5-1995

The Effects of Therapist Gender on Group Therapy for Eating-Disordered Clients

Todd A. Soutor
Utah State University

Follow this and additional works at: https://digitalcommons.usu.edu/etd
Part of the Psychology Commons

Recommended Citation
https://digitalcommons.usu.edu/etd/6075

This Dissertation is brought to you for free and open access by the Graduate Studies at DigitalCommons@USU. It has been accepted for inclusion in All Graduate Theses and Dissertations by an authorized administrator of DigitalCommons@USU. For more information, please contact dylan.burns@usu.edu.
THE EFFECTS OF THERAPIST GENDER ON GROUP THERAPY FOR EATING-DISORDERED CLIENTS

by

Todd A. Soutor

A dissertation submitted in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY in

Psychology

Approved:

UTAH STATE UNIVERSITY
Logan, Utah
1995
ACKNOWLEDGMENTS

As I look back on the long journey that brought me toward completion of this dissertation, I can think of so many people to thank. My committee was outstanding and very dedicated toward my successful completion of this research. I feel appreciative to each member for the different roles they played in my progress, both on this dissertation and in my professional training at Utah State. Each member provided me with excellent professional guidance while maintaining a personal relationship with me that sincerely enhanced my entire training experience.

I also have many friends to thank: Deetch, Freeds, Miner, Benny, Pete, and Big Ed, who provided me with numerous opportunities to enjoy free time and helped me maintain a somewhat balanced lifestyle during my graduate training.

My long-time girlfriend, Danielle Puopolo, was a great companion throughout my time at Utah State. She provided me with an opportunity to grow as a person and allowed me to experience complete emotional fulfillment during such a demanding period in my life.

Most of all I would like to thank my parents. Throughout the years, they have provided me with so much, more than I could ever repay. I consider them ultimately responsible for this achievement because they provided me with the faith and belief that I could achieve such an accomplishment.

Todd A. Soutor
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>vi</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>I.   INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>II.  REVIEW OF THE RELEVANT LITERATURE</td>
<td>6</td>
</tr>
<tr>
<td>Theoretical Bases</td>
<td>6</td>
</tr>
<tr>
<td>Etiology and Symptoms in Eating-Disordered Clients</td>
<td>8</td>
</tr>
<tr>
<td>Summary of Gender Bias Reviews</td>
<td>21</td>
</tr>
<tr>
<td>Single-Subject Experimental Design</td>
<td>25</td>
</tr>
<tr>
<td>Alternating-Treatments Single-Subject Design</td>
<td>29</td>
</tr>
<tr>
<td>III. METHOD</td>
<td>35</td>
</tr>
<tr>
<td>Subjects</td>
<td>35</td>
</tr>
<tr>
<td>Setting</td>
<td>36</td>
</tr>
<tr>
<td>Sessions</td>
<td>36</td>
</tr>
<tr>
<td>Therapists</td>
<td>37</td>
</tr>
<tr>
<td>Procedures</td>
<td>39</td>
</tr>
<tr>
<td>Experimental Design</td>
<td>40</td>
</tr>
<tr>
<td>Data Collection Procedures</td>
<td>42</td>
</tr>
<tr>
<td>IV.  RESULTS</td>
<td>45</td>
</tr>
<tr>
<td>Reliability</td>
<td>45</td>
</tr>
<tr>
<td>Content of Group Therapy Sessions</td>
<td>46</td>
</tr>
<tr>
<td>Consistent, Significant Effects Across Groups</td>
<td>47</td>
</tr>
<tr>
<td>Significant Results with Group 1</td>
<td>51</td>
</tr>
<tr>
<td>Significant Results with Group 2</td>
<td>63</td>
</tr>
<tr>
<td>Results Showing No Significance from Either Group</td>
<td>73</td>
</tr>
<tr>
<td>V.   DISCUSSION</td>
<td>77</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Eating Disorders Treatment Model</td>
<td>78</td>
</tr>
<tr>
<td>Implications of Results from the Female</td>
<td>81</td>
</tr>
<tr>
<td>Therapist-Only Condition</td>
<td></td>
</tr>
<tr>
<td>Implications of Results from the Male</td>
<td>84</td>
</tr>
<tr>
<td>Therapist-Only Condition</td>
<td></td>
</tr>
<tr>
<td>Benefits of a Mixed Gender Cotherapist Team</td>
<td>86</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>88</td>
</tr>
<tr>
<td>Implications for Future Research</td>
<td>90</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>93</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>104</td>
</tr>
<tr>
<td>APPENDIX A: Brief Description of Eating-Disorder Clients</td>
<td>105</td>
</tr>
<tr>
<td>APPENDIX B: Clients' Informed Consent Form</td>
<td>108</td>
</tr>
<tr>
<td>APPENDIX C: Agency Approval Form</td>
<td>110</td>
</tr>
<tr>
<td>APPENDIX D: Clients' Attendance</td>
<td>113</td>
</tr>
<tr>
<td>APPENDIX E: Brief Description of Therapists</td>
<td>115</td>
</tr>
<tr>
<td>APPENDIX F: Therapist Instructions</td>
<td>117</td>
</tr>
<tr>
<td>APPENDIX G: Coding Instrument</td>
<td>120</td>
</tr>
<tr>
<td>APPENDIX H: Operational Definitions of Content Categories</td>
<td>122</td>
</tr>
<tr>
<td>APPENDIX I: Ethical Procedures Form for Coders</td>
<td>126</td>
</tr>
<tr>
<td>APPENDIX J: Presentation of Raw Data</td>
<td>128</td>
</tr>
<tr>
<td>APPENDIX K: Nonsignificant Results for Group 1</td>
<td>133</td>
</tr>
<tr>
<td>APPENDIX L: Nonsignificant Results for Group 2</td>
<td>156</td>
</tr>
<tr>
<td>VITA</td>
<td>181</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group 1 Therapist Team Disagreements on Optimal Practice Questionnaire</td>
</tr>
<tr>
<td>2</td>
<td>Group 2 Therapist Team Disagreements on Optimal Practice Questionnaire</td>
</tr>
<tr>
<td>3</td>
<td>Experimental Conditions for the Eating-Disordered Group Therapy Sessions</td>
</tr>
<tr>
<td>4</td>
<td>Interobserver Reliability Coefficients for Content Coding Sheet (N=8)</td>
</tr>
<tr>
<td>5</td>
<td>Interobserver Reliability Coefficients by Session for Group 1</td>
</tr>
<tr>
<td>6</td>
<td>Interobserver Reliability Coefficients by Session for Group 2</td>
</tr>
</tbody>
</table>
### LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The frequency of intervals containing negative affect statements by Group 1</td>
<td>48</td>
</tr>
<tr>
<td>2</td>
<td>The frequency of intervals containing negative affect statements by Group 2</td>
<td>49</td>
</tr>
<tr>
<td>3</td>
<td>The frequency of intervals containing total affect/mood modulation statements by Group 1</td>
<td>50</td>
</tr>
<tr>
<td>4</td>
<td>The frequency of intervals containing total affect/mood modulation statements by Group 2</td>
<td>51</td>
</tr>
<tr>
<td>5</td>
<td>The frequency of intervals containing family weight statements by Group 1</td>
<td>53</td>
</tr>
<tr>
<td>6</td>
<td>The frequency of intervals containing personal weight statements by Group 1</td>
<td>54</td>
</tr>
<tr>
<td>7</td>
<td>The frequency of intervals containing fashion and clothing statements by Group 1</td>
<td>55</td>
</tr>
<tr>
<td>8</td>
<td>The frequency of intervals containing statements about perceptions of their own attractiveness toward males by Group 1</td>
<td>56</td>
</tr>
<tr>
<td>9</td>
<td>The frequency of intervals containing statements about negative body image by Group 1</td>
<td>57</td>
</tr>
<tr>
<td>10</td>
<td>The frequency of intervals containing total body image and attractiveness statements by Group 1</td>
<td>59</td>
</tr>
<tr>
<td>11</td>
<td>The frequency of intervals containing anger toward a specific male statements by Group 1</td>
<td>60</td>
</tr>
<tr>
<td>12</td>
<td>The frequency of intervals containing anger toward a specific female statements by Group 1</td>
<td>61</td>
</tr>
<tr>
<td>13</td>
<td>The frequency of intervals containing relationship with mother statements by Group 1</td>
<td>62</td>
</tr>
</tbody>
</table>
14 The frequency of intervals containing total parental relationship statements by Group 1 .............................................. 63
15 The frequency of intervals containing binging statements by Group 2 ............................................................................ 65
16 The frequency of intervals containing positive body image statements by Group 2 .......................................................... 66
17 The frequency of intervals containing total food and weight loss behavior statements by Group 2 .............................. 67
18 The frequency of intervals containing heterosexual relationship statements by Group 2 .......................................................... 68
19 The frequency of intervals containing relationship with father statements by Group 2 ............................................................ 70
20 The frequency of intervals containing negative body image statements by Group 2 ............................................................ 71
21 The frequency of intervals containing total body image and attractiveness statements by Group 2 ............................ 72
22 The frequency of intervals containing total interpersonal relationship statements by Group 2 .................................................. 74
23 The frequency of intervals containing exercise statements by Group 1 .............................................................................. 75
24 The frequency of intervals containing diuretics statements by Group 2 .............................................................................. 76
25 A cognitive-behavioral treatment model for eating disorders ................................................................................. 79
ABSTRACT

The Effects of Therapist Gender on Group Therapy for Eating-Disordered Clients

by

Todd A. Soutor, Doctor of Philosophy
Utah State University, 1995

Major Professor: Dr. David M. Stein
Department: Psychology

This present study examined the session-by-session content of group therapy for eating-disordered clients. The main objective of this study was to identify how therapist-client gender match affects group therapy process, regarding the disclosure of important issues relevant to eating-disordered clients. It was hypothesized that the group therapy process for eating-disordered clients would be qualitatively different if therapy was facilitated by a female as opposed to a male therapist. The evaluation of the research question required using an alternating-treatments single-subject research design, in which the presentation of treatment conditions was counterbalanced across two therapy groups. The treatments consisted of three therapist conditions (i.e., male therapist-only, female therapist-only, or both therapists) that were systematically presented during the study. All group-therapy sessions were videotaped and coded for verbal content. The results suggested that when a female
therapist alone was leading group therapy sessions, eating-disordered clients were more inclined to discuss general emotional issues and specific issues involving negative affect. Furthermore, during the male therapist-only conditions, there was a tendency for female group members to talk more about the physical symptoms of eating disorders (i.e., food-related behaviors, body image issues). The relationship of these results regarding their practical implications on therapist knowledge, training, in-session behavior was discussed.  

(185 pages)
Anorexia and bulimia are quite common in college-aged women. Halmi, Falk, and Schwartz (1981) reported a 19% prevalence rate for bulimia in this age group. Most studies, however, indicate that minimum rates of 1-3% of college-aged women are found to have a DSM-IIIR diagnosable eating disorder (Stein, 1991; Halmi, 1987), with a peak incidence around the age of 18 (Hsu, 1990). Furthermore, evidence from case record studies indicates that the incidence of eating disorders seems to be increasing in Western countries (Hsu, 1990).

In the treatment of eating-disordered clients, both individual and group therapy approaches are currently being used. Theoretically, the most efficient treatment modality for eating-disordered individuals may be group therapy, where clients have the opportunity to receive feedback from peers as well as the therapist (Hsu, 1990, Yalom, 1985). Terry (1987) recommended a group approach as the treatment of choice for eating-clients because a group therapy format provides the most cost-effective treatment approach while providing the clients with an essential social support network. More recently, Riess and Rutan (1992) suggested group therapy as one of the preferred treatment approaches for eating disorders. This suggestion is consistent with the most recent literature review on the treatment of eating disorders, which considers group therapy as an effective approach in treating many of the symptoms of eating-disordered clients (Hendren, Atkins, Sumner, & Barber, 1992). In treatment groups, key therapeutic issues are often addressed such as abnormal food-related cognitions, behaviors, and attitudes (Fairburn
& Garner, 1986), distorted body image, low self-esteem, ambivalence about identity (Zunino, Agoos, & Davis, 1991), mood disturbances (Wardle, 1988), fear of weight gain, perfectionism, and anxieties over sexuality (Inbody & Ellis, 1985), family relationships and parental conflicts (Rosen, 1987), and interpersonal relationship problems (Roth, 1986).

A major question about group therapy process research is whether therapist gender plays a role in facilitating or impeding the direction of therapy. Given that eating-disordered clients are predominantly female (DSM-IIIR, APA, 1987), arguments by various writers have been presented, suggesting that therapist gender may play a significant role in therapy outcome. These arguments center on therapist-client similarity issues and feminist philosophy. For example Simmons, Berkowitz, and Moyer (1970) proposed a theory of social and attitudinal change which addresses gender effects in therapy. Their theory proposed that therapist credibility and influence are a function of similarity between the therapist and client. Consequently, this theory suggests that relative to males, female therapists can best facilitate group therapy for eating-disordered individuals, who are primarily female. Also, current feminist theory argues that relative to female therapists, male therapists may be less understanding, empathic, and facilitative with female clients (Greenspan, 1983). With respect to the treatment of eating disorders, some theorists have suggested that the presence of a male therapist inhibits the discussion of central issues that are essential for successful treatment (Hall, 1985; Lacey, 1983).

Unfortunately, there is no empirical research addressing the importance of the role of gender matching in group therapy treatment of eating-disordered clients. The only data published to date on the impact of matching client and
therapist gender in the eating disorder area is that of Zunino et al. (1991). These authors summarized nonempirical, nonsystematic clinical data from two cases, suggesting that matching gender might have a pronounced impact upon the course and content of psychotherapy. Specifically, these authors concluded that a therapist-client gender match may accelerate the therapy process, resulting in more efficient treatment for eating-disordered clients.

There has, however, been some research (and a substantial amount of controversy) on the role of gender matching in individual psychotherapy. Some researchers and clinicians believe that gender matching of the client and therapist facilitates the therapeutic process and contributes to a beneficial therapeutic outcome (Fisher, 1989; Jones, Krupnick, & Kerig, 1987; Hill, 1975). Conversely, others conclude that client-therapist gender match has no impact on the process or outcome of therapy (Flaskerud, 1990; Kaplan, 1985; McCabe, Collins, Jupp, Walker, & Sutton, 1983). It appears that the current status of gender effects literature in psychotherapy outcome is contradictory, perhaps due to methodological and conceptual limitations. Based on the equivocal state of the literature, there is a significant need for empirical studies evaluating therapist-client gender effects in group psychotherapy (Flaskerud, 1990; Barak & Fisher, 1989). A study providing information about the impact of matching therapist gender in group therapy with eating-disordered clients would be particularly useful. Sessions led by the female therapist might result in a higher frequency of group discussion of core issues and conflicts theoretically associated with the etiology and maintenance of eating disorders (e.g., body image, food-related behaviors, relationship issues, ambivalence toward males, etc.). The primary thesis of the present study is that the group therapy process for eating-disordered
clients may be qualitatively different if facilitated by a female as opposed to a male therapist. Thus, this project examined how the process of eating-disordered group therapy (i.e., by identifying the particular issues that the group discusses) is influenced by the therapist gender.

This present study examined the session-by-session content of group therapy for eating-disordered clients. The main objective of this study was to identify how therapist-client gender match affects group therapy process, regarding the disclosure of important issues relevant to eating-disordered clients. The study examined whether the absence of one therapist in a mixed gender dyad has an effect on the process and content of the particular therapy session. Knowledge of these effects may have implications for therapists, clients, and the field of psychology. Some of the possible implications are as follows:

1. Knowledge of therapist gender effects may guide research into therapeutic tactics and strategies that facilitate therapeutic progress (i.e., does therapist gender affect which topics or issues are avoided and discussed?; how does this impact psychotherapeutic relationships, group cohesiveness, continuity of therapy?, etc.).

2. Knowledge of therapist gender effects may provide information for educators who train therapists (e.g., illustrations of the effects of the absence of one therapist, in a mixed gender dyad).

3. This research may suggest that eating-disordered women might tend to have qualitatively different therapeutic experiences over time, depending on the gender of the therapist. For example, in a certain phase of therapy, a female eating-disorder client may benefit from learning to self-disclose in the presence of an accepting and empathetic male. This could be a particularly important step
toward accomplishing the therapeutic goal of establishing healthy, satisfying relationships with males.

4. The results of this study may provide empirical data-based information about the general controversy regarding therapist-client gender matching that exists in the current literature.
CHAPTER II
REVIEW OF THE RELEVANT LITERATURE

The purpose of this literature review is, first, to present the theoretical foundation for the popular assumption among mental health professionals that therapist gender can influence psychotherapy relationships. Second, the significant women's issues that are likely to emerge in eating disorder treatment groups will be discussed. The review of recent literature revealed a reasonable consensus of opinion among professionals regarding these eating-disorder issues. It is suggested that interpersonal, psychological, and familial factors are important in the etiology of eating-disorder syndromes, and that these issues must be resolved if therapy is to have a positive outcome for individual clients. Identification of these critical issues will form the basis of the content coding instrument that was used in the present study. Third, the available empirical literature regarding therapist-client gender matching in individual therapy will be summarized. This literature on individual therapy is presented because it is the only empirical data peripherally related to the proposed study. To date, no empirical literature that targets gender bias in a group therapy setting with eating-disordered clients has been published. Fourth, a theoretical base will be established regarding the use of a single-subject experimental methodology in this study.

Theoretical Bases

Simmons et al. (1970) proposed a theory of social and attitudinal change suggesting similarity between the source (therapist) and the receiver (client) as
the primary factor in successful change. This theory of similarity, as it relates to psychotherapy, preceded modern feminist theory. Based on this feminist perspective, Greenspan (1983) indicated that for historical, political, and cultural reasons, men are socialized to see themselves as authorities (experts), while women are socialized to be subordinate and submissive. The submissiveness by women can be perceived as an attempt to please those male authorities, gain their acceptance, and acquire a sense of increased self-esteem through male acceptance. According to Greenspan (1983) and Cammaert and Larsen (1988), psychotherapy retains the general model of the male expert and the subordinate female client. Women are socialized to present as essentially passive clients, who are directed in psychotherapy by the male therapists (i.e., experts). Therefore, in a traditional therapy relationship (involving a male therapist and female client), it is difficult for women to assert and express themselves without inhibition. This thesis suggests that in the presence of males, females are unlikely to initiate and direct the course of their own therapy. Theoretically, the traditional therapy relationship results in women clients being dependent upon the male therapist; she adapts to a situation of powerlessness over her personal growth and development in therapy.

This model, stereotyping an authoritative male and submissive female, is thought to be especially damaging for women with eating disorders if this relationship is experienced in therapy. Taking a similar feminist model, Lacey (1983) theorized that in a group setting, two female therapists are associated with greater treatment satisfaction for bulimic clients. Many of the core symptoms present in eating-disordered clients typically involve intimate issues for women: body dissatisfaction, physical attractiveness, sexual activities, relationships with
parents, low self-esteem, hostility toward males, control issues, and specific food-related behaviors. Feminist theory suggests that psychotherapy with traditional male therapists may inhibit spontaneous discussion of these therapeutically critical issues. For example, the frequency of statements regarding key therapeutic issues (content) and in-session confrontive statements (process) should be lower in a particular session when a male therapist is alone in leading the eating-disorders group. This may also occur because, according to Greenspan (1983), in the traditional therapeutic relationship, women respond submissively to the role of the male expert by attempting to appease the expert, so as to gain his acceptance. Since eating-disordered clients generally feel in need of external approval (Baumann, 1992), their eagerness to please the authority figures (i.e., therapists) makes them very prone to and skillful at telling therapists what they believe the therapists want to hear (Riess & Rutan, 1992). Therefore, it is suggested that the discussion of critical issues such as personal anger toward a male, general derogation of men, past sexual abuse, preoccupation with attractiveness, emphasis on fashion conformity, and difficulty with heterosexual relationships will occur to a significantly lesser degree in the presence of a male therapist alone. Discussion of the previously mentioned issues may compromise the acceptance of the male therapist, resulting in a general reluctance by the group members to address those topics.

**Etiology and Symptoms in Eating-Disordered Clients**

Evidence of significant women's issues that are likely to be prominent in eating-disordered group therapy will be presented below. The identification of these significant issues has been formulated through a review of the recent
literature on the etiology, maintenance, and treatment of eating-disorder syndromes. It is generally agreed upon by researchers and clinicians that the psychological makeup of eating disorders goes beyond the disturbed food-related behaviors and attitudes that are necessary to diagnose a client with an eating disorder. The most comprehensive models recognize the several interrelated factors that contribute to and maintain the complex behavioral, cognitive, and emotional aspects prevalent in the eating-disorder syndrome. Understanding the link between eating disorders and the etiology suggests much about treatment. Ultimately, the healing depends on some type of psychological resolution regarding the contributing factors and social conditions that underlie the etiology. Professionals who work with eating-disordered clients recognize that at least some of these factors need to be addressed and resolved if group therapy is to have any degree of a positive outcome for individual clients. According to Halmi (1987),

Social, psychological, familial, and biological factors are important in producing eating disorders; consequently all of these factors must be considered in the effective treatment of the eating disorders. (p. 379)

These etiological factors will provide the bases of the design of a content coding instrument that was used in the present study.

Body image disturbance and attractiveness. Several authors have reported a disturbed body image as a central feature in eating-disordered clients (Williamson, Cubic, & Gleaves, 1993; Striegel-Moore, Silberstein, & Rodin, 1993; Wheeler & Schmitz, 1992). Similarly, others have acknowledged body dissatisfaction, as well as body image disturbance, as primary dimensions of eating disorders (Gleaves, Williamson, & Barker, 1993; Steiger, Leung, & Houle, 1992; Kuntz, Groze, & Yates, 1992). Invariably, body image distortion is
accompanied by an inordinate preoccupation with being thin (i.e., appearing attractive). The belief that an increase in physical attractiveness will result in social acceptance from both males and females is prevalent among the eating-disordered clients. Schlundt and Johnson (1990) suggested that the result of society's emphasis on thinness is that many women have adopted a set of goals and standards for their appearance that is physiologically unattainable. This heightened pressure on women to meet these increasingly thinner standards for physical attractiveness has likely provided the growing impetus for dieting and consequent eating disorders (Scott, 1987).

Several researchers have examined the relationship between body image and preoccupation with physical attractiveness to the presence of eating disorders and concluded that these two factors are contributory in the etiology. Steinhausen and Vollrath (1993) identified a group of adolescent anorexic clients as having a significantly poorer body image than a control group. McKenzie, Williamson, and Cubic (1993) demonstrated that eating-disordered clients judged their body size to be larger and preferred to be thinner than controls. Striegel-Moore et al. (1993) reported that social self-concerns and preoccupation with physical presentation are linked to body dissatisfaction and eating disorders. Gleaves et al. (1993) interviewed 100 bulimic clients and demonstrated the importance of body dissatisfaction as a significant component of bulimia nervosa. Goldsmith and Thompson (1989) incorporated a body image confrontation technique in the treatment of eating-disordered clients and reduced their tendency to overestimate their body size. Garner, Garner, and Van Egeren (1992) examined body dissatisfaction with a large sample of college women. These researchers statistically adjusted the Eating Disorder Inventory Body
Dissatisfaction score to eliminate the effects of individuals' relative body weight and found that the adjusted body dissatisfaction score was significantly different for eating-disordered clients when compared to controls. Thompson (1992) interviewed 18 women who admitted having an eating disorder for more than half of their lives and nearly all of these women experienced difficulties with their body image and their sense of personal attractiveness. The author suggested that dieting, binging, and purging were common ways women responded to disruptions in their body image and the emotional turmoil that accompanied the body image disturbance. Similarly, Kearney-Cook (1988) identified inappropriate food behavior as a common coping response for eating-disordered women who frequently experience the psychological consequences of body image disturbance.

Because body image and self-perception regarding attractiveness are considered influential in the etiology and maintenance of eating disorders, the discussion of these factors is important to the treatment of eating-disordered clients. Thus, categories targeting these constructs are included in the content coding instrument that will be used in the present study (i.e., body image--positive and negative, body area satisfaction/dissatisfaction, emphasis on personal and family weight, attractiveness, and fashion emphasis).

**Extreme weight loss behaviors and symptoms.** Several theories agree that the sociocultural influence regarding an individual's weight, particularly with the female population, contributes to abnormal eating behaviors and attitudes associated with eating disorders. Schlundt and Johnson (1990) reported that we live in a culture in which physical appearance is highly important, and in which "thin is in." Wardle (1988) theorized that the social pressures for thinness have
fallen more strongly on women than men, resulting in women often experiencing a desire to be thinner. These sociocultural attitudes encourage the development in many women of a fear, possibly unrealistic, of becoming fat. Hsu (1990) suggested that an emphasis on slimness may be a major precipitant of an eating disorder. This aspiration for thinness and fear of becoming fat are correlated with numerous extreme dietary behaviors common to eating disorders (e.g., food restricting, binging, purging, vomiting, laxative use, diuretic use, and exercise).

In her paper on the conceptualization of eating-disorder clients, Wardle (1988) reported that the historical antecedents of eating disorders suggest that food restraint almost always predates the onset of the eating-disordered behavior. Many researchers have produced empirical data that supports Wardle's conceptualization. Williams and Wilkins (1993) reviewed 36 bulimic cases and found a significantly high frequency of binging and purging behaviors prior to intervention. Kenny and Hart (1992) found that eating-disordered women reported significantly greater preoccupation with weight and dieting when compared to controls. Steiger, Leung, Ross, and Gulko (1992) interviewed 160 high school girls and detected clinical eating-disorder signs in 53% of the subjects by the identification of pathological eating and food-related attitudes. In an attempt to specifically define the relationship between food-related behaviors and eating disorders, Kuntz et al. (1992) compared 25 eating-disorder clients and their first-degree relatives with matched controls and their relatives. The interview results indicated that clients with an eating disorder had a greater tendency toward restrained eating patterns and binge-eating episodes. The researchers concluded that these interview data are suggestive of a chaotic and fluctuating dietary history consistent with eating-disorder behavior. Many
researchers have identified parental weight problems, restrictive eating patterns, and an overemphasis on physical attractiveness in the families of young girls, who later experienced some type of eating disorder (Vitousek & Manke, 1994; Kuntz, et al., 1992; Wardle, 1988; Alexander, 1986). Yager (1988) reviewed the literature on eating disorders and described the characteristic food-related symptoms of eating disorders as body image distortion, extreme fear of being fat (unrelated to health concerns), restrictive and fad dieting, amphetamine and cocaine use for anorexic effects, and purging by means of vomiting, laxative abuse, diuretic abuse, and hyperexercise. Similarly, Anderson (1987) described a sample of the specific food-related abnormalities in eating-disordered clients, including self-induced starvation, preparing unpalatable food combinations, secretive disposal of food, frequent weighing of self, exercise abuse, purging behavior, binge eating, eating slowly, purchasing smaller sizes of clothing, and wearing multiple layers of clothing.

It is essential that either excessively low body weight or extreme food-related behaviors be present for an eating-disorder diagnosis. Consequently, behavioral and cognitive-behavioral approaches to the treatment of eating disorders target weight normalization, the abnormal food-related behaviors (i.e., binging and purging), and the cognitive patterns regarding food and body as important therapeutic issues. Furthermore, these atypical dietary behaviors are extremely difficult for clients to control, may threaten their health, and are critical points of concern for eating-disorder clients in therapy. A number of these food-related behaviors are listed in the DSM-III-R (APA, 1987) as essential characteristics of eating disorders. Thus, such behaviors (i.e., binging, vomiting,
laxative use, diuretic use, exercise, and food restricting/dieting) will be included in
the content coding instrument that was used in the present study.

**Past and present relationship concepts and family dynamics.** There is
considerable agreement among systems theorists and researchers that family
dynamics and interpersonal relationships substantially contribute to the etiology
and maintenance of eating disorders (Alexander, 1986). Schlundt and Johnson
(1990) outlined a functional analysis as their theoretical approach to the
psychology of eating disorders. These authors suggested that family
environment, peer/social interactions, and intimate sexual relationships are
extremely important in understanding the etiology and pathology of eating
disorders. Similarly, Humphrey (1989) suggested that the families of eating-
disordered clients tend to have difficulty supporting autonomy, maintaining clear
boundaries, and effectively managing conflict. There are numerous related
theoretical perspectives describing the typical dynamics of eating-disordered
families. Researchers have identified many contributing factors including
negative and aversive family mealtime experiences, (Miller, McCluskey-Fawcett,
& Irving, 1993); seductive fathers and neurotic mothers (Bulik & Sullivan, 1993);
low maternal care paired with overprotection (Wheeler & Schmitz, 1992); family
incohesiveness or enmeshment (Steiger et al., 1992); insecure attachment with
parents (Kenny & Hart, 1992); chaotic family environment (Kuntz et al., 1992);
parental inconsistency consisting of one domineering and one distant parent
(Hambridge, 1988); and empty parental and family relationships (Anderson,
1987).

There is substantial empirical evidence to support the role that family
dynamics play in the etiology and maintenance of eating-disorder syndromes. In
their comprehensive review of family literature, Kuntz et al. (1992) determined that family factors are a significant contributor in the development and maintenance of eating disorders. Williams and Wilkins (1993) reviewed the histories of 72 eating-disordered clients and found a significant amount of childhood adversity, particularly with parental relationships, among the subjects. Bulik and Sullivan (1992) examined the clinical characteristics of families of origin for eating-disordered clients and controls. These researchers determined significant parental discord and ineffectiveness within the eating-disordered families as compared to the controls. Using a parental attachment questionnaire, Kenny and Hart (1992) found that eating-disordered women described themselves as less securely attached to their parents than controls. Humphrey (1986) found that families with eating-disordered children experienced greater conflict, detachment, and isolation than control families. This researcher concluded that eating-disordered families experience more relationship problems that were significantly more troubled than the controls. Johnson and Flach (1985) compared bulimic females with controls on family environment measures and determined that bulimic subjects perceived their families as having substantial amounts of unexpressed anger and conflict. These authors concluded that this type of environment may facilitate the type of self-regulatory difficulties associated with the eating disorders. Sights and Richards (1984) interviewed the parents of six bulimic women and six controls. The results from the interviews suggested that mothers of bulimics were perceived to be more domineering and controlling compared to mothers of controls. Fathers of the bulimics were judged to be more emotionally distant from their daughters than fathers of the controls. Furthermore, when compared with controls, parents of
bulimics were judged to be more demanding, and the families had higher levels of parent-daughter stress.

Similarly, a number of researchers have identified the interpersonal relationship characteristics manifested by eating-disordered clients as an important factor in their pathology. Subsequently, there are several treatment approaches that target interpersonal relationships as one component to the therapy for eating disorder clients (Baumann, 1992; Hendren et al., 1992; Lonergan, 1992; Yager, 1988; Halmi, 1987; Rosen, 1987; Terry, 1987).

Steinhausen and Vollrath (1993) determined that eating-disordered clients describe themselves as significantly more insecure and ineffective in their social relationships than controls. Striegel-Moore et al. (1993) demonstrated that eating-disordered women scored significantly higher on measures of social inadequacy than matched controls. These researchers suggested that this sense of social inadequacy is significantly related to the diagnostic criteria for eating disorders. In a longitudinal study covering nearly 3 years, Thelen, Kanakis, Farmer, and Pruitt (1993) found that eating-disordered subjects experienced significantly greater levels of dissatisfaction with male interpersonal relationships than controls. These data support an earlier belief by Thompson (1992) who proposed that eating problems are a manner of coping with various difficulties associated with heterosexual relationships.

Variations of these family and interpersonal relationship concepts are included in the present coding instrument as follows: discussion of heterosexual relationships, sexual interactions, dating, male friendships, female friendships, relationship with mother, and relationship with father.
Sexual abuse. Numerous researchers, theorists, and clinicians speculate that sexual abuse in childhood may precipitate an eating disorder (Hendren et al., 1992; Thompson, 1992; Hambridge, 1988; Kearney-Cook, 1988; Anderson, 1987; Scott, 1987). The available published research suggests that the relationship between sexual abuse and eating disorders is somewhat unclear. Connors and Morse (1993) reviewed the literature on sexual abuse and eating disorders and concluded that approximately 30% of eating-disordered clients have experienced childhood sexual abuse, a figure considered comparable to rates existent in the population of women at large. In an earlier review, Wheeler and Schmitz (1992) concluded that prior sexual abuse is often a precursor to a pattern of disturbed eating in women. Miller et al. (1993) determined that the rates of self-reported sexual abuse after the age of 12 were significantly greater for bulimic women, when compared to controls. Thompson (1992) interviewed 18 women, who reported having an eating disorder for more than half of their life, and reported that sexual abuse was the most common experience that the women related to the origin of their eating problems. Kearney-Cook (1988) identified binging and dieting as common coping behaviors for women who frequently experience the psychological consequences of sexual abuse. Openheimer, Howells, Palmer, and Chaloner (1985) systematically interviewed 78 eating-disordered women and found a significantly large number reported coercive sexual experiences prior to the onset of the eating disorder.

Some recent research attempted to establish a specific correlational link between eating disorders and childhood sexual abuse. Although the data did not produce conclusive evidence regarding prior sexual abuse for eating-disorder clients, most authors generally believe that sexual abuse may contribute to the
etiology of eating disorder syndromes. For example, Palmer and Oppenheimer (1992) did not find a specific association between early sexual experiences and eating disorders, but reported that it remains likely that childhood sexual experiences with adults increase the chance of the development of a later eating disorder. Similarly, Waller (1992) did not find a specific association between sexual abuse and diagnosable eating disorders, but did indicate that binging and vomiting behaviors were more frequent among women who described unwanted sexual experiences at an early age.

Each of the reported studies suggested that the relationship between sexual abuse and eating disorders remains considerable. Therefore, the frequency with which group therapy clients discuss sexual abuse will be implemented into the content coding instrument used in this study.

Global self-esteem. Hsu (1990) discussed empirical research that has repeatedly demonstrated that there is a significant correlation between self-esteem, satisfaction with body characteristics, and physical attractiveness, particularly for women. Several authors have studied characteristics in eating-disordered clients that are associated with self-esteem issues. Streigel-Moore et al. (1993) theorized that bulimic clients possess a "false self." The "false self" theory describes bulimic clients as feeling generally insecure and unable to develop a stable self-definition, which ultimately leaves them feeling indecisive, insecure, and fraudulent. In an attempt to support their theory, Streigel-Moore et al. (1993) compared bulimics with controls on several self-report measures and found that bulimic clients showed greater levels of social-self concerns (i.e., public self-consciousness, social anxiety, and perceived fraudulence). Similarly, Steinhausen and Vollrath (1993) identified adolescent anorexics as having
abnormal self-concept profiles on the Offer Self-Image Questionnaire (OSIQ). These abnormal self-concept profiles of anorexics deviated along the following scales: Impulse Control, Emotional Tone, Body Image, Social Relationships, Sexual Attitudes, and Psychopathology. Kenny and Hart (1992) reported that eating-disorder women declared significantly higher levels of personal and interpersonal ineffectiveness in comparison with a control group. In studying the etiology of eating disorders, Waller (1992) determined that poor self-esteem was related to abnormal eating attitudes. Similarly, Solomon (1986) described low self-esteem as an essential characteristic of individuals with eating disorders.

Several researchers have demonstrated that a therapeutic approach focusing on self-esteem has been effective in the treatment of eating-disorder clients. Gendron, Lemberg, Allender, and Bohanske (1992) compared a group of 24 eating-disordered subjects to a control group. These researchers determined that a group therapy approach for eating disorders that did not target food-related behaviors, instead focusing on self-esteem and interpersonal relationships, was effective in significantly reducing the frequency of binge-purge episodes and dysfunctional eating attitudes. In comparing different treatment methods for eating disorders, Anderson (1987) described lowered self-esteem as an essential ingredient in the development of eating disorders and determined that a comprehensive treatment approach effectively recognizes the low self-esteem as an important component in its treatment strategies. Other authors agree that low self-esteem contributes to the etiology and must be addressed and resolved for effective treatment (Hendren et al., 1992; Gendron et al., 1992; Rosen, 1987; Roth, 1986; Wolchick, Weiss, & Katzman, 1986). Due to the breadth of empirical research suggesting self-esteem is related to the etiology and maintenance of
eating disorders, the construct of global self-esteem is included in the content coding instrument used in this study.

Mood modulation. There is very little doubt that problems with the regulation of negative emotions are strongly correlated with eating disorders. In fact, a substantial number of researchers have advocated that eating disorders may be some form or variant of a mood disorder. These researchers have presented substantiating evidence regarding the frequent comorbidity of affective disturbance with eating disorders (Yager, 1988; Cantwell, Sturzenburg, Burroughs, Salkin, & Green, 1977). Most others, however, consider eating disorders to be a primary psychological disorder, often accompanied by affective disorders or depressive symptomology (Sunday, Levey, & Halmi, 1993).

Nagel and Jones (1992) recently reviewed the literature on predisposing factors in anorexia and suggested that affective disorders may be an antecedent condition, underlying the eating disorder pathology. In an earlier review, Halmi (1987) reported a higher prevalence of affective disorders in the first degree relatives of eating-disorder clients compared to control subjects. There are numerous examples of empirical research that validate theories linking mood disorders to eating disorders. Sunday et al. (1993) examined the incidence of affective disorders with 180 eating-disordered women and found that two-thirds had been experiencing a lifetime affective disorder. Gleaves et al. (1993) conducted a factor analysis on information provided by 100 women with eating disorders and determined that a substantial number of subjects were experiencing some type of affective disorder. Williams and Wilkins (1993) described a significant number of eating-disordered clients with concurrent clinical levels of depression. There was also a substantial number of clients with
a family history of mood disorders. Steiger et al. (1992) used the Beck Depression Inventory to measure levels of depression on 73 bulimics and found, prior to treatment, that nearly all of them presented with clinical levels of depression. Kirkley, Kolotkin, Hernandez, and Gallagher (1992) found that binge eaters exhibited significantly greater signs of psychological and emotional disturbance on the MMPI than controls. Kuntz et al. (1992) found that bulimics scored higher than controls on a diagnostic inventory for depression and concluded that eating-disordered clients have a greater tendency toward depression than controls. Similarly, Simpson, Al-Mufti, Andersen, and DePaulo (1992) found a significant majority of eating disorder clients in their study to have a concurrent major affective disorders. Bulik (1987) compared 35 bulimics with controls and found the incidence of depression to be significantly higher among bulimics than controls.

Many other authors have insisted that the recognition and resolution of individuals' emotional disturbances and mood dysregulation are imperative in the successful treatment of eating-disordered clients (Baumann, 1992; Gendron et al., 1992; Hendren et al., 1992; Lonergan, 1992; Riess & Rutan, 1992; Wardle, 1988; Yager, 1988; Anderson, 1987; Rosen, 1987; Terry, 1987; Roth, 1986).

The mood-related issues that were included in the content coding instrument fall under the following categories: clients' references to positive mood, negative mood, anger toward males, anger toward females, derogation of males, and derogation of females.

Summary of Gender Bias Reviews

Several authors have reviewed the literature on gender effects in psychotherapy. This section will provide a critical analysis of those reviews. A
somewhat dated, but well done, integrative review of factors influencing psychotherapy outcome was compiled by Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971). This review provided methodological procedures that makes the review replicable -- the only literature review that did so. These authors reported that similarity between therapist and client is a critical factor in psychotherapy effectiveness. They also identified several other factors that appear to have a significant impact on therapy outcome. These factors are the client's intelligence, psychological diagnosis of the client, total number of sessions, experience of therapist, and therapist attitude and empathy. The majority of data from this review was based on anecdotal reports, resulting in a suggestion for quantitative research methods addressing the examination of therapy process variables to better investigate the factors that may influence psychotherapy outcome. To date, this suggestion by Luborsky et al. (1971) has not been enthusiastically embraced by psychotherapy outcome researchers. Other, more recent reviews refer to the lack of empirical research in this area as a major limitation to drawing conclusions about matching gender effects in therapy outcome (Flaskerud, 1990; Barak & Fisher, 1989).

Kirshner (1978) reviewed the effects of gender on psychotherapy and concluded that male therapists, in particular, have significant difficulty in creating therapeutic relationships. This conclusion was supported by studies suggesting that male and female therapists behave in significantly different ways with female clients. For example, Hill (1975) reported that with female clients, female therapists (as opposed to male therapists) take a more empathetic approach involving a greater focus on feelings. Male therapists appeared more directive with female clients. Kirshner (1978) also suggested that age, marital status, and
experience level were other important variables that must be examined when performing therapist gender-therapy outcome research. It must be noted that this review used a narrative method, with no information regarding procedures of study collection and topic delimitation.

Mogul (1982) reviewed the literature on therapist gender effects and suggested that no specific conclusions regarding therapist gender and treatment outcome could be offered. However, the author did suggest that trends support differences in therapy outcome based on therapist gender. Specifically, therapist gender may appear to influence the treatment goals of women clients. Male therapists appeared to encourage more stereotypically "feminine" (emotional and expressive) treatment goals, while women therapists encouraged more "masculine" (assertiveness, self-confidence, and logical thinking) treatment goals. Mogul (1982) did report that other factors such as type of psychotherapy, client's cognitive level, client diagnosis, therapist experience, and therapist's attitude and sensitivity toward gender issues appear to produce effects on psychotherapy outcome. This review did not attempt to integrate the existing research and provided a narrative review of a sample of this research. The majority of the research reviewed involved anecdotal clinical case studies and psychoanalytic writings that have drastic methodological weaknesses (i.e., no control or comparison groups, nonrandomization, and other threats to internal validity). Furthermore, the results of the reviewed studies were based on reports of therapists' observations that have questionable internal validity and reliability.

Kaplan (1985) reviewed therapist gender effects, pertaining particularly to adult female clients, and reported that the available research is inconclusive. She postulated that the reasons for the inconsistent conclusions are
methodological limitations and the absence of objective outcome measurements in the current research. Kaplan (1985) suggested that attention to in-session behaviors may be more beneficial than a retrospective analysis of therapy in examining gender effects in psychotherapy.

A review by Barak and Fisher (1989) suggested that remarkable inconsistencies exist in the current therapist gender research, due to several inadequacies. These research inadequacies were identified by the authors as poor definitions of gender effects and gender bias, methodological problems in the empirical studies, and researcher bias (i.e., instrumentation as a major threat to internal validity). These authors indicated that any conclusions regarding therapist gender effects are premature due to limitations in the existing research. Furthermore, a strong emphasis on the need for conducting "naturalistic studies" with hard, behavioral outcome criteria to evaluate gender effects in psychotherapy was suggested by the authors.

The most recent review by Flaskerud (1990) provides yet another conclusion that the general results of available studies are mixed and difficult to summarize. The author reported that matching client-therapist gender seems to influence psychotherapy outcome in some studies, but not in others. The contradictory results were explained in terms of methodological shortcomings in the research and difficulties in comparing different outcome measures. It was suggested that therapist experience, theoretical orientation of treatment, and client diagnosis are critical variables that need to be addressed in therapist gender-treatment outcome research. Consistent with other reviews in this area, most of the studies examined were anecdotal studies, which are
methodologically weaker than quantitative research and more vulnerable to internal and external threats to validity.

In summary, several characteristics appear common to these previously discussed reviews. First, with the exception of the Luborsky et al. (1971) review, each review takes a narrative form and does not provide data collection procedures that are explicit and replicable. Second, the reviews concluded one of two things--either matching therapist gender did influence psychotherapy outcome or the current data was inconclusive. Those inconclusive reviews indicated methodological limitations in the existing research as the major barrier to the clarification of gender effects. Third, most of the reviews examined a large proportion of nonqualitative and anecdotal studies that do not include sound research methodologies that insure internal validity. Subsequently, these studies strongly suggest that quantitative research is needed in this area. Several authors have called for qualitative research with behavioral outcome measures as the dependent variable (Luborsky et al., 1971; Kaplan, 1985; Barak & Fisher, 1989; Flaskeurud, 1990). The present research addressed the role of gender matching in group process with eating-disordered clients, who are primarily female.

**Single-Subject Experimental Design**

The present study incorporated a single-subject research design, using group verbal behaviors as the dependent variable and therapist gender as the independent variable. A single-subject design enables the subject to serve as its own control and allows comparisons between different treatment conditions to be made. In general, single-subject designs demonstrate better control of the factors that can affect internal validity than do group designs (Kazdin, 1982a;
Several authors have indicated that a single-subject research design is an efficient way to assess the impact of certain interventions in a clinical setting (Schroeder & Wildman, 1988; Kazdin, 1982b; Barlow & Hayes, 1979; Ulman & Sulzer-Azaroff, 1975). More recently, Kratochwill and Williams (1988) suggested that single-subject designs are best in evaluating individual treatments or treatment packages. Furthermore, the single-subject experimental design is suggested by Greenberg (1986) who stated,

The intensive analysis of a few single cases of successful whole therapies and moments of change is probably the method of choice for those who want to tackle questions about specific mechanisms of change. (p.728)

There are numerous examples of single-subject methodology found in recent clinically based research on Attention Deficit-Hyperactivity Disorder (Kutcher, 1986); intellectually handicapped children (Payton, Burkhart, Hersen, & Helsel, 1989); self-injurious behavior (Wacker, Steege, & Berg, 1988); learning disabilities (McCormick, 1990); communicative disorders (Pring, 1987); aggressive behavior (Mace, Kratochwill, & Fiello, 1983); and affective disorders (Glue, 1989).

The foremost single-subject researchers suggested that two general conditions be met in order to maintain a well controlled, scientific methodology that can evaluate alternative treatments and rule out the impact of extraneous factors as rival explanations of the results (Kratochwill & Williams, 1988; Kazdin, 1983; Barlow & Hayes, 1979; Hersen & Barlow, 1976). These two general conditions are described in the literature as continuous assessment and stability of baseline.

Perhaps the most fundamental design requirement of single-subject methodology involves the reliance on repeated observations of performance over
Assessment of the subject's behavior is continuous in that it is conducted before, during, and after treatment application. This continuous assessment allows one to observe the variability of performance over time, rather than making observations prior to and after the completion of treatment. In a sense, this allows the researcher or clinician to make inferences about the sources of changes on the dependent variable by observing the subject's performance throughout all phases of the treatment. A second advantage of continuous assessment is that a researcher can immediately alter the experimental design to test out hypothesized sources of behavioral changes (Hersen & Barlow, 1976). The opportunity to make immediate alterations in the design permits one to have repeated illustrations of the effects of particular experimental phases on the target behaviors, which ultimately allows the researcher to make stronger conclusions about treatment effects.

The second condition involves maintaining a baseline assessment until some stability or consistency has been established. The purpose of the baseline assessment is to gather data under nonexperimental conditions, which allows one to predict future performance. The baseline data are used for analysis purposes when considering the effects of the treatment, by comparing the data gathered under experimental conditions to the baseline data. According to Kazdin (1983),

The extrapolation of the baseline level of performance suggests the likely course of the symptoms in the immediate future. Essentially, the projected level of baseline serves as a criterion to evaluate if treatment has led to change. (p. 425)

Because the baseline data serve as a point of reference from which treatment evaluations are made, the methodology of single-subject design is based on the stability of the baseline data. Therefore, it is suggested by many single-subject
researchers that the baseline phase continue until the measured behaviors reach a stable level. Unfortunately, accomplishing stability with the baseline data can be particularly difficult and quite exhaustive when the experiment is measuring a large number of behaviors, which is the case in this study. Under these difficult conditions, several recommendations are found in the literature on single-subject methodology. Hayes (1981) suggested having at least three measurement points to establish estimates of stability, level, and trend in the baseline data. When a study has a baseline with three data points, the researcher can often make up for short baselines by using other design elements later (i.e., withdrawals, several returns to baseline) or by replicating the effects with other subjects (Hayes, 1981). Similarly, Schroeder and Wildman (1988) suggested combining the measurements taken during the several baseline phases throughout the experimental design. Data from these measurements can then provide an adequate sample of behavior for baseline, thereby allowing for comparison to the experimental conditions. Kazdin (1983) suggested that under many circumstances, single-subject designs can handle a considerable degree of instability in the baseline data because trends in the data and fluctuation in performance themselves usually change in response to different interventions or phase changes. This implies that an effective intervention should produce a change in the data to such a degree that the magnitude of change can be easily distinguished from the instability of the baseline data. Furthermore, continuous measurement of the dependent variable in both the presence and absence of the independent variable over a period of time avoids the attribution of change to historical accidents and other chance variables (McCormick, 1990).
According to many researchers, single-subject research designs are best in evaluating individual treatments or treatment packages (Kratochwill & Levin, 1992; Kratochwill & Williams, 1988; Kazdin, 1982b; Hayes, 1981; Hersen & Barlow, 1976). However, in order to best evaluate the effects of any treatment, the researcher must develop a methodologically sound research design that can rule out major threats to internal validity. This is generally done by using the basic components of a single-subject design to construct a methodologically sound design sequence which will most effectively answer the research question. Hayes (1981) stated that all single-subject designs are built from a small set of building blocks, and there are potentially as many specific single-subject designs as there are designs for brick buildings; the core elements of each are comparably simple. This allows a researcher the luxury and flexibility to construct a specific experimental design that answers the particular research question. The most basic elements of a single-subject design include the collection of initial baseline data on the target behavior (phase A), an application of a particular treatment condition (phase B), a return to the initial baseline phase (phase A), followed by a second application of the treatment condition (phase B). This basic design is called an A-B-A-B or reversal design. To make logical, causal statements about the effectiveness of the treatment, one would hope to see consistent and systematic changes in the dependent variable based on the presence or absence of the intervention. This logic provides the basic rationale for single-subject experimental designs, while allowing the researcher the flexibility to construct a design to fit the needs of the experiment. Thus, when formulating a specific single-subject research design, the experimenter must
consider the research question and determine the best experimental design to answer that question.

When considering the effects of two treatments within a single subject, it is best to use an alternating-treatments experimental design (Kratochwill & Levin, 1992; Kazdin, 1982b; Hayes, 1981). The basic feature of alternating-treatments design is the systematic alternation of two different treatment conditions, so that two treatments are in effect, but never at the same time. Kazdin (1982b) reported if two or more treatments are to be compared, it is important to be able to terminate each of the interventions quickly so that they can be rapidly alternated over time. The rapid alternation of differing treatment phases will allow several opportunities for the treatment effects to be repeated within an experimental design. According to Hayes (1981), interventions suitable for alternating-treatments designs need to have distinct beginning and ending points, so no lingering effects will occur that may obscure evaluation of the separate effects of the interventions. Furthermore, interventions that do not produce relatively immediate effects (i.e., certain pharmacological treatments where it may take days or weeks before one can observe the effects of the intervention) are inappropriate for alternating-treatments design. Barlow and Hayes (1979) stated,

In the typical design, after a baseline period, two treatments are administered, alternating with each other, and the effects on one behavior are observed. Conditions which might affect data other than the treatments, such as treatment order, are counterbalanced as the experiment continues. Because confounding factors have been neutralized by alternating and counterbalancing, and because the two treatments are readily discriminable by subjects, differences in the data corresponding with each particular treatment should be attributable to the treatment. (p. 220)
In order to effectively use an alternating-treatments design, there are some necessary conditions of the target behavior used in the study. Kazdin (1982a) suggested that the behaviors studied in alternating-treatments designs must be susceptible to rapid changes. Behaviors that depend upon improvements over an extended period may not be able to shift rapidly in response to session-by-session changes in the intervention. For example, target behaviors such as weight loss, score on an IQ test, or the amount of secondary smoke in the lungs would not be responsive to rapid alterations in experimental conditions, therefore making these types of behaviors unsuitable for an alternating-treatments design.

Aside from being able to change rapidly, the frequency of the behavior may also be a determinant of the extent to which interventions can show changes in alternating-treatments designs (Kazdin, 1982b). If several opportunities exist for the behavior to occur within a certain time period, the effects of certain interventions may be relatively rapid. Subsequently, low-frequency behaviors and behaviors with a ceiling (i.e., an upper limit to the number of responses that can be made) may present problems for reflecting differences among interventions. This suggests that behaviors that are dependent upon specific and discrete opportunities for occurrence are unsuitable for such designs. In general, differential effectiveness of the intervention is likely to depend on several opportunities for the behavior to occur.

A final behavioral condition of alternating-treatments design concerns the "reversibility" of the target behavior, since a reversal of the behavior is critical in drawing causal inferences about the effect of the intervention. The alternating-treatments design is not appropriate for evaluating treatments with behaviors that
are not likely to be reversed. Skill acquisition tasks, such as writing one's name, solving mathematical problems, or performing an assembly task would not be appropriate for alternating-treatments designs.

The two major forms of interference in alternating-treatments design are sequencing or order effect and carryover effect. Sequencing effect refers to the order in which the specific interventions are presented. If two or more treatments are applied to the same subject, they are given in separate phases so that one comes before the other at some point in the design. The sequence in which the interventions appear partially restricts the conclusions that can be reached about the relative effects of alternative treatments. The effects of the two interventions may be very different if they were administered by themselves without one being preceded by the other (Kazdin, 1982b). Barlow and Hayes (1979) indicated that sequential confounding is the major reason why it is not possible to compare two treatments in a standard A-B-A-B design. Because treatment B follows the A treatment, its effects are confounded by the prior administration of A. These authors suggest that an alternating-treatments design (i.e., allowing each treatment phase to proceed the other at some point in the design) controls for the effects of sequencing by counterbalancing the treatments.

Hayes (1981) suggested that when comparing the effects of treatments B and C, one should combine an A-B-A sequence with an A-C-A sequence, making an overall A-B-A-C-A design. This allows us to ask if B and C are effective or allows for a comparison of the two treatments, but is weak, because order effects are possible. To account for order effects and strengthen this comparison, either the same subject might receive an A-C-A-B-A sequence at a different point in time or a second subject might receive the A-C-A-B-A sequence. If the trend in
the data is similar and the conclusions are the same, then the believability of the treatment comparison is strengthened. For example, Kutcher (1986) used a single-subject alternating-treatments design to evaluate the effects of stimulant medication with adolescents diagnosed as Attention Deficit-Hyperactivity Disorder. Kutcher used an A-B-C-A-B-C design (A = baseline, B = placebo, C = medication). The conclusions about the effectiveness of the medication were somewhat guarded because the design was not counterbalanced and did not account for sequencing effects.

Altering the design slightly to include one instance where the C phase would occur before the B phase (i.e., A-B-C-A-C-B) would counterbalance the design, thereby accounting for the order effects, which would allow a stronger conclusion. Barlow and Hayes (1979) reported that counterbalancing is made possible by rapid alternation of the treatment phases, which allows for more administrations of the two treatments in a shorter period of time than is possible with the standard A-B-A design, where phases may last for weeks or months.

The second major form of interference in alternating treatments design is the carryover effect. Kazdin (1982b) described carryover effects as the influence of one treatment on an adjacent treatment, irrespective of overall sequencing. Again, counterbalancing the order of treatments should minimize carryover effects if data are similar across the respective phases of the treatment. Furthermore, presenting only one condition per session minimizes carryover effects by allowing for a considerable amount of time to pass before applying the second therapeutic condition (Barlow & Hayes, 1979; Hersen & Barlow, 1976). If one can construct a methodologically sound alternating-treatments design that accounts for sequencing and carryover effects, the testing of two treatments in
the same subject produces one of the most elegant controls for most threats to internal validity (Hayes, 1981).
CHAPTER III
METHOD

Subjects

Since this study was attempting to assess the effects of therapist gender on the content of statements made by eating-disorder group members, the subjects in this study attended one of two therapy groups for eating disorders. The participants in the groups were individuals who presented at participating treatment centers with diagnosable eating disorders. Clients were recruited by advertisements through the local newspapers and radio stations. The advertisements asked for female participants who were concerned about general eating issues. All participating individuals met DSM-III-R criteria for anorexia nervosa, bulimia nervosa, or eating disorder-not-otherwise specified. A brief description of the eating-disorder clients involved in this study is presented in Appendix A. At the beginning of the study, both Group 1 and Group 2 had a total of five participants. All potential participants were initially screened for appropriateness of group therapy involvement by interviewing with an intake therapist. Clients were excluded if they appeared to be extremely shy and introverted, appeared to be unwilling to easily discuss their specific eating disorder, appeared to be experiencing psychotic episodes, or appeared unable to benefit from a group therapy experience. When considered appropriate for a group therapy approach, the clients agreed to participate in this group therapy intervention by signing the Informed Consent Form describing their role in the experimental setting. The clients' Informed Consent Form is presented in Appendix B.
Setting

This experiment was conducted concurrently at the following two sites: (a) Utah State University Community Clinic, a university-based psychology clinic available to both students and the general population of Cache County, Utah. This center is staffed by seven doctoral-level psychologists and approximately 20 psychology graduate student-Ph.D. trainees each year; and (b) Utah State University Counseling Center, a university-based treatment center available to both students and their immediate family members. This center is staffed by eight (five doctoral-level and three master-level) therapists and routinely trains approximately five Ph.D. psychology graduate students. Each center director authorized an Agency Approval Proposal stating that there were no objections to the study. The Agency Approval Form is presented in Appendix C.

Sessions

The group treatment programs consisted of 14 sessions. The weekly sessions lasted approximately 90 minutes each. All sessions were videotaped for coding purposes. The groups were homogenous (i.e., an eating disorder as the clients' presenting problem). Initially, all groups had established a closed attendance policy (i.e., new members were not allowed after the group's first session). In an attempt to maintain attendance to the sessions, the primary investigator offered group members two theater tickets, as an incentive, when they attended five therapy sessions. Due to client attrition, both groups added new members during the eighth session--in a baseline phase of the experimental design--(the Community Clinic group added one new member and the Counseling Center group added two new members). In making the decision to add new members to the groups, the primary investigator discussed the issue
with the respective supervising therapists and the group therapists. The therapists agreed to discuss the possibility of adding new members with the existing members of the groups, and none of the group members objected to the addition. The decision to add new members was made to ensure a minimum of three clients during the group sessions. Appendix D shows which group members attended each particular therapy session throughout the study.

**Therapists**

Each of the two groups was lead by a cotherapist team, consisting of one male therapist and one female therapist. All therapists were blind to the purpose of the study. Throughout the study, each therapist team remained at one particular site and led their respective groups (i.e., there was no therapist-group crossover). All four therapists were Ph.D. graduate students, enrolled in the Professional-Scientific psychology program at Utah State University. Three therapists were in their third year of formal training in the program, and the other therapist was in his fourth year. A brief description of all therapists is presented in Appendix E. In order to meet the legal, ethical, and training obligations of each participating site, both therapist teams were supervised by licensed Ph.D.-level psychologists who were highly experienced in the treatment of eating disorders.

Besides selecting therapists who were approximately at the same point in their doctoral training program, three other attempts were made to ensure that the treatment approach was as similar as possible. First, each participating therapist completed a questionnaire adapted from Mahoney and Craine (1991). This questionnaire assessed the therapists' current beliefs about human psychological development and optimal therapeutic practice. The questionnaire consists of 20 questions in which the respondents decide whether they strongly
agree, agree, disagree, or strongly disagree with the particular statement. Each therapist's answers were compared to the answers of their group leading partner for similarities and differences. Overall, both therapist teams responded in ways indicating a general agreement on optimal practices for psychotherapy. The therapist team for Group 1 differed with respect to agreement-disagreement on only 2 of the 20 items in the questionnaire. These differences are presented in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Group 1 Therapist Team Disagreements on Optimal Practice Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item (an optimally helpful therapist should)</td>
</tr>
<tr>
<td>offer interpretations of dreams and fantasies</td>
</tr>
<tr>
<td>confront client during episodes of resistance</td>
</tr>
</tbody>
</table>

The therapist team for Group 2 differed with respect to agreement-disagreement on four of the twenty items in the questionnaire. These differences are presented in Table 2.
### Table 2

**Group 2 Therapist Team Disagreements on Optimal Practice Questionnaire**

<table>
<thead>
<tr>
<th>Item (an optimally helpful therapist should)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>offer relevant self-disclosures</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>avoid discussions of ethical or moral issues</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>share feelings of anger or frustration toward client</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>reflect rather than directly answer client's questions</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

Second, the researcher required the therapists to take a strict, client-centered orientation with the groups. Thus, there was no structured format for treatment. Aside from this constant, the therapists and supervising psychologists were given several additional instructions regarding the therapists' role and the functioning of the group. See Appendix F for those instructions. The primary investigator reviewed the tape of each session and periodically reviewed these instructions with the therapists to ensure adherence to the treatment instructions. Third, an attempt was made to choose therapists who themselves were within normal ranges of height and weight.

**Procedures**

Three treatment manipulations were used in this study: (A) baseline (presence of both female and male cotherapists), (B) presence of female therapist-only, and (C) presence of male therapist-only.
(A) **Baseline:** During this phase, data were collected on the verbal content of the group when both the female and male therapists were co-leading the session.

(B) **Female Therapist Condition:** During this phase, data were collected on the verbal content of the group when only the female therapist was leading the session.

(C) **Male Therapist Condition:** During this phase, data were collected on the verbal content of the group when only the male therapist was leading the session.

**Experimental Design**

The evaluation of this research question required using an alternating-treatments single-subject research design, in which the presentation of treatment conditions was counterbalanced. This particular design attempted to control for sequence and carryover effects by alternating intervention phases across group sessions (i.e., after baseline, the alternation of B and C phases across groups) and counterbalancing the order of treatment conditions across groups (i.e., after baseline, Group 1 has A-B-A-C-A and Group 2 has A-C-A-B-A). This design also allowed for the continuity of service. A therapist was scheduled to conduct a group therapy session only under the condition that he or she had attended the previous session. Table 3 illustrates the experimental design used in this study.
### Table 3

**Experimental Conditions for the Eating-Disordered Group Therapy Sessions**

<table>
<thead>
<tr>
<th>Group</th>
<th>Experimental Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Approx. 4 Sessions (A) Alternate B-A-C-A-B-B-A-C-C-A</td>
</tr>
<tr>
<td>Group 2</td>
<td>Approx. 4 Sessions (A) Alternate C-A-B-A-C-C-A-B-B-A</td>
</tr>
</tbody>
</table>

Kazdin (1982b) indicated that an alternating-treatments research design is useful in comparing two or more interventions within the same "subject." The rational for using each sequence within the design is outlined below.

**First four sessions: Condition A.** The first four sessions constituted the baseline phase of the design. This phase provided information about rates of occurrence of specific behaviors (i.e., frequency of discussion of specific topics) before the single therapist interventions began. It also allowed for general group cohesion to develop and provided time for the establishment of client roles and stabilized attendance. Furthermore, the baseline phase provided a frame of reference for comparing measures of the dependent variable with other experimental conditions.

**A-B-A and A-C-A.** These two sequences were used to determine the effects of treatments B and C, respectively, relative to the baseline. As Kazdin (1982b) indicated, the effects of the intervention are clear if performance changes
during the intervention phase and reverts to or approaches original baseline levels of performance when treatment is withdrawn.

A-B-B-A and A-C-C-A. These sequences were used to examine the effects of treatments B and C, respectively, when the particular treatment condition followed itself, rather than following condition A. It is possible that the absence of one of the therapists (B=male absent, C=female absent) may have produced a more pronounced effect over two consecutive sessions (versus one session). The design allows for the assessment of more stable, average effects across two sessions.

**Data Collection Procedures**

All group therapy sessions were videotaped for coding purposes. Each 90-minute therapy session was coded by recording the frequency of clients' statements during 1-minute intervals. Client's statements were coded for content. The coding instrument was developed by the present author, in collaboration with two Ph.D. psychologists and two graduate students who treat eating disorders. It consisted of items that are theoretically relevant to the therapy for eating-disorder clients. Appendix G presents the coding instrument that raters used in data collection. The operational definitions of the content categories are presented in Appendix H. After coding of the videotapes was completed, data were summated for each session for the 31 specific content categories (i.e., positive body image, negative body image, etc.) and the six general constructs (i.e., total body image disturbance and attractiveness, total extreme weight loss behaviors and symptoms, etc.) that were presented in the etiology and symptoms section of this document.
A pilot study was conducted to establish the reliability of the coding instrument. Eight (four male and four female) undergraduates were trained to code a 40-minute individual therapy videotape. Interrater reliability was established using the following formula: Total Agreements divided by Agreement plus Disagreements. The coding results from one rater, selected at random, were compared to coding from a second rater, yielding four reliability correlations. Table 4 shows the reliability coefficients.

Table 4
Interobserver Reliability Coefficients for Content Coding

Sheet (N=8)

<table>
<thead>
<tr>
<th>Rater Numbers</th>
<th>Interrater Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 and 2</td>
<td>.92</td>
</tr>
<tr>
<td>3 and 4</td>
<td>.92</td>
</tr>
<tr>
<td>5 and 6</td>
<td>.92</td>
</tr>
<tr>
<td>7 and 8</td>
<td>.97</td>
</tr>
</tbody>
</table>

Two coders collected data (i.e., counted frequencies of topics discussed) from the videotapes. Before the raters began collecting data, they signed an Ethical Procedures Form (see Appendix I). Throughout the duration of the study, biweekly reviews of raters' adherence to the ethical procedures agreement were performed to ensure confidentiality. In addition, the raters were trained to use the
coding instrument through instruction, modeling, practice, and feedback. Raters began coding actual sessions when they attained an interrater reliability level of at least .90 on training tapes. It was necessary to have four 1-hour training sessions before the two raters achieved an interrater reliability of at least .90. Interrater reliability was assessed using the same formula that was used in the pilot study: Total Agreements divided by Agreement plus Disagreements.

A graphical display and visual inspection method suggested by Kazdin (1982b) was used to analyze whether the effects of contrasting the presence and absence of male and female therapists were consistent and significant. As a first step, the frequency of each verbal interaction code was summed for each session. Means were calculated, and differences between treatment conditions were graphed to determine if the interventions were related to consistent changes. Second, discontinuity of frequencies of topic discussions from the end of one condition to the beginning of the next was analyzed to determine whether the manipulation of conditions produced reliable effects across treatment conditions (Kazdin, 1982b). Third, the identification and analysis of any trends in the data were considered to determine any systematic effects on group verbal interactions over time. If data were sensitive to the aforementioned analyses, the data were considered significant with regard to treatment conditions used in this study.
Reliability

Interobserver reliability measures were obtained for 85% of all sessions by having two observers independently code videotapes of the therapy sessions. Interobserver agreement was calculated using the same point-by-point formula (i.e., Total Agreements divided by Agreement plus Disagreements) used in the pilot study that established the reliability of the coding instrument. The coding results from one observer were compared to the coding from the second observer, yielding a reliability correlation. Table 5 shows the point-by-point reliability coefficients for each Group 1 therapy session. Table 6 shows the point-by-point reliability coefficients for each Group 2 therapy session. The initials NA are used to signify the sessions that both observers were unable to code, therefore making point-by-point reliability coefficients unavailable.

Table 5

Interobserver Reliability Coefficients by Session for Group 1

<table>
<thead>
<tr>
<th>Session</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coefficient</td>
<td>.98</td>
<td>.99</td>
<td>.99</td>
<td>NA</td>
<td>NA</td>
<td>.99</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
</table>
Table 6

Interobserver Reliability Coefficients by Session for Group 2

<table>
<thead>
<tr>
<th>Session</th>
<th>Coefficient</th>
<th>Session</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.98</td>
<td>8</td>
<td>.99</td>
</tr>
<tr>
<td>2</td>
<td>.98</td>
<td>9</td>
<td>.99</td>
</tr>
<tr>
<td>3</td>
<td>.98</td>
<td>10</td>
<td>.99</td>
</tr>
<tr>
<td>4</td>
<td>.99</td>
<td>11</td>
<td>.99</td>
</tr>
<tr>
<td>5</td>
<td>.99</td>
<td>12</td>
<td>.99</td>
</tr>
<tr>
<td>6</td>
<td>.99</td>
<td>13</td>
<td>.99</td>
</tr>
<tr>
<td>7</td>
<td>1.00</td>
<td>14</td>
<td>.99</td>
</tr>
</tbody>
</table>

Content of Group Therapy Sessions

This study assessed the effects of therapist gender on the content of statements made during group therapy sessions, by eating-disorder group members. The formal presentation of raw data for each particular session can be found in Appendix J. It must be noted that data for session 13 of Group 1 (Counseling Center) were not recorded due to a malfunction of the audio component of the taping. Therefore, the male therapist-only condition for Group 1 will have two data points for each content category, rather than three data points that was planned in the experimental design.

All data will be presented graphically. The abscissa represents the frequency of 1-minute intervals, during the 90-minute session, when group members made statements referring to a particular content category. The ordinate represents the session number over time. The visual inspection of the results generally determined that the data settled into one of three conditions. Of the content categories observed in this study, two categories showed marked, consistent effects across both therapy groups, several categories showed noticeable results in one of the two groups, and many categories showed no
observable trends in the data. Specific findings of the first two conditions are presented below. The graphic representations of the data where no noticeable trends were observed are presented in Appendix K for Group 1 and Appendix L for Group 2.

**Consistent, Significant Effects Across Groups**

This section describes results that were significant and consistent across both therapy groups in this study (see page 43 for criterion of significance).

Figure 1 shows the frequency of intervals containing negative affect statements for Group 1. During the initial baseline condition, the mean frequency of intervals including negative affect statements for this group was $\bar{X} = 21$. This initial baseline mean slightly differs from the mean of negative affect statement intervals per session during all baseline phases of the experiment (i.e., total baseline mean), which was $\bar{X} = 26$. The mean of negative affect statement intervals per session for Group 1 during the female therapist-only condition was $\bar{X} = 50$; and the mean of negative affect statement intervals per session during the male therapist-only condition was $\bar{X} = 21$.

Figure 2 shows data representing the frequency of intervals containing negative affect statements for Group 2. During the initial baseline condition, the mean frequency of negative affect statement intervals for this group was $\bar{X} = 20.5$. Similar to Group 1, this initial baseline mean differs only slightly from the mean of negative affect intervals per session ($\bar{X} = 24$) during all baseline phases of the study. Again, analogous to data collected from Group 1, the mean of intervals containing negative affect statements for Group 2 during the female therapist-only condition increased to a level of $\bar{X} = 41$. By comparison, the mean
of negative affect intervals during the male therapist-only condition ($\bar{X} = 21$) remained near initial baseline levels.

![Diagram showing frequency of intervals containing negative affect statements by Group 1.]

**Figure 1.** The frequency of intervals containing negative affect statements by Group 1.

As mentioned in the method section, a total summation of statement intervals per session of the six general constructs was also conducted. Results of statements concerning total affect/mood modulation from both groups were very similar. Figure 3 shows the frequency of intervals containing total...
Figure 2. The frequency of intervals containing negative affect statements by Group 2.

affect/mood modulation statements for Group 1. During the initial baseline condition, the mean frequency of total affect statement intervals for this group was $\bar{X} = 34.5$. This initial baseline mean generally did not differ from the mean of total affect intervals during all baseline phases of the experiment, which was $\bar{X} = 36.1$. During the female therapist-only condition, the mean of intervals containing total affect statements per session drastically rose to $\bar{X} = 80$, while the mean of total affect statement intervals for this group during the male therapist-only condition was $\bar{X} = 31$. 
Figure 3. The frequency of intervals containing total affect/mood modulation statements by Group 1.

Figure 4 presents very similar results, as Figure 3, on intervals with total affect statements for Group 2. The initial baseline data were very stable; the per session mean was $\overline{X} = 25$. The mean for total affect statement intervals averaged over all baseline phases ($\overline{X} = 30.4$) was slightly higher than the initial baseline mean. The trend in data for female only and male only conditions for Group 2 was nearly identical to matching data from Group 1. During the female therapist-only condition, the mean of intervals containing total affect statements per session for Group 2 was $\overline{X} = 49.3$, while the total affect intervals in the male
therapist-only condition for this group ($\bar{X} = 25.3$) essentially duplicated the mean of total affect statement intervals during the initial baseline phase.

Figure 4. The frequency of intervals containing total affect/mood modulation statements by Group 2.

**Significant Results with Group 1**

This section will describe results that were significant only with Group 1. When compared to the baseline and female therapist-only conditions, it is apparent that Group 1 showed an increased tendency to make more statements
about weight, body image, and appearance in the male therapist-only condition. The figures below illustrate that, on average, members of Group 1 made more statements per session about family weight, personal weight, clothing and fashion, their own attractiveness to males, negative body image, and total body image and attractiveness during the male therapist-only condition.

Figure 5 shows data on the frequency of intervals where statements were made about family weight issues for Group 1. During the initial baseline condition, the mean frequency of family weight intervals per session for this group was \( \overline{X} = 1.3 \). This initial baseline mean differs only slightly from the mean of family weight intervals per session \( (\overline{X} = 0.8) \) during all baseline phases of the study. During the male therapist-only condition, the frequency of intervals when Group 1 made family weight statements significantly increased \( (\overline{X} = 7) \). This is substantial considering that family weight was not discussed by group members during the female therapist-only condition.

Group 1 also discussed personal weight issues more often in the male therapist-only condition, as shown in Figure 6. Both initial baseline and total baseline means of personal weight statement intervals were \( \overline{X} = 3 \). During the male therapist-only condition, the frequency of personal weight intervals significantly increased \( (\overline{X} = 9.5) \). Again, this difference in the data appears significant since the mean frequency of intervals containing statements about personal weight issues during the female therapist-only condition was negligible \( (\overline{X} = 0.3) \).
Figure 5. The frequency of intervals containing family weight statements by Group 1.

Aside from an increased tendency to discuss personal and family weight issues during the male therapist-only condition, Group 1 members also appeared to discuss issues related to their appearance, attractiveness, and body image more often in the male therapist-only condition. The group's discussion of topics related to current clothing fashion and dress appeared to occur more often when the male therapist was alone in leading the therapy session. Figure 7 graphically displays the data regarding statements about clothing and fashion. The variance between the means of the initial baseline condition ($\overline{X} = 1.3$) and the total
Figure 6. The frequency of intervals containing personal weight statements by Group 1.

Baseline condition ($\bar{X} = 1$) was minimal. Furthermore, there was no discussion by group members about conforming to current clothing fashion or related fashion issues while the female therapist was alone in leading the group. However, relative to the baseline and female therapist conditions, the group members did discuss clothing and fashion issues more often during the male therapist-only sessions ($\bar{X} = 7$).

Members for Group 1 discussed their perception of their own attractiveness toward men more often in the male therapist-only condition.
Figure 7. The frequency of intervals containing fashion and clothing statements by Group 1.

Figure 8 presents the data regarding statements about personal attractiveness toward men. The initial baseline mean frequency per interval of such statements was $\overline{X} = 1.3$, and the mean frequency of intervals when attractiveness toward men statements were made was $\overline{X} = 0.6$ during all baseline phases of the study. While these mean frequencies appear to be very low, visual analysis of Figure 8 reveals that, during subsequent baseline and female therapist phases, this topic basically was not discussed by group members after the very first session.
Figure 8. The frequency of intervals containing statements about perceptions of their own attractiveness toward males by Group 1.

Yet during the male therapist-only sessions, the mean frequency of attractiveness toward men statement intervals was $\overline{X} = 4$, equal to the frequency of intervals containing such statements during the first therapy session.

It is apparent from Figure 9 that Group 1 members discussed negative body image issues more often in the male therapist-only condition. During the initial baseline condition, the mean frequency of negative body image statement intervals for this group was $\overline{X} = 5.3$. This initial baseline mean differs only slightly from the mean of negative body image intervals ($\overline{X} = 3.4$) during all baseline phases of the study. During the male therapist-only condition, the frequency of intervals when Group 1 members made negative body image statements
Figure 9. The frequency of intervals containing statements about negative body image by Group 1.

significantly increased ($\bar{X} = 7$). This higher frequency during the male therapist-only condition is substantial considering that negative body image was not discussed by group members ($\bar{X} = 0.3$) during the female therapist-only sessions.

Similarly drastic differences in the data can be found in Figure 10, which illustrates the frequency of intervals containing total body image and attractiveness statements for Group 1. The visual inspection of the data shows that statements about topics included in this total body image and attractiveness construct were quite frequent during the first two therapy sessions. As the initial baseline continued, such statements decreased to an interval level of five per session. Throughout the subsequent baseline and female therapist-only
conditions, the frequency of intervals containing statements about body image and attractiveness remained comparable to the final two sessions of the initial baseline phase. When considering the male therapist-only sessions, intervals including group members' statements about general body image and attractiveness rose dramatically to a mean per session level of $\bar{X} = 37$, which was even greater than the frequency of intervals containing such statements during the first two therapy sessions.

While it appeared that Group 1 discussed weight, attractiveness, and body image issues more often in the male therapist-only condition, observations of the data from this group indicated an increased tendency to discuss anger and parental relationships more often in the female therapist-only condition.

Figure 11 presents a graphic display of the data measuring intervals of statements by Group 1 expressing anger toward a specific male. During the initial baseline, the mean frequency of intervals containing such statements was $\bar{X} = 1.5$, and the mean frequency of anger-toward-a-male statement intervals was $\bar{X} = 0.9$ during all baseline phases of the study. While these mean frequencies appear to be very low, visual analysis of Figure 11 reveals that, during subsequent baseline and male therapist-only phases, this topic basically was not discussed by group members after the initial baseline phase. Conversely, during the female therapist-only sessions, the mean frequency of anger-toward-a-male intervals was $\bar{X} = 9.3$. In fact, the number of intervals containing anger-toward-a-male statements made during each of the three female therapist-only sessions was greater than any other session throughout the entire study.
Figure 10. The frequency of intervals containing total body image and attractiveness statements by Group 1.

Figure 12 shows very similar data regarding differences in expressing anger toward a specific female. During the initial baseline condition, the mean frequency of anger-toward-a-female intervals for this group was $\bar{X} = 0.5$. This initial baseline mean differs only slightly from the mean of intervals when anger-toward-a-female statements were made ($\bar{X} = 1$) during all baseline phases of the study. During both the female and male therapist-only conditions, the frequency of anger-toward-a-female intervals significantly increased (i.e., female therapist $\bar{X} = 14.7$; male therapist $\bar{X} = 5$). However, based on a visual analysis of the data, it appears that the increase in intervals containing such statements during the
Figure 11. The frequency of intervals containing anger-toward-a-specific-male statements by Group 1.

female therapist-only condition was more dramatic and substantial than the increase in anger-toward-a-female intervals during the male therapist-only condition. Similar to the data presented in Figure 11, the number of intervals containing anger-toward-a-female statements made during each of the three female therapist-only sessions was greater than any other session.

Data shown in Figures 13 and 14 suggest that members from Group 1 discussed relationships with their mothers and total parental relationships more often in the female therapist only-condition. A visual inspection of Figure 13
Figure 12. The frequency of intervals containing anger-toward-a-specific-female statements by Group 1.

reveals that during the initial baseline, total baseline, and male therapist-only phases, the mean frequency of intervals containing statements regarding clients' relationships with their mothers was comparable (i.e., initial baseline $\bar{X} = 9.3$; total baseline $\bar{X} = 7.5$; male therapist-only $\bar{X} = 8.5$). Yet during the female therapist-only condition, the mean frequency of intervals containing such statements dramatically rose to a level of $\bar{X} = 30.6$.

Figure 14 shows data on the frequency of intervals containing total statements about parental relationships issues for Group 1. During the initial baseline condition, the mean frequency of parental relationships statement
Figure 13. The frequency of intervals containing relationship with mother statements by Group 1.

Intervals for this group was \( \bar{X} = 14.3 \). This initial baseline mean differs slightly from the mean of parental relationships intervals (\( \bar{X} = 10.8 \)) during all baseline phases of the study. Observations of the data during the female therapist-only sessions demonstrate a substantial increase in intervals containing such statements to a mean frequency per session of \( \bar{X} = 34.3 \). During the male therapist-only condition, the frequency of intervals when parental relationships statements were made slightly increased (\( \bar{X} = 18 \)) from baseline levels. However, this mean frequency may be misleading. During one male therapist-only session, members of Group 1 made parental relationship statements during
Figure 14. The frequency of intervals containing total parental relationship statements by Group 1.

27 intervals, while during the second male therapist session, members made such statements in only 9 intervals. Nevertheless, during each of the three female therapist only-sessions, the number of intervals when total parental relationship statements were made was greater than any other session throughout the entire study.

Significant Results with Group 2

This section will describe results that were significant only with Group 2. The figures below illustrate that, relative to the baseline and female therapist-only
conditions, it is apparent that Group 2 showed an increased tendency to make more statements about binging, positive body image, total food/weight loss behaviors, and male relationships in the male therapist-only condition.

Figure 15 presents the frequency of intervals containing binging statements for Group 2. The visual inspection of the data shows that intervals including statements about binging occurred relatively frequently during the first two therapy sessions. As the initial baseline continued, the frequency of binging statements decreased, demonstrating a downward trend in the data. Throughout the subsequent baseline and female therapist-only conditions, the trend in data of binging statement intervals continued in an expected manner comparable to the downward trend indicated by the initial baseline phase. When considering the male therapist-only sessions, intervals containing binging statements returned to a mean frequency per session level of $\bar{X} = 6.3$, which was similar to the frequency of intervals containing such statements during the first three therapy sessions.

Figure 16 shows a graphic display of statements about positive body image. It is apparent from visual analysis of Figure 16 that Group 2 members discussed positive body image issues more often in the male therapist-only condition. During the initial baseline, total baseline, and female therapist-only conditions, group members basically did not make statements referring to positive body image. However, during the male therapist-only condition, the frequency of intervals containing positive body image statements per session increased somewhat to a level of $\bar{X} = 4$. Although this increase in positive body image intervals does not have a large numerical value, this higher frequency during the male therapist-only condition is worth consideration since positive
body image was not discussed by Group 2 members during the baseline and female therapist-only sessions.

Figure 17 presents the frequency of intervals containing total food and weight loss behavior statements for Group 2. The visual inspection of the data shows that statements about food and weight loss occurred frequently during the first three therapy sessions. As the initial baseline continued, the frequency of intervals containing such statements decreased, demonstrating a downward trend in the data. Throughout the subsequent baseline and female therapist-only conditions, the trend in data of total food and weight loss behavior statements continued in an expected manner, suggested by the downward trend indicated by
Figure 16. The frequency of intervals containing positive body image statements by Group 2.

the initial baseline phase. However, in the male therapist-only sessions, intervals including statements about food and weight loss behavior returned to a mean frequency per session level of $\bar{X} = 14.7$, which was similar to the frequency of intervals containing such statements during the last two initial baseline sessions. Furthermore, during all male therapist-only sessions, the frequency of intervals when food and weight loss behavior statements were made was greater than any other session after the first three therapy sessions.

Interestingly, it appeared that Group 2 discussed their interpersonal relationships, particularly relationships with males, more often during the male
Figure 17. The frequency of intervals containing total food and weight loss behavior statements by Group 2.

therapist-only sessions. Figure 18 illustrates the frequency intervals containing statements about heterosexual relationship issues for Group 2.

During the initial baseline condition, the mean frequency of heterosexual relationships statement intervals per session for this group was $\overline{X} = 8.5$. This initial baseline mean differs slightly from the mean of heterosexual relationship statement intervals ($\overline{X} = 7.1$) during all baseline phases of the study. Observations of the data, during the male therapist-only sessions, demonstrates a substantial increase in intervals including such statements to a mean frequency
Figure 18. The frequency of intervals containing heterosexual relationship statements by Group 2.

per session of $\bar{X} = 18$. During the female therapist-only condition, the frequency of heterosexual relationship intervals decreased from initial baseline, total baseline, and male therapist-only conditions to a level of ($\bar{X} = 5.6$). Furthermore, the number of heterosexual relationship intervals during each of the three male therapist-only sessions was greater than any other session throughout the entire study.

The frequency of intervals containing statements about clients' relationships with their fathers is presented in Figure 19. A visual inspection of Figure 19 reveals that during the initial baseline, total baseline, and female
therapist-only phases, the mean frequency of intervals containing statements regarding clients' relationships with their fathers was comparable (i.e., initial baseline $\bar{X} = 2$; total baseline $\bar{X} = 2.3$; female therapist-only $\bar{X} = 2$). Yet during the male therapist-only condition, the mean frequency of intervals including such statements dramatically rose to a level of $\bar{X} = 10$.

Besides the negative affect and total affect categories (see Figures 2 and 4), there was only one other content category where Group 2 discussed issues more often under the female therapist-only condition. Figure 20 presents data on negative body image statements for Group 2. It is apparent from visual analysis of Figure 20 that Group 2 members discussed negative body image issues more often in the female therapist-only condition. During the initial baseline condition, the mean frequency of intervals containing negative body image statements for this group was $\bar{X} = 1.8$. This initial baseline mean does not differ from the mean of negative body image statement intervals ($\bar{X} = 1.5$) during all baseline phases of the study. During the male therapist-only condition, the frequency of negative body image statement intervals remained near baseline levels ($\bar{X} = 1$). Yet during the female therapist-only sessions, the mean frequency of negative body image intervals was $\bar{X} = 6.7$. In fact, the number of negative body image intervals during each of the three female therapist-only sessions was greater than any other session throughout the entire study. Furthermore, this higher frequency during the female therapist-only condition is substantial considering that negative body image was essentially not addressed by group members during the baseline and male therapist-only conditions. Data from Figure 20 are particularly interesting since the data on this same content category from Group 1 (see
Figure 9) show an opposite effect, where negative body image issues were discussed more often under the male therapist-only condition.

Figure 19. The frequency of intervals containing relationship with father statements by Group 2.

Figure 21 shows some unique and interesting data about total body image and attractiveness statements from Group 2. The visual inspection of the data shows that statements about body image and attractiveness occurred frequently during the first two therapy sessions. As the initial baseline continued, the frequency of intervals containing such statements decreased, demonstrating a downward trend in the data. Throughout the subsequent baseline sessions, the
Figure 20. The frequency of intervals containing negative body image statements by Group 2.

frequency of total body image and attractiveness intervals remained low, conforming to the downward trend established during the initial baseline phase. During both the female and male therapist-only conditions, the mean frequency of intervals including total body image and attractiveness statements significantly increased (i.e., female therapist $\bar{X} = 15.7$; male therapist $\bar{X} = 12$) to a level at or above the mean frequency of the initial baseline. However, based on a visual analysis of the data, it appears that the increase in such intervals during the female therapist-only condition was slightly more substantial than the increase in
Figure 21. The frequency of intervals containing total body image and attractiveness statements by Group 2.

body image and attractiveness intervals during the male therapist-only condition, since the number of intervals containing body image and attractiveness statements during each of the three female therapist-only sessions was greater than any of the male therapist-only sessions.

This slight difference in mean frequency of body image and attractiveness statement intervals for Group 2, with more intervals under the female therapist-only condition, contrasts with data from Group 1 regarding the same construct (see Figure 10). The mean frequency of intervals containing statements about general body image and attractiveness for Group 1 rose dramatically during the
male therapist-only condition, while remaining negligible during the female therapist-only condition.

**Results Showing No Significance from Either Group**

This section describes results that did not show significance or consistency across experimental conditions. If the data fell into one of three basic graphic patterns, it was considered not significant and was included in this section. The first pattern of insignificant data included data that appeared significant but, on further analysis, was likely inconsequential. The second pattern involved data where no consistent results were observed across experimental conditions. The third pattern contained data where the particular topic was simply not discussed by the therapy group. Three exemplary graphs of the nonsignificant data patterns will be presented below, while the remaining graphs of nonsignificant data will be presented in Appendices K and L.

An example of erroneous significance is illustrated by Figure 22, which shows the frequency of intervals containing statements about total interpersonal relationships for Group 2. Based on visual analysis of the data, it appears that Group 2 discussed issues related to total interpersonal relationships more often in the male therapist-only condition. However, when considering the data from the specific content categories that are included in the total interpersonal relationships construct (i.e., heterosexual relationships, sexual interaction, dating, male friendship, and female friendship), it appears that the significance of data on total interpersonal relationships is simply a second way of demonstrating the significance of the heterosexual relationships data that were initially presented in Figure 18. When the data from the heterosexual relationships category were
excluded, no significance in total interpersonal relationships is observed. For this reason, data of this type were not considered significant and were reported in the appropriately defined results section.

Figure 22. The frequency of intervals containing total interpersonal relationship statements by Group 2.

An example of the second pattern of nonsignificance where no consistent results were observed across experimental conditions can be found in Figure 23, which shows the frequency of intervals containing statements about exercise issues by Group 1. A visual observation and subsequent analysis of the data reveals no consistency across the different experimental conditions. Furthermore, a calculation of the mean frequency of exercise statement intervals
does not differentiate between the baseline ($\bar{X} = 1.5$), female therapist-only ($\bar{X} = 2.7$), and male therapist-only ($\bar{X} = 2.5$) conditions.

Figure 23. The frequency of intervals containing exercise statements by Group 1.

The third example of nonsignificant data can be found in Figure 24, which shows the frequency of diuretics statement intervals by Group 2. This graphic display illustrates that Group 2 did not discuss diuretics during their therapy. Similar data where the particular group infrequently discussed issues (i.e., once or twice per session) related to the specific construct were also included in this pattern of nonsignificant data.
Figure 24. The frequency of intervals containing diuretics statements by Group 2.
CHAPTER V
DISCUSSION

This study assessed the effect of therapist gender on the content of discussions among women involved in group therapy for eating disorders. Two eating-disordered therapy groups were established in two settings that provide psychotherapeutic services to clients while offering Ph.D.-level psychology students the opportunity for practical psychotherapy training. Each group was led by separate cotherapist teams consisting of one male and one female therapist. The therapists in this study were relatively young, and roughly comparable in highest degree held, years and type of training, opinion of optimal therapeutic practice, and amount of experience. Both cotherapy teams maintained a strict client-centered therapeutic approach/orientation to treatment. These features, in conjunction with the manipulation of the presence/absence of each therapist in the single-subject design, suggest that therapist gender influenced the groups' tendency to discuss certain topics. The major contribution to the literature made by the present study is that it provides empirical, quantitative data on the effects of therapist gender on group therapy processes.

Under the particular circumstances of this study, there were several topics that seemed to be meaningfully discussed regardless of therapist gender. Both therapy groups appeared to discuss certain topics (such as food retention and dieting, vomiting, exercise, positive affect issues, male friendships, female friendships, general interpersonal relationships, and self-esteem) in a consistent manner regardless of the gender of the group-leading therapist. There were also many topics that were not discussed by either of the two groups (i.e., sexual
interaction, laxative use, derogation of males, derogation of females), regardless of the therapist composition. On the other hand, some topics were systematically associated with the presence of male and female therapists per se. These issues are discussed below.

**Eating Disorders Treatment Model**

Before discussing the significance of the results of this study, a brief outline of a preferred eating disorder treatment model (i.e., cognitive-behavioral model) may help highlight the implications of the results. In general, such a model assumes that the behaviors, cognitions, and emotions of an individual interact in a complex manner to contribute to the maintenance of an eating disorder. Therefore, a comprehensive treatment approach would target each of these components. In describing such a model, Yager (1988) suggested that the treatment of eating disorders needs to go beyond the simple targeting of physical eating disorder symptoms and address the psychological distress and complications in the individual's life. The model described below is comprised of elements that are common to a number of treatment approaches for eating-disordered clients (see Yager, 1988; Fairburn, 1985; Garner, Rockert, Olmsted, Johnson, & Coscina, 1985, Hall, 1985). Figure 25 illustrates the components of a cognitive-behavioral treatment package.

1. Eating-disordered clients need to establish some degree of control over eating by developing a stable eating pattern. Furthermore, clients need to become educated about their disturbed sensations of hunger and satiety, their body image dissatisfaction, and their misconceptions about food, eating, body shape, and weight. Often this is accomplished through the use of self-monitoring.
Figure 25. A cognitive-behavioral treatment model for eating disorders.
food and nutrition journals, strict scheduling of meals and daily activities, discussions of food-related and body image issues in therapy, and contingencies that reinforce acceptable food-related behaviors.

2. Clients need to identify, discuss, and modify the dysfunctional thoughts, beliefs, attitudes, and values associated with their disorder. These maladaptive cognitions may focus on issues concerning interpersonal relationships, food-related behavior, weight, self-concept, body image, self-control, etc. For example, clients may be challenged, in therapy, on the rationale of a particular belief that being thinner will result in unconditional and authentic parental acceptance.

3. Invariably, eating-disordered clients need to learn to identify, label, and express their negative emotions. Furthermore, it is essential for clients to draw the connection between their emotions and the physical symptoms of the eating disorder by understanding how their emotions can lead to specific eating-disorder behavior. For example, one part of a treatment approach for bulimic clients would focus on having clients develop an awareness of their behaviors, cognitions, and emotions (i.e., feeling angry and frustrated toward one's spouse) prior to engaging in binging behavior.

4. Clients need to develop an awareness of how certain negative experiences eventually develop into symptomatic behavior through an understanding of how behaviors occur in relationship to one another (i.e., within a behavioral chain). For example, an anorexic client needs to understand how disappointment over receiving a "B" grade on an exam late in the morning might relate to an afternoon episode of relentless exercising.
5. Clients need to develop and implement appropriate, healthy coping responses when experiencing the behavioral, cognitive, and emotional antecedents to a maladaptive eating-disorder behavior (i.e., binging, purging, restricting). Clients can develop a list of alternative, acceptable behaviors that are incompatible with symptomatic behavior. Often, a variation of assertiveness training, which focuses particularly on expression of negative emotions is also incorporated into such a treatment program. Ultimately, the client is to engage in these alternative behaviors, as early as possible in the behavioral chain, when feeling the particular antecedents to the eating disorder behavior. For example, when feeling like binging after being mistreated by her boyfriend, a bulimic client may go for a walk, confront the individual, or visit a friend until the urge passes.

6. Finally, clients may be introduced to the need for other adaptive skills, such as the development of general problem-solving abilities, relaxation behaviors, and effective stress-management techniques that can be used to manage and avoid the high risk situations that previously led to engagement in symptomatic behavior.

Implications of Results from the Female Therapist-Only Condition

The results suggested that when a female therapist alone was leading group therapy sessions, eating-disordered clients were more inclined to discuss general emotional issues and specific issues involving negative affect. These results were consistent across both therapy groups. For example, it is interesting to note that the increase in the tendency of group members to discuss emotional issues during the sessions led by a female therapist is supported by the opinion
of Hill (1975) and others, who believe that with female clients, female therapists may elicit a greater focus on clients' feelings and emotions.

Many eating-disorder experts suggest that eating-disorder clients often have extreme difficulty identifying and appropriately expressing negative emotions (e.g., anger, frustration) and conflicts (i.e., Gendron et al., 1992; Hall, 1985). Often, this difficulty in emotional expression is accompanied by an inability or unwillingness to therapeutically address such topics in their relationships or in group therapy. Due to this general difficulty, eating-disorder clients tend to become highly skilled in building defenses (i.e., continual discussion of physical symptoms, repetitive emoting, rationalizing behavior) that appear to have therapeutic benefits, but may reflect treatment resistance. Based on the present results, it is possible that both groups exhibited manifestations of these defenses during this study. During the female therapist-only condition, both groups demonstrated an increased tendency to discuss emotional issues. If such discussions consist of repetitive emoting and do not move toward therapeutic resolution (i.e., appropriate expressions of emotions, development of adaptive, alternative behaviors), the group may be demonstrating treatment resistance. Therapists who work with eating-disordered clients need to increase awareness and consider the content, context, and direction of group's discussions as the discussions relate to possible defenses and avoidance by the group.

The results also suggest that female eating-disordered clients, in general, may feel more comfortable and be more spontaneous in discussing emotional topics under the guidance of a female therapist. Because eating-disordered women will more naturally discuss emotional topics in the presence of a female
therapist, it is important that female therapists develop an awareness that the group might become unduly entrenched in emoting without moving toward therapeutic resolution (e.g., learning emotional coping skills). It would appear that female therapists may need to encourage the group to go beyond the emoting stage toward the development of skills in recognizing, labeling, experiencing, and coping with the typically avoided feelings that may inhibit therapeutic growth. For instance, this might be accomplished by prompting clients to recognize the role of their emotions as potential "precursors" to the maladaptive, unhealthy behaviors associated with eating disorders (i.e., excessive exercising, binging, purging). Furthermore, therapists can also guide their clients toward developing appropriate coping mechanisms when experiencing these negative emotional states. For example, female therapists may facilitate a therapeutic exercise where the group develops a list of alternative, acceptable behaviors when feeling anxious over their body image.

When considering the training, supervision, and in-session behavior of the novice female therapist, it may be necessary for her to identify when the discussions and expressions of content are dominated by emotion and catharsis. It is generally agreed that clients' expression of emotions is therapeutically beneficial, and therapists should be encouraged to guide such expressions toward therapeutic resolution (i.e., learning emotional coping skills). However, if these cathartic discussions become consistently repetitive and do not move toward resolution, the therapist must gently redirect the focus of therapy toward assessing the relationship between emotions, food-related behaviors, and body image issues. This may be of particular importance, for example, with inpatient clients who are severely emaciated and are struggling with their health.
Continued discussions of emotional issues, without focusing on their relationship to food and weight issues (i.e., stabilized eating), may be considered countertherapeutic since issues concerning the maladaptive food-related behaviors and the poor health of the client are not directly addressed. Training suggestions that may aid female therapists in directing clients toward such a focus include the use of nutrition journals, structured meal planning, and behavioral contingencies that target stabilized eating patterns.

Implications of Results from the Male Therapist-Only Condition

During both the initial baseline and male therapist-only conditions, there was a tendency for female group members to talk more about the physical symptoms of eating disorders (i.e., food-related behaviors, body image issues). Specifically, Group 1 appeared to discuss symptomology in terms of total body image and attractiveness, negative body image, attractiveness to the opposite sex, family weight, personal weight, and fashion emphasis. In a similar vein, Group 2 tended to focus on symptomology in terms of positive body image, binging, and total food and weight loss behaviors. These results suggest that the presence of a male therapist alone creates an environment that promotes discussions of general eating-disorder symptoms, food-related behaviors, and body image issues. Indeed, although both groups discussed emotional issues to some extent during the male therapist-only sessions, the frequency of these discussions was notably increased during the female therapist-only condition. Subsequent to this, the reentry of the male therapist into the group resulted in a general decrease in the group’s tendency to discuss emotional topics.
Hall (1985) described the expression of feelings as an important process in group therapy for eating-disordered clients. Through honest expression of emotions, eating-disorder clients can begin to formulate gratifying relationships that reduce isolation and aid in facing difficulties with interpersonal, body image, and food-related issues. Unfortunately, undue focus on expressing the negative emotions may amplify those same feelings within the group members. Also, it may result in the avoidance of feelings in future sessions (i.e., by clients not attending therapy sessions) (Riess & Rutan, 1992). Male therapists need to be particularly aware of possible reasons for avoiding feelings and the potential consequences of the clients' initial expressions of emotions. Emphasizing his understanding of the clients' difficulties with emotions and reminding them that effective emotional expression will take time to develop is an essential step toward therapeutic growth that must be displayed by male therapists when facilitating discussions of emotional issues.

Guiding the group to discuss and explore emotional issues has implications for the training of the novice male therapist, considering the tendency for less emotional discussion in the male therapist-only sessions. One implication of these results is that male therapists (relative to female therapists) may need to more actively support, encourage, prompt, and guide eating-disordered clients into discussions of emotional issues. Male therapists may need to employ a variety of therapeutic skills, such as using emphatic, directive responses that embrace feelings, commenting on the absence of expression of feelings, or asking direct questions that focus on emotional issues (Lacey, 1983).
Benefits of a Mixed Gender Cotherapist Team

The results of this study may have somewhat different implications for the direction and course of eating-disorders treatment, depending on one's theoretical and philosophical approach to the treatment of such clients (i.e., whether one believes that emotional issues or behavioral symptoms are most significant). Perhaps female therapists may be best suited working with clients who have somewhat stabilized eating patterns, but have not resolved the underlying psychological and emotional aspects of eating disorders, whereas, male therapists may be more efficient with highly symptomatic, symptom focused, or inpatient clients with maladaptive food-related behaviors and inappropriate body image characteristics.

Perhaps the most salient implication of the results is that therapists, both male and female, be aware of what issues tend to be avoided in the presence of male versus female therapists. It is a distinct possibility that regardless of their verbal behaviors, the therapists may contribute to the group's avoidance of certain topics by their own biases against talking about particular areas (i.e., males therapists with decreased affect discussions, females therapists with decreased behaviors/symptoms/body image discussions). Furthermore, clients may have expectations, based simply on therapist gender, about what issues can be more spontaneously discussed. Using this knowledge may help the therapists be more efficient and effective in their therapeutic approach to eating disorders group therapy. It may matter less what the therapist gender is if therapists develop an increased awareness of the tendencies demonstrated in this study.

Based on this research, it is suggested that using a mixed gender cotherapist team may provide eating-disordered groups with the greatest
therapeutic opportunities. While the involvement of a male therapist may inhibit the tendency for female clients to spontaneously discuss emotional topics, his presence could allow clients to have a qualitatively different psychotherapy experience. Involving a male cotherapist in the group could allow female clients the opportunity to more effectively express their emotions in the presence of an empathic and accepting male. By generalizing this therapeutic experience to situations involving other males, female clients may discover that some males may indeed be interested in and value their expression of feelings and emotions. Thus, the presence of a male therapist could enable some eating-disordered clients to overcome difficulty in communicating with men, which may be a significant therapeutic hurdle. Lacey (1983) suggested the use of a mixed gender cotherapist team in just this manner. Specifically, the presence of a female therapist encourages the expression of emotional topics, while a nonthreatening male cotherapist may provide a safe atmosphere for discussing some of the assumptions and distortions about men.

Furthermore, the presence of a mixed gender cotherapist team may prompt eating-disordered groups to discuss parental and heterosexual relationships in a qualitatively different manner, relative to groups led by single gender teams. This study produced some data (though not consistent across both groups) suggestive of a complimentary transference reaction (i.e., in the presence of the male therapist-only, group members addressed paternal issues, while in the female therapist-only sessions, the group discussed issues about relationships with their mothers). Data from Group 1 showed an increase in discussions about relationships with mothers in the female therapist-only condition, while data from Group 2 demonstrated an increase in discussions
about relationships with fathers during the male therapist-only sessions. Therapists may be perceived by their clients as possible parental figureheads which, as was the case in some instances of this study, may lead to an increased tendency to discuss relationship issues of the parents whose gender matched the group-leading therapist (Zunino et al., 1991). Unfortunately, these data were not consistently obtained throughout the study, and therefore must be denoted as speculation at this point.

It can also be speculated that a mixed gender cotherapist team may serve as a model for healthy heterosexual relationships by demonstrating cooperative and effective communication. This relationship may prompt the group into addressing the current functioning of heterosexual relationships and provide a model for appropriate and effective communicative behaviors within an emotionally intimate relationship.

Limitations of the Study

There were several limitations in this study which encourage one to take caution when interpreting the results. First, the instability of the group members' attendance to therapy sessions over the course of the study limits the results and conclusions. One of the major advantages of single-subject methodology is that it accounts for most threats to internal validity by comparing the subject to him/herself. Unfortunately, because group attendance varied throughout the study, one must be cautious when interpreting these results since comparing the group to itself--when a slightly different composition of members was present--does not, by design, rule out some threats (i.e., history, maturation) to the internal validity of this study. Furthermore, it seems logical to assume that different group
members bring different issues to the therapy sessions and thus influence the topics of discussions.

A second limitation of this study was caused by a malfunction in the taping equipment during Group 1's 13th session. Essentially, the session was videotaped without sound, making it impossible for the coders to gather data from that session. Therefore, only two data points for the male therapist-only condition (Group 1) were available for analysis. Since the taping malfunction occurred during the second session of the male therapist-only two-session set, it is not known whether the back-to-back male therapist-only sequence influenced the data in the second of two male therapist-only sessions. Although this particular sequence did not have a substantial effect on the data from Group 2, one cannot make inferences about its possible effects on Group 1.

A third limitation of this study is that it involved only two therapy groups. The study did provide some interesting inconsistencies across groups. One such inconsistency involved the group members' tendency to discuss negative body image. Group 1 tended to increase discussions in this area during the male therapist-only condition, while Group 2 demonstrated an increased tendency to discuss such issues during the female therapist-only condition. It appeared that this inconsistency in the data can be explained by providing a description of the context of the discussions. An analysis of the particular therapy sessions indicated that Group 1 made negative body image statements while discussing the physical symptoms and manifestations with regard to their disorders (i.e., "I just need to stay on this diet because I feel so fat."). The negative body image comments by Group 2 were made more in the context of negative emotions and
affect discussions (i.e., "I feel so depressed, inferior. It's the worst in the morning when I have to dress this chubby body.").

Similarly, a second inconsistency appeared in the data from Group 2. An increase in total body image and attractiveness discussions occurred during both the female-only and male therapist-only conditions. The increase did persist when the therapists led the group together. These data may be somewhat suggestive of the threats to group cohesion, which may result in an increase in discussion of symptoms (see Yalom, 1985). A replication of this study, involving a third group, with an additional set of male and female therapists, would provide information that may clarify these discrepancies in the data. Further, use of a third group may provide more information to help answer questions about conflicting, or apparently nonsignificant data (found with the two sets of therapists in this study).

Finally, the therapy approach used in this study involved a strict client-centered orientation. It is uncertain whether similar results would be obtained with other theoretical approaches (i.e., psychoanalytic, cognitive-behavioral, etc.) Therefore, it is advised that one remain conservative when interpreting these results. Furthermore, it cannot be certain that similar results would occur with therapy groups that included members of both genders or with therapy groups that consisted of members with diagnoses different from eating disorders.

**Implications for Future Research**

Besides replicating this particular study, several variations in methodology might be worthwhile to examine in future studies. For example, a study that codes both therapist and client statements would provide data that would allow for a functional analysis of verbal interactions between therapists and clients.
Such a study would also suggest whether a particular therapist response to a client's interactions inhibit or facilitate subsequent discussion of the specific statement.

Also, considering that verbal expression does not occur independently from cognitions, emotions, and behaviors, it is highly probable that nonverbal expressions, within the group, influence subsequent verbal behavior. Such a study may lead to an increased understanding of the relationship between nonverbal behavior and group process for eating-disorders therapy. Also, eating-disordered clients tend to be very sensitive to external cues and might be perceiving things in the therapist (both verbal and nonverbal) that help limit the discussion of certain topics. More assessment of the therapist's ability to detect his or her own biases toward issues of eating-disordered clients would add clarity to the group treatment of eating disorders. Further investigation of these relationships in the context of a group psychotherapy setting is needed.

Third, it would be useful to assess the client's preference for a male or female therapist before and after therapy. Could matching or not matching the clients' preference of therapist gender influence the content of therapy sessions? Research addressing gender preference issues with respect to the content of therapy sessions would be particularly informative to those living and working in situations (i.e., rural settings, school settings) where a therapist of one gender is unavailable.

Finally, it is interesting to consider the results of this study in context of the group therapy stages of Yalom (1985). Yalom noted that symptom description is normally a favorite early topic for groups, which promotes general approval and acceptance among group members. This stage is considered to be an essential
component to the development of group cohesiveness. Yalom (1985) also indicated that therapy group members generally suppress their expression of negative emotions when the group's cohesion is in question. Could the increase in symptom description, and decrease in affect and negative affect discussions suggest that the group cohesion was threatened in the sessions when the female therapist was absent? The results of this study provide data that invite such a speculation, especially since the frequency of statements regarding eating-disorder symptoms often returned to initial baseline levels when the female therapist was absent. Unfortunately, the literature on group therapy lacks specific, empirically based research on the general progression and flow of group process for eating-disordered clients. The development of a study that leads to a better understanding of group therapy process for eating-disordered clients might be useful in discovering certain factors that threaten the process of the group.
REFERENCES


APPENDICES
APPENDIX A:

Brief Description of Eating-Disorder Clients
Brief description of clients in eating-disorders group 1

initials: MB
age: 24
presenting problem: Bulimia Nervosa

initials: AF
age: 20
presenting problem: Bulimia Nervosa

initials: LH
age: 20
presenting problem: Anorexia Nervosa

initials: AS
age: 19
presenting problem: Eating Disorder NOS (Compulsive Binging/Exercising)

initials: AV
age: 20
presenting problem: Eating Disorder NOS (Compulsive Binging)

clients added after seventh session

initials: AJ
age: 26
presenting problem: Eating Disorder NOS (Compulsive Binging)

initials: TL
age: 18
presenting problem: Bulimia Nervosa
Brief description of clients in eating-disorders group 2

<table>
<thead>
<tr>
<th>Initials</th>
<th>Age</th>
<th>Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>JC</td>
<td>18</td>
<td>Bulimia Nervosa</td>
</tr>
<tr>
<td>CK</td>
<td>22</td>
<td>Anorexia Nervosa</td>
</tr>
<tr>
<td>JL</td>
<td>19</td>
<td>Bulimia Nervosa</td>
</tr>
<tr>
<td>KM</td>
<td>31</td>
<td>Eating Disorder NOS (Compulsive Binging)</td>
</tr>
<tr>
<td>MU</td>
<td>19</td>
<td>Bulimia Nervosa</td>
</tr>
</tbody>
</table>

Client added after seventh session

<table>
<thead>
<tr>
<th>Initials</th>
<th>Age</th>
<th>Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>19</td>
<td>Anorexia Nervosa</td>
</tr>
</tbody>
</table>
APPENDIX B:

Clients' Informed Consent Form
INFORMED CONSENT FORM (CLIENTS)

I understand that I am being invited to voluntarily participate in an experiment regarding group therapy treatment of eating disorder clients. I understand that the process will take place at the Utah State University Counseling Center. My participation will involve voluntary attendance of videotaped group therapy sessions for eating disorder clients. I understand that the videotapes will be secured in a locked cabinet and will be used only for supervision and data collection purposes. The videotapes will be erased no later than two weeks after the session occurred.

I understand that all data will be collected in a confidential manner and in no way will identify me. I understand that those involved in the experiment have agreed to keep all information confidential and will not discuss the content or occurrences of this research and therapy with anyone. I understand that maintaining confidentiality is essential to those who participate.

I understand that the group therapy program will consist of a predetermined number of sessions (15) focusing on eating disorders and associated issues. After fifteen sessions, data will no longer be collected for the purposes of this study, however the group may continue pending a decision of the group members. One group session per week will occur, each lasting approximately 90 minutes.

The proposed study contains a number of potential benefits. First, several individuals can receive professional, psychological treatment for eating disorders and associated issues. Second, the group therapy format will allow the opportunity for female eating disorder patients to self-disclose in the presence of an accepting and empathetic male. This is a particularly important step toward accomplishing one therapeutic goal of establishing healthy, satisfying relationships with males. Third, the therapy groups will be free of charge to those who are participating. There is one potential risk inherent in this research. The maintenance of confidentiality of all participating clients (i.e. group members) must be considered, however informed consent will be secured from all participants in an attempt to minimize that risk. The research procedures have been explained to my satisfaction. I understand that I may withdraw at any time from this experiment without penalty.

I have read the above material and understand my responsibilities. All questions that I have asked were answered to my satisfaction. If questions arise regarding my rights in this research, I can contact Todd Soutor at the Utah State University Psychology Department at 750-1460.

Participant
________________________________________
Signature
________________________________________
Date
APPENDIX C:
Agency Approval Form
AGENCY APPROVAL FORM

Mary Doty, Ph.D.
Utah State University Counseling
UMC 0115
Utah State University
Logan, UT, 84322

Dear Dr. Doty,

It is my desire to conduct a research project in your center with therapists and clients who are under your supervision. At this point, neither the therapists nor the clients have been selected, but it is hoped that upon your approval, suitable individuals will be found.

Enclosed is a copy of the Utah State University Counseling Center Request for Research Proposal. A similar proposal has been approved by my Dissertation Committee at Utah State University. Dr. David Stein is the committee chair and can be contacted at UMC 2810, Department of Psychology, Utah State University, Logan, Utah, 84321. Feel free to contact Dr. Stein or me, Todd A. Soutor, at 750-1460 if you have any questions.

Once you have read the proposal and reviewed the research proposition with your staff, I need you to send me a signed statement on identifiable letterhead stating that you have read and approve of the proposed project.

Sincerely,

Todd A. Soutor, M.A.
AGENCY APPROVAL FORM

Elwin Neilsen, Ph.D.
Utah State University Community Clinic
UMC 2810
Utah State University
Logan, UT, 84322

Dear Dr. Neilsen,

It is my desire to conduct a research project in your clinic with therapists and clients who are under your supervision. At this point, neither the therapists nor the clients have been selected, but it is hoped that upon your approval, suitable individuals will be found.

Enclosed is a copy of the research proposal. This proposal has been approved by my Dissertation Committee at Utah State University. Dr. David Stein is the committee chair and can be contacted at UMC 2810, Department of Psychology, Utah State University, Logan, Utah, 84321. Feel free to contact Dr. Stein or me, Todd A. Soutor, at 750-1460 if you have any questions.

Once you have read the proposal and reviewed the research proposition with your staff, I need you to send me a signed statement on identifiable letterhead stating that you have read and approve of the proposed project.

Sincerely,

Todd A. Soutor, M.A.
APPENDIX D:

Clients' Attendance
### EATING DISORDERS ATTENDANCE (GROUP 1)

<table>
<thead>
<tr>
<th>NAME</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>MB</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>AF</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>LH</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>AS</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AV</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>AJ (added after 7th)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TL (added after 7th)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EATING DISORDERS ATTENDANCE (GROUP 2)

<table>
<thead>
<tr>
<th>NAME/SESSION</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>JC</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CK</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>JL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>KM</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MU</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>BP (added after 7th)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME/SESSION</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>JC</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>CK</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>JL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>KM</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MU</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
APPENDIX E:

Brief Description of Therapists
Brief description of therapists for eating disorders group 1

Female Therapist

Name: TB  
age: 27  
Highest degree: MA  
Years of experience: 3 years, part-time  
Year in Ph.D. Program: 3rd  
Primary therapeutic approach: Eclectic/Cognitive-Behavioral

Male Therapist

Name: SC  
age: 31  
Highest degree: MS  
Years of experience: 5 years, part-time  
Year in Ph.D. Program: 4th  
Primary therapeutic approach: Cognitive-Behavioral/Eclectic

Brief description of therapists for eating disorders group 2

Female Therapist

Name: DW  
age: 42  
Highest degree: MSW  
Years of experience: 3 years, part-time  
Year in Ph.D. Program: 3rd  
Primary therapeutic approach: Cognitive-Behavioral

Male Therapist

Name: KN  
age: 38  
Highest degree: MA  
Years of experience: 3 years, part-time  
Year in Ph. D. Program: 3rd  
Primary therapeutic approach: Cognitive-Behavioral
APPENDIX F:

Therapist Instructions
GENERAL INSTRUCTIONS FOR THERAPISTS

The following general instructions will be given to the therapists of the eating disorder groups.

1. The therapy groups will be exclusively for women to discuss their concerns regarding their eating issues and other related topics.

2. The therapists will orient the group in terms of establishing group rules outlining:
   a. The importance of maintaining confidentiality of all group members as well as adhering to a policy of not discussing therapy topics outside of the group.
   b. The importance of member attendance, regarding the understanding that non-attendance by one group member underlies the progress of the entire group.

3. Therapists should start each session by inviting the group to discuss relevant issues. Examples of opening questions are, "Where should we begin this week?" and "What things have come up within the past week?"

4. Therapists will be asked to facilitate therapy in the following ways: making reflective statements, inviting group members to discuss and disclose, and confronting individuals when other group members have failed to do so.

5. Therapists will be asked to refrain from taking a directive role within the group. He or she will refrain from initiating the discussion of topics, or lending opinions to issues presented. Questions directed to the therapist will be re-directed to the group by encouraging and prompting interaction and feedback among group members.
6. Therapists will be encouraged to redirect the group discussion under the following circumstances:
   a. when the group is perseverating on one particular topic of discussion.
   b. when the group is discussing topics that are unrelated to their therapy.
   c. when there is excessive derogation toward one group member.

7. The therapists will be asked to refrain from structuring specific session-by-session topics of discussion.

8. The therapists will be asked to refrain from self-disclosure of personal experiences, as this may directly alter the groups' focus of discussion.
APPENDIX G:

Coding Instrument
<table>
<thead>
<tr>
<th>Coder: Date of session:</th>
<th>Number 1 2 3 4 5 6 7 8 9 10 11 12</th>
<th>Date of coding:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
<th>1 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive body image</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>negative body image</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>body area satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>body area dissatisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attractiveness to opposite sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>family weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>personal weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fashion emphasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>binging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>laxative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diuretics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>food retention &amp; dieting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>heterosexual relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sexual interaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male friendship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>female friendship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>physical or sexual attraction toward another</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sexual abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>derogation of males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>derogation of females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>anger toward a male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>anger toward a female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>negative affect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive affect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>self esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationship with mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationship with father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>within group confrontation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Positive and negative body image, body area satisfaction and dissatisfaction, attractiveness to opposite sex, family and personal weight, fashion emphasis, binging, vomiting, laxatives, diuretics, exercise, food retention and dieting, heterosexual relationships, sexual interaction, dating, male and female friendship, physical or sexual attraction, sexual abuse, derogation of males and females, anger toward males and females, negative and positive affect, self-esteem, relationship with mother and father, and within group confrontation are the topics covered in this document.
APPENDIX H:

Operational Definitions of Content Categories
CODING DEFINITIONS

Positive Body Image- positive global statement referring to perception of one's own body, in a general sense.

Negative Body Image- negative global statement referring to perception of one's own body, in a general sense.

Body Area Satisfaction- qualitatively positive statement about a specific area of one's body (i.e., stomach, thighs, hips, etc.).

Body Area Dissatisfaction- qualitatively negative statement about a specific area of one's body (i.e., stomach, thighs, hips, etc.).

Attractiveness to Opposite Sex- qualitative statement appraising one's degree of attractiveness or appeal to opposite sex.

Family Weight- statement referring to current or past weight issues in family.

Personal Weight- reference to client's current or past weight gain or loss (reporting of numbers is not necessary).

Fashion Emphasis- statement which entails disdain about one's clothes or concern about conforming to current clothing fashion.

Binging- rapid consumption of a large amount of food in a discrete period of time.

Vomiting- an attempt to rid the body of consumed food or undesired calories (i.e., self-induced vomiting).

Laxative- statements referring to the acquisition or use of some substance to facilitate a bowel movement.

Diuretics- statements referring to the acquisition or use of a diuretic (i.e., water pills).

Exercise- reference to exercise or attempts to "burn calories" through excessive activity.

Food Retention/Dieting- statement that highlights any reference to current or past diet attempts.
Heterosexual Relationships- statement regarding any issues about relationship with a male who is not related to that person making the statement (i.e., reference to boyfriend, fiancee, spouse).

Sexual- statement regarding any intimate or sexual (i.e., kissing, sexual collaboration) interaction.

Dating- any reference to dating, "going out" on a date, or date-like appointments that entail personal interest.

Male Friendship- description of a platonic relationship with a male.

Female Friendship- description of a platonic relationship with a female.

Physical/Sexual Attraction toward Another- qualitative statement about sexual arousal or sexual interest or toward another.

Sexual Abuse- sexual actions with someone that were unwanted (i.e., on a continuum from hugging and kissing to intercourse).

Derogation of Males- general derogatory statement or stereotypic belief about male behavior, traits, or attitudes.

Derogation of Females- general derogatory statement or stereotypic belief about female behavior, traits, or attitudes.

Anger toward a Male- negative statement (i.e., of displeasure, dislike) directed toward one male.

Anger toward a female- negative statement (i.e., of displeasure, dislike) directed toward one female.

Negative Affect- any statement that uses words that describe unpleasant, aversive emotions or feelings.

Positive Affect- any statement that uses words that describe pleasant, delightful emotions or feelings.

Self Esteem- statements referring to a general confidence or satisfaction in oneself; references to one's "self-esteem", "self-concept", "identity as a person", "sense of self", etc.
Relationship with Mother- statement regarding any interaction or relationship with a mother or step-mother.

Relationship with Father- statement regarding any interaction or relationship with a father or step-father.

Within Group- confrontation (i.e., taking some action to resolve a conflict) statement directed toward group members.
APPENDIX I:

Ethical Procedures Form for Coders
ETHICAL PROCEDURES FORM (CODERS)

I understand that I am being invited to voluntary participate in an experiment regarding group therapy treatment of eating disorder clients. I understand that the process will take place at either the Utah State University Community Clinic or the Utah State University Counseling Center. My role will require approximately three hours per week over a five month span.

I understand that all data will be coded so that my answers will be confidential and in no way will identify me. I understand that I may withdraw at any time without penalty.

The research procedures have been explained to my satisfaction. I agree to keep all information confidential and will not discuss the content or occurrences of this research with anyone. I understand that maintaining confidentiality of all clients and therapists is essential to my participation.

I have read the above material and understand my responsibilities. All questions that I have asked were answered to my satisfaction.

Participant

Signature

Date
APPENDIX J:

Presentation of Raw Data
## Raw Data for Group 1 (Counseling Center): Content of statements per minute by session

<table>
<thead>
<tr>
<th>Content Category/Session</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive body image</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>negative body image</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>body area satisfaction</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>body area dissatisfaction</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>attractiveness to opposite sex</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>family weight</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>personal weight</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>fashion emphasis</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>binging</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>vomiting</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>laxative</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>diuretics</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>exercise</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>food retention &amp; dieting</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>heterosexual relationships</td>
<td>7</td>
<td>9</td>
<td>12</td>
<td>6</td>
<td>10</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>sexual interaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>dating</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>male friendship</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>female friendship</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>physical or sexual attraction toward other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>sexual abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>derogation of males</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>derogation of females</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>anger toward a male</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>14</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>anger toward a female</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>12</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>negative affect</td>
<td>26</td>
<td>20</td>
<td>24</td>
<td>14</td>
<td>64</td>
<td>28</td>
<td>21</td>
</tr>
<tr>
<td>positive affect</td>
<td>15</td>
<td>6</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>self esteem</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>relationship with mother</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>12</td>
<td>30</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>relationship with father</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>within group confrontation</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Content Category/Session</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>positive body image</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>negative body image</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>body area satisfaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>body area dissatisfaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>attractiveness to opposite sex</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>family weight</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>personal weight</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>---</td>
<td>6</td>
</tr>
<tr>
<td>fashion emphasis</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>binging</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>vomiting</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>---</td>
<td>3</td>
</tr>
<tr>
<td>laxative</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>diuretics</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>exercise</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>food retention &amp; dieting</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>heterosexual relationships</td>
<td>11</td>
<td>13</td>
<td>14</td>
<td>12</td>
<td>3</td>
<td>---</td>
<td>5</td>
</tr>
<tr>
<td>sexual interaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>dating</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>male friendship</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>female friendship</td>
<td>17</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>---</td>
<td>6</td>
</tr>
<tr>
<td>physical or sexual attraction toward another</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>sexual abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>derogation of males</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>derogation of females</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>anger toward a male</td>
<td>0</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>anger toward a female</td>
<td>1</td>
<td>21</td>
<td>11</td>
<td>3</td>
<td>6</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>negative affect</td>
<td>34</td>
<td>48</td>
<td>37</td>
<td>30</td>
<td>21</td>
<td>---</td>
<td>31</td>
</tr>
<tr>
<td>positive affect</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>---</td>
<td>3</td>
</tr>
<tr>
<td>self esteem</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>1</td>
</tr>
<tr>
<td>relationship with mother</td>
<td>3</td>
<td>34</td>
<td>28</td>
<td>7</td>
<td>8</td>
<td>---</td>
<td>5</td>
</tr>
<tr>
<td>relationship with father</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>within group confrontation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>---</td>
<td>0</td>
</tr>
</tbody>
</table>
### Raw Data for Group 2 (Community Clinic): Content of statements per minute by session

<table>
<thead>
<tr>
<th>Content Category/Session</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive body image</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>negative body image</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>body area satisfaction</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>body area dissatisfaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>attractiveness to opposite sex</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>family weight</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>personal weight</td>
<td>8</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>fashion emphasis</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>binging</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>vomiting</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>laxative</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>diuretics</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>exercise</td>
<td>13</td>
<td>9</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>food retention &amp; dieting</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>heterosexual relationships</td>
<td>10</td>
<td>13</td>
<td>6</td>
<td>5</td>
<td>17</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>sexual interaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>dating</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>male friendship</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>female friendship</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>physical or sexual attraction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>toward another</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>sexual abuse</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>derogation of males</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>derogation of females</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>anger toward a male</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>anger toward a female</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>negative affect</td>
<td>21</td>
<td>19</td>
<td>20</td>
<td>22</td>
<td>21</td>
<td>29</td>
<td>39</td>
</tr>
<tr>
<td>positive affect</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>self esteem</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>relationship with mother</td>
<td>15</td>
<td>7</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>relationship with father</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>within group confrontation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Content Category/Session</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---</td>
<td>---</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>positive body image</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>negative body image</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>body area satisfaction</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>body area dissatisfaction</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>attractiveness to opposite sex</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>family weight</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>personal weight</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>fashion emphasis</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>binging</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>vomiting</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>laxative</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>diuretics</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>exercise</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>food retention &amp; dieting</td>
<td>0</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>heterosexual relationships</td>
<td>5</td>
<td>21</td>
<td>16</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>sexual interaction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>dating</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>male friendship</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>female friendship</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>physical or sexual attraction toward another</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>sexual abuse</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>derogation of males</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>derogation of females</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>anger toward a male</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>anger toward a female</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>negative affect</td>
<td>27</td>
<td>18</td>
<td>23</td>
<td>29</td>
<td>43</td>
<td>42</td>
<td>28</td>
</tr>
<tr>
<td>positive affect</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>self esteem</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>relationship with mother</td>
<td>15</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>relationship with father</td>
<td>4</td>
<td>10</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>within group confrontation</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
APPENDIX K:

Nonsignificant Results for Group 1
Body Area Satisfaction

Frequency

Session

A B A C A B A C A

10

5

0
Body Area Dissatisfaction

Frequency

Session

A B A C A B A C A

1 2 3 4 5 6 7 8 9 10 11 12 13 14
A B A C A B A C A

Frequency

Session
Laxative Use

Frequency

Session

A  B  A  C  A  B  A  C  A

20

15

10

5

0

1  2  3  4  5  6  7  8  9  10  11  12  13  14
Diuretics

A  B  A  C  A  B  A  C  A

Frequency

Session
Food Retention and Dieting

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>A</th>
<th>C</th>
<th>A</th>
<th>B</th>
<th>A</th>
<th>C</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Frequency</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Heterosexual Relationships

Frequency

Session
Sexual Interaction

A
B
A
C
A
B
A
C
A

Frequency

0
5
10
15
20

Session

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Male Friendship

A B A C A B A C A

Frequency

Session
Female Friendship

Session

Frequency

A
B
A
C
A
B
A
C
A
Total Interpersonal Relationships

Frequency

Session
Physical/Sexual Attraction toward Another

Session

Frequency
Derogation of Males

A  B  A  C  A  B  A  C  A

Frequency

0  5  10  15  20

Session

1  2  3  4  5  6  7  8  9  10  11  12  13  14
Derogation of Females

Frequency

Session
Relationship with Father

Session

Frequency

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Within Group Confrontation

Frequency

Session
APPENDIX L:

Nonsignificant Results for Group 2
Body Area Satisfaction

Frequency

Session
Attractiveness to Opposite Sex

Frequency

Session
Fashion Emphasis

A  C  A  B  A  C  A  B  A

Frequency

0  5  10  15  20

Session

1  2  3  4  5  6  7  8  9  10  11  12  13  14
Vomiting

Frequency

Session
Sexual Interaction

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>C</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>C</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

Frequency

Session
Dating

A C A B A C A B A

Frequency

Session
Female Friendship

Frequency

Session

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Physical/Sexual Attraction toward Another

Session

Frequency

A CABA CAB A
C A B A C A B A

1 2 3 4 S 6 7 8 9 10 11 12 13 14
Derogation of Males

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>C</th>
<th>A</th>
<th>B</th>
<th>A</th>
<th>C</th>
<th>A</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
</table>

Frequency

Session
Derogation of Females

Frequency

Session

A C A B A C A B A

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Anger toward a Male

Frequency

Session
Anger toward a Female

Session

Frequency
Total Parental Relationships

Frequency

Session

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Within Group Confrontation

A C A B A C A B A

Frequency

Session
VITA

TODD A. SOUTOR

Business Address
Denver General Hospital
Mail Code 0320
777 Bannock Street
Denver, CO 80204
(303)436-6393

Date of Birth 1/31/63

Home Address
1087 1/2 So. Ogden
Denver, CO 80209
(303)765-0503

ACADEMIC HISTORY

UTAH STATE UNIVERSITY
Logan, UT 84321
Professional-Scientific Psychology
Emphasis: Clinical Psychology
Doctor of Philosophy
Recipient of USU annual Women and Gender Research Grant
Anticipated: August, 1995

MANKATO STATE UNIVERSITY
Mankato, MN 56001
Clinical Psychology
Phi Kappa Phi Honor Society
Master of Arts
August, 1990

DARTMOUTH COLLEGE
Hanover, NH 03755
Major: Psychology
Bachelor of Arts
Pillsbury Scholar
Unico Scholar
Dragon Honor Society
Captain of Hockey Team
June, 1985

CLINICAL EXPERIENCE

PRESTON SCHOOL DISTRICT
Preston, ID 83263
Oakwood Elementary School. Licensed School Psychologist.
UTAH STATE UNIVERSITY Logan, UT 84321
Utah State University Community Clinic. School Psychology
Student Practicum. Supervision of Masters level school psychology
students in psychological assessment, diagnosis, and treatment of
distressed adults, adolescents, and children.
150 CLINICAL HOURS (1993-1994)

Utah State University Community Clinic. Student Practicum.
Psychological assessment, diagnosis, and treatment of distressed adults,
adolescents, and children.
800 SUPERVISED CLINICAL HOURS (1990-1994)

Center for Persons with Disabilities-Clinical Services. Case
Coordinator. Psychological assessment, diagnosis, and treatment of
psychologically disabled individuals. Case Coordinator of a
multidisciplinary team specializing in assessment and treatment of
distressed children and adolescents. Provision of case supervision to
practicum students.
800 SUPERVISED CLINICAL HOURS (1992-1993)

Utah State University Counseling Center. Graduate Assistant.
Psychological assessment, diagnosis, and treatment of distressed college
students.
600 SUPERVISED CLINICAL HOURS (1991-1992)

BEAR RIVER MENTAL HEALTH CENTER Logan, UT 84321
Student Practicum. Psychological assessment, diagnosis, and
treatment of distressed individuals.
300 SUPERVISED CLINICAL HOURS (1992-1993)

IMMANUEL ST. JOE'S HOSPITAL-Riverview Clinic Mankato, MN 56001
Clinical Psychology Intern. Psychological assessment, diagnosis, and
and treatment of distressed children and adolescents.
500 SUPERVISED CLINICAL HOURS (1989-1990)

TEACHING EXPERIENCE

UTAH STATE UNIVERSITY Logan, UT 84321
Teaching Assistant. Lecturer, assessment supervisor, and teaching
assistant for graduate level intelligence, personality, emotional, and

Teaching Assistant. Lecturer and teaching assistant for Rural
School Psychology Graduate Seminar. (Fall, 1993)

Adjunct Faculty. Instructor for Introduction to Counseling and
Psychotherapy. USU extension program. (Spring, 1994)
Adjunct Faculty. Instructor for Introductory Psychology. USU extension program. (Winter, 1994)

Adjunct Faculty. Instructor for Applied Behavior Analysis. USU communications network program. (Spring, 1993)

Adjunct Faculty. Instructor for Introductory Psychology. USU extension program. (Spring, 1992)

Adjunct Faculty. Instructor for Introductory Psychology. USU extension program. (Spring, 1991)

Teaching Assistant. Lecturer and teaching assistant for Abnormal Psychology course. (Fall, 1990; Spring, 1991)

MANKATO STATE UNIVERSITY Mankato, MN 56001
Adjunct Faculty. Instructor for Introduction to Clinical Psychology course. (Spring, 1990)

Adjunct Faculty. Instructor for Abnormal Psychology course. (Spring, 1989)

Teaching Assistant. Physical Education Department. Instructor of college students on techniques of ice skating. (1987-1988)

RESEARCH EXPERIENCE

UTAH STATE UNIVERSITY Logan, UT 84321
Research Assistant. Project Coordinator of rural school psychology research project. (1993-1994)

EARLY INTERVENTION RESEARCH INSTITUTE Logan, UT 84321
Research Assistant. Project Coordinator of national survey of home visiting training programs. Trained and certified Battelle Development Inventory Tester. (1990-1991)

LEADERSHIP EXPERIENCE

MANKATO STATE UNIVERSITY Mankato, MN 56001
Assistant Hockey Coach. Athletic Department. Instruction, coaching, and counseling of 45 student-athletes on hockey, weight training, academics, and college life. (1987-1990)

GALLO WINE COMPANY Los Angeles, CA 90040
District Manager. Managed ten sales representatives and sixty accounts with sales in excess of $18 million per week. (1986-1987)
Sales Trainer. Organized and supervised orientation classes for approximately 100 sales representatives. Responsible for the subsequent development of these individuals. (1986)

Sales Representative. Responsible for the sales and service of twenty accounts with sales in excess of $6 million per week. Completed management training program focusing on motivation, instruction, problem solving, and public speaking. (1985-1986)

SCHOLARLY ACTIVITIES

Publications


Paper Presentations


Poster Presentations


CONSULTATION EXPERIENCE


