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Shorter communication

Examination of early group dynamics and treatment outcome in a randomized controlled trial of group cognitive behavior therapy for binge eating disorder

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ABSTRACT

This study examined whether perceptions of group dynamics early in treatment predicted eating disorder outcomes in a sample of adults (N = 190) with binge eating disorder (BED) who participated in a 15-session group cognitive behavior therapy (gCBT) treatment with differing levels of therapist involvement (therapist led, therapist assisted, and self-help). The group dynamic variables included the Engaged subscale of the Group Climate Questionnaire – Short Form and the Group Attitude Scale, measured at session 2 and session 6. Treatment outcome was assessed in terms of global eating disorder severity and frequency of binge eating at end of treatment, 6-month, and 12-month follow-up. Session 2 engagement and group attitudes were associated with improved outcome at 12-month follow-up. No other group dynamic variables were significantly associated with treatment outcome. Group dynamic variables did not differ by levels of therapist involvement. Results indicate that early engagement and attitudes may be predictive of improved eating disorder psychopathology at 12 month follow-up. However, the pattern of mostly insignificant findings indicates that in gCBT, group process variables may be less influential on outcomes relative to other treatment components. Additionally, participants were able to engage in group treatment regardless of level of therapist involvement.

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1. Introduction

Binge eating disorder (BED) is characterized by recurrent episodes of binge eating (eating an unusually large amount of food accompanied by a sense of loss of control) that are associated with marked distress, in the absence of compensatory behaviors (American Psychiatric Association, 2013). Cognitive behavior therapy (CBT) is the most extensively studied psychotherapeutic treatment for BED (Wilson, Grilo, & Vitousek, 2007) and received the highest rating by the National Institute for Clinical Excellence (NICE, 2004). CBT has been adapted for either individual or group delivery in BED (e.g., Mitchell, Devlin, de Zwaan, Crow, & Peterson, 2008; Wilfley et al., 2002). CBT for BED focuses on targeting behavioral stimuli and cognitions associated with binge eating, as well as addressing self-esteem, mood enhancement, body image, and relapse prevention (Mitchell et al., 1993).

CBT for BED has been associated with decreases in binge eating frequency and associated eating disorder pathology when delivered individually and in groups (Grilo, Masheb, & Wilson, 2005; Peterson, Mitchell, Crow, Crosby, & Wonderlich, 2009; Peterson et al., 2001; Wilfley et al., 2002). Group psychotherapy has the additional advantage of being more cost-effective than individual interventions, making group CBT (gCBT) for BED an especially appealing treatment for further study. However, despite the relative efficacy of this group intervention, 20–50% of participants receiving gCBT do not achieve abstinence from binge eating (Hilbert et al., 2012; Peterson et al., 2009; Wilfley et al., 2002). Additionally, gCBT suffers from unexplained high dropout rates (Brownley, Berkman, Sedway, Lohr, & Bulik, 2007).

One unique characteristic of group psychotherapy is that it fosters the interplay of complex interpersonal dynamics, including

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those among members and between members and leaders. Thus, these interactional dimensions (e.g., group dynamics) may influence treatment outcomes. However, relatively few studies have investigated the association of various elements of group dynamics (e.g., group climate,[1] group cohesion[2]) with treatment outcomes in interventions for those with BED, including gCBT. The predictive validity of group dynamics on treatment outcomes in this population is therefore not well established.

An initial study ($N = 65$) of group dynamics in a gCBT for BED treatment which consisted of 12, 90-min long sessions found that perceptions of a positive group climate early in treatment, defined as session 2 or 3, discriminated treatment responders (i.e., those who were abstinent from binge eating with stable weights and adherence to a regular exercise program) from non-responders (Castonguay, Pincus, Agras, & Hines, 1998). Additionally, positive perceptions of the group early in treatment were associated with reduced binge eating frequency at post-treatment. Although this study provided initial support for the hypothesis that early group dynamics may be associated with end of treatment outcome in BED, the findings were limited by the small sample size and not including follow-up data.

In a larger study of 162 participants with BED comparing gCBT to group interpersonal therapy, both of which consisted of 20, 90-min long sessions (Wilfley et al., 2002), scores from the Group Climate Questionnaire Scale (GCQ) and the Group Attitude Scale (GAS) at session 6 and session 10 were used to predict treatment outcome at follow-up (Hilbert et al., 2007). Whereas GCQ scores did not predict treatment outcomes, group attitudes, as measured by the GAS, were significantly related to one-year follow-up outcomes. Specifically, participants who endorsed less positive group attitudes during the early and middle phases of treatment were significantly less likely to respond to treatment. Therefore, in addition to group attitudes potentially influencing positive treatment outcomes, the lack of positive group attitudes may also contribute to negative outcomes. However, this study only included participants who were still attending treatment at session 6, and thus was unable to examine the association of earlier treatment group dynamics with treatment outcome.

The present study used data from a large, multicenter randomized controlled trial of outpatient gCBT for adults with BED which compared differing levels of therapist involvement (self-help, therapist assisted, and therapist led; Peterson et al., 2009). The primary aim of the present study was to identify whether group dynamics, specifically facets of group climate as well as group attitudes, early in treatment was associated with eating disorder symptomatology at end of treatment and at follow-up. Specifically, we were interested in the predictive validity of early group dynamics on treatment outcomes and hypothesized that perceptions of group dynamics early in treatment would significantly predict outcomes at end of treatment and follow-up, with more positive group dynamics predicting better outcomes. We also included an exploratory analysis to determine whether group dynamics were associated with treatment retention. If group dynamics assessed early in treatment are predictors of reductions in post-treatment eating pathology or treatment retention, this could inform the development of more efficacious treatments emphasizing early group dynamics that may lead to a greater number of individuals benefitting from treatment.

[1] Group climate captures perceptions of engagement, conflict, and avoidance of group members (MacKenzie, 1983).

[2] Group cohesiveness describes a sense of belongingness to a group at both an individual and group level (Yalom & Lesczc, 2005) and is a factor of group engagement (MacKenzie, 1983).

The secondary aim of the study was to examine group dynamics with respect to the varying levels of therapist involvement. This aim is a novel addition to the literature on group dynamics and treatment outcomes, and is particularly compelling given that group cohesion may actually be greater in self-help groups than therapist-led groups (Toro, Rappaport, & Seidman, 1987). Given this, we hypothesized that participants in the self-help condition would report more positive group dynamics compared to participants in the therapist-led and therapist-assisted groups.

2. Method

2.1. Participants

Of the 259 participants who were enrolled in the main study (Peterson et al., 2009), 190 participants were in an active treatment condition and completed either the GAS and GCQ-S at session 2 and/or session 6 and were included in the present study.

2.2. Measures

Group Attitude Scale (GAS; Evans & Jarvis, 1986). The GAS is a 20-item questionnaire using a 9-point Likert scale ranging from *agree* (1) to *disagree* (9) to measure an individual's self-reported attraction to their therapy group, with scores ranging from 20 to 180. The coefficient alpha in the present study was 0.87.

Group Climate Questionnaire − Short Form (GCQ; MacKenzie, 1983). This frequently used self-report measure of group climate consists of 12 items using a seven-point Likert scale ranging from *not at all* (0) to *extremely* (6). The GCQ yields three factor-analytically derived scales: Engaged, which indicates a positive working group atmosphere and group cohesion; Conflict, which reflects anger and tension in the group; and Avoiding, which describes behaviors indicating avoidance of personal responsibility of group work by members. Subscale scores range from 0 to 6. One previous study found good to high alpha coefficients for the three subscales (0.94, Engaged; 0.92, Avoiding; 0.88, Conflict; Kivlighan & Goldfine, 1991); however, others have found alpha coefficients in the poor to good range (0.74, Engaged; 0.40 Avoiding; and 0.75, Conflict; Johnson, Spitzer, & Williams, 2001). In the present study, we found the coefficient alpha to be good for the Engaged subscale (0.74) but unacceptable for Avoiding (0.17) and poor for Conflict (0.52). Thus, we elected to only use the Engaged subscale (GCQ-E) in the analyses.

Eating Disorder Examination (EDE; Fairburn & Cooper, 1993; Fairburn, Cooper, & O'Conner, 2008). The EDE is a widely-used clinician-administered interview comprised of four subscales (Restraint, Eating Concern, Shape Concern, & Weight Concern) reflecting the severity of specific dimensions of eating disorder psychopathology, as well as a Global score. A recent review of the psychometric properties of the EDE indicates that scores on this measure exhibit adequate reliability and that the measure demonstrates validity for the assessment of eating disorder symptoms (Berg, Peterson, Frazier, & Crow, 2012; Fairburn et al., 2008). The EDE has demonstrated good test-retest reliability in a sample of BED patients, with correlations ranging from 0.50 to 0.88 (Grilo, Masheb, Lozano-Blanco, & Barry, 2004). A random sample (20%) of audio recordings from the full sample ($N = 259$) used for the current study were coded for inter-rater reliability, which ranged from 0.955 to 0.982 for the subscales and Global scores (Peterson et al., 2009). The EDE also measures frequency of objective bulimic episodes (OBEs) in the past four weeks (28 days).

Treatment Outcome. Treatment outcome was assessed two ways, both of which were derived from the EDE. The treatment outcome measures included 1) EDE Global score and 2) number of

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