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Emotion-Focused Group Therapy for Women With Symptoms of Bulimia Nervosa

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This study provides outcome pilot data for an outpatient emotion-focused therapy group for 12 women with DSM-IV *diagnoses of binge-eating disorder, bulimia nervosa, or eating disorder not otherwise specified. The emotion-focused therapy group involved 16 weekly sessions that targeted problematic emotions connected to eating disorder symptoms. Semi-structured clinical interviews were conducted pre- and post-treatment and self-report questionnaires were administered. From pre- to post-treatment, changes in binge eating and scores on self-report measures were statistically significant. Participants reported a decrease in the frequency of binge episodes, improvements in mood, and improvements in emotion regulation and self-efficacy.*

While helpful for a significant numbers of individuals with bulimia nervosa (BN) and binge-eating disorder (BED), standard treatments for these disorders are unhelpful for about 50% (Wilson, Grilo, & Vitousek, 2007). Individuals with bulimic disorders (disorders that include bingeing and/or compensatory mechanisms) report greater negative emotions overall (Whiteside et al., 2007). Explanatory models of binge eating in BN and BED suggest that painful emotions are important precipitating and maintaining

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factors and that binge eating plays an instrumental role in regulating affect (McManus & Waller, 1995).

Treatments that focus on emotions may thus offer important tools. Emotion-focused therapy (EFT) is designed to help individuals change problematic emotions that are related to psychological disorders. The theoretical foundations of EFT are well-developed (Greenberg & Watson, 2005) and outcome research has found EFT to be helpful in treating problems including depression (Greenberg & Watson 1998). In research EFT is typically delivered in 16 individual weekly sessions and a recently published study found that a group approach for individuals with anxiety and depression was effective (Lafrance Robinson, McCague, & Whissell, 2014).

The core theoretical assumption of EFT is that emotions are innately adaptive and provide important information. Through learning they are organized into emotion schemes, networks of cognition, bodily sensation, and action urges triggered by internal or external stimuli specific to the individual (Greenberg, 2002).

Dysfunction results from the frequent activation of maladaptive emotion schemes that interfere with healthy adjustment (Greenberg & Pascual-Leone, 2006). Examples of maladaptive emotion schemes are deep fears of abandonment or shame about perceived incompetence.

The central goal of EFT is to transform maladaptive emotion schemes by increasing awareness of and expressing emotion, learning to regulate emotions, and activating adaptive emotions (Greenberg, 2002; Greenberg & Watson, 1998). Once maladaptive emotion schemes are transformed, psychological symptoms recede and disappear because they are no longer required to cope with emotion.

In terms of technique, EFT combines the person-centered stance of empathic attunement and positive acceptance with the Gestalt therapy approach of focusing on moment-by-moment experience and chair work. Therapists use empathy and chair work to resolve internal conflicts such as self-criticism and unresolved feelings toward a significant other. While problematic behaviors or symptoms are not tracked using diaries, symptoms are discussed to assess progress and understand the connection between emotions and symptoms.

The aim of the current pilot study was to evaluate the feasibility of an Emotion-focused Therapy Group (EFT-G) for 12 women with bulimic disorders. While groups are superior to no treatment for individuals with eating disorders, the superiority of any one therapeutic modality has not been demonstrated (McKisack & Waller, 1997). EFT-G was developed as part the first author's doctoral dissertation project during a 3-year process that involved review of relevant literature, training of therapists, and development of a treatment protocol based on work with individual clients with eating disorders. Please contact the first author for more information.

METHODS

Participants

Participants were recruited from the outpatient adult eating disorders program at The Credit Valley Hospital in Mississauga, Ontario, Canada, a suburb of Toronto. The research was approved by the research ethics boards of both York University, Toronto, and the Credit Valley Hospital.

Study participants: (a) were 18 years old or more, (b) female, and (c) reported two or more binge eating and/or one self-induced purging episode in the past 28 days. Exclusion criteria were: (a) presence of a psychotic disorder, (b) imminent suicide risk, (c) body mass index of less than 17.5, (d) significant current problems with substances, and (e) plans to enroll in another treatment during the course of EFT-G.

All potential participants completed a brief phone screen. Eligible participants provided signed informed consent and completed a semi-structured interview of eating disorder symptoms and pre-treatment questionnaires. Over the 11-month recruitment period, 44 individuals were informed about the study. Thirty were not recruited. The most commonly identified reason (16/44) was interfering work and/or school commitments.

Outcomes were eating disordered symptoms, psychopathology, emotion regulation, and self-efficacy. The Past 28 Days Eating and Symptoms Interview was used to assess for bingeing and purging as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (*DSM-IV*; American Psychological Association, 2000; Dolhanty, 2005). Self-report measures used were: (a) the Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983); (b) the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004); (c) the Beck Depression Inventory (BDI; Groth-Marnat, 1990); and (d) the Symptom Checklist–Revised–90 (SCL-90-R; Derogatis, 1977). Self-efficacy (Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002) ratings were collected at the end of each session via a self-report questionnaire with two questions. The first measured symptom self-efficacy: "If you decided to stop your eating disorder symptoms (bingeing, vomiting, strict dieting, over-exercising, etc.) how confident are you that you would succeed?" The second measured emotion self-efficacy: "How confident are you that you are going to be able to deal with your feelings in healthier ways?" Both were rated on a 10-point Likert scale, ranging from 1 (*not at all*) to 10 (*very much*).

Procedure

Emotion focused therapy group treatment. Two separate, 16-week groups were facilitated, each composed of seven members. The first group was from April 2007 to July 2007, and the second from November 2007 to March 2008. Participants were required to be followed by a family physician

that was aware of and monitored their medical status. Treatment was delivered according to standard EFT protocol (Elliott, Greenberg, & Lietaer, 2004) by two female facilitators (S.W. and J.D.) experienced in working with individuals with eating disorders and in delivering EFT. One of the facilitators (J.D.) led chair work exercises and the other (S.W.) assisted in guiding discussions. The first session involved orientation to the treatment, introductions, and psychoeducation about eating disorders and emotion. Participants were provided with a manual that detailed this information. Subsequent sessions began with a 15–20 minute "check-in" where group members took turns summarizing their current struggles. Key themes identified during the check-in served as the starting point for chair work. Group members requested or where invited to participate in a chair work exercise while the rest of the group observed. Two to three chair work episodes were facilitated each session, varying from 15–30 minutes in duration.

In keeping with the EFT protocol (Elliott, Greenberg, & Lietaer, 2004), chair work was of two types: two chair and empty chair. Two-chair work involves a split or conflict between two aspects of the self and is further divided into self-evaluative splits and self-interruptive splits. Empty chair work refers to "unfinished business," involving unmet needs by a past significant other, usually a parent.

Self-evaluative splits involve identifying the critical self-talk or messages the client directs at herself, and symbolically "splitting" these into two chairs. A chair is placed in front of the client and she is directed to physically move into that chair, which represents her internal self-critic, and to verbalize the self-critical messages to the chair opposite her, which represents her "experiencing self," the part of herself that bears the brunt of the critical messages. A typical client's self-critical messages might include, "You're fat and ugly and need to lose weight." After expressing these criticisms, the client is instructed to physically move into the "experiencing" chair opposite, and to express the emotional impact of these criticisms. Clients switch chairs several times in one chair work episode, and with skilful facilitation from the therapist the criticisms become increasingly representative of core maladaptive schemes. Criticisms in self-evaluative chair work often focus on the client's dissatisfaction with her appearance at first, then deepen into core schemes about her lovability or worth as a person. The goals of two-chair work are for the client to gain awareness of and verbalize her self-evaluative thoughts; to recognize and experience the painful emotions associated with these criticisms; to recognize that she has some control over these messages, and to ultimately find ways to transform the critical part of herself. In this process, clients uncover healthier aspects of themselves, such as assertiveness.

In self-interruptive splits, the client identifies ways in which she stops herself from fully experiencing and expressing emotion, or from identifying and stating needs. The client is directed to physically move into the chair in front of her, which now represents the "self-interruptive" part of herself,

and to verbalize the messages that stop her from feeling emotions to the chair opposite her, which represents her experiencing self. A client might learn that she stops herself from feeling anger because it is frightening, and this leads to urges to binge. With time and repetition, the client becomes more comfortable allowing and learning from her emotions, which helps her access healthier needs and goals.

Empty chair work involves processing neglect/abandonment and abuse/trauma caused by a past significant other that is often the source of self-criticism and self-interruption. In this chair work, the chair that is placed in front of the client represents an internalized significant other from the past whose actions made a lasting, hurtful impact on the client. From the "significant other" chair, the client is instructed to verbalize the key messages that impacted her. She then returns to the original chair, which represents her experiencing self, and expresses the impact of the messages from the "significant other" chair. For example, a client might express hurt and anger towards her mother for criticizing her about her weight, leaving her feeling rejected. The goals and outcomes of empty chair work involve helping the client access and express emotions and unmet needs, to validate herself, and to let go of unresolved feelings by understanding, forgiving, or clearly seeing the limitations of the significant other.

Over the course of the 16-week group, chair work began with two chair splits and progressed to empty chair work, so that between the fifth and eight sessions, group members began participating in empty chair work. After each chair work exercise, the group debriefed and discussed what they had observed and commented on how the chair work episode related to their own issues. Sessions were planned so that each group member participated in roughly the same number of chair exercises over the course of the 16 weeks.

Analytic Plan

The Statistical Package for the Social Sciences version 16 was used for analyses. Non-parametric tests were chosen because they are uniquely suited to small samples and non-normally distributed data (Pelt, 1977). The Wilcoxon Matched Pairs signed ranks test was used for pre- to post-treatment analyses. These computations result in sample means and medians, and in a Z score and a significance level (p).

RESULTS

Participant Demographics and Eating Disorder Diagnoses

Five patients from the first group and seven patients from the second group were included in analyses. One of the excluded participants declined

participating in chair work exercises so did not receive the full treatment, while the second excluded participant disclosed in the first session that she had stopped binge eating. Mean age was 32.6 years (SD = 11.84). All participants reported post-high school education. One was unemployed, two were stay-at-home mothers, two were students, and the remainder worked full time. One woman was divorced, four were married or in common-law relationships, and seven were single. All identified as Caucasian. Seven participants (58.3%) were diagnosed with BN, four (33.3%) with BED, and one (8.3%) with EDNOS.

Retention and Outcome Data

The mean number of groups attended by participants was 11.83/16 while the mean number of chair work exercises completed was 5.33 (SD = 2.15). All participants completed all pre-treatment measures and the post-treatment interview. No participants dropped out of treatment. Mean body mass index (BMI) pre-treatment was 28.70 (SD = 13.57), and 31.63 (SD = 10.52) at post-treatment, a non-significant difference.

The average frequency of binge episodes decreased from 13.83 (SD = 8.19) before treatment to 7.75 (SD = 8.19) post-treatment, $Z = -2.09$, $p = .04$. Three participants reported they had stopped binging by the end of treatment. Vomit episodes decreased in frequency but not significantly. Significant improvements were found in four EDI subscales: Interoceptive Awareness, $Z = -2.68$, $p = .01$; Bulimia, $Z = -2.25$, $p = .02$; Body Dissatisfaction, $Z = -2.20$, $p = .03$, and Ineffectiveness, $Z = -2.15$, $p = .03$. Regarding emotion regulation, mean DERS scores improved from 109.27 (SD = 16.39) to 84.82 (SD = 21.48), $Z = -2.67$, $p = .01$. Significant improvements between pre- and post-treatment were found in mood: BDI scores decreased from a mean of 22.75 (SD = 9.16) to 14.58 (SD = 10.23), $Z = -2.67$, $p = .01$. Psychiatric distress measured by the SCL-90-R decreased from 1.15 (SD = .38) to .85 (SD = .49); $Z = -2.60$, $p = .01$. See Table 1.

TABLE 1 Comparison of Pre-Treatment and Post-Treatment Outcomes (N = 12)

	Pre			Post				
Measure	*M*	*Mdn*	*SD*	*M*	*Mdn*	*SD*	*Z*	*p*
BEF-28	13.83	11.00	8.19	7.75	4.00	8.16	−2.09	.04
VEF-28	4.83	.00	8.83	3.25	.00	4.77	−.32	.75
DERS	109.27	115.00	16.39	84.82	81.00	21.48	−2.67	.01
BDI	22.75	22.50	9.16	14.58	16.00	10.23	−2.67	.01
RSES	13.42	13.00	4.81	15.92	15.50	5.27	−2.20	.03
SCL-90-R	1.15	1.23	.38	.85	.81	.49	−2.60	.01

Note: BEF-28 = Binge episode frequency in the past 28 days; VEF-28 = Vomit episode frequency in the past 28 days; DERS = Difficulties in Emotion Regulation Scale; BDI = Beck Depression Inventory; RSES = Rosenberg Self-Esteem Scale; SCL-90-R = Symptom Checklist 90 Revised.

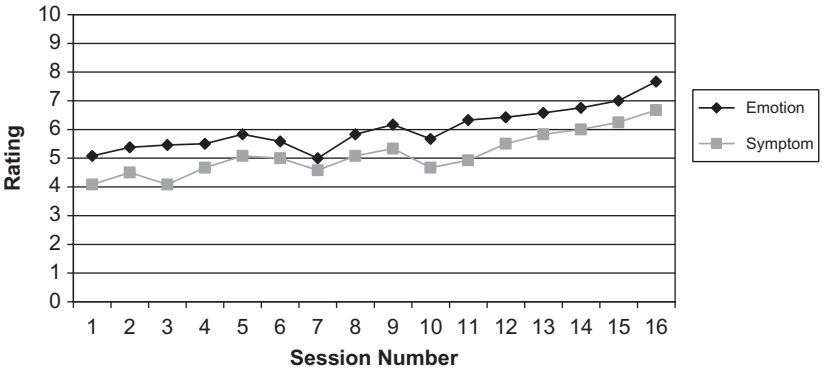

FIGURE 1 Symptom and emotion self-efficacy ratings by session ($N = 12$).

Symptom self-efficacy increased significantly from $M = 4.08$ ($SD = 2.23$) to 6.67 ($SD = 2.87$), $Z = –2.25$, $p = 02$. Emotion self-efficacy increased significantly from $M = 5.08$ ($SD = 1.78$) to 7.67 ($SD = 1.73$), $Z = –3.08$, $p = .002$. See Figure 1.

DISCUSSION

The aim of the present study was to evaluate the effectiveness of a 16-week EFT-G for women with bulimic disorders. To our knowledge, this was the first study to utilize an EFT group treatment for this population. Participation in EFT-G was associated with significant decreases in the frequency of binge episodes, improvements in eating disorder symptoms, depression, emotion regulation, general psychiatric distress, and self-efficacy. The reductions in binge episode frequency are consistent with the results from research on other group treatments for eating disorders (Jacobi, Dahme, & Dittman, 2002; Riess, 2002; Shiina, Nakazato, Mitsumori, & Koizumi, 2005). Our findings are consistent with those of Lafrance Robinson et al. (2014) in showing that a group EFT approach may result in successful client outcomes.

The improvements on the DERS suggest that key therapeutic goals of EFT can be attained by women with bulimic disorders and may contribute to symptom improvement. Though eating disorder behaviors are not directly addressed in EFT-G, improvement in the underlying emotional processes may mitigate the need for these symptoms to regulate emotions. This is similar to findings regarding Interpersonal Psychotherapy for eating disorders, which likewise does not directly address eating disorder symptoms (Apple, 1999).

Regarding limitations, the small sample size and lack of a control group means we can draw only tentative conclusions. Important variables were not controlled, such as psychiatric comorbidity. We cannot rule out therapist

effects, given that the same two therapists delivered the treatment. Future research should also evaluate individual EFT for eating disorders and should involve follow-up periods. Statistical methods should be used to identify the timing and nature of change and the relationships among variables. In summary, this pilot study is an important first step in evaluating EFT for eating disorders.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Apple, R. F. (1999). Interpersonal psychotherapy for bulimia nervosa. *Journal of Clinical Psychology*, *55*, 715–725.

Derogatis, L. R. (1977). Confirmation of the dimensional structure of the symptom checklist 90: A study in construct validation. *Journal of Clinical Psychology*, *33*, 981–989.

Dolhanty J. (2005). *Symptom control and self-efficacy with electronic self -monitoring of bulimia nervosa: A randomized controlled trial*. (Unpublished doctoral dissertation.) York University, Toronto, ON.

Elliott, R., Greenberg, L., & Lietaer, G. (2004). Research on experiential psychotherapy. In M. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (pp. 439–539). New York, NY: Wiley.

Garner D., Olmsted, M. P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorders inventory for anorexia and bulimia. *International Journal of Eating Disorders*, *2*, 15–24.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, *26*, 41–54.

Greenberg, L. S. (2002). *Emotion-focused therapy*. Washington, DC: American Psychological Association.

Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology*, *62*, 611–630.

Greenberg, L. S., & Watson, J. (1998). Experiential Therapy of Depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research*, *8*, 210–224.

Greenberg, L. S., & Watson, J. C. (2005). *Emotion-focused therapy for depression*. Washington, DC: American Psychological Association.

Groth-Marnat, G. (1990). *The handbook of psychological assessment* (2nd ed.). New York, NY: John Wiley & Sons.

Jacobi, C., Dahme, B., & Dittman, R. (2002). Cognitive-behavioral, fluoxetine and combined treatment for bulimia nervosa: Short and long-term results. *European Eating Disorders Review*, *10*, 179–198.

Lafrance Robinson, A., McCague, E. A., & Whissell, C. (2014). "That chair work thing was great": A pilot study of group-based emotion-focused therapy for anxiety and depression. *Person-Centered & Experiential Psychotherapies*. DOI:10.1080/14779757.2014.910131

McKisack, C., & Waller, G. (1997). Factors influencing the outcome of group psychotherapy for bulimia nervosa. *International Journal of Eating Disorders*, *22*, 1–13.

McManus, F., & Waller, G. (1995). A functional analysis of binge eating. *Clinical Psychology Review*, *15*, 845–863.

Pett, M. A. (1977). *Nonparametric statistics for health care research: Statistics for small samples and unusual distributions*. Thousand Oaks, CA: Sage.

Riess, H. (2002). Integrative time-limited group therapy for bulimia nervosa. *International Journal of Group Psychotherapy*, *52*, 1–26.

Shiina, A., Nakazato, M., Mitsumori, M., Koizumi, H., Shimizu, E., Fujisaki M., & Iyo, M. (2005). An open trial of outpatient group therapy for bulimic disorders: Combination program of cognitive behavioral therapy with assertive training and self-esteem enhancement. *Psychiatry and Clinical Neuroscience*, 59, 690–696.

Whiteside, U., Chen, E., Neighbors, C., Hunter, D., Lo, T., & Larimer, M. (2007). Difficulties regulating emotions: Do binge eaters have fewer strategies to modulate and tolerate affect? *Eating Behavior*, *8*, 162–169.

Wilson, G. T., Fairburn, C. G., Agras, W. S., Walsh, B. T., & Kraemer, H. D. (2002). Cognitive behavior therapy for bulimia nervosa: Time course and mechanisms of change. *Journal of Consulting and Clinical Psychology*, *70*, 267–274.

Wilson, G. T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist*, *62*, 199–216.