

Group Analysis: Looking systematically at group development, structure, and function in an eating disorder program

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Abstract: *This paper reflects upon groupwork with patients in a hospital-based eating disorder treatment program. It discusses the importance of reflection and evaluation of our own practice, as well as specific challenges and successes that I encountered while doing groupwork. This paper also relates groupwork theory to my individual work, and outlines key concepts that are central to practicing group therapy.*

Keywords: *commonality, mutual aid, context, goals, ambivalence, communication, relationships, cohesion, leadership*

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Introduction

After leading groups for the entire academic year in an eating disorder program, I believe that I have gained invaluable skills that can be applied to any population in any group therapy setting. The timing of my weekly group, as well as the constant change of clientele were among some of the challenges that I faced when planning and running the group. While we as practitioners hope to make the environment as favorable as possible for our group members, there are often agency regulations and constraints that we cannot control. Thus, having experience working within these constraints has taught me to be more creative when developing group topics, and to rely more on the group members themselves to dictate the direction and flow of each session.

Background

The need that my specific group aims to meet is broad and somewhat generalized. Because the patients in the program are in groups from 7am to 7pm, including meals and snacks, they are immersed in the treatment process. My goal has been to not only address challenges and successes in recovery from their eating disorder, but also to promote positive thinking and emotional well-being. While there needs to be a 'clinical' focus to the groups that I run each week, I make a strong effort to allow each member of the group to have time to enjoy one another, laugh, or talk about themselves in ways unrelated to their disorder. As the strengths perspective makes clear, constantly focusing on pathologies, problems, or illnesses does not support health (Saleebey, 2005).

All members of the group share the commonality of being in treatment for an eating disorder, yet their actual diagnosis may be very different. They also often share certain personality traits. For example, many of the patients with anorexia nervosa strive for perfection in everything they do, and some have obsessive compulsive tendencies. While these are the pathological commonalities, it has been rewarding to watch group members find other commonalities with each other that are related to who they are outside of their eating disorder. I believe this has strengthened the mutual aid process through support, where 'the group culture supports the open expression of feelings [and] members

can empathize with one another' (Shulman, 2009).

While clearly there is a larger societal pressure that relates to the development of eating disorders, it was not often the topic of conversation in groups. Understandably, many members are focused on their own health, their own recovery, and their own challenges with the process. Thus, bringing the larger societal constructs to light seemed important in order for the group to establish a universal perspective, where members hold less personal blame and can view their problems in a larger context (Shulman, 2009). One of the weekly group topics I have done with various groups of patients was to examine other cultural images of beauty in order to illustrate how subjective and culture-driven our perceptions about women's bodies are. An image of a geisha with her face painted pure white, as well as an African woman with large nose and lip ornaments was passed around to the group members to facilitate a discussion of societal norms. Discussions would often begin by examining other cultures, but would end with examining our own American culture and how it dictates what is 'beautiful' in terms of shape and size.

Practice context

Attendance in groups is mandatory, thus all patients in treatment attend each of the daily sessions. Sometimes a patient may have a doctor's appointment during a group, or may need to meet with their clinician to have an individual therapy session or a family therapy session, but most patients are in attendance for all groups. This has presented some challenges for me as the facilitator, as members are tired and sometimes overwhelmed by the time 1pm on Wednesday rolls around. This leads to disengagement, members falling asleep, or even hostility towards 'staff' in general. A way that I have learned to address this is to begin the group by talking about a neutral topic. We may spend the first few minutes most days talking about a member's children, or a blanket that someone is knitting. This seems to bring the group back to reality and remind them of important or enjoyable things in their lives. Duncan, Hubble, and Miller (1997) describe the integral process of allowing clients to be who they are, and to recognize their personal qualities aside from their disorder or illness.

We have learned to listen more [and] turn off the intervention spigot... The greater success we have experienced in doing this, the more room clients have had to be themselves, use their own resources, discover possibilities, attribute self-enhancing meanings to their actions, and take responsibility. (Duncan, Hubble, & Miller, 1997, p.207)

Toseland and Rivas also point out that members will need to express their own identities, but this expression through topics needs to be time limited so that the group members may work to achieve their treatment goals (Toseland & Rivas, 2009).

Patients flow in and out of the program, and thus my group's composition is never exactly the same. Still, over the course of the year I have noticed certain communication patterns and styles of group interaction that are typical. While I try to promote a more 'free floating style,' where all members take responsibility for communicating about the topic, most often, the interaction style is 'maypole,' where I am the central figure as the facilitator and communication mainly occurs between me and each group member (Toseland & Rivas, 2009). Group members are more accustomed to a leader-centered group structure because many of the other groups in the program are led this way. Therefore, unless I make a strong effort to encourage members to talk to one another, they tend to direct their comments to me. This may be because the nature of the groups is treatment focused, and the clinician often spends a lot of the group time teaching certain skills, or challenging individual thoughts or behaviors that are discordant with treatment goals. Still, I make an effort to allow the group members to challenge each other, rather than allowing my opinions or 'professional knowledge' dictate the group process. As Saleebey notes, 'we make a serious error when we subjugate clients' wisdom knowledge to official views' (Saleebey, 2006, p.18).

Developmental challenges

Developmentally, patients are at varying stages. Within the program we treat a large age range; anyone 13 and older may be in the program together at any given time. This presents some challenges based on what members are looking for from the group, as well as what they can comprehend or take away from treatment. Still, what is interesting

is that each member, no matter what age, shares the developmental challenge of learning to take care of him/herself and gaining personal responsibility for their own health. This has a powerful force on the group, and appears to devalue any ageism that might normally be present. Typically, members of my groups experience an 'all in the same boat phenomenon' regardless of their life stage (Shulman, 2009).

Ambivalence and value clarification

Group members often have similar goals, although these may vary day to day. Due to the ambivalence that members experience throughout treatment, clarifying goals and values has been an important part of my facilitation of groups.

By exploring ambivalence and considering the readiness of a client to change, a structure is created that builds collaboration between therapist and client. (Killick & Allen, 1997, p.33)

Typically, the goal of the program is to provide a patient with the partial hospitalization level of care through the ambivalence stage, and into a stage where they experience more clarity. Once this is achieved, more work may be done with an outpatient therapist in order to continue working through challenges that arise. The 'group phases of dealing with trauma and loss' also seem to apply to my groups; trust is built first and foremost, conflict often emerges soon after, patients are ambivalent for quite some time, and then their reality becomes clearer (St. Thomas & Johnson, 2007). Group members help one another recognize ambivalence, and challenge each other to clarify what it is they want, and why they are in treatment.

Individual needs

There may be clients who need special, individual attention during my weekly group. Usually, this is because he/she is going through a particularly difficult personal challenge with their eating disorder. For example, one such Wednesday, a young woman was disengaged,

listening to her headphones at the start of group. After I encouraged her to participate, it eventually became clear that she had restricted her food intake the night before, and had excessively exercised. She was experiencing a feeling of intense shame, and had not been able to share this information with anyone yet. As the group processed this event, the young woman heard from other group members who had had similar experiences at some point in their treatment stay. This helped to normalize her difficulties, and to realize that this was often part of a typical recovery process. It did not mean that she was a 'failure' or that she was slipping back into her eating disorder, rather the group helped her to see that this was an important learning experience. Most of the group time that day was dedicated to this young woman's personal challenge, yet it allowed the other members to relate their own stories, as well as give feedback and support to someone else in need.

Helping members respond to each other fosters information sharing, mutual aid, and the building of a consensus about how to approach a particular problem. (Toseland & Rivas, 2009, p.112)

Multiple service providers

Clients in my groups have multiple service providers. Our treatment team is made up of doctors, nurses, dieticians, recreational therapists, and social workers. Therefore, their various needs are met by many different people within the program. Patients may also have outpatient providers set up for aftercare. These are typically people who they saw previously to be admitted, such as outside therapists, primary care providers, and dieticians. If a client does not have outpatient providers already in place, we work to set these up before they leave us. The service providers that we recommend first for aftercare are those that have a specialization in working with eating disorders, thus many patients see our program outpatient therapist and dietician during their private practice hours. This allows patients to stay connected to the program and our staff after they leave partial hospitalization, which maintains a semblance of continuity even when they leave the group.

Confidentiality issues

Confidentiality within the group has been very important, especially because many of the patients in the group know other patient's families. One of the many groups that patients participate in each week is a multiple family group, which includes support people who are helping their loved one through treatment. Therefore, it is important that each group member maintain confidentiality about things said in daily patient groups when in multiple family group. Typically, this is not a problem, yet there are times when these boundaries become blurred. For example, during one of my weekly groups, a patient had discussed the pros and cons of discharging early and battling recovery on her own. She was anxious to get back to school and her 'normal life' and felt that she could maintain her meal plan at home. Her decision to leave was not finalized, as she was still in the contemplative stage. She had not told her family that she was thinking about leaving because she was afraid that they would be fearful or upset. Another patient did not realize that her family was unaware, and before multiple family group one morning, asked the patient's father, 'so, _____ is discharging next week?' Of course, this was an unintentional breach of confidentiality that caused everyone to revisit the importance of maintaining this in our group. As Toseland and Rivas point out the group should be reminded about confidentiality during life of the group in order to maintain the trust and cohesion necessary (Toseland & Rivas, 2009).

Being where the client is

Each week, the group content is primarily determined by me. Yet, I make sure to listen in to other groups during the beginning of the week to find common themes that are emerging as possible challenges or issues to discuss. Based on discussions in class, as well as through readings and research, I decided to facilitate a group just last week around ways to break problems or challenges down into smaller, more manageable tasks. One thing that I had noticed about this particular group of clients was that they were repeatedly talking about how daunting and overwhelming the challenge of recovering from an eating disorder was. Many discussions were formed in self-evaluation groups around fears

and concerns that they would be unable to fully recover, or that they would relapse, or not be able to follow-through in the long-term. By pulling themes from what patients had said in other groups, I formed a loose idea about how to help them break down recovery into smaller objectives that felt manageable. I hoped that by keeping it loose, it would allow for the group members themselves to expand upon the topic and take it in the direction they felt would serve them the most. I also hoped that as we started to break things down, the members might notice which areas they were having the most difficulty with, and be able to problem solve a bit better.

Most often, the norm in this particular group of patients has been to allow one woman, an emergent leader, to speak about the given topic. Other patients would subsequently follow her lead and speak on a similar track. Therefore, I asked another member of the group, a member who is typically more quiet, to start us off with an idea of how to break down the challenge of recovery. She looked surprised, but offered 'following your meal plan' as one smaller factor in the process. Encouraging member input has been important in this group, as it allows for multiple perspectives to be examined, rather than my own or those of the most vocal members (Toseland & Rivas, 2009).

Relationships

This particular group also has formed subgroups that have impacted the entire group's cohesion. In the past, many of the members of my group have been supportive, open, and communicative with everyone and were not discriminatory in any way. Interestingly, we currently have a primarily young adult and adolescent population, and relational issues are much more present than I have seen them before. Thus, as a facilitator, I have had to use my mediating skills, and what I have learned about dealing with conflict, to move the group forward. Helping the group view conflict as an inevitable process that arises, as well as a way to clarify personal values, boundaries, and expectations has been imperative (Toseland & Rivas, 2009).

Presently, the quality of the relationship between me as the facilitator and my group members is generally good, yet it depends on the individual group member. This is because there are members who

have only been in the program for a few days, and therefore we have not been able to establish the quality of relationship that I have with certain other members who have been in my group for weeks. Because the patients are typically only in treatment for 15 days, trust needs to be established quickly. The relatively short stay for most patients presents obvious challenges in creating group cohesion and a strong bond between staff and group members.

Currently, the problems in the group often arise from members being ambivalent or unmotivated for treatment. While this is expected to a certain extent, when this continues, other patients often become defensive and 'triggered,' which arises in conflict. Also, conflict may arise between these patients and staff members when staff begin to put pressure on their eating disorder. For example, during my group two weeks ago, two patients were arguing because earlier in the day, one of the girls had tried to hide her snack and throw it away without staff noticing. The other patient discussed how this made her feel frustrated and concerned, and also prompted her to want to get rid of her own snack. She angrily commented, 'Why are you here if you're trying to throw away your snack? You're supposed to be here to recover. It's really triggering to me to see other people using eating disorder behaviors.' As the facilitator, I mediated the conversation, and allowed each member to voice their personal challenges and concerns to the other. Then, interestingly, the angry patient directed her anger toward me, stating, 'In reality, I'm really mad at staff for not noticing that people are using eating disorder behaviors. That's your job.' As Shulman points out, 'Group members will often make the workers feel exactly the way the members themselves feel' (Shulman, 2009, p.383).

Conclusion

Overall, I believe the group has been successful in meeting the specific needs of each individual. The group is typically relatively small, enabling each member to have a chance to share and get feedback from others. Therefore, the group has been successful in achieving its purpose, which is to allow members to express their feelings regarding the challenges and successes in their recovery process, and to help challenge eating disorder thoughts and behaviors. Throughout the course of the year, I

have learned invaluable skills through leading the group. Initially, my tendency was to over plan and to really 'lead' the group by teaching and talking. Yet, as I became more comfortable with the group process and saw the benefits of allowing the members to dictate the general direction, I saw the group take on its own life where the real therapeutic work could be done.

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