GROUP COUNSELING FOR ADOLESCENTS WITH FEEDING AND EATING DISORDERS

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

By

Alexandra Oved

December 2015
The graduate project of Alexandra Oved is approved:

_________________________________________  Date
Professor Bruce C. Burnam  

_________________________________________  Date
Alison Murphey, MFT  

_________________________________________  Date
Professor Shari Tarver-Behring, MFT  

_________________________________________  Date
Stan Charnofsky, Ed.D, Chair  

California State University, Northridge
DEDICATION

I would like to dedicate this project to my selfless, loving husband Jarrett Portnoy. Thank you for dedicating hours of painstaking editorial assistance, for your patience, love, deep friendship, and humor. Thank you for being here for me through thick and thin, and believing in me. Your devotion has allowed me to grow, learn, and excel in this program, and throughout my life. Thank you for showing the positive path in life, by setting an example of your love and kindness to humanity.

I would like to take this opportunity to dedicate this project to one of the most inspiring people I have met within these past two years. Lindsay Gooze, you have been my study buddy, my teacher, my colleague, my team mate, and my twin, but throughout all of it, most importantly, you have been my friend. You are bound for great things as a therapist, and I am so honored to have been a part of your life during this experience.

I would also like to dedicate this project to my family because they believed in me, encouraged me, and taught me how to pursue my dreams with passion and love. Thank you for always putting life in perspective, being amazing role models, and teaching me how to see the glass as half full.
ACKNOWLEDGEMENTS

I wish to acknowledge the members of my committee for their support and guidance during the completion of my graduate project. To my readers; Professor Bruce C. Burnam and Alison Murphey, MFT, I cannot thank you enough. Without your time, dedication, optimism, and encouragement, I would not have been able to complete this project. You are both great team players, and role-models. To my chair; Dr. Stanley Charnofsky, you have been such an inspiration. Thank you so much for your patience, time, and extensive feedback on my project. Your empathy and compassion to others is remarkable and very admirable. I have been very lucky to have you as my mentor, teacher, and friend during this program.
# Table of Contents

Signature Page ii
Dedication iii
Acknowledgments iv
Abstract vii

Chapter 1: Introduction 1
  Statement of the Need 2
  Statement of Purpose 3
  Definition of Term 4
  Bridge to the Review 5

Chapter 2: Review of Literature 6
  Feeding and Eating Disorders 6
  Interventions 9
  Family Therapy 12
  Group Therapy 13
  Limitations to Individual Therapy 17
  Group Therapy Models 18
  Psychoeducational Group 18
  Cognitive Behavioral Group Therapy 20
  Mindfulness Group Therapy 22
  Art Group Therapy 23
  Conclusion 26
ABSTRACT

GROUP THERAPY FOR ADOLESCENTS SUFFERING FROM A FEEDING EATING DISORDER: A GROUP THERAPY FOR ADOLESCENTS

By

Alexandra S. Oved

Master of Science and Counseling, Marriage and Family Therapy

There are many reasons as to why people develop eating disorders. The National Eating Disorder Association (NEDA, 2014) documents that some factors may be psychological, interpersonal, societal, or biological. According to King (2013), women suffering from an eating disorder often report feeling a lack of control, anxiety, depression, obsession, intense hyper vigilance, and self-doubt. Participating in psycho-educational groups is essential for recovery when working with adolescents suffering from an eating feeding disorder for several reasons. Group counseling sessions help clients feel support and acceptance (less isolated, and detached from others). It allows group members to build meaningful relationships with each other (learn how to communicate feelings, promote friendships, and additional resource for support), educates clients on the disorder (as well as educate one another from personal experiences), and encourages client to work through confrontation and disagreements (clients are challenged, and challenge each other by discussing situations from personal perspective) (Costin, 2007). Due to the mentioned factors (as well as the realization that during the adolescent age, it is a critical age in which adolescents are transitioning to adulthood, and are affected by their environment) (McLeod, S. A. 2008, p.5), it is
important that adolescents are educated, challenged, and supported by peers and educators who relate to and understand them.

This project develops a group therapy for teenage girls between ages 14-18 suffering from an eating disorder. The group is for youths who are interested on overcoming their disorder, are open to receiving education about their disorder, learn different tools on how to cope with triggers, as well as learn different techniques for rehabilitation (such as meditation, art therapy, cognitive behavioral therapy). As a result of our growing population of youth suffering from eating disorders, in which up to 50% of teenage girls engage in unhealthy eating patterns (ANAD, 2015), it is imperative that youth are educated and informed about the disorder, the causes, as well as identify therapeutic interventions they can use when feeling triggered.
CHAPTER I

Introduction

According to the American Academy of Child and Adolescent Psychiatry (1992), ten out of 100 females will suffer from some type of feeding or eating disorder at a certain time in their lives. During this period in life in which adolescent females (also called teenagers) transition from childhood to adulthood, they will experience changes. These changes may be physical, interpersonal, emotional, and social in nature. One must consider that teenagers are at a point in their lives in which they are becoming more independent. They are essentially working towards defining their identity, as well as their role in life, all in preparation for adulthood (McLeod, S. A., 2008).

Although there are many positive aspects when maturing into adulthood, a time of growth and independence, some teenagers may experience turmoil, isolation, social pressure, low self-esteem, and personal problems that may negatively affect their growth and development. Some of these stressors may be expressed as depression, anxiety, isolation, avoidance, and through preoccupation with food (Bell, D., Foster, S. & Mash, E., 2005).

At this fragile point in life, it is imperative to educate youth on physical, emotional, and spiritual health, so that they can live a secure life, without having to deprive themselves of health and nutrition. This psycho-educational group therapy with adolescents suffering from a feeding eating disorder will focus on several factors to increase positive self-autonomy and growth. Apart from educating youth on the short term/long term health consequence of food deprivation, as well as discussing unrealistic
societal expectations there are in today’s society, this group will focus on self-growth and group cohesiveness. This group will give adolescents the opportunity to connect with other members suffering from the same, or similar disorders. Doing so will benefit youth as they build confidence, share and explore different meaning to their disorder, relief stress (by sharing feelings with group members who identify and support each other), reduce isolation (by relating to each other), place a sense hope with one another (by learning about shared experiences of other group members), bring a sense of cohesiveness between group members, and will give youth the opportunity to learn about themselves by expressing feelings, to promoting stability, awareness, and positive change for the future.

Statement of Need

According to the National Association of Anorexia Nervosa and Associated Disorders (ANAD, 2015), up to 50% of teenage girls engage in unhealthy eating patterns. Approximately 50% of individual’s suffering from an eating disorder have been diagnosed with depression as well (ANAD, 2015). As a result of the prevalence of this disorder in our teenage population, it is essential that treatment is easily accessible for this population.

Group therapy is beneficial to all individuals struggling with emotional disorders, physical ailments, mental health concerns, and other pain syndromes (Yalom & Leszcz, 2008). Participating in a group setting, and sharing similar experiences with others who can identify with the presenting problems has proven to decrease isolation, increase a sense of hope, improve on social skills, and increase the sense of autonomy (Yalom &
Leszcz, 2008). Adolescence is a stage in which children transition into young adults. During this time period, it is crucial that they receive the greatest amount of support from their family, friends, peers, and other mentors and role-models. This ensures they are developing into healthy adults. This group format will provide adolescents with knowledge about feeding and eating disorders to ensure they have a heightened awareness and clarity on the disorders, and access to resources when feeling emotionally troubled. By remaining active in group therapy, members will gain knowledge and hope, relate to others, learn how to express themselves, develop socializing techniques, develop narratives to their identity, reflect on past actions (and negative/positive impact), as well as be able to determine future goals (Yalom & Leszcz, 2008).

**Statement of Purpose**

The purpose of this project is to develop group therapy for adolescents between ages 14-18 suffering from an eating feeding disorder (specifically anorexia, bulimia nervosa, and binge eating disorder). Youth attending this workshop will be informed and educated on the different eating feeding disorders, causes and effects of the disorder, learn to develop healthy coping skills, work toward positive self-esteem and body image, learn about unrealistic cultural expectations of thinness, and participate in mindfulness activities (to promote nurturing of the mind, body, and spirit). During the final session, the co-facilitator will meet individually with each client and discuss current progress, as well as future goals.

The following review of literature will discuss feeding and eating disorders (specifically anorexia, bulimia nervosa, and binge eating disorders), as well as causes,
and treatments for these disorders (through identifying beneficial coping skills). This paper will also discuss the benefits of being a part of a group (in accordance to Yalom’s eleven primary therapeutic factors). In addition, there will be coverage of group therapy, whose purpose is to encourage members to participate by sharing personal stories and feelings with regards to challenges they have faced. In doing so group members will gain support, autonomy, as well as learn about self-empowerment.

**Definition of Terms:**

**Co-Facilitators:** In this project the term is used to describe more than one person who is assisting with organizing, completing, and conducting the counseling session.

**DSM IV:** Diagnostic Statistic Manual of Mental Disorders (DSM) “is the standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems)” (APA, 2000).

**DSM-5:** Diagnostic Statistic Manual of Mental Disorders, Fifth edition (DSM-5), “is the current edition and has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. It can be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors. It is also a necessary tool for collecting and communicating accurate public health statistics” (APA, 2014).
**NEDA:** National Eating Disorder Association [NEDA] is a non-profit organization whose mission is to provide assistance and support to individuals and families who are affected by an eating disorder. The NEDA provides resources, volunteer programs, and options for those seeking assistance (NEDA website).

**Group Therapy:** In this project the term is used to describe a therapy session with one or more counselors, working with more than one person at the same time.

**Bridge to the Review of the research and remainder of the graduate project:**
Chapter two will provide a literature review of the feeding and eating disorders. This will include a brief discussion of the history and overview, and the current clinical description by Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) of the three most prominent disorders (anorexia nervosa, bulimia nervosa, and binge eating). This paper will include factors contributing to these disorders, treatment of the disorders, limitations to individual therapy, three models of group therapy, and preventative measures which may decrease the likelihood of these disorders initially developing.

Chapter three will provide a guide for the implementation of the project and directly address the qualifications and specifications for the intended audience. Chapter four will consist of a summary and conclusion that includes potential problems for this group and ideas for alternative arrangements. Following will be an appendix that consists of the group curriculum for a six week group therapy session.
Chapter II

Review of Literature

Feeding and Eating Disorders

Feeding and eating disorder initially appeared in the Diagnostic and Statistical Manual of Mental Disorders in 1980 labeled as “Anorexia Nervosa.” Due to an increase in diagnoses throughout the years, it became a distinct category in the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) as “Eating Disorder,” and in the diagnostic and statistical manual of mental disorders (DSM-5.) is referred to as “Feeding and Eating Disorders” (Kring, A., Johnson, S., Davison, G., & Neale, J., 2012).

The Diagnostic Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) explains that these “disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food that significantly impairs health or psychosocial functioning” (p.329). Although there are seven distinct sets of criteria in the Diagnostic Statistical Manual of Mental Disorders, the paper will examine only three of the disorders, including anorexia nervosa, bulimia nervosa, and binge-eating disorder.

According the DSM 5 (APA, 2013), Anorexia Nervosa is the restriction of behaviors that promote healthy weight (body weight is below average), the intense fear of gaining weight and being fat, and distorted body image or sense of body shape.

According to Hoek and van Hoeken (2003), Anorexia typically develops in early to middle teenage years, after an episode of dieting, and the occurrence of a life stressor. The lifetime occurrence is less than 1% in the general population, but is up to 10 times
more common in women than men (2003). Baker, Mitchell, Neale, and Kendler (2010) postulate that women suffering from Anorexia are often diagnosed with the following disorders: depression, obsessive-compulsive disorder, phobias, panic disorders, substance use disorder, and various personality disorders. Some physical consequences of Anorexia Nervosa are low blood pressure, slow heart rate, kidney and gastrointestinal problems, decline in bone mass, dry skin, brittle nails, change with hormonal levels, and mild anemia (2010).

According to Carolyn Costin (2012), recovery is often slow and very difficult. As she states, “Recovery takes a long time, and lots of work, but can turn out to be one of the biggest triumphs of your life.” (p.11). Approximately 50-70% of people recover from this disorder; however recovery is slow (often takes 6-7 years), and relapses are likely before stability occurs (Davison, & Neale, 1974).

According to Costin (2007), Bulimia Nervosa-is derived from the Greek word meaning “hunger of an Ox” (p.10), which has been made in reference to Romans who used to engage in rituals involving vomiting and binge eating. The DSM 5 (APA, 2013) explains that Bulimia consists of recurrent episodes of binge eating, and is characterized by both of the following: eating large portions of food (within any two hour period), defined as an amount of food that is larger then what most individuals would eat in a similar period of time, under similar conditions, and a sense of lack of control regarding eating during the episode (feeling that the individual cannot stop eating). The criteria include: recurrent episodes of binge eating, recurrent compensatory behaviors to prevent weight gain (such as induced vomiting, misuse of laxatives, diuretics, medications, fasting, or exercise), and body shape and weight being extremely important for self-
evaluation. Behaviors must occur, on average, at least once per week for three months. Unlike Anorexia Nervosa, the individuals suffering from bulimia nervosa may be normal or overweight (2013). According to Mehler (2010), there are many adverse consequences to Bulimia, which include frequent purging (causing potassium depletion), changes to electrolytes, heartbeat irregularities (due to use of laxatives, which induce diarrhea), tearing tissue in the stomach and throat, loss of dental enamel, and menstrual irregularities, among others.

According to Costin (2007), “about 50 percent of patients suffering from bulimia nervosa fully recover, 30 percent improve, and 20 percent continue to meet the full diagnostic criteria” (p. 29). She further explains that while recovery is possible; it may take as long as 10 years to fully recover (2007)

The DSM 5 (APA, 2013) states that Binge-Eating Disorder is characterized by both of the following: eating in a discrete period of time (within any two hour period) an amount of food that is larger than what most people would eat in a similar period of time under similar circumstances, as well as a sense of lack of control over eating during the episode (feeling that they cannot stop eating or control what or how much they are eating). The Binge-Eating episodes include three of the following five: eating more rapidly than normal, eating until uncomfortably full, eating large amounts of food when not physically hungry, eating alone because of embarrassment, and feeling disgusted, depressed, or guilty after the binge (2013). Davison and Neale (1974) posit that the binge usually occurs at least once per week for three months. Physical consequences may include obesity, type II diabetes, insomnia, joint/muscle problems, cardiovascular problems, and breathing problems (1974) .
Keel and Brown (2010) mention that approximately 25-85% of people recover from this disorder, and the recovery time is approximately 14.4 years (which is lengthier than anorexia and bulimia nervosa).

There are many factors that may increase the likelihood for a person to develop an eating disorder. NEDA (2014) explains that eating disorders arise, “due to a combination of behavioral, biological, emotional, psychological, interpersonal, and social factors that have been combined in that person’s life” (para., 1). Psychological factors include low self-esteem, anxiety, anger, stress, and feeling a lack of control. Interpersonal factors include a history of physical sexual abuse, difficulty expressing emotions, history of being teased, and troubled personal relationships. Social factors include culture pressure that glorifies “thinness,” and having the “perfect body,” cultural norms that place emphasis on physical beauty (as opposed to inner value and strengths), society’s expectation of “beauty,” and the unrealistic pressure for individuals to strive for these unrealistic goals (NEDA, 2014, para,4). Biological factors may include eating disorders running in the family. Young women are 10 times more likely to develop an eating disorder compared to the male population (Strober, M., Lampert, C., Morrell, W., Burroughs, J., & Jacobs, C.,1990).

**Interventions**

There are many different therapeutic interventions when treating an eating disorder. The use of different interventions is dependent on the severity of the disorder (mental, emotional, and physical health), as well as what each individual appears to be most responsive to. Costin (2007), discusses beneficial therapeutic interventions when working with individuals suffering from an eating disorder, including, psychodynamic
therapy, cognitive behavioral therapy, interpersonal therapy, dialectical behavior therapy, and family therapy.

According to Costin (2007), psychodynamic therapy emphasizes internal conflicts, motives, and unconscious forces. These behaviors are expressed through the disorder, as opposed to resolution of the inner conflict through communication. The goal of psychodynamic theory is to sort through past events, feelings, and understand past connection to current issues with the disorder, which would eventually decrease the disorder, and increase emotional well-being. Costin explains, “Psychodynamic therapy can offer a lot to eating disordered individuals and may be an important factor in treatment, but a strict psychodynamic approach alone-with no discussion of the eating- and weight-related behaviors-has received little empirical support” (2007, p.114).

Costin (2007) posits that Cognitive Behavioral Therapy (CBT) is one of the most popular therapeutic approaches when working with anorexic clients. This approach teaches clients how to identify distortions, and choose not to “act on them or, better still, to replace them with more realistic, positive ways of thinking and thus behaving” (2007,p.115). This therapeutic intervention educates clients about the disorder (and dieting), purging, medical conditions, and other necessary information about the disease. Homework, monitoring, and journals are also included in treatment throughout the week (2007). Keel and Klump (2003) indicate that CBT is most successful in treating bulimia and binge eating disorder; however results are not as promising with anorexia nervosa.

Costin (2007) notes that Interpersonal Therapy (IPT) places great emphasis on underlying relationship issues of eating disorders. Therapy mainly focuses on interpersonal problems (such as the inability to express feelings effectively, difficulty
forming long lasting relationships, etc…), transitions (college, moving, getting married), and grief, as opposed to food, weight, and societal pressure. According to Costin, after a long term study, both IPT and CBT have similar results. 70-80 percent of subjects for both CBT and IPT remained symptomatic after one year of treatment. Therefore, this researcher Costin suggests that combining both IPT and CBT may have more successful results when treating eating disorders. This combination is known as Dialectical Behavior Therapy (2007).

According to Costin (2007), Dialectical Behavior Therapy (DBT) is a combination of both interpersonal and cognitive behavior therapies. This type of therapy focuses on harmful behaviors and acting out prior to working on interpersonal issues, however both are included in treatment. Treatment mainly focuses on skill building (treatment goals and building skills are geared towards nutrition and weight), mindfulness (awareness, developing the ability to be introspective, responding to one’s internal healthy self, rather than emotionally reacting), distress tolerance (clients are trained to identify destructive behaviors, and how these are not long term solutions for solving problems, to tolerate painful feelings, and to learn how to replace/cope with these feelings), interpersonal effectiveness (developing/improving relationships with others and oneself, to ensure client has a support system to fall back on), and emotional regulation (teaching clients how to regulate emotions without acting on negative emotions, also known as affect regulation). Although there has been little research on Dialectical Behavior Therapy, one controlled study showed that this therapeutic intervention has been successful with bulimia nervosa. Additionally, in two uncontrolled studies, DBT has shown to be successful with bulimia and binge eating (2007).
Family Therapy

Family Therapy is another therapeutic intervention that has proven effective when working with adolescents suffering from a feeding eating disorder (Lock & Le Grange, 2005). According to Murray and Le Grange (2014), Family Based Therapy incorporates the family system when working with a client suffering from an eating disorder. Although there are different types of family therapy, Family Based Treatment is one of the most promising therapeutic interventions when working with clients who have been diagnosed with a feeding eating disorder. Family Based Treatment theory bases its notion on the fact the family is a source of strength when working with an adolescent suffering from an eating disorder, and that parents in particular are one of the most effective resources for the client (2014). Lock and Le Grange (2012) explain that this type of therapy is divided into three phases. During the initial phase, the parents establish authority, and determine appropriate times for the client to eat, as well as what to eat. At the same time, the client is encouraged to seek out peers and siblings for support and comfort. Once the client has stabilized with weight gain, accepts the parents’ role of determining food intake, and is compliant with the parental rules; the family and client enter the second phase of treatment, in which the family works together on identifying and addressing problems within the family system. Once the client stabilizes with weight, and family problems and concerns have been addressed, the family enters the third phase in which the family determines appropriate boundaries amongst family members. In this phase, parents are encouraged to allow the client to gain personal autonomy and independence, according to their age and development (2012).
According to Stice, Marti, Spoor, Presnell and Shaw (2008), taking preventative measures prior to the onset of these conditions may decrease the development of eating and feeding disorders. Three of these different preventive didactic interventions that have been developed, including psycho-educational approaches (educating children/adolescents about the disorder and the prolonged effects, in order to prevent them from developing symptoms), de-emphasizing sociocultural influences (bringing awareness to children/adolescents about unrealistic societal pressures and expectations to be thin), and a risk factor approach (recognizing individuals who may be more prone to developing an eating disorder, and attempting to intervene and work through these concerns to prevent drastic measures). Risk factors may be things like being overweight, having dietary restraints, or having body image concerns. A meta-analysis of these prevention studies conducted by Stice et al., ranging from 1980 to 2006, has shown only modest support for this type of preventative intervention, and concludes that a more interactive program, which includes teenage girls meeting for multiple sessions seems to be more effective. These programs focus on de-emphasizing sociocultural influences, and include dissonance reduction interventions by using role playing, integrative discussions, writing, and challenging society’s notions of beauty (Stice et al., 2008).

**Group Therapy**

Group therapy has proven to be as effective as individual therapy, in addition to being more cost efficient (McRoberts, C., Burlingame, G. M., & Hoag, M. J., 1998). Yalom and Leszcz discuss the eleven primary therapeutic factors that contribute to human development and growth when participating in group. The eleven group factors include:
• Instillation of hope- clients participating in group with different life experiences, as well as sharing these experiences with one another (during group therapy), create a sense of hope to recover from these disorders and excel.

• Universality- clients seeking treatment often feel isolated and shamed for having to seek out an outside source for support. Although sharing information that is personal, uncomfortable, and may carry a sense of intimidation and fear, there is a strong sense of relief after listening to other group members disclosing personal information in which they can relate to. This in turn may promote others suffering from similar behaviors to feel more inclined to open up to others.

• Imparting information- clients gain information about their current health, mental illness, receive suggestions, advice, and comments from group counselors and other team members about relevant matters in group therapy. This enhances the clients’ ability to reframe and process information in accordance to their own perception and experience.

• Altruism- group members are both able to bring insight and suggestions to other group members, as well as receive criticism, advice, and suggestions. Through this act, group members are learning how to be selfless, critical, and compassionate to one another’s experience.

• The corrective recapitulation of the primary family group- similarly to the family system, being a part of a group operates similarly. In group therapy, just like in a family system, clients expose intimate details about their lives,
past experiences, thoughts, and feelings. Clients may often reflect attachment to other group member and facilitators similarly to their familial system. Clients may view facilitators as authority figures. Amongst group members there may be rivalries, alliances, as well as attempts for members to split facilitators. In such cases (which is considered normal for a group), it is imperative that the therapist relieves such tensions effectively. In doing so, clients learn healthy relationships, as well as how to correct unhealthy patterns from past familial experiences.

- Development of socializing techniques- group members are naturally inclined to develop socializing techniques when participating in group therapy. Whether it is directly (if the group session relates to role playing different situations that require social situations) or indirectly, group members are interacting with one another, and learning how to effectively develop these skills through criticism, acknowledgment, and commentary.

- Imitative behavior- through observing and recognizing communication patterns that therapists and group members display during discussions, open conversations, and interactions, imitation and modeling responses of other peers and leaders can be expected. Displaying imitative behaviors are beneficial because it allows group members to experience new behaviors, as well as “try on bits and pieces of other people and then relinquish them as ill fitting” (Yalom, & Leszcz, 2008, p.18).

- Interpersonal learning-self growth and new awareness are learned during group in four different ways: learning how they are viewed by other group
members and facilitators, gaining an understanding of unhealthy patterns in their life, understanding motivations for their behaviors (the purpose of certain behaviors they do, and why they do them), and understanding why they behave the way they do from a genetic/familial perspective. Clients are able to identify certain behaviors, and work through them.

- Catharsis—group members get a sense of relief by being able to self-disclose and talk about concerns, and in so doing, gain support from other group members.

- Existential factors—accepting responsibility for actions taken in life, and understanding that there are variables in life in which are out of one’s control (Yalom, & Leszcz, 2008).

There are many factors that may contribute to the development of feeding and eating disorders. These may include genetic factors, cognitive behavioral factors, sociocultural factors, gender influence, personality influence, and family enmeshment. Although recovery is often slow and prolonged, several treatments for eating disorders have been developed, and these have served to educate clients about the disorder, along with focusing on personal influences that may have contributed to the development of the disorder. Some treatments include psychodynamic therapy, interpersonal therapy, cognitive behavioral therapy, dialectical behavior therapy, and family therapy. Although a wide range of therapies have been developed, and new recovery models are being devised and evaluated even today; treating clients with feeding and eating disorders
continues to be very difficult, and prolonged success rates are still relatively low (Yalom, & Leszcz, 2008).

Clearly it is important to take preemptive measures prior to the development of these disorders to challenge teens in society, and educate them on current trends that may be unrealistic. Some preventative interventions include both dialectical education and interactive interventions. Both interventions challenge society, and the unrealistic expectations of beauty and value that are often displayed. Though feeding eating disorders can be difficult to treat, through various methods reviewed in this paper (specifically group therapy), many patients have found success in managing, minimizing, and even preventing their conditions all together (2008).

Limitations to Individual Therapy

Although there are many positive aspects when participating in individual therapy, group therapy is considered as beneficial, and in some cases, even more productive therapeutically. This is especially true for disorders such as major depressive disorders, obsessive compulsive disorders, social phobia disorders, and feeding eating disorders such as binge-eating, and bulimia nervosa (Paturel, 2012).

While the benefits for individual therapy are numerous, there are some limitations as well. For example, according to Gunborg (2008), individual therapy allows for more flexibility when arranging meetings, but group therapy provides more structure, which can be very helpful for many clients. Group therapy is cost effective, which in turn makes it available to a wider range of the population in need of treatment. Although individual therapy may be more tailored to the client, who may receive in depth analysis, group
therapy allows individuals to gain additional perspectives from others in their situation, build autonomy, as well as understand that they are not so isolated in their condition. Individual therapy may be more comforting for individuals desiring undivided attention from their therapist, as well as being confident that the therapist will be able to maintain confidentiality, however individuals participating in group therapy can receive greater and more varied emotional support, encouragement, and a general sense of connectedness by relating to each other. Co-facilitating with other therapists also poses many benefits for members in group. Co-facilitators are able to gain additional interpretation from arising situations presented during group. Additionally, each therapist has areas of expertise and comfort, as well as strengths and weaknesses. With multiple therapists, areas of strength are maximized and areas of weakness or discomfort are minimized. Therefore, though some benefits can only be achieved through individualized therapy, group therapy seems to be a better overall choice for many clients (Gunborg, 2008).

**Group Therapy Models**

This section of the literature review will discuss four models of group used with patients suffering from an eating disorder, and will discuss the purpose of the groups, characteristics, techniques, as well as leadership approaches.

**Psychoeducational group**

According to Bieling, McCabe and Anthony (2013), the psychoeducational group format focuses on educating group member suffering from an eating disorder about the disorder, the history of the disorder, mental and physical effects of the disorder, common behaviors influenced by the disorder, along with the short term and long term
consequences. In addition to discussing the disorder itself, it is important to educate
group members on the link between self-esteem and dietary restriction, comparing and
 contrasting binge eating to food restricting, the short term/long term physical and mental
consequences when using laxatives, excessive exercising, and diuretics.
Psychoeducational groups should also include strategies for healthy eating, as well as
understanding what healthy weight is, in comparison to “prescribed ideal weight” in
society (2013).

Sydiaha (2004), the purpose of this type of group format is to instill awareness,
provide options for change, and highlight resources that are available to group members.
In turn, by being aware of the disorder (through provided information), the group will
increase the likelihood that individuals can prevent continued destructive behaviors
associated to the disorder in the future (Sydiaha, D. 2004).

Brown (2011) states that co-facilitators are advised to take a leadership role of
educator. Group leaders will often compile resources for the group topic, and should be
skilled and knowledgeable on the topic as well. Group leaders will maintain the structure
of the group. When planning for psychoeducational group therapy, the facilitators should
be considerate of group members’ demographic, age, education level, current emotional
state, current level of fear, and developmental level, to ensure that group members can
relate to the group format, and feel comfortable asking questions, sharing personal
feelings, concerns, and insecurities (Brown, 2011).
Psychoeducational groups are beneficial for educating and understanding theory about the disorder, however cognitive behavioral therapy (skill development) can be more beneficial for putting these theories into practice.

**Cognitive Behavioral Group Therapy**

Whitefield (2010) postulates that cognitive behavioral therapy for groups is designed to teach members useful coping skills, as well as utilizing other group members as medium for change. Group members are taught by co-facilitators, as well as other group members, on how to cope with identified challenges, and manage emotions in a healthy way. Group members participating in this type of therapy can benefit from sharing emotions, gaining empathy from one or more participants in group, gain a sense of universality relating to their disorder, as well as a sense of normalcy. When working with adolescents suffering from an eating disorder, it is important to challenge their thinking by using cognitive strategies (2010). Bieling, McCabe, and Anthony (2013) mention that group format should include the following: Identifying the relationship between thoughts, triggers, and effects (for example: refusing to eat cake, because of the thought that thighs will become thicker). Exploring evidence, and challenging cognitive distortions (for example: challenging black/white thinking; if a group member discusses how she thinks no one will like her as a result of being “fat,” the therapist could in turn ask if she would judge another person based on physical appearance, as opposed to liking someone for being a good person). Behavioral experiments (encouraging group members to test their belief system, such as eating pizza or a snack during the day causing instant weight gain). Relapse prevention strategy (developing coping strategies to manage stress,
identify triggers in emergency situations, being able to access resources after group has completed for the purpose of maintenance (2013).

Whitfield (2010) contends that co-facilitators often work collaboratively with other group members when discussing learned behavioral skills. According to Bieling et al. (2013), co-facilitators are encouraged to show empathy, understanding, and remain a source of support to other group members. Whitfield (2010) notes that since group members have first-hand knowledge of the disorder, they are encouraged to offer insight which the therapist cannot. This process of identifying challenges, sharing knowledge, and processing with other group members assists with changing the cognitive distortions other members may have regarding the disorder, as well as the behavioral changes and modification directed to the member expressing distress about this disorder. Co-facilitators are encouraged to challenge group members, mediate disagreements (between other members), teach skills presented during session, and review homework (2010).

According to Bieling et al. (2010), it is important that co-facilitators working with adolescents suffering from an eating disorder examine their relationship with food, since group members suffering from such disorders will compare and examine the group leader’s habitual eating and perception of food as well. Therefore, it is recommended that co-facilitators have healthy perceptions of their own body image (typically non-dieters), and are able to demonstrate healthy eating to other group members (2013).

Cognitive behavioral group therapies are similar to mindfulness therapy in the sense that they both address behavior in relations to food, distorted thinking, and
behavioral substitutions for eating. However, mindfulness emphasizes the “internalizing and maintaining change” Kristeller, Baer, and Quillian-Wolever, 2006).

**Mindfulness Group Therapy**

According to Kristeller et al. (2006), mindfulness therapy is an approach which guides group members on how to become aware of their eating habits, as well as hunger and satiety signals. Mindfulness eating therapy places attention on eating patterns and the ability to distinguish between real hunger and over-eating, as well as patterns of deregulation. Mindfulness meditation can be divided in two sections: increasing awareness of instinctive eating patterns and extinguishing reactive eating (2006).

This therapeutic approach is beneficial for treating feeding and eating disorders since it promotes awareness of group members’ suffering from an eating disorder, and awareness of feelings, behaviors, and experiences related to food restriction, binge eating, and other dysfunctional eating habits. Mindfulness meditation is beneficial in assisting individuals with balancing their relationship with food and their physical stimuli (2006).

Kristeller et al. (2006) assert that group sessions should incorporate the following: Short forms of meditation in which group members are encouraged to be more aware of thoughts and feelings during meal times and throughout the day. Guided meditation in which group members are encouraged to focus on sensations, feelings, thoughts, hunger, binge triggers, and satiety. Focusing on different food and its complexity. Initially group members explore simple foods, and progressing to more multifaceted foods. Incorporation of mindful body work, self-soothing, touch, and mindful walking. Meditation related to forgiveness for the mind, body, and spirit (Kristeller et al, 2006).
According to Bowen, Chawla and Marlatt (2011), co facilitators are encouraged to have experience in the area in which they will be guiding mindfulness groups. Facilitators are also encouraged to attend training seminars where they are trained to guide a mindfulness group. Facilitators are encouraged to display empathy, understanding, curiosity, and acceptance. This is to promote honesty, openness, interpersonal growth, and comfort for group members. Facilitators are also encouraged to meet clients at their level of progress (2011).

**Art Group Therapy:** Art therapy groups incorporates non-verbal interventions while working with clients. Some art interventions include the incorporation of acting, art, and music into counseling. This type of therapy can be beneficial when working with adolescents suffering from an eating disorder for several reasons. According to Covey (1990), only 10% of human communication is through verbal language. Holmes and Karp (1991) assert that individuals suffering from an eating disorder have difficulty identifying how their disorder is associated with a correlated problem that isn’t related to their weight and body image. Therefore, incorporating other means of expression and communication into the group treatment subconsciously gives clients the opportunity for self-expression and disclosure through art.

According to Meyer (2010), incorporating art therapy into treatment will not only benefit clients, but will allow therapists and co-facilitators to gain more insight into core issues that their clients are relaying. In doing so, therapists are able to identify what treatment goals would be best suited to their clients. Meyer asserts that there are several types of art therapies, including drama/role play, art therapy, and music (2010).
Meyer (2010) posits that Drama/role play therapies can be presented to clients during group therapy sessions. Often times clients are asked to identify a character they know, and identify with (could be from a magazine, movie, real person, etc.). The client is encouraged to explain how she/he is feeling during that particular day, and how this character affects the client’s mood. Other sessions may include clients acting out scenarios with individuals who cause them distress and/or make them feel uncomfortable. Discussion about body image is included in this scenario. Group members are asked a set of questions that challenge their beliefs and behaviors, as well as empathic questions to support character identity (Meyer, D.D., 2010).

By incorporating the use of drama and role play, clients who have difficulty admitting to their eating disorder, or are less aware of underlying psychological problems are given a variety of ways to express themselves, reveal their emotions, and enhance their awareness through the medium of acting (Meyer, 2010). According to Wurr and Pope-Carter (1998), this opportunity also allows clients to take responsibility for their actions, develop new ways of connecting to others (building relationships), and help support group members by developing their autonomy.

Brooke (2008) points out that similarly to drama/role play therapy, art therapy promotes the freedom of expression through art. In doing so, clients will be able to enhance awareness of underlying issues, as well as create positive associations between art and themselves. Through art therapy, clients are able to address control and perfectionism issues that are more prominent with clients suffering from eating disorders. Clients are able to gain a new sense of awareness and comfort when realizing
imperfections in art. Clients are also able to understand that art is a non-compatible source of expression, and is a matter of taste as opposed to a mastery of some sort (Brooke, S. 2008). When working in group settings, art gives the team members the opportunity to bond through self-disclosure, non-verbally and without feeling criticism.

Although there are very few studies or literature written on music therapy and eating disorders, Dokter (1994), asserts that incorporating music into therapy is valuable. Incorporating music therapy provides the client with the opportunity to explore and express feelings that may be difficult to express through verbal communication. Incorporating music into therapy for individuals suffering from eating disorders also encourages the client to explore her/his body through music and movement. In doing so, clients are able to reevaluate their relationship with their body, and see how using their body through movement of music can be a positive experience. Participating in group music therapy allows clients to process emotions of the “here and now,” and encourages bonding between group members and the facilitator. Clients are able to identify, separate, and share conflicting feelings they have not been able to verbally communicate (Dokter, D. 1994).

Brooke (2008) contends that art therapy is a good approach to working with clients with an eating disorder, since it provides the client the opportunity for non-verbal exploration of feelings and expression through an external medium. Doing so in a group context, clients are able to share their experiences with others and bring up non-confrontational discussion which assist clients with addressing underlying problems. Through art, clients are able to confront emotions which they were unaware of, process
them individually or with others, accept their feelings without judgment, and nourish themselves through this non-conformational, playful structure of therapy (Brooke, S. 2008).

**Conclusion:** These four models represent different approaches to group therapy. The psychoeducational group focuses on educating group members on the disorder, while cognitive behavioral therapy focuses on addressing undesired behaviors, and changing them. Mindfulness group therapy mainly addresses body and spirit, and how to be aware the physical needs the body has. Art therapy is included in the group format to increase client expression through art. All four group therapy models presented supply beneficial components when working with adolescents suffering from an eating disorder, and often work most effectively when used in conjunction with each other.

This chapter has addressed an overview of feeding eating disorders and their treatment. General definitions of the three major disorders (anorexia, bulimia nervosa, and binge eating) were given, as well as their common interventions, including psychodynamic therapy, cognitive behavioral therapy, interpersonal therapy, dialectical behavior therapy, and family therapy. The limitations encountered when dealing with individual therapies were addressed, and additional benefits to group therapies were noted. Eating and feeding disorders are common to teenage girls and can extremely determinate to their overall life time health, and although feeding eating disorders can be extremely difficult to treat (and recovery may be slow and arduous), using many of the treatments and information discussed in this paper, it is possible to effectively treat this population and help them to grow and thrive both during and after treatment.
CHAPTER III

Project Development

Introduction

It has been made clear through the review of literature that there are many benefits to being involved in group therapy when working with adolescents suffering from an eating disorder. This chapter will discuss the intended audiences of the project and to whom it can be most helpful. The subsequent chapter will clarify the qualifications of the professionals who provide the services and skills needed to ensure that group treatment is delivered most effectively. Chapter three will also discuss the space and materials needed to complete the curriculum for the group therapy session, which lasts for six weeks (two hours per session).

Development of Project

During my adolescent years, I suffered from an eating disorder that began after moving overseas. This was a very trying time in my life for several reasons. I had to adapt to a new country & culture, make sure that I was on par with my educational level, adjust to a new set of friends, and grieve for friends and family I would no longer be able to see on a regular basis. Reflecting on this drastic change during my adolescent years, I realized how isolated and lonely I felt at the time. Thinking about this from a broader perspective made me realize how awful it must be for many others suffering from similar situations who have feelings of disconnectedness and isolation.

Once I realized how isolated and lonely I felt during that time in my life, I started asking myself what would have worked for me during that time. I started replaying prior
scenarios in my head, recalling the different treatments I have been through, each unfortunately unsuccessful. I am lucky to say that I did have a strong support system. I met with a therapist, as well as a nutritionist, and I had a very supportive family who were able to set strong boundaries with me. However, there was something missing from the equation. It wasn’t until I met one of my classmates, and now one of my best friends Lindsay Gooze, was when I realized that the missing part of the equation was the sense of belonging and security I felt when meeting someone who knew exactly what I went through. It was the importance of having someone to really talk to, who has been in a similar situation, which finally helped me to gain insight, strength, and inspiration.

In order to make this project happen, I began gathering information on various group methods that are well-known and popular, as well as learning the benefits for group therapy in general. I used peer reviewed research articles, studies, and books as references. Additionally, I gathered census information from government websites.

Researching different types of group therapy made me realize how group therapy can benefit individuals. Group therapy installs hope, increases universality amongst others suffering from a similar disorder, and allows others learn more about the disorder (on a more personal level). Group therapy allows for self-expression, the ability to help others, develop socializing techniques, self-growth, and the ability to gain a sense of relief through disclosure/exchange of personal experience without judgment. Learning about different types of group therapy made me realize how much group therapy has to offer, and the unimaginable sense of relief one can gain from being a part of a system with which one can resonate.
Intended Audience

The intended audience for this group therapy session is adolescent girls between ages 14-18 years. Group is intended to assist individuals suffering from an eating disorder (anorexia, bulimia nervosa, and binge eating disorder). This group is applicable to girls coming from any type of race, social economic statues, and religion, who are willing to share and explore their feelings pertaining to their eating disorder, discuss their personal history of the disorder (including setbacks, triggers, coping skills, etc.), and are open to education, meditation, and feedback from other group members.

Personal Qualifications

Co-therapists who will be leading group should be experienced in working with youth, or others with an eating disorder, and specialize in the field of eating disorders. Co-therapists leading group should be marriage and family therapists (M.S. and LMFT), school counselors (M.S), licensed professional clinical counselors (M.S., L.P.C.C), or licensed clinical psychologists (Psy.D., Ph.D). Co-therapists who are assisting facilitating groups can be interns or trainees. It is required for them to meet for supervision with an experienced licensed therapist working in this field. Co-facilitators should have a wide range of knowledge about the disorder, and should demonstrate that they are secure with themselves and their body by discussing healthy eating, and must present with comfortably eating in front of other group members.

Environment and Equipment

The space needed to conduct group sessions should be a medium size room that is able to accommodate approximately 7-10 clients, as well as two co-facilitators. There must be enough room to seat between 10-12 chairs, or have enough couch space to have
clients sit comfortably in each session. The room should be spacious enough for the clients and staff to stretch out and move (for meditation sessions). Necessary equipment throughout the six weeks of group sessions includes: chairs/sofas, writing board, crayons, markers, colored paper, homework journals (which will be given to each client), balloons (helium balloons for one session), pictures of different models from different time periods, tapes/videos (meditation videos), yoga mats, and healthy snacks (for every group session). Each group will take approximately 2 hours once a week, and will run a course of 6 weeks.

**Outline of the Project: Content, Activities, and Procedures**

This project will implement an outlined curriculum of six group therapy sessions for the clients. The appendix section will include the complete outline of the project, including the activities during each session, as well as the materials needed for the group session for that specific week. The following is an overview of the curriculum for each session and the topics that will be included in each session of the youth group. The group meeting will take place once a week, for a 90 minute session. Group will incorporate a combination of psychoeducation, cognitive behavioral therapy, art therapy, meditation and mindfulness, assertiveness, and coping skills.

<table>
<thead>
<tr>
<th>Session</th>
<th>Subject</th>
</tr>
</thead>
</table>
| Session 1 | **Week 1: Introduction and Education on Eating Disorder**  
- Getting to know you activity “Ice Breaker”  
- Confidentiality, facilitators role in group, clients effort towards recovery  
- Education on eating disorders  
- Goals for recovery (write in journal) |
<table>
<thead>
<tr>
<th>Session</th>
<th>Week 2: Eating as coping; developing alternative coping strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Check-In</td>
</tr>
<tr>
<td></td>
<td>• Group Norms</td>
</tr>
<tr>
<td></td>
<td>• Homework Journal</td>
</tr>
<tr>
<td></td>
<td>• Today’s topic: coping skills</td>
</tr>
<tr>
<td></td>
<td>• Alternative coping skills educational sheet</td>
</tr>
<tr>
<td></td>
<td>• Activity: Pre-Relapse Traffic Signs</td>
</tr>
<tr>
<td></td>
<td>• Sharing with the group (on coping skills that work best)</td>
</tr>
<tr>
<td></td>
<td>• Homework assignment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session</th>
<th>Week 3: Anger/Depression/Perfectionism working towards Positive Self-Esteem:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Check-In</td>
</tr>
<tr>
<td></td>
<td>• Group Norms</td>
</tr>
<tr>
<td></td>
<td>• Homework Journal</td>
</tr>
<tr>
<td></td>
<td>• Today’s topic: Anger/depresson, and perfectionism, working</td>
</tr>
<tr>
<td></td>
<td>towards healthy self esteem</td>
</tr>
<tr>
<td></td>
<td>• Activity #1: working towards positive self esteem</td>
</tr>
<tr>
<td></td>
<td>• Activity #2: Helium balloon activity: “Letting Go”</td>
</tr>
<tr>
<td></td>
<td>• Closing session: group discussion</td>
</tr>
<tr>
<td></td>
<td>• Homework assignment</td>
</tr>
</tbody>
</table>

**Week 4: Beauty Within**

<table>
<thead>
<tr>
<th>Session</th>
<th>Week 4: Beauty Within</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Check-In</td>
</tr>
<tr>
<td></td>
<td>• Group Norms</td>
</tr>
<tr>
<td></td>
<td>• Homework Journal</td>
</tr>
<tr>
<td></td>
<td>• Activity #1: What is beauty?</td>
</tr>
<tr>
<td></td>
<td>• Activity #2: Inner beauty</td>
</tr>
<tr>
<td></td>
<td>• Closing session: group discussion</td>
</tr>
<tr>
<td></td>
<td>• Homework assignment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session</th>
<th>Week 5: Meditation-relaxing your mind, body, and spirit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Check-In</td>
</tr>
<tr>
<td></td>
<td>• Group Norms</td>
</tr>
<tr>
<td></td>
<td>• Homework Journal</td>
</tr>
<tr>
<td></td>
<td>• Activity #1 Mindfulness exercise</td>
</tr>
<tr>
<td></td>
<td>• Today’s topic: Meditation, mindfulness, and their benefits.</td>
</tr>
<tr>
<td></td>
<td>• Activity #2: Mindful eating exercise</td>
</tr>
<tr>
<td></td>
<td>• Closing session: group discussion</td>
</tr>
<tr>
<td></td>
<td>• Homework assignment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session</th>
<th>Week 6: Culminating Experience-final group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Check-In</td>
</tr>
</tbody>
</table>
| Session 6 | Group Norms  
|          | Homework journal  
|          | Activity #1-Letting go-balloon activity  
|          | Activity #2-Individual meetings with co-leaders  
|          | Activity #3-Open discussion with group members |

References
CHAPTER IV

Conclusion

Summary of Project

The purpose of this project is to develop a psychoeducational group for teenagers (ages 14-18) suffering from an eating disorder. As a result of the growing population of teenage girls engaging in unhealthy eating patterns (up to 50% of teenage girls in today’s society) (ANAD, 2015), it is essential that treatment and psychoeducation are easily accessible for this population. This group will provide youth with the knowledge, tools, and motivation to learn about feeding eating disorders. By interacting with other group members experiencing turmoil and distress, clients will have a safe place to explore feelings and commonalities between group members. The group format will include psychoeducation for clients on feeding and eating disorders, implement cognitive behavioral skills, and incorporating both mindfulness and art therapy. Groups like this are a necessary resource for addressing the various challenges that clients suffering from an eating disorder may experience. It serves to assist them in dealing with stressors by supporting and educating them on how to best manage and cope with this disorder.

Based on the research I have acquired in this field, along with my own personal experience, I can conclude that this group will be valuable to clients dealing with an eating disorder. Incorporating an educational approach, along with teaching clients useful coping skills, and incorporating mindfulness and art therapy into a group setting will assist clients in gaining a new perspective on their disorder from other group members, new understanding of their disorder, as well as tools (verbal, and art based) which they can learn to use when necessary. It is important to understand that, while this group could
be highly beneficial to this population, it would be most effectively used by clients who are willing to work on themselves, and share with others in order to explore inner change.

**Recommendations for Implementation**

It is recommended that anyone facilitating this group be comfortable with their physical body, as well as their eating patterns. This group is to be facilitated by a Marriage and Family Therapist intern/ licensee with an interest in eating disorders, because there will be a lot of processing in this group. However, an individual who is familiar with the field of feeding and eating disorders (who has obtained their MFT intern/license) may co-facilitate and assist throughout the group. The co-facilitators are to use provided material, and are permitted to incorporate additional material using their own discretion as well.

The group is intended for use by facilitators in a community such as counseling centers, schools, activity centers, as well as any other local community resource centers available, to ensure that families are aware of the group. It is recommended that group start time is either during weekday evenings or the weekends, to ensure that there is flexibility for clients who have a consistent schedule.

The involvement of all group members is highly encouraged. It is essential that all group members participate, and are willing to share personal experiences in order to create a safe environment for other participants involved in the group. Parents are encouraged to touch base with facilitators at least two times throughout the schedule modality of group, however are not part of the group.

**Recommendations for Future Research**
This eating disorder group is meant to help youth struggling with an eating disorder. It is encouraged that facilitators include their own suggestions, recommendations, and modifications to the curriculum as they see fit, especially if certain groups gravitate to different topics within the curriculum. While doing this research project, I learned that clients suffering from an eating disorder gain many benefits by incorporating nonverbal expressive arts into therapy, using mindfulness techniques, learning different coping skills, and receiving education about this disorder. Unfortunately, there is no research mentioning a group incorporating eclectic therapeutic interventions (such as the one I have created) in a relatively short amount of time, and the outcomes that result.

I would be interested in researching the effectiveness of eclectic group therapy for youth suffering from an eating disorder, compared to group therapies specializing in only one method (only mindfulness, only psychoeducation, only art therapy, or only cognitive behavioral therapy). I would like to learn whether one specific approach works better than other therapeutic approaches when working with this type of population.
References


http://www.simplypsychology.org/Erik-Erikson.html


National Eating Disorders Association. (NEDA, 2014). *Factors that may contribute to eating disorders*. (Retrieved on November 12th, 2014 from:
http://www.nationaleatingdisorders.org/factors-may-contribute-eating-disorders


Appendix

Week One: Group Introduction and Education on Eating Disorders:

Tools: crayons, markers, colored paper, and a journal to disperse to each group member.

Leader will introduce themselves, and discuss group format, and expectations: group therapy, meeting two hours per week, for six weeks (10 minutes).

1) Group members (including facilitators) will engage in a “Getting Know You” (see week one activity #1), in which members of the group will have a sheet of paper, with different questions. The questions are designed in which each member will need to interact with other group members.

2) Co-facilitators will discuss their role in group (are here from a non-judgmental standpoint, and to facilitate/educate and support girls during the six sessions).

Group will develop group norms, discuss efforts towards recovery, confidentiality, group rules, and general group format.

3) Topic: Education on eating disorders: co leaders will go over these topic informally, and ask group members to participate (when they know the answer).

Co-leaders will go over fact sheet (see week one activity #2).

4) Group will create goals for recovery and write them in the journal dispersed to them.

5) Group will summarize the day, and will go over a check out.

Homework: Clients will receive a journal. For week one, clients will write about a situation that has been difficult during the week involving food, and will write what positive action they have taken to improve their feeling.
Week 1: Activity #1-Ice Breaker!

Conversations:

Each person is given a sheet of paper with a series of instructions to follow. This is a good mixing game and conversation starter as each person must speak to everyone else.

For example:

- Count the number of brown eyed girls in the room.
- Find out who has made the longest journey.
- Who has the most unusual hobby?
- Find the weirdest thing anyone has eaten.
- Who has had the most embarrassing experience?
- Who knows what ‘hippotomonstrosesquippedaliophobia’ a fear is of? Nearest guess wins. If that is too easy you can try Alektorophobia, Ephebiphobia, or Anglophobia (answers on the bottom of the page).

For Co-facilitators:

- Hippopotomonstrosesquippedaliophobia - Fear of long words (not a giant hippo in sight!)
- Alektorophobia - Fear of chickens. (No McDonalds today then!)
- Ephebiphobia - Fear of teenagers (tough phobia for a youth worker!)
- Anglophobia - Fear of England or English culture. (Be afraid, be very afraid!)

1 Adapted from: http://insight.typepad.co.uk/40_icebreakers_for_small_groups.pdf
Week 1: Activity #2 - Topics for Discussion:

Side note: everything that is not in bold is for the co-facilitators to talk about. Co-facilitators are encouraged to ask clients these questions, validate & and correct them on discrepancies.

What does it mean to have an eating disorders? ²

The mark of an actual eating disorder is when your relationship with food reaches an extreme level. The eating disorders anorexia nervosa, bulimia nervosa, and binge-eating disorder, and their variants, all feature serious disturbances in eating behavior and weight regulation. They are associated with a wide range of adverse psychological, physical, and social consequences. A person with an eating disorder may start out just eating smaller or larger amounts of food, but at some point, their urge to eat less or more spirals out of control. Severe distress or concern about body weight or shape, or extreme efforts to manage weight or food intake, also may characterize an eating disorder.

What is Anorexia Nervosa?

Many people with anorexia nervosa see themselves as overweight, even when they are clearly underweight. Eating, food, and weight control become obsessions. People with anorexia nervosa typically weigh themselves repeatedly, portion food carefully, and eat very small quantities of only certain foods. Some people with anorexia nervosa also may engage in binge eating followed by extreme dieting, excessive exercise, self-induced vomiting, or misuse of laxatives, diuretics, or enemas. Symptoms of anorexia nervosa include:

- Extremely low body weight
- Severe food restriction
- Relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight
- Intense fear of gaining weight
- Distorted body image and self-esteem that is heavily influenced by perceptions of body weight and shape, or a denial of the seriousness of low body weight
- Lack of menstruation among girls and women.

What is Bulimia Nervosa?

People with bulimia nervosa tend to binge on food and then compensate for the calories by purging — by deliberate vomiting or inducing diarrhea with laxatives, exercising excessively, or fasting. The binging part of bulimia is different from simply overeating; people with bulimia feel out of control when binging and eat way beyond being full. Like anorexia, bulimia primarily affects women and begins during adolescence or early adulthood. Experts estimate that 1.5 percent to 3 percent of women have bulimia and they tend to be of normal weight or are overweight. Research shows that about half of those with anorexia go on to have bulimia.

People with bulimia tend to:

- Binge at least twice a week for three months

Feel as if they can’t control eating binges
Think constantly about food and their weight
Eat in secret and very quickly
Binge until there’s no food left, someone interrupts them, or their stomach is very uncomfortable
Feel guilty after the binge and may purge, drastically restrict food later, or exercise excessively

Binging and purging can cause serious problems, such as an imbalance in electrolytes (minerals in your blood and bodily fluids), dehydration, and heart problems. It can even cause sudden death.

What is Binge-Eating Disorder?

People with binge eating disorder feel out of control as they eat large amounts of food. Unlike those who have bulimia, people who binge don’t purge, fast, or exercise excessively to lose weight afterward. Binge eating disorder also has been called compulsive overeating, emotional eating, or food addiction.

Loss of feeling in control when you eat- you feel like you can’t stop, even when you want to.

The most common of the three types of eating disorders, binge eating affects about 3.5 percent of women and 2 percent of men, and it usually starts during their early 20s.

People with binge eating disorder tend to:
- Binge at least twice a week for at least six months
- Binge in secret
- Binge during a negative mood
- Feel uncomfortably full afterward
- Often feel distressed, guilty, and depressed after binging
- Be overweight or obese

Eating disorders are about feelings, not food:

Eating Disorders are not just about food and weight. They are an attempt to use food intake and weight control to manage emotional conflicts that actually have little or nothing to do with food or weight. Eating disorders do not occur in an otherwise satisfied, productive, and emotionally healthy person. People with eating disorders are struggling with a number of emotional problems. This may be a hard concept to accept. Many people with eating disorders appear to be functioning at a high level, such as enjoying success with school or work. Often, the only problem appears to be with eating. However, healthier eating habits or stronger willpower are not the missing ingredients that will make the problem disappear. AN EATING DISORDER IS AN EXTERNAL SOLUTION TO INNER TURMOIL.

Adapted from: http://www.eatingdisorderfoundation.org/EatingDisorders.htm
Psychological Factors that can contribute to Eating Disorders:

- Low self-esteem
- Feelings of inadequacy or lack of control in life
- Depression, anxiety, anger, or loneliness

Interpersonal Factors that Can Contribute to Eating Disorders:

- Troubled family and personal relationships
- Difficulty expressing emotions and feelings
- History of being teased or ridiculed based in size or weight
- History of physical or sexual abuse

Social Factors that Can Contribute to Eating Disorders:

- Cultural pressures that glorify "thinness" and place value on obtaining the "perfect body"
- Narrow definitions of beauty that include only women and men of specific body weights and shapes
- Cultural norms that value people on the basis of physical appearance and not inner qualities and strengths

Other Factors that can contribute to Eating Disorders:

- Scientists are still researching possible biochemical or biological causes of eating disorders. In some individuals with eating disorders, certain chemicals in the brain that control hunger, appetite, and digestion have been found to be imbalanced. The exact meaning and implications of these imbalances remains under investigation.

Eating disorders are complex conditions that can arise from a variety of potential causes. Once started, however, they can create a self-perpetuating cycle of physical and emotional destruction.

**Can people recover from an eating disorder?**

Sustained recovery requires careful planning, and a team approach. For many patients, that means utilizing the full continuum of care. Typically, recovery does not happen once, but takes place over years of mindful application of the lessons learned in treatment. In other words, care goes hand and hand with aftercare.

It can be challenging to re-enter into the environment that one’s eating disorder had previously developed. However, going back with a realistic treatment plan can help to facilitate the recovery process.

Trust your team. Follow their recommendations for when it is time to step down. It is important to not cut yourself off from support, even when you feel like things are going “fine”. Challenges will come up, and while you might have the skills to respond to them without eating disorder behavior it’s helpful to have a professional as “backup”. They will be able to help you create a plan that includes being aware of what may have triggered you in the past, and help you to work towards creating effective and healthy coping skills.

---

4 Adapted from: http://www.nationaleatingdisorders.org/recovery
Week Two: Eating as coping; developing alternative coping strategies:

Tools: crayons, markers and colored paper, homework journals.

1) Group will go over a check in, and rate from scale 1-10 on feelings and emotions
2) Group will go over group norms (from first session)
3) Go over journal homework from week #1.
4) Co-leaders will introduce today’s topic: What are coping skills? What do you do/use to control eating disorder symptoms? What do you do when you feel like you can’t cope with different urges (to eat, or not to eat)?
5) Educational Piece on: Alternative Coping Skills (awhealth.org): Co-leaders will go over coping skills, and disperse this educational piece (see page attached). This sheet is beneficial for clients to have handy in case they need to refer back to whenever they feel triggered.
6) Activity for the day: Pre-Relapse Traffic Signs- Goal of this activity is to create a safety sheet to refer back to when feeling negative, or when wanting to relapse.
7) Discuss a time when you felt sad/negative, and used a safe coping skill (you listed on the traffic light sign). Discuss before and after feelings (did you feel empowered, did you celebrate your accomplishment, etc...).
8) Closing session, homework: think about your situation from this week in which you felt triggered or upset. Discuss what happened. Were you able to use your safe coping skills sheet.
Handout Sheet: Useful Coping Skills

How to Improve Body Image: put away scale, think about body parts you are proud of, be comfortable with your body, and recognize unrealistic thoughts you are having about your body.

How to Control Urges to Binge: go for a walk, listen to music, talk to a friend, exercise, shop, work on crafts, clean, and take a warm bath.

How to Cope with Eating & Avoid Urges to Binge: set a scheduled eating routine, have healthy snacks (if you can’t eat a meal), eat healthy instead of junk food, talk to someone you feel comfortable about your eating when feeling frustrated, make shopping list and stick to it, set time limit for eating,

How to Deal with Feelings after a Binge: forgive yourself, find something to do, talk to someone, self-talk, and nurture yourself.

How to Deal with Isolation: develop a hobby, plan

How to Improve Self Esteem & Tell Yourself that You are Okay: acknowledge your feelings, set short term/long term goals, allow yourself to be good enough (as opposed to perfect), be assertive (create a list of positive qualities), allow yourself quiet time, look at the positives of being away from your symptoms, allow yourself quiet time, get satisfaction from relationships rather than food, remember your strengths.

How to Nurture and Reward Yourself: shop for yourself, exercise, take a vacation, listen to music you like, buy something you like for yourself, call a friend, play a game, make time for yourself if you are busy, go to a movie, smile and be open to others.

How to Deal with Tension & Hold Your Own Assertively: accept your feelings (cry, and let your emotions out), shout into a pillow, be assertive of your rights, keep a journal, meditate, use grounding skills, change the subjects, allow time outs, clarify when things aren’t going well, ask others, try to be open (even though you don’t want to), be willing to negotiate, keep good eye contact, acknowledge when the other person is right in a situation, say what you need to say and be strong on your rights.

---

5 Adapted from: https://www.uwhealth.org/healthfacts/psychiatry/4515.html
Week 2: Activity #1- Pre-Relapse Traffic Signs!6

Goal of this activity is to create a safety sheet to refer back to when feeling negative, or when wanting to relapse.

On a sheet of paper draw a traffic light.

On the red light-write situations in which behaviors are destructive and not logical (deciding I am not hungry enough to eat, binging/purging, isolating myself, lying about eating),

On the yellow light-write about thoughts and feelings before/during/after behaviors (anxiety, obsessive thoughts, calorie counting, weighing myself, etc.)

On the green light-write about positive actions you can take to prevent from relapsing (be assertive and trust your body, engage in an activity, talk to someone or talk to yourself about healthy eating, write in a journal)

See example for reference:

Red Light Signs:
Telling myself I don’t need a meal plan.
Lying about eating/using behaviors
Isolating myself and avoiding social situations.
Only eating “safe foods”
Frequently binging/purging
Cheating on my meal plan

Yellow Light Signs:
Increased anxiety around food.
Weighing myself frequently.
Checking nutrition info online.
Measuring/weighing food.

Green Light Signs:
Not being afraid of the unknown or calories.
Following my meal plan.
Developing other interests and spending less time on my ED.
Being willing to surrender control over food.

Adapted from: https://www.pinterest.com/pin/153052087310825275/
Week Three: Anger/Depression/Perfectionism working towards Positive Self-esteem and Body Enhancement:

Tools: Helium balloons, markers, papers, homework journals.

1) Group will go over a check in, and rate from scale 1-10 on feelings and emotions
2) Group will go over group norms (from first session)
3) Group will discuss homework assignment (coping skills)
4) Co-leaders will introduce today’s topic: Anger, Depression, and Perfectionism Working towards Healthy Self-esteem. Co-leaders will begin session with asking the following questions (see reference sheet for co-leaders):
5) Activity #1: Working towards Positive Self Esteem (see week #3 activity one sheet)
6) Activity #2: Helium Balloon Activity: “Letting Go”
7) Closing Session: Group members will go around the room, and will discuss feelings about today’s group, and feelings about positive affirmation.
8) Homework: Group members will re-read self-affirmations they wrote about themselves at least one time per day, for the whole week. Group members will write down if they felt that this exercise assisted with positive self-outlook? If yes or no, please explain.
Week #3 Topic for Discussion:

A) What are things that make you feel good? What does that feel like?

B) What are things that make you feel sad? How does that feel like?

C) Co-leaders will discuss negative actions as a result of self-doubting, and the lack of self-acceptance. Co-facilitators will discuss self-forgiveness, and self-acceptance.

Topic for Discussion:

If we can accept ourselves, and forgive ourselves, this will alleviate negativity and encourage us to take positive risks, value ourselves, and life. Co-leaders will go over the effect of positive/negative self-talk, can affect our actions (and how we can stop the repetitive cycle of negative self-talk by exchanging this with a positive affirmation about ourselves, and reminding ourselves to do this). In doing so we are improving our emotional well-being, and can make positive strides to attaining our future goals.
Week #3 Handout Sheet: Positive Affirmation Guideline & Positive Affirmation

Positive Affirmation Guideline:

1) Choose a short affirmation

2) Repeat them when you have time during the day (during lunch break, during homework break, prior to going to sleep).

3) Be focused, relaxed, and calm when repeating affirmation.

4) Pay attention to what you are saying, and try hard to believe what you are saying.

5) Use positive words without a negative connotation (for example, don’t say: “I am not lazy”, instead you can say: “I am motivated to get good grades in school”).

6) Use present tense form. For example, you can say: “I am smart”.

Examples of Positive Affirmations:

I am presenting my school project confidently

My thoughts are under my control

I am open to life challenges, and what may come

I accept and love myself, as I am

I am willing to forgive myself

I have wonderful friends and family I can go to for support

I radiate love!

I am active

I am helpful around the house

7 Adapted from: http://healingforeatingdisorders.com/positive-affirmations
Week 3: Activity #1 & #2

Activity #1: Each group member will go around and discuss positive qualities they like about themselves and other group members. Each member will document positive qualities (co-facilitators are to participate in this activity as well).

Activity #2: Each member will receive a balloon (helium balloon), and a colored paper. On the balloon, each group member will write down situations in which they have used negative self-talk. On the piece of colored paper the group members will challenge the negative self-talk, by documenting what positive quality they can write about themselves. Group members will take the balloon with the negative comments, and will talk about “letting the emotions go”. Co-leaders and clients will go outside and set the balloons to fly away (setting free negative self-talk & emotions).
Week Four: Beauty Within

Tools: paper, markers, time period pictures, magazines from different ethnicities & cultures, homework journals.

1) Group will go over a check in, and rate from scale 1-10 on feelings and emotions

2) Group will go over group norms (from first session)

3) Group will discuss homework assignment (coping skills)

4) Prior to introducing today’s topic, therapists will hold up different art pictures, and will ask clients to choose a picture they like the most.

5) Co-leaders will introduce today’s topic: Beauty and how it is defined differently amongst different cultures, states, time period, as well as individual’s personal taste.

6) Activity #1: What is Beauty? (See week #4 activity one sheet)

7) Activity #2: Inner Beauty (See week #4, activity two sheet)

8) Closing session: Co-leaders will go around the room, and ask group members about their thoughts and feelings about today’s group.

9) Homework: Write in journal two different situations in which you initially encountered someone you thought positively or negatively about, and how your thoughts drastically changed after getting to know them, and their personality.
Activity #1: Group members will be given different sets of magazines from different parts of the world, as well as pictures from different time periods. Group members will identify differences in beauties, and what is identified as “beauty”, and the expectation of “thinness” to that specific culture. Goal of this exercise is to understand that beauty is defined differently to other cultures, and to other people.

Co-leaders will then discuss inner beauty, and will transition into activity two.

Co-leaders will discuss: self-love, confidence, growth, charity, health, and happiness.

How these attributes create positive healthy relationships within one’s self and to others, and will ultimately conquer the idea of living up to the expectations of needing to fit in a physical category.

Activity #2: Group members will write down on pieces of paper positive inner qualities, and on other pieces challenges and insecurities they would like to over-come. After this task is completed, group members will divide negative reflection notes in one bag, and negative reflection in a separate bag. Co-leaders will hold on to this for next group (see week number six).

---

8 Adapted from: http://www.uen.org/cte/family/explore/downloads/choices/eating_overview.pdf
**Week Five: Meditation-relaxing your mind, body, and spirit**

Tools: Co-leaders will bring laptops, tapes/videos (for meditation activity), yoga mats, and homework journals, snacks such as: apple, raisin, M&M’s (at least three different snacks of your choice).

1) Group will go over a check in, and rate from scale 1-10 on feelings and emotions
2) Group will go over group norms (from first session)
3) Group will discuss homework assignment (coping skills)
4) Activity #1: Mindfulness exercise
5) Co-leaders will introduce today’s topic: Meditation. Co-leaders will discuss mindfulness, and its benefits:
6) Activity #2: Mindful eating exercise
7) Closing Session: Group members will go around the room, and will discuss different mindfulness exercise that they can engage in, and that appeal to them.
8) Homework: Group members are requested to research a mindfulness activity at home that appeals to them, and participate in the session at least 2x during the week. Group members are to write in journal how they felt prior to engaging in a mindfulness exercise, and how they felt after the exercise.
Week 5: Activity #1

Activity #1: Have clients sit or lie down in a comfortable position, making sure that you do not have any constriction. Loosen any tight clothing.

Starting with your feet, pay attention to the physical feelings in them: any pain, discomfort, coolness, warmth, tension, tightness, whatever. Simply pay attention to the physical feelings and sensations. Don’t judge them as good or bad, don’t try to change them, just be aware of them.

Slowly allow your awareness to drift up from your feet to your lower legs, again simply paying attention to any physical sensations in that part of your body, including any tightness, pain or discomfort. Then slowly let your awareness drift further up your body, doing the same gentle noticing for all of the parts of your body – your upper legs, hips, buttocks, pelvic region, stomach, chest, your lower back, upper back, fingers and hands, lower arms, upper arms, shoulders, neck, your head, forehead, temples, face – eyes, cheeks, nose, mouth, jaw line.

Then let your awareness drift gently and slowly back down your body, noticing any other places where there is pain, discomfort or tension and simply noticing this, until you awareness settles back at your feet.

Commence doing this exercise just for 5 minutes. It can be done sitting down in a chair or lying in bed. Over time, don’t worry about how long it takes – just allow yourself to pay attention to the sensations in your body. If, while doing this exercise, thoughts intrude, that’s okay – just notice the thoughts, notice yourself noticing the thoughts and gently guide your awareness back to your body.

Note: One variation on this is to focus on parts of your body that you don’t like – do this in front of a mirror, noticing your thoughts & feelings as you do the exercise.

---

9 Adapted from: http://www.livingwell.org.au/mindfulness-exercises-3/6-body-scan/
Week #5 Topic for Discussion:

A) What do you know about mindfulness?

B) What do you do when you feel angry, sad, depressed?

C) Co-leaders will discuss what is mindfulness, and its benefits.

a. **What is mindfulness:** Both involves concentrating and paying attention to our thoughts and how these thoughts make us feel, and accepting our thoughts without judging ourselves. Remaining aware in the present, and learning how to identify these emotions.

b. **Benefits of mindfulness:** mindfulness can relieve stress, improve concentration, reduce anxiety & depression, increases social connections, decreases loneliness, increase self-acceptance, less emotional reactivity, and resilience during tough times.

c. **Types of mindfulness exercises, some include:** mindful breathing, mindful eating, mindful touch, compassion mindfulness, mindfulness of difficulties/painful thoughts, etc...
Week 5: Activity #2:  

- Choose which snack you would like to use for this exercise (an apple, a raisin, M&M)
- Explore this food, using all of your senses (sight, smell, touch).
- First, look at the food (texture and color).
- Close your eyes, and explore the food with your sense of touch. What does this food feel like?
  Is it soft or hard? Grainy or sticky? Moist or dry?
- Notice that you’re not being asked to think, but just to notice different aspects of your experience, using one sense at a time. This is what it means to eat mindfully.
- Before you eat, explore this food with your sense of smell. What does it smell like?
- Now, begin eating. Take at least two bites to finish it.
- Take your first bite. Please chew very slowly, noticing the actual sensory experience of chewing and tasting. Close your eyes to focus on the sensations of chewing and tasting. You don’t need to think about your food to experience it.
- Notice the texture of the food; the way it feels in your mouth.
- Notice if the intensity of its flavor changes, moment to moment.
- Take about 20 more seconds to very slowly finish this first bite of food, being aware of the simple sensations of chewing and tasting.
- It isn’t always necessary to eat slowly in order to eat with mindfulness. But it’s helpful at first to slow down, in order to be as mindful as you can.
- Please take your second and last bite.
- Like before, Chew very slowly, while paying attention to the sensory experience of eating: the sensations and movements of chewing, the flavor of the food as it changes, and the sensations of swallowing.
- Just pay attention, moment by moment.

10 Adapted from: http://www.mindfulnessdiet.com/program/articles/a-mindfulness-eating-exercise-simple-instructions
Week Discussion:

Using a mindfulness eating exercise on a regular basis is only one part of a mindfulness approach to your diet. The liberating power of mindfulness takes stronger effect when you begin to pay close attention to your thoughts, emotions, and bodily sensations, all of which lead us to eat. Mindfulness (awareness) is the foundation that many people have been missing for overcoming food cravings, addictive eating, binge eating, emotional eating, and stress eating. What are some areas in life people can take a mindfulness approach? Do you participate in any form of mindful meditation?
Week Six: Culminating Experience

Tools: Journals, helium balloons, Bristol paper, healthy snacks, markers, crayons, scissors, glue, glitter, paint, magazines.

1) Group will go over a check in, and rate from scale 1-10 on feelings and emotions

2) Group will go over group norms (from first session)

3) Group will discuss homework assignment (mindful meditation)

4) Activity #1: “Letting Go” - balloon activity.

5) Activity #2: Co-leaders will discuss individual personal goals with group member (short term and long term future goals). Co-leaders will meet with each client while others are participating in the art activity.

6) Activity #3: Co-leaders will lead an open discussion about their experience in group. Co-leaders will ask group members open ended questions about their experience in group. Some questions include: what portion of group they resonated with the most, what coping skills has worked best for them, what they learned, and if they felt the received help through psycho-education topics presented during group.
Activity #1

Co-leaders will bring the stacks of negative and positive attributes clients wrote in session #4 (activity #2). Co-leaders will disperse one balloon to each group member and request that they glue on the negative attributes they wrote about themselves on the balloon. Clients along with Co-leaders will go outside and set the balloons off to fly away. Co-leaders will bring up the topic of letting go of the negative feelings, and discuss how the activity made you feel.

Co-leaders will return to the room (when everyone is ready), and will disperse the positive attributes pile they collected from activity #2 (in session 4). Co-leaders will also disperse Bristol papers, markers, paint, glue, crayons, colored pencils, scissors, glitter, etc…Co-leaders will request that girls create anything they want on the Bristol paper that incorporates positive attributes they wrote/received from other group members.
Activity #2

Co-leaders will lead an open discussion about their experience in group, and ask open-ended questions. Some questions may include: what portion of group they resonated with the most, what coping skills has worked best for them, what they learned, and if they felt the received help by the psycho-education topics. Other group members are encouraged to talk amongst each other, exchange contact info (if they would like), discuss their artwork, or write in their journal.