

**Effectiveness of Group Treatment Programs for Females With
Bulimia Nervosa**

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Introduction

The purpose of this paper is to examine the effectiveness of group treatment programs for bulimia nervosa among women. People who have bulimia go through periods where they eat a lot of food in a very short amount of time and then make themselves sick. According to NIMH the average age of onset for bulimia is 20 years old. The National Eating disorders association estimates that between 10 and 20% of women in college suffer from an eating disorder. Bulimia nervosa affects 1-1.5% of females and there is a 10:1 ratio of females to males suffering from the disorder (American Psychiatric Association [APA], 2013). About 50% of people who have been anorexic develop bulimia or bulimic patterns (Anred, 2015).

There has been a substantial amount of research prior to 2010 on women with bulimia nervosa and group treatment. Of those studies that were done, one involved researcher's recruiting 17 anorexic and/or bulimic college women to take part in an eating disorders group for 3 semesters. The sessions were conducted for 1 hour each week and averaged 5 students per session. They observed a three-stage progression for the group members. The first stage was the members admitted previous denial, shame and embarrassment over their eating disorder. Second, their conversation was mostly centered on symptoms of food intake, weight, purging, and nutrition. In the last stage they began to talk about self-esteem, family and other things that lead to their problem. Of the 17 women they worked with, 3 experienced complete relief symptoms, 8 experienced substantial relief, 3 experienced some relief, 1 had little change in symptoms and they lost contact with 2 participants (Weber et al., 1984).

Another group treatment study that helped college students with bulimia is a Mindfulness-Based Eating Disorder Treatment Group. The experience of 6 college-age women with bulimia nervosa were examined after they participated in an 8-week mindfulness-based eating disorder treatment group. Each session contained 4 components: experiential meditation practice, psychoeducation, discussion and assigned home practice. This study used individual interview and pre- and post-treatment self-portraits. Participants described their experience of transformation from emotional and behavioral extremes, disembodiment, and self-loathing to the cultivation of an inner connection with themselves resulting in greater self-awareness, acceptance, and compassion. They reported less emotional distress and improved abilities to manage stress. One of the 6 girls who participated in this study said she hasn't purged since she started the group. She is more self-aware of her actions and that she suspects this is directly responsible for lowering her impulsiveness to purge. This treatment may help the 40% of women who do not improve with current therapy (Proulx, 2008).

To discuss this topic, this first section offered a history of the research prior to 2010. The next section discussed current literature. This section includes demographics, definitions, diagnostic criteria, risk and protective factors, and health-related consequences. Additionally, this section offers specifics about group treatment and bulimia. The following section focuses on alternative perspectives. The final section of the paper will include a conclusion offering a summary of the material as well as recommendation for future research, policies and education.

Effectiveness of Group Treatment Programs for Females With Bulimia Nervosa

The purpose of this section is to present the current research regarding the effectiveness of group treatment programs for females with bulimia nervosa. This section includes demographics, definitions, diagnosis, risk and protective factors, health-related consequences and treatment research.

Demographics

Bulimia is five times more common in women than men and approximately 4.7 million of the US female population has experienced bulimia in their lifetimes (Crow et al., 2009). The mortality rate for women with bulimia is approximately 3.9%, with the most common causes of death being suicide and medical complications related to the eating disorder (Crow et al., 2009). The lifetime prevalence of bulimia for women is estimated to be 1%-3%, compared to 0.5% for anorexia (APA, 2000). Studies have found that bulimia is more prevalent among white women compared to women of other ethnic backgrounds. Additionally, women from higher socioeconomic backgrounds may also be at a greater risk of developing bulimia (NEDA, 2018).

Research shows that 88% of hospital admissions for bulimia nervosa are younger than 40 years and 92% of hospital admissions for bulimia nervosa are for women (Patel et al., 2018). In a study of adolescents, researchers found that Hispanics were more likely to suffer from bulimia nervosa than their non-Hispanics.

Definitions

The purpose of this section is to define the terms used throughout this paper. Bulimia nervosa is a serious eating disorder. People with bulimia may secretly binge eat large amounts of food with a loss of control over the eating and then purge, trying to get

rid of the extra calories in an unhealthy way. People with bulimia may regularly self-induce vomiting or misuse laxatives, weight-loss supplements, diuretics, or enemas after bingeing. They may also use other ways to get rid of calories and prevent weight gains, such as fasting, strict dieting, or excessive exercise (Mayo Clinic, 2018).

Group therapy is a therapy modality wherein clients learn and practice recovery strategies, build interpersonal skills, and reinforce and develop social support networks (Substance Abuse and Mental Health Services Administration). Group therapy involves one or more psychologists who lead a group of roughly five to 15 patients. Typically, groups meet for an hour or two each week [SAMHSA], 2021).

Diagnostic Criteria

This section discusses the criteria for females with bulimia nervosa. There are three essential features of bulimia nervosa: recurrent episodes of binge eating, recurrent inappropriate compensatory behaviors to prevent weight gain, and self-evaluation that is unduly influenced by body shape and weight. Recurrent episodes of binge eating are eating in a discrete period of time. It's a sense of lack of control, the feeling that one cannot stop eating or control what or how much one is eating. Recurrent inappropriate compensatory behavior to prevent weight gain includes self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise (APA, 2013). There are levels of severity of bulimia, moderate is an average of 4–7 episodes of inappropriate compensatory behaviors per week. Severe an average of 8–13 episodes and extreme an average of 14 or more episodes of inappropriate compensatory behaviors per week (APA, 2013).

Risk and Protective Factors

The purpose of this section is to discuss the risk and protective factors of bulimia nervosa. Some risk factors of bulimia are temperamental issues, environmental issues, genetic, and physiological issues. Temperamental Factors include weight concerns, low self-esteem, depressive symptoms, social anxiety disorder, and childhood anxiety disorders. Environmental includes, internalization of a thin body, have been found to increase the risk of developing weight concerns. Individuals who experienced childhood sexual or physical abuse also have an increased risk for the development of bulimia. Lastly, genetic and physiological factors including childhood obesity and early pubertal maturation increase the risk for bulimia nervosa. Familial transmission of bulimia nervosa may be present, as well as genetic vulnerabilities for the disorder (APA, 2013).

Some protective factors of bulimia are individual, family, socio-cultural, body acceptance, a healthy relationship with food, and media literacy. Individuals include high self-esteem, positive body image, school achievement, good social skills, and emotional well-being. Family factors include eating regular meals with family and having a family that doesn't over-emphasize weight and physical attractiveness. Socio-cultural factors include belonging to a culture that accepts a range of body shapes and sizes. To have peer or social support structures and relationships where weight and physical appearance are not high or concerning. Body acceptance occurs when a person can accept and appreciate their body. Body acceptance improves self-esteem, self-acceptance, and healthy outlook and behaviors. A healthy relationship with food and eating includes eating from all different food groups, eating an appropriate quantity of food, eating with flexibility and enjoyment, and listening to body cues. Lastly, for

media literacy, it is important to develop the ability to critically access, analyze, evaluate, and safely create media (National Eating Disorders Collaboration, 2023).

Health Consequences

The purpose of this section is to discuss the health consequences of bulimia nervosa. Individuals with bulimia nervosa may exhibit a range of functional limitations associated with the disorder and have reduced health-related quality of life. A minority of individuals report severe role impairment, with the social-life domain most likely to be affected by bulimia nervosa. Bulimia may cause dehydration and heart problems such as heart failure. Bulimia can also cause severe tooth decay and gum disease from vomiting and can cause absent or irregular periods (APA, 2013). Other health consequences include digestive problems, anxiety, depression, personality disorders, bipolar disorder and self-injury, suicidal thoughts, or suicide. Bulimia may also cause alcohol or drug problems. Bulimia has been found to cause severe digestive, muscle, and heart problems such as acid reflux disorder or an imbalance of electrolytes which contributes to the chance of suffering a heart attack (Mayo Clinic, 2018).

Treatment

Without treatment, bulimia nervosa readily progresses to a chronic illness with deleterious medical, psychological, and social outcomes. Group therapy is a therapy modality wherein clients learn and practice recovery strategies, build interpersonal skills, and reinforce and develop social support networks (SAMHSA, 2021). Group therapy can provide a sense of support and understanding from others who are going through similar experiences. It can also allow individuals to receive feedback from others about their thoughts, feelings, and behaviors related to their eating disorder.

One form of group treatment that works well with bulimia patients is Cognitive-Behavioral Therapy. The aim of CBT for Bulimia nervosa is to break the vicious cycle of dieting and bingeing by establishing a regular eating pattern and correcting the cognitive distortions related to the disorder. This treatment provides a rich source of ideas for brainstorming, suggestions for alternative strategies, and models for role-playing (Daniel et al., 2016).

One study that used CBT evaluated the efficacy of a brief group cognitive behavior therapy program in treating a large cohort of patients diagnosed with bulimia nervosa. The results were 38.8% of the participants were bingeing less than once a week on average; and 15% of patients no longer continued to purge, with 37.8% purging less than once a week on average. The study showed significant reductions in eating disorder pathology on all measures of bulimia-related behavioral symptoms (Jones et al., 2013). Another study that used the CBT model involved 20 sessions of CBT over the course of 5 months. After 5 months, 42% of patients had stopped binge eating and purging. By the end of the treatment, substantial improvements in eating disorder features and general psychopathology were observed (Poulsen et al., 2013).

Another type of group therapy is Interpersonal Group Therapy. Interpersonal therapy specifically focuses on how an individual relates to other people in their lives and believes that if these relationships improve and a person learns to better handle conflict, loss, transition, and relational deficits, there will be an improvement in behaviors related to bulimia (Choate, 2010). One study explored the use of interpersonal group therapy for patients with eating disorders involving both cognitive and interpersonal group therapy for patients with bulimia and other eating disorders.

The participants were randomly assigned to receive either group CBT or group interpersonal psychotherapy. Both treatments were delivered in 20 weekly sessions over the course of five months. Both group CBT and group interpersonal psychotherapy were effective in reducing binge eating and purging behaviors in individuals with bulimia. At the end of the 60-week follow-up period, individuals who received group CBT or group IPT maintained their treatment gains and continued to show significant improvements in eating disorder symptoms (Fairburn, 2009). Overall, the study provides evidence for the effectiveness of both group CBT and group IPT in treating bulimia.

Another group therapy model that is used to treat bulimia is Emotion-Focused Group Therapy [EFT]. EFT is designed to help individuals change problematic emotions that are related to psychological disorders. The central goal of EFT is to transform maladaptive emotion schemes by increasing awareness of expressing emotions, learning to regulate emotions, and activating adaptive emotions (Wnuk et al., 2015). One study that used Emotion Focus Group therapy involved 16 weekly sessions that targeted problematic emotions connected to eating disorder symptoms. In this study, they used empty chair work which involves processing neglect, abandonment, abuse, and trauma caused by a past significant other that is often the source of self-criticism and self-interruption. At the end of the study participants reported a decrease in the frequency of binge episodes, improvements in mood, and improvements in emotion regulation and self-efficacy (Wnuk, et al., 2015). Another study that used Emotion and Social Mind Focused Therapy and Cognitive-Behavioral Therapy had participants that were randomized to either EFT or CBT Group treatment programs. All participants were offered 13 group and 4 individual sessions. The odds of patients who attended the EFT

group attending an additional session are 3.5 times as high as the odds of the patients who attended the CBT group. Patients in both treatment groups significantly improved over time on primary and secondary outcome variables, which did not differ significantly between treatments (Dejong, et al., 2012).

Additional Perspectives

The purpose of this section is to present the current research regarding alternative perspectives for Bulimia Nervosa and group treatment. This section includes males who are diagnosed with bulimia, and male athletes and Gay/Bisexual Males.

Males

Bulimia nervosa is less commonly diagnosed in males compared to females, but research suggests that it is still a significant problem for some men. Males account for 5-10% of patients with Bulimia Nervosa. The mean age of onset for bulimia is between 18 and 26 for males. Males with bulimia nervosa may be more likely to have co-occurring disorders such as substance abuse, anxiety, or depression (Murray et al., 2017). Males with bulimia nervosa are less likely to seek treatment for their eating disorder than females with the disorder. Many men avoid seeking treatment for eating disorders because of their feelings of shame, due to a common belief that eating disorders are a female issue, not male.

Additionally, research suggests that male athletes may be at a higher risk for developing bulimia nervosa compared to non-athletes. Many athletes tend to conflate confidence and performance with weight and body composition and utilize a variety of restrictive and bulimic behaviors in an attempt to manipulate these variables. A study of male athletes found that those who reported pressure to gain or maintain weight for

their sport were more likely to engage in disordered eating behaviors, including binge eating and purging (Petrie et al., 2008). Another study of male college athlete's found that those who participated in sports that emphasized weight and body shape, such as wrestling and bodybuilding, were more likely to engage in disordered eating behaviors and have a higher risk for bulimia nervosa compared to those who participated in non-weight-focused sports (Sundgot-Borgen et al., 2004).

Research also suggests that individuals who identify as LGBTQ+ may be at a higher risk for developing eating disorders, including bulimia nervosa, compared to heterosexual individuals. A study of college students found that gay and bisexual males had a higher prevalence of bulimia nervosa compared to heterosexual males. Specifically, 7.6% of gay males and 12.5% of bisexual males reported a history of bulimia nervosa, compared to 2.1% of heterosexual males. A study reported that 9.3% of gay males and 8.4% of bisexual males reported purging behaviors, compared to 1.6% of heterosexual males (Austin et al., 2009).

In terms of studies specifically focusing on the treatment of bulimia nervosa in males, there is limited research available. However, some studies found that Cognitive-Behavioral Therapy, Mindfulness-based Cognitive Therapy, Group Therapy work best on treating males with bulimia (Mayo Clinic, 2018). One CBT program focuses on changing the attitudes about self and food for males. The program breaks the therapy into three phases lasting about 20 sessions over 6 months (Lock, J. & Fitzpatrick, K., 2007). A study that used Mindfulness-based Cognitive Therapy had men participate in a 8 week group session. The study showed improvement on mindfulness skills, decrease in anxiety and depression and decrease in Bulimia symptoms (Sala, et,

al., 2021). Another study found that supportive-expressive group therapy was effective in reducing binge eating and purging behaviors in males with bulimia nervosa (Fahy et al., 1995). Additionally, more research is needed to determine the most effective types of group therapy for males with bulimia.

Conclusion

The following section will summarize the major findings and recommendations for future research, education and policy.

Based upon the research, group treatment programs for females with bulimia nervosa are effective, (SAMHSA, 2021: Daniel et al., 2016: Jones et al., 2013: Poulsen et al., 2013: Choate, 2010: Fairburn, 2009: Wnuk et al., 2015: Dejong, et al., 2012).

In summary, there are three essential features of bulimia nervosa: recurrent episodes of binge eating, recurrent inappropriate compensatory behaviors to prevent weight gain, and self-evaluation that is unduly influenced by body shape and weight (APA, 2013). Based on research risk factors that are associated with bulimia are temperamental, environmental genetic, and physiological. Some protective factors that are associated with bulimia are individual, family, socio-cultural, body acceptance, a healthy relationship with food, and media literacy (NEDC, 2023). Bulimia can cause a variety of health consequences. Some health consequences of bulimia include digestive problems, anxiety, depression, personality disorders, bipolar disorder and self-injury, suicidal thoughts or suicide, and alcohol or drug problems. Based on research concerning treatment it was found that Group Cognitive-Behavioral Therapy, Interpersonal Group Therapy, and Emotion-Focused Group Therapy is more effective for treating women with bulimia. The study by (Jones et al., 2013) showed that CBT

therapy helped with significant reductions in bingeing and purging. Another study for Interpersonal Group Therapy showed that participants were able to maintain their treatment gains and continued to show significant improvements in eating disorder symptoms (Fairburn, 2009). Lastly, for Emotion-Focused Group Therapy a study by (Wnuk, et al., 2015) showed the participants reported a decrease in the frequency of binge episodes, improvements in mood, and improvements in emotion regulation and self-efficacy.

Future Research

Given the limitations of research regarding race and bulimia, future research should focus more on race when it comes to bulimia. Research on bulimia has predominantly focused on White, middle-class females, and there is a need for more research that includes diverse populations to better understand the unique experiences and needs of individuals from different backgrounds. Researchers should prioritize recruiting diverse study populations, including individuals from different racial and ethnic backgrounds, to better understand the unique experiences and needs of these groups. Researchers can also explore cultural factors that may impact the experience of bulimia among different racial and ethnic groups. This can include examining how cultural values and beliefs about body image, food, and mental health may influence the development and presentation of bulimia.

Education

One recommendation for education is to incorporate mindfulness-based approaches. Mindfulness can help individuals with bulimia to become more aware of their thoughts, emotions, and behaviors, and to develop greater self-compassion and

acceptance. Education on mindfulness-based approaches can include information on techniques such as meditation, deep breathing, and body scans. By practicing mindfulness regularly, individuals with bulimia can learn to identify triggers and develop strategies to manage difficult emotions and urges to binge and purge.

Mindfulness-based approaches can also help to reduce shame and self-criticism, which are common experiences for individuals with bulimia. By learning to approach their experiences with compassion and curiosity, individuals with bulimia can develop a more positive and accepting relationship with themselves. Incorporating mindfulness-based approaches into education on bulimia can provide individuals with practical skills and strategies to support their recovery and improve their overall well-being.

Policy

One policy recommendation for addressing bulimia at a national level is to increase access to evidence-based treatment options. This can be done through policy initiatives that increase funding for mental health services and ensure that insurance coverage for the treatment of eating disorders is comprehensive. Many individuals with bulimia face significant barriers to accessing treatment, such as long wait times for appointments, lack of insurance coverage, and high out-of-pocket costs. By increasing access to evidence-based treatment options, individuals with bulimia can receive the care they need to manage their symptoms and improve their overall health and well-being. Overall, policy initiatives that increase access to evidence-based treatment options can help to address the significant public health impact of bulimia and support individuals with the disorder in their recovery.

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