PRACTICING AGENCY AND COLLABORATION IN RECOVERY: A NARRATIVE THERAPY GROUP PROGRAM FOR ADOLESCENTS WITH ANOREXIA NERVOSA

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

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"The future belongs to those who believe in the beauty of their dreams." - Eleanor Roosevelt

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lives, and society at large. When these women are no longer stifled by their eating disorders, they will be able to pursue their dreams and impact the world in great ways.
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ABSTRACT

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By
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Masters of Science in Counseling,
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The purpose of this project is to create a group program that will give adolescents with anorexia nervosa and their families the agency to co-create a satisfying and empowering treatment experience. Since anorexia nervosa responds better to treatment in adolescence than adulthood, early intervention is critical (Von Holle et al., 2008). However, traditional psychological treatments that are used for anorexia are based on practices of control (Gremillion, 2004). Therefore, treatment satisfaction varies, with some feeling disempowered, mistrustful of treatment professionals, and disappointed with treatment outcomes (Maisel, Epston, & Borden, 2004).

The group program proposed in this paper challenges traditional control-based psychological practices by using a narrative therapy theoretical framework. According to Golan (2013) and Weber (2006), narrative therapy has shown to be effective in treating eating disorders, while empowering clients to practice autonomy and agency over their own recovery. Although research has been conducted on narrative therapy in group and family settings, there is little information in the literature applying this research to family
groups (Golan, 2013; Weber, 2006). Therefore, this project aims to fill the gap in this area of study, and capitalize on prior research.

The group program is designed for adolescents with anorexia nervosa to participate in an adolescent-only group and a family group concurrently. The group program is designed to facilitate adolescent autonomy and agency in recovery, while giving family members tools to best support their loved ones through this process. The mission of the group is to allow participants to develop alternative stories to create new opportunities for identities, relationships, and futures without the eating disorder.
CHAPTER ONE

INTRODUCTION

Background and Significance

Anorexia nervosa is a potentially life threatening illness characterized by fear of weight gain, despite severe food restriction and considerably low body weight. According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013), the manual that is most often used to diagnose mental illnesses, anorexia nervosa is relatively uncommon. Although anorexia nervosa only affects 0.4% of the population, it comes at a huge cost to individual patients, families, and the public healthcare system. Anorexia is sometimes chronic and has a mortality rate of about 5% per decade. Death is associated with either the physical consequences of anorexia, like organ failure, or suicide. Anorexia nervosa may result in organ damage, interruption of menstruation, and loss of bone density. The lack of nourishment in anorexia nervosa also is associated with many psychological effects, including depression, isolation, irritability, and sleep problems (American Psychiatric Association, 2013).

Since anorexia nervosa has lasting physical consequences, early intervention is critical (Von Holle et al., 2008). According to Hurst, Read, and Wallis (2012), the median age of onset is 17 years old, occurring 10 times more often in girls than boys. The causes of anorexia nervosa are complex, but include genetic factors, personality traits such as perfectionism, and early dieting. Anorexia nervosa typically develops in adolescence, due to physical maturation during puberty, which may trigger preoccupation with weight (Hurst et al., 2012).
Treatment for anorexia nervosa has the highest success rates in adolescence and has better outcomes when treated early in its development (Von Holle et al., 2008). There are not currently any evidence-based interventions for anorexia in adulthood, which has led to a gloomy prognostic reputation (Murray, Thorton, & Wallis, 2012). However, when treated in adolescence, anorexia nervosa has been shown to have high long-term recovery rates. In a naturalistic study by Strober, Freeeman, and Morrell (1997), 76% of adolescent patients studied achieved full recovery in 15 to 20 years, and only 30% relapsed after initial treatment. Therefore, adolescents should be treated early to avoid a chronic and life-threatening course of illness.

Statement of Need

According to Brotha (2009), the most common treatments for anorexia nervosa are modernist or evidence-based, which emphasize practices of control in treatment. These treatments are based on a traditional, pathologizing paradigm which emphasizes the patient’s problem or deficit and the expert knowledge of the therapist (Brotha, 2009). The assumptions underlying this paradigm are that the problem: is caused by a structural abnormality, lies within individuals or families, can be diagnosed into a set category, and should be treated by a professional who possesses a “true” and objective account of the patient’s problem (Brotha, 2009). According to Brotha, “When persons are related to with this ‘objective’, modernist approach, they tend to be regarded as objects thus inviting them to be positioned in the relationship as passive, powerless recipients of the knowledge of the ‘expert’” (p.23). Traditional objective, psychological treatment has discounted the knowledge of people with anorexia as “disordered” and inherently problematic (Golan, 2013). Therefore, treatment satisfaction varies, with some feeling
dismembered, mistrustful of treatment professionals, and disappointed with treatment outcomes (Maisel, Epston, & Borden, 2004).

According to Golan (2013) and Weber (2006), research has shown that narrative therapy can reduce eating disorder symptoms, while allowing clients to practice agency and autonomy over their recovery. Narrative therapy has been shown to be effective in group and family settings, however, there has yet to be research on a treatment program that utilizes a family group to capitalize on prior research. The aim of the group program proposed in this project is to fill this gap.

**Purpose of Project**

The purpose of this project is to create a group program that will give adolescents with anorexia nervosa and their families the agency to co-create satisfying and empowering treatment experiences and lives outside of the eating disorder. The group program will consist of two groups: a group for adolescents with anorexia and a separate group for the adolescents and their families. These groups will be conducted in parallel, as adolescents are to attend both these groups for a six week period. The group curriculum will be based on a postmodern, narrative therapy theoretical framework, which prioritizes the subjectivities of the group participants as experts over their own lives (Freedman & Combs, 1996). Therefore, the group will provide them with meaningful and fulfilling opportunities to reauthor their lives without their eating disorder, and give their family members tools on how to best support them in this process. The goal of the group is for participants to develop alternative stories to create new opportunities for identities, relationships, and futures that lie outside the eating disorder.
Terminology

- Adolescence - the period of physical, psychosocial, and intellectual development from 11-21 years old. This project will focus on middle to late adolescence (ages 15-21) which primary tasks are identity formation and preparation for adulthood (“Stages of Adolescence,” 2014).

- Anorexia nervosa - a potentially life threatening illness characterized by fear of weight gain, despite severe food restriction and considerably low body weight (5th ed.; DSM-5; American Psychiatric Association, 2013). In this project, anorexia nervosa will be used interchangeably with the broader term, eating disorder.

- Anti-eating disorder narrative - beliefs, practices, and values that counter the eating disorder narrative (Maisel et al., 2004).

- Co-research - a process of inquiry in which knowledge is generated, in order to create new meanings. These meanings can be utilized in the creation of alternative identities and life opportunities (Maisel et al., 2004).

- Eating disorder self - the disordered part of a person with an eating disorder, which originally develops for some adaptive function. The eating disorder self drives the progression of the illness (Costin, 2007).

- Evidence-based - the use of current research to make decisions for client care (Evidence-based health care and systematic reviews, 2014).

- Externalization - a practice of viewing the problem as something impacting a person’s life, but not inherent in the person’s being (Freedman & Combs, 1996).
• Family-based treatment- also known as Maudsley Family Therapy; an evidence-based form of family therapy for adolescents with anorexia nervosa based on intensive parental involvement in adolescent weight gain (Murray et al., 2012).

• Healthy self- also known as the soul self; the part of a person with an eating disorder that is whole and representative of the person at their core. Recovery is viewed as the strengthening of the healthy self in order to heal the eating disorder self (Costin, 2007).

• Modernism- a philosophy based on objective, expert knowledge and the existence of universal truth (Brotha, 2009).

• Narrative therapy- a therapeutic approach conceptualizing people’s lives as stories that can be re-experienced in more fulfilling and meaningful ways. Narrative therapy is based on postmodern and social constructionist assumptions and prioritizes lived experience. Clients are viewed as separate from the problem and experts in achieving new life directions (Freedman & Combs, 1996).

• Postmodernism- a worldview based on multiple truths or realities, which are socially constructed, created through language, and structured and maintained in a narrative form (Freedman & Combs 1996).

• Preferred narratives- stories that an individual finds to be more meaningful and fulfilling than their problem story (Freedman & Combs, 1996).

• Social construction- a theory that the elements of reality (e.g. beliefs, values, customs) are constructed through interaction with other people and institutions (Freedman & Combs, 1996).
• Sparkling events- also known as unique outcomes or anti-eating disorder steps; events that contradict the problem story (Freedman & Combs, 1996).

• Witnessing- a practice by which a family member, or another person, listens to understand and incorporate another person’s story in their worldview (Freedman, 2004).

**Transition to the Next Chapter**

The next chapter of the paper will be a literature review, which will explore traditional, modernist and evidenced-based treatments that emphasize practices of control. Then, it will introduce narrative therapy and the elements of narrative therapy in the treatment of eating disorders. This will be followed by a vignette applying narrative therapy to an adolescent with anorexia. The literature review will close with the current research on narrative therapy for eating disorders and the implications for the development of future treatment.

The next chapters of the project will focus on the group program. Chapter III will provide an overview of the project audience and implementation factors. This will be followed by Chapter IV, which will review earlier sections of the project and propose directions for the future of the group program and further research. The Appendix includes the curriculum for the six week group program.
CHAPTER TWO

Literature Review

Introduction

In the mental health field, anorexia nervosa is considered to be quite pernicious in its possibility of chronicity or life-threatening outcomes (Wonderlich et al., 2012). Moreover, treatment may be complicated by client ambivalence or resistance to recovery (Golan, 2013). According to Golan (2013), clients may be reluctant to give up the sense of control, autonomy, and achievement their eating disorder brings them. Client resistance may be intensified by traditional modernist and evidence-based treatments that emphasize the client’s problem and use expert knowledge and authority to control the problem (Brotha, 2009).

Unlike treatments based on practices of control, narrative therapy gives clients the agency to be experts over their own lives. Narrative therapy can empower adolescents to reauthor their lives and reclaim freedom from their eating disorders (Freedman & Combs, 1996). Narrative therapy externalizes the eating disorder as separate from the person, which creates the space for clients to collaborate with treatment professionals and family members (Golan, 2012). Narrative therapy allows for clients to work collaboratively with these “anti-eating disorder allies” to create preferred identities, relationships, and opportunities outside of the eating disorder (Maisel, Epston, & Borden, 2009). Therefore, narrative therapy can serve as a bridge in uniting adolescent clients, parents, and treatment professionals by empowering clients to disengage from their eating disorders and construct more meaningful and fulfilling lives.
This literature review will explore the practices of control in modernist and evidenced-based treatment. Then, it will introduce narrative therapy and the elements of narrative therapy in the treatment of eating disorders. This will be followed by a vignette about an adolescent with anorexia nervosa and the application of narrative therapy to the vignette. The literature review will culminate with the current research on narrative therapy for eating disorders and the implications for future treatment.

**Modernist Treatment**

According to Brotha (2009), modernist treatment for anorexia nervosa locates the problem within the individual or family and the solution within the specific treatment or therapist. Treatment is problem-centered and pathologizing, focusing on clients’ diagnostic symptoms and identity, while ignoring their unique strengths, resources, hopes, and desires. Since the problem is the focus of treatment, it is believed that it can be “fixed.” Because anorexia’s main diagnostic feature is low body weight, treatment is focused on weight gain (Brotha, 2009). While proper nourishment is required to restore healthy cognition, many adolescents with anorexia report that they felt like physical recovery was prioritized to the exclusion of their psychological recovery in their treatment (Offord, Turner, & Cooper, 2006). Offord, Turner, and Cooper (2006) reported that this made adolescents feel like their psychological and emotional needs were not viewed as important. Offord et al. also found that when psychological treatment did not accompany weight gain, clients reported great distress at their sense of loss of control.

According to Gremillion (2002), treatment that focuses on excessive control and surveillance to achieve the therapeutic ends of weight gain may be counterproductive to long-term recovery. In Gremillion’s anthropological research of eating disorder
treatment centers, she describes how many traditional treatment practices replicate the control and rigidity that is inherent in eating disorders. This is significant because these treatment practices prevent self-direction and autonomy in recovery. Therefore, narrative therapy, a treatment modality that prioritizes each individual’s lived experience and influence over recovery will be discussed later in this literature review.

One of the ways in which treatment centers appropriate the rigidity and control characteristic of eating disorders is by emphasizing weight, calories, and food. Anorexia is characterized by preoccupation with food and body size (American Psychiatric Association, 2013). Instead of minimizing this preoccupation with food and weight in clients, treatment centers reinforce the importance of food and weight. Moreover, weight gain is considered the central marker of progress in recovery, sometimes to the exclusion of important psychological factors in recovery. Therefore, every calorie consumed and pound gained is measured. Patients are closely monitored, as there is an expectation that patients would not exercise agency in their own recovery and would continue to lose weight if not controlled by professionals (Gremillion, 2002). Although weight gain is vital to recovery, it is important that individuals are empowered to create fulfilling values, identities, and life choices outside of their eating disorder, food, and weight.

While it is true that eating disorders pose serious health risks and are often difficult for patients to challenge, professionals’ expectation of secrecy and manipulation tarnishes the therapeutic relationship and prevents the development of alternative identities outside the eating disorder (Gremillion, 2002). According to Maisel et al. (2004), many professionals believe that people with eating disorders are spoiled, attention-seeking, and cannot be trusted. These professionals use the label “anorexic” to
not only define a set of symptoms but also a set of pathologizing personality traits (Maisel et al., 2004). Therefore, the expert professional defines the totality of the person on his or her own terms, disallowing the individual any agency to construct her own unique, alternative identity outside the eating disorder (Gremillion, 2002).

Due to the extensive control exerted on patients, they may develop adversarial relationships with professionals and resist treatment (Gremillion, 2002). According to Gremillion (2002), this is problematic because treatment practices based on control replicate the practices of control that are inherent in eating disorders. Although some patients report that they were relieved to give up control to treatment professionals, others experienced this as punishment and powerlessness (Offord et al., 2006). Reluctant to give up their control, some patients will try to subvert the treatment practices used to control them, by manipulating their weight by drinking excessive amounts of water or hiding heavy objects in their underwear (Gremillion, 2002). According to Bezance and Holiday (2013), some patients may adopt a “perfect patient” façade, eager to discharge quickly from treatment and lose the weight they gained. In order to achieve genuine, long-lasting recovery, treatment professionals must allow their clients to have power over their own recovery.

The dynamics of traditional treatment for eating disorders create an environment that inadvertently encourages patients to fight the treatment professionals that control them, rather than their eating disorders (Bezance & Holiday, 2013). According to Gremillion (2002), patients that are restricted from exercising agency and independence in recovery may choose to exert independent action by engaging in acts of resistance to treatment. Unfortunately, this pattern of control and resistance prevents clients from
exploring fulfilling alternatives to their eating disorders (Gremillion, 2002). Moreover, it may leave clients even more vulnerable to their eating disorder following treatment (Maisel et al., 2004). Therefore, it is essential to look outside the control-centered treatment paradigm for more sustainable, empowering treatment options.

**Evidence-based Treatment: Family-Based Treatment (FBT)**

In the following section, family-based treatment (FBT) will be reviewed as it is the only treatment for adolescents with anorexia nervosa that has an evidence-based designation (Murray et al., 2012). According to Murray et al. (2012), FBT is focused on empowering parents of children with anorexia to restore their child’s weight. Substantial weight gain, over the course of weeks or months, is required before the adolescent is allowed to take more responsibility over their treatment. After the majority of symptoms have abated, more psychologically-focused interventions on adolescent identity are put into place (Murray et al., 2012). FBT is an alternative to usual individual treatment for anorexia, which may take place outside the child’s natural environment, at a hospital or treatment center. Therefore, supporters of FBT propose it as more affordable, family-centered, and evidence-based than other treatments (Le Grange & Lock, n.d.).

FBT departs from traditional modernist treatment in that it views the person as separate from the problem and locates the solution to the problem within the family. However, like modernist treatment, agency is taken away from the adolescent and their food intake and daily activities are highly controlled. FBT empowers parents as experts in facilitating their adolescent’s recovery, but the tools they use to achieve these ends are excessive control and authority. Bezance and Holliday (2013) found that adolescents experienced treatment based on control as disempowering and were more satisfied by a
collaborative approach in which parents and professionals were involved in a supportive way. When adolescents were given some autonomy to make choices in their treatment, they felt respected and empowered to take responsibility for their recovery (Bezance & Holiday, 2013).

In her memoir, *Brave Girl Eating: A Family's Struggle with Anorexia*, Harriet Brown (2011) describes how she helped her daughter recover using FBT and extensive monitoring. She recounts how her daughter slept on her bedroom floor, went to work with her, was supervised at every meal and snack, and even cried herself to sleep in her mother’s arms. Since FBT requires such extensive involvement of parents, different family structures and dynamics may complicate treatment outcomes. These include single-parent families or low income families in which child is unsupervised for long periods of time, parental mental illness or eating disorder, parental criticism and hostility, or family interactional patterns that may have contributed to the eating disorder (Ellison et al., 2012).

Although family involvement is important in eating disorder treatment, the cost of parents replicating the eating disorder’s practice of control on adolescents’ experience of treatment and recovery has not been extensively researched. According to Bezance and Holiday (2013), the lack of qualitative research on the experience of adolescents in treatment may be due to the evidence-based driven demand for quantitative research to uncover scientific “truths” about the best treatment. However, this research fails to represent individuals’ unique truths and the influence of social discourses, interaction, and lived experience (Bezance & Holiday, 2013).
Despite the evidence-based status of FBT, some adolescents may experience their parents’ control and surveillance similarly to that of a treatment center. Although some consider FBT to be the treatment of choice for adolescents with anorexia, Rosenvinge and Klusmeier (2002), found that 31.3% of people with anorexia said that family treatment made situations worse. They found more favorable results with younger adolescents, but after this age, family therapy may be experienced as less helpful.

Since a major developmental task during adolescence is separating from one’s family and developing a unique, autonomous identity, adolescents may resist the extensive parental control and authority required in FBT (Marsden, Meyer, Fuller, & Waller, 2002). Moreover, FBT limits the potential meanings the adolescent can create about their eating disorder as it does not encourage exploration of family dynamics, the function of the eating disorder, or contributing factors to its development. Since the adolescent is not seen as the expert in FBT, the meanings about their treatment and recovery that are prioritized are not their own (Marsden, Meyer, Fuller, & Waller, 2002).

The research on FBT demonstrates its efficacy in individual studies (Lock et al., 2010). However, it is less clear if the research supports the effectiveness of FBT in clinical settings due to small sample size and methodological limitations (Murray et al., 2012). These same limitations are also found in the qualitative research examining adolescents’ experience of family therapy. Therefore, more research is necessary to determine how FBT compares to other forms of therapy in terms of both effectiveness and client satisfaction (Couturier, Kimber, & Szatmari, 2012).
Narrative Therapy

Narrative therapy shifts the paradigm from the traditional problem-centered approach commonly used in modernist and evidenced-based approaches to one that makes room for alternative stories that exist outside the problem (Freedman & Combs, 1996). According to Freedman and Combs (1996), an assumption in narrative therapy is that “problems are problems and people are people.” Narrative therapy holds that problems are maintained by problem stories, which offer limiting, unpleasant, or nonpreferred choices. In narrative therapy, the therapist collaborates with the client to discover new or overlooked stories in their lived experience that they find useful and enriching to their lives. These stories allow for people to cultivate new identities, relational possibilities, and paths for the future (Freedman & Combs, 1996).

Narrative therapy is based on postmodern and social constructionist theories about reality. According to Freedman and Combs (1996), postmodernism is a worldview that values individuals’ unique truths, which is very different from the modernist worldview that underlies much of traditional therapy. Postmodern theory rejects the modernist belief in a single objective truth. According to Freedman and Combs (1996), narrative therapy is based on postmodern assumptions about reality, as reality is considered to be socially constructed, influenced by language, and shaped by a narrative form. Social construction is the idea that beliefs, practices, and the social status quo are created and maintained through social interaction. Dominant narratives are socially constructed to make the hierarchical power relations that marginalize groups of people seem like taken for granted truths (Freedman and Combs, 1996). The therapeutic relationship in narrative therapy is a departure from the traditional therapeutic hierarchy in which the therapist is
seen as an objective expert. Narrative therapy prioritizes the truths of marginalized people and empowers them to be experts of their own lives. Moreover, narrative therapists are critical of their position in the world and what they bring into a therapeutic relationship, as to not overshadow client’s truths with their own (Freedman & Combs, 1996).

According to Freedman and Combs (1996), narrative therapy places primacy on its worldview and the type of therapeutic relationship it engenders, rather than a set of techniques. However, there are some common interventions used, including co-researching problem stories and preferred narratives and externalizing problems as separate from the person. Questions are especially important in narrative therapy, as they can aid in the creation of preferred narratives and life directions (Freedman & Combs, 1996).

**Elements of Narrative Therapy**

Unlike modernist and evidenced-based treatment that places an emphasis on practices of control, narrative therapy allows for the creation of preferred identities, relationships, and opportunities for the future outside of their eating disorder (Brotha, 2009). Narrative therapists recognize the resistance and ambivalence that people with eating disorders may have in treatment and recovery (Golan, 2013). Therefore, they empower clients by prioritizing their role in therapy, as only they have the “insider” knowledge about their experience living with an eating disorder (Maisel et al., 2004). Narrative therapy uses externalization, co-research, anti-eating disorder narratives, and family therapy to facilitate resistance against the eating disorder and enable the adolescent to reclaim their life.
**Externalization.** Externalization is a tool used to combat client resistance and power struggles in the treatment of eating disorders (Golan, 2012). According to Golan (2012), this technique gives adolescents, parents, and therapists the distance to identify, objectify, and critique the eating disorder, instead of directing criticism towards one another.

In her work treating adolescents with eating disorders, Golan (2012) uses externalization to reveal to clients how their eating disorders have taken control of their lives (e.g. by damaging relationships, punishing their mind and body, disconnecting them from their sense of self, and by making promises it cannot deliver upon). According to Golan, externalization also enables a team approach in which the therapist facilitates the formation of a united front. In this team approach, parents can support their adolescents in reclaiming their lives from their eating disorder. In this way, adversarial relationships between adolescents and parents or therapists can be avoided. Therefore, there is less blame and guilt to separate the people involved in therapy, so more attention can be dedicated to fighting the eating disorder and not each other (Golan, 2012).

Externalization also gives adolescents the clarity to see the tactics that the eating disorder uses to bring them under its control (Maisel et al., 2004). Although the eating disorder may have served some functionality in the past, like regulating emotions, providing a sense of safety and control, or mitigating family conflicts, its false sense of protection becomes destructive (Golan, 2013). Some common tactics the eating disorder uses to bring adolescents under its control are encouraging disconnection from loved ones, feelings of worthlessness, and the erasure of one’s sense of self (Maisel et al., 2004).
**Co-research.** Co-research is a process of inquiry in which knowledge is generated, in order to create new meanings (Maisel et al., 2004). According to Maisel et al. (2004), these meanings can be utilized in the creation of alternative identities and life opportunities. The aim of co-research is not to generate objective knowledge, but to develop meanings that encourage resistance against the eating disorder. Co-research calls into question aspects of people’s experience that contradict the eating disorder’s voice, and empowers them to act autonomously against their eating disorder (Maisel et al., 2004). A turning point in this process is when people come to realize that their well-being and very survival depend not on their commitment to their eating disorder, but their condemnation of it (Maisel et al., 2004). Feelings of anger and outrage to the eating disorder foster resistance to the eating disorder and exploration of possibilities outside its control (Maisel et al., 2004).

In addition to co-researching the eating disorders influence over the adolescent’s life, it is also useful to co-research the influence they have exerted over the eating disorder. According to Golan (2012), this type of co-research can also thicken a client’s anti-eating disorder story by building upon times in which they challenged the eating disorder. These exceptions to the problem are known as sparkling events, unique outcomes, or anti-eating disorder steps. Sparkling events, like resisting the urge to restrict, can set the foundation for client-directed, anti-eating disorder change (Golan, 2012).

**Anti-eating disorder narrative.** According to Maisel et al. (2004), once adolescents achieve a sense of separation and resistance to the eating disorder, they may begin to see that the eating disorder’s preferences, values, and hopes for the future
conflict with their own. Since eating disorders can disconnect people from themselves and the world, people with eating disorders may have difficulty discerning their preferred ways of being outside the eating disorder (Maisel et al., 2004).

To reconnect to what the eating disorder has separated them from, it may be helpful to imagine their “healthy self” as a separate entity from the eating disorder. In her work with people with eating disorders, Costin (2007) helps clients access their “healthy self,” also called the “soul self.” Costin says that as the healthy self gets stronger, it becomes easier for clients to identify and challenge the eating disorder voice, or the “eating disorder self.” According to Costin, the healthy self gets stronger by “talking back” to the eating disorder and by nourishing the healthy self.

Maisel et al. (2004) describes spirit-nourishing activities, like prayer, art, or viewing nature, as experiences that disengage the person from the eating disorder and allow them to engage in spiritual knowing. By engaging in different meanings outside the eating disorder, adolescents may begin to live for their alternative narrative, and no longer simply against their eating disorder narrative (Maisel et al., 2004).

**Family therapy.** In narrative family therapy, the therapist acts as a consultant who helps the family work collaboratively (Maisel et al., 2004). According to Maisel et al. (2004), the adolescent has expert knowledge of her eating disorder and what is helpful in her recovery. Therefore, the adolescent with the eating disorder is considered the leader of their family’s anti-eating disorder team and an advisor to their parents them on how to best support them (Maisel et al., 2004). Parents also have a privileged position in therapy, as they witness how the eating disorder impacts their adolescent on a daily basis. Therefore, their accounts of the eating disorder’s cruelty and deception can be
particularly useful in therapy (Maisel et al., 2004). By witnessing their family members’ accounts of the eating disorder, adolescents can evaluate the eating disorder’s influence on their lives and thicken their anti-eating disorder narrative (Freedman, 2014).

Family therapy may also be an effective space to explore the cultural and familial stories that feed the eating disorder (Freedman & Combs, 1996). Many of these stories are related to the gendered expectations of female beauty and self-sacrifice, or other western values such as achievement (Maisel et al., 2004). According to Gehart (2014), intergenerational beliefs may sustain family problems, so it may be useful for the family to co-research these beliefs and explore how they impact or create problems in their lives. This awareness increases the family’s agency to relate to these beliefs in different ways and invest in more empowering beliefs that support the resolution of the eating disorder and other family problems (Gehart, 2014).

**Narrative Therapy Applied to Vignette**

**Vignette.** Hannah Cohen is a 15 year old girl brought into therapy due to her parents’ concern for her physical health. Before Hannah began showing signs of anorexia, she seemed to be extremely well-adjusted. Hannah grew up in an upper middle class Jewish family that encouraged education and provided every opportunity for success. Hannah seized these opportunities and was a straight-A student, captain of the volleyball team, and a student council representative. Hannah’s parents say that her eating disorder took them by surprise, because “she never needed any help.” Hannah’s parents say they miss their perfect little girl who was “the family mediator” and their “biggest helper.” They say she transformed from a loyal daughter who always followed the rules to a rebellious teenager who was disrupting their home.
Hannah’s parents brought her to a psychiatrist, so they could voice their concerns. Hannah sat quietly while her parents told the doctor “what was wrong with her.” Although Hannah’s parents, Nancy, 44, and George, 50, fight often, they agree about one thing—Hannah needs to gain weight. Her mother, Nancy, says that she is distraught because every time she tries to care for and offer food to her daughter, Hannah refuses. Her father, George says that Hannah needs to follow his rules and he demands to weigh Hannah, even if she puts up a fight. Hannah’s brother, Ben, 17, has also become worried about their sister’s gaunt appearance and irritable mood. Hannah is especially nasty to Ben, who she secretly resents for all the attention he received from their parents over the years.

The second half of the consultation, the psychiatrist asks Hannah’s parents to leave, since Hannah has remained silent for the entire session. Hannah says that she just wants to be left alone and that she hates how controlling her parents are. She says restricting her food makes her feel in control in her house that is really “chaotic” and loud. Hannah says she is under a lot of pressure to be perfect, because her family is so flawed.

As the session is ending, the psychiatrist remarks about Hannah’s insight into how her feelings about her family fuel her eating disorder. Hannah replies that she knows her eating disorder is about more than the food and the weight, but she is still not willing to gain weight or stop restricting. She says, “it would be nice to have my parents off my back about my weight, but there is no way I am giving up the only thing in my life that makes me feel in control, safe, and like I have a purpose.”
**Application of narrative therapy to vignette.** In the vignette, Hannah’s identity has been consumed by her eating disorder, at the expense of her mental and physical health, as well as her relationship with her family. However, she lacks the motivation to give it up. Narrative therapy may allow Hannah to develop an anti-eating disorder narrative by separating from her eating disorder, witnessing and co-researching family members’ alternative narratives, and exploring problematic family beliefs that encourage her eating disorder.

The use of externalization in narrative therapy may help Hannah separate from her eating disorder. Externalization would be useful because Hannah’s identity has been overtaken by the eating disorder, and she has come to believe that she and the eating disorder are one in the same. Moreover, the eating disorder has transformed her personality in such a way that she has become unrecognizable to her family. Externalizing the eating disorder as separate from Hannah could give her the clarity to see the strategies it uses to control her, which leads to problematic outcomes in her life and in her relationships with family members.

Externalization would also allow Hannah to see how her eating disorder robs her of any agency or control over her own life. Hannah’s life narrative has become so constricted; it only has room for her eating disorder alone. Moreover, the eating disorder blinds her from seeing how her life difficulties are related to the control it has over her life (Golan, 2013). Hannah is so consumed by the eating disorder that she abandons her once highly held values and desires, in exchange for those related to food restriction and weight loss.
Before her eating disorder, Hannah’s relationships were very meaningful in her life. However, in the eating disorder’s grasp, Hannah neglects and violates all her relationships, except her relationship to her eating disorder. The eating disorder causes Hannah to lie, argue, and deride the people she loves if anything they say or do interferes with the narrow, single-stranded eating disorder story. Hannah has come to believe that she is her eating disorder, and has the same values and desires as her eating disorder. However, using narrative therapy to highlight her values and desires outside the eating disorder narrative may increase her motivation to regain agency over her life and live in preferred ways outside of the eating disorder (Scott, Hanstock, & Patterson-Kane, 2013).

By involving her family in therapy, Hannah can gain a multilayered understanding of her eating disorder, which may create the space for the development of new meanings (Freedman, 2014). According to Freedman (2014), witnessing a family member’s story facilitates listening in such a way to understand the story as it is being told. In the Cohen family, both Hannah and her parents do not listen to understand each other’s stories. Instead, they are planning their rebuttal to the other party’s argument.

Taking the witnessing position would allow Hannah’s parents to enhance their understanding of her eating disorder from her perspective. As Hannah’s parents begin to understand the role the eating disorder plays in her life and in their family, they may be able to support Hannah in a way that would enable her to enact preferred narratives. For example, preferred narratives may emerge when Hannah tells her parents about her need for independence. Understanding Hannah’s need as a normal part of her development could allow Hannah and her parents to relate in new ways without defensiveness and hostility. Previously, when Hannah felt misunderstood by her parents, she turned to her
eating disorder as her only ally. However, expressing her needs to her parents could facilitate new opportunities for appropriate closeness to develop in their relationship. Therefore, Hannah’s needs for both connection and independence could be met without the eating disorder.

Witnessing her family members’ perspectives may allow Hannah to gain new understanding of her eating disorder and her relationships. Hannah has developed adversarial relationships with her parents, and she believes they are the enemy. Hannah rarely listens to understand her parents, and most of the time she immediately disregards what her parents say as “stupid” or “just out to get me.” By witnessing her parents’ stories for their meaning, Hannah may be able to see that her parents are not against her but her eating disorder (Lock, Epston, & Maisel, 2004). Her parents’ narrative is one of fear that they will lose their daughter to her eating disorder, as both her physical health and their relationship with her are in dire states. By witnessing their accounts of genuine concern and sadness, Hannah could develop new ways of relating to them and her eating disorder.

By collaborating and co-researching the eating disorder with her brother, Hannah may develop the clarity to see how the eating disorder influences her and her relationships. Before Hannah developed her eating disorder, she had a good relationship with her brother, Ben. However, the eating disorder influenced Hannah by telling her that she was superior to Ben, as he needed indulgent attention and help from their parents and Hannah did not. Therefore, Hannah became convinced that she should not spend time with Ben, because he was “needy” and “weak.” The eating disorder also told Hannah that it would help her to distance herself from her family, so she did not become
reliant on them like Ben. Therefore, Hannah concluded that she did not need the things that other people needed like attention, affection, and a sense of belonging, as her eating disorder made her so strong she could ignore any physical or emotional need. However, Hannah secretly longed for parental attention and was jealous of the attention Ben received, which compounded the animosity Hannah felt towards him.

By witnessing her brother’s accounts of sparkling events in their relationship, Hannah may be able to thicken her anti-eating disorder and develop a preferred relationship with Ben. The witnessing position in narrative therapy may allow Hannah to listen to understand Ben, instead of replying immediately with a disparaging comment. Therefore, Ben could tell Hannah that he still saw glimpses of his fun-loving, kind, and goofy sister when they were playing with their dog, so he knows that the Hannah he loves is still there. By witnessing her brother’s narrative, Hannah not only gains a fresh perspective outside of her problem narrative, but she also can build on this sparkling event and thicken her anti-eating disorder narrative (Freedman & Combs, 1996).

This sparkling event is significant because it is an opening in Hannah’s life when the eating disorder is not there, and it is when she is happiest. It highlights the eating disorder’s impact on her once fulfilling relationship with Ben, while bringing to light her preferred self-image as fun-loving, kind, and goofy. Moreover, it resonates with Hannah’s spirit, which allows her to engage in a narrative separate from her eating disorder and to reconnect with her values for connection and self-fulfilling activities (Maisel et al., 2004). Hannah can build upon this sparkling event by developing an anti-eating disorder lifestyle, in which she can make spirit-resonating choices in her life that defy the eating disorder (Maisel et al, 2004). In this way, Hannah can begin to construct...
a preferred narrative that contains meaningful and fulfilling opportunities for identity development, connection, and paths for the future without her eating disorder.

A narrative approach to family therapy would also help Hannah and her family to explore how her eating disorder fed on beliefs supported in her family for generations (Scott et al., 2013). In the Cohen family, there are beliefs that sustain intergenerational problems, which are manifested in Hannah’s eating disorder. Using a narrative therapy framework could highlight how the beliefs that influence the lived experience of the Cohen family are created and sustained through interaction (Freedman & Combs, 1996). In western society, there are beliefs about gender that position women in a particular way in families and society. In the Cohen family, there is a narrative that women should be self-sacrificing martyrs, which has been modelled in both parents’ families of origin. Underlying this narrative is the belief that the denial of one’s own needs is noble.

This intergenerational belief creates problems in both Hannah’s life and in her mother, Nancy’s life. Nancy has grown resentful because she always puts the needs of her children and husband before her own. Hannah has utilized this narrative by creating an identity around being “the family mediator” and her parents’ “biggest helper.

Externalizing Hannah’s eating disorder could reveal how it exploits the family belief in self-denial to convince her that denying her needs, including that for food and pleasure, is a noble act (Scott et al., 2013). Exploring how socially constructed beliefs about the role of women have supported problem narratives in Cohen family could provide space for the family to create new, preferred stories based on self-care and personal fulfillment. Moreover, a change in Hannah’s relationship to these beliefs could alter future generational patterns (Freedman, 2014).
**Research on Narrative Therapy**

Although narrative therapy appears to be promising as applied to the Cohen family, there has been little research about narrative therapy in the treatment of eating disorders. According to Epston, Stillman, and Erbes (2012), the lack of scientific research about narrative therapy, in general, may be in part due to its theoretical stance. Narrative therapy holds that there are multiple truths and is critical of claims that a single, objective, and measurable truth can be obtained through research (Epston et al., 2012). However, narrative therapists have ventured into creating research informed by narrative perspectives with an emphasis on client agency and co-creation in the research process (Epston et al., 2012).

The client-centered focus of research on narrative therapy for eating disorders is particularly important because many traditional psychological discourses and practices have discounted the knowledge of people with eating disorders as “disordered” and inherently problematic (Golan, 2013). The research on narrative therapy has demonstrated externalization to be efficacious in producing alternative outcomes to the eating disorder story, as measured by reported changes in belief systems, eating disorder behavior, and sense of agency and identity (Golan, 2013; Weber, Davis, and McPhie, 2006.)

Externalization has shown to be an effective technique in research on narrative therapy. According to Weber et al. (2006), in a study of eight women in an eating disorder therapy group based on narrative therapy principles, participants reported that externalizing the eating disorder facilitated separation from the eating disorder, in such a way that encouraged preferred outcomes. These outcomes included less eating disorder...
behavior (bingeing and purging), less self-criticism, more body acceptance, and more flexibility in daily routine. The results were gathered from both quantitative scale and qualitative survey. The scale used was the Eating Disorders Inventory (EDI), which assesses for psychological markers that are common in eating disorders. According to the pre- and post-EDI scores, there were very significant decreases in many of the participants’ cognitions about perfectionism, self-esteem, and aestheticism (Weber et al., 2006).

In the subjective survey assessment, the participants also reported that externalization was a useful strategy to disengage from eating disorder behaviors (Weber et al., 2006). They reported that externalization allowed them to develop a critical eye for the strategies of the eating disorder, which facilitated their resistance to it. Another important component of externalization that the participants identified was the space it provided for them to explore their values, personality traits, hopes, and dreams, outside the eating disorder (Weber et al., 2006).

In a large study examining outcomes after treatment, narrative therapy emphasizing externalization proved to be efficacious. Golan (2013) followed 645 women with eating disorders treated with narrative therapy in a community-based facility. Although the participants reported that they were experiencing difficulties in most areas of life, they lacked insight in how their eating disorder contributed to these difficulties. Therefore, they reported varying levels of ambivalence and opposition to treatment. Treatment lasted from 15 months to four years, and its goal was theoretically based in narrative therapy. The aim for treatment was for participants to regain a sense of agency
and fuller sense of identity. Externalization was used to bring about alternative possibilities and identities, as a means of enhancing motivation (Golan, 2013).

Golan (2013) was interested in the effects of narrative therapy in the years following treatment, and its impact on eating disorder symptoms and psychosocial and occupational functioning. Golan found that 68% of those who were treated with anorexia and 83% of those who were treated with bulimia were fully recovered or in recovery at a four year follow up point. Recovery was measured by symptom resolution, including weight maintenance, regular menstruation, and abstinence from eating disorder behaviors. However, Golan also considered recovery to lie in things outside the eating disorder. Golan saw engagement in social and career pursuits as indicators of recovery. In this light, the study showed favorable outcomes, as all the participants who completed the program were employed or going to school four years following treatment (Golan, 2013).

The research on narrative therapy for eating disorders may have important implications for the Cohen family. Both studies by Weber et al (2006) and Golan (2013) highlight the importance of using externalization to identify the eating disorder’s tactics and impact in various areas of life. Weber used a group format with women with eating disorders. Group therapy may be useful to Hannah because she feels that no one could understand her or her eating disorder. The eating disorder has isolated Hannah from everyone, even from her best friend. Connecting with others in the group may help Hannah reconnect to her pre-eating disorder value for relationships.

Although group therapy alone was efficacious in Weber et al.’s (2006) study, Hannah would benefit from individual and family therapy, as well. In Golan’s (2013)
study, individual treatment focused on externalizing the eating disorder and exploring its impact on participants’ agency, hopes, dreams, and preferred outcomes. This would be a useful treatment focus for Hannah as she has become powerless to the eating disorder’s desires and disconnected from her own.

The focus of family therapy in Golan’s study (2013) was to explore the impact of the eating disorder on family members and the family, as a whole. Exploring family perspectives would allow Hannah to witness alternative stories about the eating disorder (Freedman & Combs, 1996). Family therapy could expand Hannah’s narrative, which had been constricted to only include the positive functions of the eating disorder. Family therapy may also allow Hannah to co-research her eating disorder. By co-researching her eating disorder, she may be able to see that the eating disorder did not elevate her family by giving them a “perfect” daughter, as it tricked her into believing. Hearing her family members’ perspectives would contradict the eating disorder’s compelling story and possibly create the space for Hannah to notice other areas of contradiction.

Although the research on narrative therapy appears to be applicable to Hannah, there are some limitations to the evidence base. Other than Golan (2013) and Weber et al.’s (2013) studies, most of the research on narrative therapy and eating disorders is limited to case studies. Therefore, it cannot be known how generalizable research is to clinical populations (Weber et al, 2006). Moreover, there has yet to be a randomized-control trial, so it cannot be determined how narrative therapy compares to other psychological treatments (Lock, Epston, & Maisel, 2004). Diversity factors also must be considered, as narrative therapy has mainly been studied in adult women with the
exception of Golan’s study. Therefore, more research has to be done to determine outcomes with people of all ages and both genders.

**Synthesis of Literature Review**

Narrative therapy is a radical shift from modernist and evidenced-based approaches to eating disorder treatment (Golan, 2013). Unlike treatments based on practices of control, narrative therapy gives clients the agency to be experts over their own lives. Narrative therapy can empower adolescents to reauthor their lives and reclaim freedom from the eating disorder (Freedman & Combs, 1996). Research has shown that narrative therapy may facilitate symptom remission and engagement in life outside the eating disorder (Golan, 2013; Weber, 2006). Therefore, it would be useful to build upon the current research by implementing a group for adolescents with eating disorders and their families.

Research has shown narrative therapy to be effective for adolescents with eating disorders in both group and family therapy settings (Golan, 2006; Weber et al., 2013). Therefore, the group program proposed in the remainder of this project will capitalize on both group and family therapy factors. In the group program, the adolescents will participate in two groups over the course of a week for six weeks. One group will be an adolescent-only group, which will focus on the development of a healthy adolescent identity outside the eating disorder. The other group will include adolescents and their families with the goal of establishing a parent-child alliance against the eating disorder and helping parents best support their child's recovery.

Unlike the major works of research reviewed in this paper, this project will include both family and group therapy. Golan (2013) used family therapy as a resource
in identifying the eating disorder’s tactics and supporting their child in fighting it. Weber et al. (2006) used a group format to create an anti-eating disorder culture, in which group participants could support each other against their eating disorders. This group program will bridge the treatments described in Golan and Weber et al. by providing treatment that uses both a family group and an adolescent-only group, which was the recommended treatment outlined for Hannah earlier in this paper. The group program will build upon prior research to enhance preferred, anti-eating disorder outcomes. Through this group process, adolescents and their families can rewrite the nightmare of the eating disorder into a story of courage, solidarity, and ultimate triumph.
CHAPTER THREE

PROJECT AUDIENCE AND IMPLEMENTATION

Introduction

Traditional treatments for eating disorders emphasize practices of control in
treatment (Brotha, 2009). Unlike these control-based treatments, narrative therapy
empowers clients as experts in creating preferred outcomes in their lives (Freedman &
Combs, 1996). The current research on narrative therapy for the treatment of eating
disorders shows that it is effective in family and group settings (Golan, 2013; Weber,
2006). However, there has yet to be research on a narrative therapy treatment program
that combines elements of both family and group therapy. This project will utilize
narrative therapy in both family and group settings to capitalize on prior research.

The target population of the group program is adolescents with anorexia. The
group participants will attend two groups per week for a total of six weeks. The two
groups include an adolescent-only group and a group for the adolescents and their
families.

In this chapter, the group program will be described in detail. This description
includes information on the development of the group program, its intended audience, the
personal qualifications suggested for the professionals leading the groups, the
environment and equipment required for the groups, and a brief outline of the adolescent-
only and family groups.

Development of Project

The development of this project went through many phases, each influenced by
different contributors in the field of eating disorders. In the first stage of project
development, the group was conceptualized as an adolescent-only group, which was
similar to the group format in Weber et al. (2006). This phase of project development was also influenced by the work of Carolyn Costin, the founder of Monte Nido & Affiliates Eating Disorder Treatment Centers. As an employee of Monte Nido & Affiliates, I have drawn from Costin’s work and incorporated it in the group curriculum. The practices developed by Costin used in this paper include the Lifemap activity, the eating disorder/healthy self-dialogue, the commemorative document, and closing ceremony (Borden, 2007; Costin, 2007).

In the second stage of project development, the focus of the group program shifted from simply including individuals in therapy to also including their families. In writing the vignette presented in the literature review, it became apparent how integral family therapy is in the treatment of eating disorders for adolescents. Therefore, I began to conceptualize the group program as consisting of two separate groups. The individual adolescent-only group would give adolescents the space to talk about their eating disorders among “insiders,” or people who share the experience of living with an eating disorder (Maisel et al, 2004). This would allow them to express themselves freely, unencumbered by the perceived judgment of their families.

Family involvement in a separate group would honor the adolescents’ autonomy and agency over their treatment and recovery, while allowing them to benefit from the support of their families. The family group was influenced by the work of Maisel et al. (2004), which emphasizes the importance of the parents’ role as allies in resistance to the eating disorder. As allies, parents can encourage and support their child’s recovery when they are showing signs of ambivalence and resistance. Moreover, parents can serve as a
safeguard to recovery when adolescents come under the control of the eating disorder or lose hope in recovery (Maisel et al., 2004).

The decision to include a family group was also influenced by my training as a marriage and family therapist. According to Sprenkle, Davis, and Lebow (2009), effective marriage and family therapy conceptualizes problems in relational terms and disrupts problematic relational patterns. In my training, I have been taught to use a relational lens, even when looking at what may seem like an individual as opposed to a family problem, like anorexia. Therefore, in this family group, anorexia is conceptualized as a problem that is influenced by outside forces, including problematic family and societal beliefs. The family group also includes interventions focused on disrupting problematic relational patterns (Sprenkle et al., 2009). These include those targeted on externalizing the eating disorder to make room for adolescents to relate to their parents and their eating disorder in ways that are more aligned with their values and visions for the future (Maisel et al., 2004).

**Intended Audience**

The target population for the group program is adolescents with anorexia and their families. Since adolescence spans a broad age range, the group will only include adolescents in the middle to late stages of this developmental period (15-21 years old). This age range was chosen as it spans the developmental task of individuation, or creating a unique sense of self, and separating from the family (Marsden, Meyer, Fuller, & Waller 2002). A component of the group that targets this developmental task is healthy identity development outside of the eating disorder. For those in recovery, the full criteria, including that for low weight need not be met for inclusion in group.
Participant selection and inclusion aims to capture the familial and social forces that are of great significance in narrative therapy. Multiple family members will be encouraged to attend the family group, including siblings; however, the parent-child relationship will be of primary focus. The group will comprise predominantly of females, as the relationships between gender, the female body, and anorexia will be explored.

As anorexia can pose serious physical complications and the possibility of fatality, measures will be taken to manage risk in this population. Participants must undergo a medical clearance, in which they will be screened for physical health risk by their primary care physician. Only those deemed to be appropriate for outpatient care will be included in the group. General medical stability and ability to manage weight restoration in outpatient setting is required for group participants. Referrals to higher levels of care will be made for people whose condition requires more medical attention.

The group program is intended to serve as an adjunct to outpatient individual treatment and not a standalone treatment. Group participants will be required to attend weekly sessions with their personal therapists and dietitians. It is essential that group participants have outpatient teams to closely monitor psychological and physical health. Participants must submit releases allowing group therapists to contact outside treatment professionals, including medical doctors, psychiatrists, individual therapists, and dietitians. Contact with these professionals will be made as needed and summaries of progress will be sent to individual therapists upon the culmination of the group. Since the length of recovery is indeterminate and may require multiple attempts in treatment, it is essential that treatment be continued after the group ends.
Personal Qualifications

The group will require two group leaders with training in eating disorders, narrative therapy, and family therapy. They can be marriage and family therapists, social workers, or psychologists. The group leaders can be licensed or unlicensed professionals, but supervision will be required of unlicensed professionals. The group leaders should be familiar with the application of narrative therapy to eating disorders, so it is highly recommended that they read, *Biting the Hand that Starves You: Inspiring Resistance to Anorexia/Bulimia* by Maisel et al. (2004). It also may be helpful for the group leaders to have personal experience dealing with eating disorders, whether they have recovered from an eating disorder or have been support people for a loved one with an eating disorder. Although this is not a requirement for group leaders, therapists that are recovered may possess the “insider” knowledge of living with eating disorder, which may facilitate joining and trust within the group (Maisel et al, 2004).

Environment and Equipment

The group requires a quiet room with enough seating for adolescents and their families. There is minimal outside materials required for the group. The group leader will bring paper, pens, and art supplies to each group for activities. The group also requires the use of a white board or poster board for one activity.

Project Outline

The group will meet two times a week over the course of six weeks. The group will meet once a week for the adolescent-only group and once for the family group. Each group will be two hours. The adolescent-only group will be a closed group of a maximum of six members who will be screened and selected prior to the commencement
of the group. Group members are required to attend each week and will be given a warning of termination from the group if absent more than two times. Participants may also be referred to a higher level of care if their condition deteriorates and requires more containment.

The general structure of the group will include a planned check-in question or follow up on the homework assigned the prior week and a topic for discussion or activity. Some groups will also include a homework assignment.
CHAPTER FOUR
SUMMARY AND CONCLUSION

Summary

The purpose of this project is to create a group program that will give adolescents with anorexia nervosa and their families the agency to co-create satisfying and empowering treatment experiences. Since anorexia responds better to treatment in adolescence than adulthood, early intervention is critical (Von Holle et al., 2008). However, traditional psychological treatments that are used for anorexia are based on practices of control (Gremillion, 2004). Therefore, treatment satisfaction varies, with some feeling disempowered, mistrustful of treatment professionals, and disappointed with treatment outcomes (Maisel, Epston, & Borden, 2004).

The group program proposed in this paper challenges traditional control-based psychological practices by using a narrative therapy theoretical framework. According to Golan (2013) and Weber (2006), narrative therapy has shown to be effective in treating eating disorders, while empowering clients to practice autonomy and agency over their own recovery. Although research has been conducted on narrative therapy in group and family settings, there is little information in the literature applying this research to family groups (Golan, 2013; Weber, 2006). Therefore, this project aims to fill the gap in this area of study and capitalize on prior research.

The group program consists of an adolescent-only group and a family group, which are designed to take place concurrently. The intention of the group program is to facilitate adolescent autonomy and agency in recovery, while giving family members tools on how to best support adolescents in this process. The mission of the group is to
allow participants to develop alternative stories to create new opportunities for identities, relationships, and futures without the eating disorder.

**Future Work/Research**

The development of the curriculum for the group program is in its beginning stages and is meant to evolve by incorporating feedback of both treatment professionals and clients. The first step in this process would be to implement the current curriculum of the group program in an outpatient setting. In order to recruit group participants, group leaders will present information about the group to local eating disorder professionals, including therapists and dietitians. These professionals can then refer their adolescent clients that they believe will benefit from the group program. After participants are recruited and the group program runs its six week course, participants will be asked to evaluate the group. Since narrative therapy considers clients to be experts of their own experience, the continued development of the group program will be highly influenced by client feedback (Freedman & Combs, 1996).

Although the group will prioritize client feedback, the development of the group would also benefit from more objective research. It would be useful to conduct an outcome study to evaluate symptom remission after the group. Although the group’s main focus is not on weight gain, this component of recovery is essential. An outcome study would reveal whether a six week course could begin the process of recovery and weight restoration. The group program is meant to be only one component of treatment, therefore, it is expected that adolescents will need support from an outpatient team (e.g. therapist, dietitian, and doctor) during and after the group (Von Holle et al., 2008).

Prior research has shown that narrative therapy facilitates eating disorder symptom remission in group and family therapy (Golan, 2013; Weber, 2006). There has
yet to be research applying narrative family group therapy to eating disorders. An outcome study based on the group program would fill in the gap in the literature on this topic. However, more research should be conducted studying narrative therapy for eating disorders in a variety of settings. There is a lack of research on narrative therapy, in general, which may be due to its theoretical stance that is skeptic of objective, scientific knowledge (Epston et al., 2012). According to Epston et al. (2012), narrative therapy can stay true to its theoretical stance by creating research with an emphasis on client agency and co-creation in the research process. In this way, the personal narratives of individuals could have a huge impact on the field of psychology, which would be empowering for the individual and potentially groundbreaking for eating disorder research in general.


Golan (2012). Eating Disorders Treatment: An Integrative Model by Means of Narrative Counseling, Motivational Interviewing, and Traditional Approaches, Relevant topics in Eating Disorders, Prof. Ignacio Jáuregui Lobera (Ed.).


Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry, 67*(10), 1025-1032.


APPENDIX

NARRATIVE THERAPY GROUP FOR ADOLESCENTS WITH ANOREXIA NERVOSA AND THEIR FAMILIES

ADOLESCENT-ONLY GROUP

Session 1

Goals

- Introducing group members by highlighting strengths
- Establishing rapport and connection within the group
- Allowing the group members to define themselves outside the problem in order to counter problem-centered identities
- Building new reputations and opportunities for the future outside anorexia by reauthoring identities based on relationships, values, and preferences

Activities

1. **Introduction of group and group leaders** (10 minutes)

   - Group leaders (therapists) introduce themselves and the group’s focus and goal.
     Group leaders will answer questions participants may have about group.
   
   - Group leaders may include:
     
     - Personal and professional history with eating disorders
     - Impact of eating disorders on people’s lives and identity
     - Focus of group- Participant strengths and identity outside the eating disorder
     - Goal of group- Provide space to empower participants to resist eating disorder and make self-directed and recovery-oriented life decisions
2. **Introduction of group members and check-in question** (20 minutes)
   - Group members will be asked to introduce themselves by name and answer the check-in question.
   - Check-in question- Who are you besides the problem that brought you to group?

3. **Life Map\(^1\) activity** (70 minutes)
   - Introduction, instructions, and questions about activity (5 minutes)
   - In words or pictures, create a representation of yourself that includes your values, relationships, and preferences.
   - Life Maps may answer the following questions:
     - What do you like to do?
     - Who do you love and care about?
     - What are some stories your family tells about when you were growing up?
     - What stories would your friends tell us if they wanted us to get a better picture of you?
     - What are your wishes for your experience in group?
     - How do you envision your life after you complete the group course?
     - What is something you have always wanted to try?
   - Creative time to make Life Map and informal conversation (30 minutes)
   - Sharing Life Maps (35 minutes)

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\(^1\) The Life Map is an activity used in Monte Nido & Affiliates treatment centers. A thorough description can be found in Borden (2007).
4. Closing (20 minutes)

- How was your experience representing yourself in this way? What steps can you take in the coming week to live according to the values and goals that you shared in your Life Map?
- Homework: Set an intention to take a step aligned with your goals and values. Next week, plan to share a step you took in this direction.

Session 2

Goals

- Identifying ways to challenge eating disorder
- Increasing insight on how eating disorder interferes with ability to make self-directed life choices
- Externalizing anorexia by naming it
- Identifying the eating disorder voice and learning how to use one’s healthy voice to combat it

Activities

1. Check-in question (30 minutes)

   - Last week, some of you identified steps you could take to live in ways more aligned with the values and goals illustrated in your Life Map. How have you been able to implement those steps? How has your eating disorder tried to interfere with these self-directed steps?

2. Transition (10 minutes)

   - Summarize group members’ responses to how the eating disorder tries to interfere with relationships, values, and preferences
• Introduce externalization as a way for group members to separate themselves from the eating disorder. Discuss how the eating disorder can be challenged in this way.

• Answer questions from group about externalization.

3. **Drawing the eating disorder** (60 minutes)

• Introduction, instructions, and questions about activity- Take some time to draw what your eating disorder looks like. Come up with a name for your eating disorder and let us know a little about its persona. What are its values and intentions? (5 minutes)

• Drawing the eating disorder with art supplies on paper (25 minutes)

• Sharing and processing drawings (30 minutes)

4. **Check-out question** (20 minutes)

• How are your eating disorder’s values different from your own? What do you need to do differently to act in accordance with your values?

**Session 3**

**Goals**

• Exploring the effects of the eating disorder in various areas of life

• Increasing motivation for change by identifying negative effects of eating disorder

**Activities**

1. **Check-in question** (30 minutes)

• In the last week, how has the eating disorder attempted to interfere with your life?” “Last week we discussed how the values and intentions of your eating disorder differ from your own. The eating disorder tries to control your life
according to its own values and intentions, without regard for how it may be disrupting your life. In the last week, how has the eating disorder attempted to interfere with your life? What did you do in response?”

2. Exploring the eating disorder’s impact in various areas of life (60 minutes)
   
   - Introduction, instructions, and questions about activity - Many of you shared how the eating disorder can be very good at disrupting your lives. Let’s take some time to think about the different, pervasive ways in which the eating disorder operates in multiple areas of your lives. (5 minutes)
   
   - Activity - Group leaders write various areas of life on a white board or poster board. Categories may include home, school, family relationships, peer relationships, hopes, and values. Group members write on the board how their eating disorders interfered in each area of life.
   
   - Completion of activity (20 minutes)
   
   - Sharing and processing activity (35 minutes)

3. Check-out question (25 minutes)
   
   - How do you feel about the influence the eating disorder has over your life? What is your position on it? Why is/isn’t it ok with you?

4. Introduction, instructions, and questions about homework assignment (5 minutes)
   
   - Write a letter to your eating disorder about how you feel about its impact on your life.
Session 4

Goals

- Identifying the “voice” of the eating disorder
- Connecting to oneself outside of the eating disorder
- Challenging eating disorder with healthy self

Activities

1. **Check-in** (60 minutes)
   - Follow up on homework for last session- Group members will read their letters to their eating disorder and receive feedback and support from the group.

2. **Transition** (5 minutes)
   - Introduction to concept of eating disorder voice and questions from group- “It seems like the eating disorder tries to control your lives and that you may want to exert some control back over it. When the eating disorder’s voice gets loud, this is difficult to do. However, it may be useful to “talk back” to the eating disorder to increase the strength of the healthy part of yourself. The rest of group session will focus on how you can talk back to your eating disorder and strengthen your healthy self.”

3. **Eating disorder/healthy self dialogue** (50 minutes)
   - Introduction to concept of healthy voice and questions from group- “It can be useful to identify your eating disorder’s voice, in order to “talk back” to it and challenge it. When your eating disorder tells you that you do not need to eat

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Costin, 2007
dinner or that you look fat, you do not have to believe it or act upon its orders. You can practice resistance to it by channeling your healthy voice.

Your healthy voice is the part of you that recognizes the lies, deceit, and destruction of the eating disorder. It is the part of you that will help you get better. It wants you to make healthy life choices so you can live your lives in self-directed, meaningful, and fulfilling ways. In order to strengthen your healthy self, it is useful to practice with the help of your supporters in this room.” (5 minutes)

- Introduction, instructions, and questions about activity (5 minutes) – “Think about the last thing the eating disorder said to you, and what you said back to it. If you did not respond back to it, think about what you will say to it in the future if it tries to convince you to believe what it says or to follow its commands. When the eating disorder is particularly convincing, it can be hard to challenge what it says. If you cannot think of what to say to challenge your eating disorder, you can get help from a friend in the group.”

- Sharing eating disorder/healthy self dialogues (40 minutes)

4. **Homework assignment** (5 minutes)

- Instructions and questions about homework (eating disorder/healthy self dialogue)- In the upcoming week, write down five instances when you heard the eating disorder’s voice. Keep track of what it is saying to you and how your healthy self is responding back to it.

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Session 5

Goals

- Disengaging from the eating disorder
- Constructing a life without the eating disorder
- Preparing for the last session of group

Activities

1. **Check-in discussion** (30 minutes)
   - Follow up on last week’s homework assignment. Group members will share eating disorder/healthy self dialogues.

2. **Disengagement from eating disorder** (20 minutes)
   - Question for discussion: How have you disengaged from your eating disorder during your time in group? What supports your recovery?

3. **Constructing a life without the eating disorder** (60 minutes)
   - Discussion guided by following questions: What would being fully recovered look like to you? What would you do and how would you think and feel from the time you woke up to the time you went to sleep? Who would be in your life? Be as detailed and specific as possible.

4. **Preparing for the last session of group** (10 minutes)
   - The last session of group will be a closing ceremony to honor the work that has been done up to this point and the longer journey ahead.
   - Homework assignment

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3 Costin, 2012
4-5 The closing ceremony and commemorative document is modeled after the ones used at Monte Nido & Affiliates. For a more detailed description of each, see Borden, 2007
Introduction, instructions, and questions about homework assignment- For this last session, you are to create a commemorative document about your journey in group. Choose a name for it that fits with your unique story. Here are some questions you can answer in your document:

1. What was your experience before you started group?
2. What were you hoping to get from group?
3. What have you learned from your fellow group members?
4. How have the relationships you made in group facilitated desired changes in your life?
5. What have you done to make meaningful, fulfilling changes in your life?
6. What do you consider the most important thing you have done while in group that you would like group members to know?
7. What do you want your peers in group to remember you for?
8. What do you think lies ahead for you in your journey?
9. What will you tell yourself when it gets difficult? What has helped in your time in group?
10. What will you take from group in the rest of your journey?

**Session 6**

**Goals**

- Strengthening preferred identity by sharing narratives of their journey
- Providing the community opportunities to connect on shared themes and values

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4-5 The closing ceremony and commemorative document is modeled after the ones used at Monte Nido & Affiliates. For a more detailed description of each, see Borden, 2007
- Reflecting on accomplishments and directions for the future

Activities

1. **Sharing transitional document (homework assignment)**
   - Each group member will share their document and receive feedback and support from the community (110 minutes)
   - Feedback and support may be guided by the following questions:
     - What do you appreciate about this person?
     - What special memories do you have of this person?
     - How have you seen this person act in accordance with their values?
     - What have you learned this person holds deeply or cares about?

2. **Closing song and blowing out of candles** (10 minutes)
   - The group leaders will present the group members with a song that they believe best represents the knowledge and meanings gathered from the group and the upcoming journey ahead.
   - After the song is played, the group will mark the end of this phase of their journey and the beginning of a new one by blowing out candles.
FAMILY GROUP

Session 1

Goals

- Introducing group members by highlighting strengths
- Establishing rapport and connection
- Decentralizing problem narrative
- Allowing the group members to thicken preferred narratives
- Instilling hope and expectation of change

Activities

1. **Introduction of group and group leaders** (10 minutes)

   - Group leaders (therapists) introduce themselves and the group focus and goal.
     Group leaders will answer questions participants may have about group.

   - Group leaders may include:
     - Personal and professional history with eating disorders
     - Impact of eating disorders on people’s lives and identities
     - Focus of group- Adolescent and family strengths and identities outside the eating disorder
     - Goal of group- Provide space to empower adolescents to resist eating disorder and make self-directed and recovery-oriented life decisions supported by their loved ones
2. **Introduction of group members and check-in question**

- Group members (adolescents and family members) will be asked to introduce themselves. They may include name, age, profession, or anything that participants would want the group to know about them. (15 minutes)

- Check-in question- What do you want to continue happening in your family?

- Preface and context of check-in question-“Tonight’s check in question may sound a little strange and may be challenging. Are you up for the challenge? (Listen for permission). Ok, great. Before we start, brainstorm with your family members something that you want to continue to have happen in your family.

  It may be a strength you notice in your family or an activity you do together that you all enjoy. This will require teamwork since the eating disorder can make family life challenging. If you can’t think of anything that currently is happening in your family, feel free to draw on past things about your family that you would like to happen again.” (5 minutes)

- Family members and adolescents brainstorm answer to check-in question (10 minutes)

- Family members and adolescents share answers to check-in question with group (40 minutes)

- Explanation of purpose of check in-question- “This check-in question may seem like a strange way to start group. After all, you all came here prepared to talk about a problem that is glaringly obvious—the eating disorder.

  However, in order to effectively fight the eating disorder, families must be able to use their strengths to work as a team. Since anorexia’s mission is to
consume every member of the family and minimize everything outside of its web, families must be especially adept at fortifying and honoring their strengths.” (5 minutes)

3. **Question for discussion**

- How has anorexia attempted to interfere with what you shared you enjoyed about your family? If it has succeeded, what can you do to reclaim those things you hold dear in your family?
- Parents answer question and daughter responds to their answer (40 minutes)

**Session 2**

**Goals**

- Identifying differences in values between the person and the problem
- Introducing the concept of externalization
- Increasing client motivation to change through externalization
- Allowing clients to witness family members’ anti-eating disorder narratives to gain alternative perspectives and new meanings
- Strengthening client-parent alliance by establishing a team against the eating disorder
- Highlighting eating disorder’s tactics to encourage client to make alternative choices

**Activities**

1. **Check-in question** (50 minutes)

   - (For parents) How is your daughter different from her eating disorder?
   - (For daughters) Share your reflections on the differences your parents perceived. How do you think you are different from your eating disorder?
2. **Transition** (10 minutes)

- Group leaders will introduce externalization and answer questions about it—“You may have noticed that during the past two sessions, the eating disorder has been talked about as a distinct entity separate from the person who has it. We (the group leaders) believe that it is useful to view the eating disorder as separate from the person, in order to form an alliance in which daughter and parents are fighting against the eating disorder and not each other.”

- Group leaders will explain how externalization can build parent-child alliance against eating disorder and answer group questions—“Although the eating disorder is experienced much differently by parents and daughters, it causes intense pain and suffering to all members of the family. Parents understandably become outraged at the eating disorder for robbing their daughter of her health and happiness, but they may mistakenly take their anger out on their daughter and not the eating disorder. However, they may be unwittingly strengthening the eating disorder’s grasp on their daughter, as the eating disorder will use relationship conflict to fuel feelings of guilt and worthlessness.

  Moreover, parents are losing out on an important opportunity to highlight the eating disorder’s deception and control. By presenting their observations of the eating disorder, parents can help their daughter evaluate how the eating disorder may be influencing her and what she wants to do about it.”

3. **Empty chair activity** (50 minutes)

- Introduction, instructions, and questions about activity—“The activity tonight will require you all to use your imagination. Are you all ok with that? (Listen for
permission). Ok, great. Imagine your daughter’s eating disorder is sitting in this chair right in front of you. Parents, you will get a chance to speak directly to the eating disorder and talk to it about how you see it influencing your daughter and family and how you feel about its influence.

Daughters, witness what your parents are saying, in order to understand their truths. Then, share what stood out to you about what your parents said. The purpose of this exercise is not for you to agree with your parents, but just for you to notice the story they tell about the eating disorder.” (5 minutes)

- Activity and processing (45 minutes)

4. **Closing and homework** (10 minutes)

  - Introduction to homework assignment- “Before next week’s session, parents are to voice an observation about the eating disorder to their daughter. For example, parents may point out to their daughter when they see the eating disorder treating them badly and that they are there to support her against it. Daughters are to witness parents’ story and process their experience next week.”

**Session 3**

**Goals**

- Practicing externalizing language and viewing of the eating disorder
- Exploring the eating disorder’s influence on family dynamics
- Developing preferred picture of family dynamics once recovery is achieved
- Identifying small, realistic steps family members can take to work towards preferred family picture
Activities

1. **Check-in discussion** (40 minutes)
   - Follow up on last week’s homework - Last week, the parents were asked to point out an observation of the eating disorder to their daughters. For this week’s check in, the daughters will let us know how it went.
   - (For daughters) How was it for you to hear your parents speak about your eating disorder as separate from you? How was it to hear your parents’ observation of how the eating disorder was influencing you?

2. **Family sculpture** (60 minutes)
   - Introduction, instructions, and questions about activity - “For tonight’s activity, each daughter will create a real life family sculpture of her family. She will select non-family group members to stand in for her family members and the eating disorder. Then, she will arrange the group members in terms of distance/closeness, body posture, actions/interactions, and feelings.

   The family will stand back and view the sculpture for a few moments and see what comes up for them.

   Finally, the daughter will arrange the sculpture to depict what the family would like once recovery is achieved.”

   - Activity and processing
     - What is the family member’s impression of their daughter’s family sculpture?
     - What do they agree and disagree with? What do they think about their daughter’s experience?
3. **Closing** (20 minutes)
   - Check-out question: What is one thing you can do to bring your family a step closer to achieving the recovery sculpture?
   - Homework: Plan to utilize your answer by taking the step you identified to bring your family closer it in the next week. Answers will be shared next session

**Session 4**

**Goals**

- Identifying roadblocks to creating preferred picture of family dynamics
- Exploring dominant social and familial beliefs that encourage the eating disorder
- Identifying anti-eating disorder beliefs that support recovery
- Encouraging family members to acknowledge clients’ anti-eating disorder behaviors to thicken anti-eating disorder narrative

**Activities**

1. **Check-in question** (45 minutes)
   - Last week, each family identified and planned to do one thing to bring you closer together. What was it like for you to do this? Did the eating disorder or other things in the family try to stop you?

2. **Family values activity** (60 minutes)
   - Introduction, instructions, and questions about activity- "For tonight’s activity, parents and daughters will explore what family values fuel the eating disorder. As many of you know, eating disorders feed off many commonly held values in western culture. Although many of us do not have eating disorders, we are not immune to participating in and contributing to the culture that is fertile ground"
for eating disorders. This culture places primacy on thinness, female beauty, external achievements, perfection, and self-sacrifice.”

- Each family will take time to discuss some family values that may support the eating disorder (e.g. thinness, female beauty, external achievements, perfection, and self-sacrifice). Then, they will identify some anti-eating disorder or recovery-oriented alternative values. (15 minutes)

- Processing and sharing (45 minutes)

3. **Closing and homework** (15 minutes)

- Introduction to homework assignment- Parent acknowledgement of daughter resistance to eating disorder

- “Tonight, we explored some beliefs that encourage the eating disorder and some alternative beliefs that ignite resistance. Parents, in the coming week, notice how your daughter resisted the eating disorder. For this assignment, focus on things other than food. For example, did your daughter act according to the anti-eating disorder values discussed in group today? Did she act against perfectionism by forgiving herself for making a mistake? Did she find joy in being with her friends? Did she show renewed interest in an activity she used to enjoy?”

**Week 5**

**Goals**

- Thickening anti-eating disorder narrative through retelling of client resistance

- Identifying clients as experts on how parents can best support them

- Providing psychoeducation on how parents can support daughters without their evaluating behavior
• Identifying client’s preferred ways to receive parents support

• Strengthening parent-child alliance through collaboration

Activities

1. **Check-in question** (35 minutes)
   - Follow up on last week’s homework- (For parents) How did your daughter practice resistance to eating disorder?
   - (For daughters) How did it feel to be acknowledged in this way?

2. **Psychoeducation and questions and feedback from group** (15 minutes)
   - How to best support daughters with eating disorders using a narrative therapy theoretical framework: “In the future, it may be helpful for parents to acknowledge their daughter’s resistance without evaluating the behavior as good or bad. For example, when parents comment that their daughter did well at dinner, the eating disorder may distort this by telling her that she must have eaten too much, so she is bad.

   *A parent might on the other hand say, “What do you think about how you cared for your body tonight instead of letting your eating disorder punish you?” This has little to do with evaluation, and instead may empower your daughter in her resistance."

   - Education on techniques they can use to support daughters- Some helpful ways to acknowledge your daughter’s resistance to her eating disorder may be:
     - Appreciate it silently
     - Say you noticed it

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6 Maisel, Epston, & Borden, 2004
o Say you noticed it and ask her if she noticed it too

o Ask if and how she considers her behavior to be anti-eating disorder behavior

o Ask what supported the behavior

o Be curious about the significance. For example, parents can say “I noticed how you took some time to rest today. I’m curious about the anti-eating disorder significance that it may have.” If she cannot make sense of it you may ask if you can speculate. For example, parents can ask, “Do you mind if I say what I think the significance could be? Is it possible you are becoming more attuned to your body’s needs?”

o Ask what negative thoughts she may be experiencing as a result of disobeying the eating disorder

• Questions and feedback from group about psychoeducation

3. **How to help me book**\(^7\) (70 minutes)

• Introduction, instructions, and questions about activity- “Daughters, I want you to serve as a consultant for your parents, as you are the best people to guide your parents in what may be helpful to you in the recovery process. Please collaborate with your parents to create a book for them to use as a resource when you are having a difficult time.

  You may want to label each page with different struggles that you anticipate having. For example, what to do when I want to restrict, what to do when I want to isolate, what to do when I feel hopeless, etc.” (30 minutes)

• Processing and sharing activity (30 minutes)

\(^7\) Monte Nido & Affiliates activity
4. **Preparing for last session** (10 minutes)
   - Next session, will be the group’s final session. Over the next week, reflect on your progress, as well as your family member’s. The closing session will be dedicated to honoring the progress made in group and harnessing strengths in the journey ahead.

**Session 6**

**Goals**

- Strengthening anti-eating disorder identity and family relationships by highlighting strengths and progress
- Addressing anticipated challenges and the resources that can be used to overcome them
- Solidifying parent-child alliance by witnessing one another’s accounts of each other’s strengths and progress
- Commemorating the end of a phase in the family’s journey and honoring the parent-child alliance by creating a representative certificate

**Activities**

1. **Check-in question** (40 minutes)
   - (For daughters) How do you anticipate the eating disorder challenging your parents in the recovery process? (For parents) How do you anticipate the eating disorder challenging your daughter in the recovery process? (For daughters and parents) What personal strengths can you use to combat the eating disorder? What family strengths can you use to combat the eating disorder as a team?
2. **Witnessing progress** (45 minutes)
   - Introductions, instructions, and group questions about activity (5 minutes)
     - (For daughters) Recount the progress you have seen your parents make during this group.
     - (For parents) Witness your daughter’s story about your progress and share what spoke to you about what she said.
     - Then, parents will to share the progress they have seen their daughter make in group. Daughters will witness their parents’ acknowledgement of their progress and share what stood out to them about what they said.
   - Sharing and processing (40 minutes)

3. **Anti-eating disorder alliance certificate** (35 minutes)
   - Introduction, instructions, and group questions about activity (5 minutes)
     - As a marker of the progress you have made in your journey thus far, make a family certificate commemorating your family’s anti-eating disorder alliance. You can document each other’s strengths and progress on the certificate, and include symbols or words that represent your group experience.
     - Finally, sign your documents and ask one of your fellow group members to sign as a witness to your family’s anti-eating disorder efforts.
   - Activity and processing (30 minutes)