Roth & Ross, 1988).

Next, the co-leaders could engage members in a relaxation or guided imagery exercise to help reduce anxiety and increase body awareness. Relaxation and imagery help individuals recovering from Anorexia experience their bodies more positively which helps to correct distorted body image perceptions (Kerr & Piran, 1990).

After group members are sufficiently relaxed, the group leaders can present the week's topic to the group and distribute related hand-outs. Topics could address specific informational deficits inherent to Anorexia Nervosa including nutrition, healthy weight management, physical and psychological effects of starvation and purging, and cultural influences (Garner, 1997). Since individuals afflicted with Anorexia have difficulties expressing emotions, asserting themselves,

building satisfactory relationships, and have low self-esteem (Garfinkel & Garner, 1982; 1983), these can be discussed as well. Members may also benefit by participating in activities related to the topic ranging from art projects to writing assignments (Shisslak et al., 1986).

Following the topic presentation, the group generally would process the discussion and activities. In the early sessions, this section might be relatively short, but as group members feel more comfortable with each other and build trust, they interact with each other rather than through the therapist (Corey & Corey, 1997; Hall, 1985; Roth & Ross, 1988; Yalom, 1985).

Group leaders can conclude the group with an inspirational reading, occasional homework assignments, and a session evaluation. Members have the opportunity to exchange phone numbers and receive an outside reading/resource list. Hall (1985) and Hartley (1988) mention that exchanging phone numbers helps group members build their support systems and encourages group cohesion.

Interacting on a consistent weekly basis might be an effective way for members to build their social skills, improve assertiveness, learn to trust others, and feel more comfortable discussing their personal issues. Riess and Rutan (1992) reported that "(a)bout half way through the highly structured psychoeducational groups, most members begin to feel comfortable enough to express feelings, to share personal experiences, and to sense that their eating symptoms have a great deal to do with their inner life" (p. 82). Therefore, processing time may grow longer as the group experience progresses naturally to discussing personal issues.

Advantages and Disadvantages

Because individuals with Anorexia Nervosa highly value their thin body shape, they consider weight loss as an accomplishment and positive reinforcer (Way, 1993), which makes

Anorexia notoriously difficult to treat (Bruch, 1985; Garfinkel & Garner, 1982; Garner & Bemis, 1985). They are proud of the self-discipline needed to maintain emaciation, so people with Anorexia view therapy and necessary weight gains as a threat to their self-control (Bruch, 1985). Treatment outcomes reflect that about a third of patients with Anorexia relapse, a third chronically maintain less severe anoretic symptoms, and a third will completely recover (Butler, 1988; Hsu, 1990). Group therapy is especially challenging, with high drop-out rates and inexpressive interaction patterns (Polivy, 1981; Hall, 1985; Marx, 1991; Riess & Rutan, 1992; Shisslak et al., 1986).

Hall (1985) points out that individuals suffering from Anorexia typically have characteristics that do not seem to be conducive to groups, as described by Yalom (1985). Specifically, they are socially ineffective, do not have a psychologically-oriented attitude, they deny and somatize their problems, and many may not be motivated to change. Other drawbacks are that group members sometimes teach each other their pathological weight loss methods, withdraw, and have difficulty articulating their feelings. However, Polivy (1981) asserts that aspects such as distorted body image, lowered self-esteem, nutritional misconceptions, feelings of specialness, and fears about adulthood and sexuality make individuals recovering from Anorexia good candidates to benefit from group interactions. Further, the sense of hope, confidence (McFarland, 1995), and decreased isolation (Hsu, 1990; Lieb & Thompson, 1984) instilled by group interactions are valuable benefits. The feedback, nutrition information, validation, support, and education gained in a group environment helps individuals recovering from Anorexia view themselves and their disorder objectively, decreasing denial (Lieb & Thompson, 1984). Inbody and Ellis (1985) found that group members recovering from Anorexia did not attend to leaders'

objective views of their body size, but grew aware of their emaciated appearance as they interacted with other group members, which encouraged them to improve their eating habits and gain weight.

Conclusion

Participating in a psychoeducational group can be a less threatening endeavor than in-depth psychotherapy. Members are not initially expected to share and process their pathological conflicts and cognitions, but to learn accurate information about the dangers of their eating disordered behavior, discover how to replace disordered eating with healthier eating habits, critically analyze distorted and unrealistic cultural messages concerning female body size and shape, and build social skills in a factual manner. Because the time-limited short-term format requires less commitment and seems more likely to result in success, members are more likely to complete the group sessions without dropping out (Riess & Rutan, 1992). The connections they make about the relation between their eating behavior and underlying issues combined with the positive experiences related to group belongingness and decreased feelings of isolation and aloneness may increase the likelihood that members will pursue further in-depth psychotherapy (Riess & Rutan, 1992). Therefore, a psychoeducational approach is an effective prelude and enhancement to longer-term group and other types of therapy for individuals with Anorexia Nervosa.

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