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# THE IMPACT OF NARRATIVE STORYTELLING ON COGNITIVE RE-COMPOSITION IN INDIVIDUALS STRUGGLING WITH EATING DISORDERS

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By

Chelle' Lodge-Guttery

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THE IMPACT OF NARRATIVE STORYTELLING ON COGNITIVE RE-COMPOSITION IN INDIVIDUALS STRUGGLING WITH EATING DISORDERS

A Dissertation APPROVED FOR THE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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## ABSTRACT

Externalization is the separation of the person from the problem. This narrative based research used a mixed method research design conducted with 16 participants. Participants engaged in writing stories from an externalized perspective of the eating disorder. Relevant themes emerged from the externalized writing process. Themes included: self concept, family/social relationships, eating disorder character, allies to eating disorder, deification of eating disorder, sexuality, inner strength, and voice of eating disorder. Although quantitative analysis did not yield significant results, qualitative findings yielded information that may facilitate understanding and psychological treatment of persons struggling with eating disorders.

# The Value of Narrative Therapy in Creating Space and Change in Individuals Struggling with Eating Disorders

Current treatment for eating disorders has primarily focused on means to alter underlying fears and obsessions that lead to dysfunctional eating behaviors, such as the cognitive behavioral approach (Bowers, 2002, 2001) as well as psychoeducational, psychodynamic individual, group therapy (Brisman, 1996; Morris, 2001), and various forms of family therapy (Colahan & Robinson, 2002; Eisler, 1996; Fishman, 1996) However, despite their individual successes and usefulness, relapse is high, and overall treatment is often incomplete in the long term.

Recent alternative approaches, which do not abandon, rather extend, the above approaches has evolved from postmodern thinking. Foundational for much of the postmodern philosophies are the idea that reality is socially constructed. That is, what we call "reality" is filtered through individual and collaborative language, which is never a perfect replica of an external reality. A recent psychological approach emerging from the postmodernism/social constructionism Gergen (2001) espouses is Narrative psychology, developed by Michael White and David Epston (1990). Narrative psychology offers individuals a means of understanding the world in terms of the stories they tell themselves. Central to narrative psychology is the premise that meanings are socially constructed yet experienced by every individual subjectively. This social construction has provided a philosophical framework for many psychologists to apply new approaches to practice with individuals in crisis. Assuming the socially constructed aspect of eating disorders, narrative psychology believes they have begun to make some critical advances in terms of success with these individuals that have not been seen in more popular

therapies (Duran, Cashion, Gerber, & Mendez-Ybanez, 2000; Kahle, & Robbins, 1998; Zimmerman & Dickerson, 1994).

Research of social constructionist approaches, in particular, narrative psychology has proven to be challenging. The Idiographic Self Perception Inventory (I-SPI), which will be used in the present study, is a computer psychometric instrument developed and tested by Mike Knight and Bill Frederickson on the University of Central Oklahoma campus (Knight & Doan, 1994). I-SPI is postulated on Q-methodology and uses a Q-sort technique. The I-SPI allows individuals to rank order adjectives according to its level of "fitness" to any given condition of instruction. Adjectives, normed by Anderson (1968) comprise the concourse. Adjectives are "rank ordered" for each condition of instruction and analysis is used by identifying significant correlations between these conditions.

Brown (1999) has provided a possible explanation in the form of subjective behavior analysis utilizing a Q-methodology. This methodology allows behavior to be studied subjectively, one individual at a time. Thus an individual struggling with an eating disorder is able to explore her perceptions and thoughts through a statistical procedure that is both inductive and deductive.

The first task will be to discuss key methodologies in a theoretical framework. The first subsection is a description of eating disorders from individual, social, and biological contexts. The second section looks at current treatment models. The third and fourth subsections discuss basic predispositions and principles of narrative therapy as well as the effectiveness of a story journaling treatment.

## The Issue

*What is an eating disorder?*

Eating disorders include features found in obsessive-compulsive or addictive behaviors. It is often seen as similar to obsessive compulsive disorder, with the compulsion being in relation to restriction or bingeing on food, and obsessive behaviors towards calorie counting or exercise (American Psychological Association [APA], 2000). Mood alterations have also been linked to eating disorders. With any sub-category of eating disorder, mood-altering chemicals in either the food or the body are activated (Castillo, 1997). For example, bingeing on high sugar items or excessive exercise will induce chemical changes in the body that mimic those of other drugs. There are three main categories of eating disorders included in the Diagnostic and Statistical Manual Fourth Edition, (APA, 2000) Anorexia nervosa, Bulimia nervosa, and Eating Disorder Not otherwise specified.

Anorexia nervosa has been defined as refusal to maintain a normal body weight, within 85% of normal weight for height and age and intense fear of gaining weight or becoming fat regardless of low body weight. Other characteristics include disturbance in how weight is perceived; including obsession about weight, food intake, and shape, the denial of seriousness of weight, and the cessation of menstruation in age-appropriate females. There are two sub-categories within the diagnosis of anorexia known as restricting type, consisting of only restriction of calories and exercise, and binge-purge type, which is characterized by occasions of bingeing on foods purging them (APA, 2000).

The DSM-IV defines Bulimia nervosa as recurrent episodes of binge eating. Binge eating is consuming an amount of food that is usually greater in quantity than most people would eat during a similar period of time and under similar circumstances and/or a sense of lack of control over eating during the episode. Another symptom is usage of compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise. These compensations occur on average at least twice a week for 3 months. Finally, the perception of self is influenced by body shape/weight. The DSM-IV (2000) further divides Bulimia Nervosa into two types, Purging and Non-purging. The first involves self-induced vomiting and misuse of laxatives, diuretics, and enemas. The later does not involve use of behaviors described in purging type, but rather the use of excessive exercise or fasting as a means of compensating (APA, 2000).

The third type of eating disorder, which was not formally addressed until the fourth edition of the DSM, is diagnostically referred to as Eating Disorder Not Otherwise Specified, (NOS), which is defined as a combination of behaviors included in Anorexia and Bulimia nervosa, and occurs with more frequency than the aforementioned types. These individuals often show an intense fear of being "fat", however cannot maintain the restriction which is characteristic of Anorexia nervosa (APA, 2000). Another example of Anorexia nervosa NOS entailed meeting all criteria for Anorexia nervosa except for the cessation of menses. Schwitzer and Bergholz (1998) continue to reinforce the necessity of the NOS diagnosis based on two conditions. These include symptomology not fully fitting the diagnosis yet consistent with behaviors that lead to extreme debilitation.

*How common are eating disorders?*

Eating disorders have become the most misunderstood and perhaps the most culturally acceptable of all the psychological disorders. It is through the encouraging and perpetuating of thinness as the ideal that some individuals find themselves in the grip of eating disorders. For example, several researchers have noted that the overall body dissatisfaction of women has increased as the ideal body weight has decreased (Garner, Garfinkel, Schwartz, & Thompson1980; Gordon 2000). This message, juxtaposed with the concern over individual emaciation and food control, may be sending contradictory information to individuals that may be predisposed to eating disordered behaviors, like perfection, lack of control, fear of adulthood, and low self-esteem.

Anorexia and Bulimia Nervosa are more common in females, accounting for 90% - 95% of the eating disordered population. They occur primarily in adolescence and young womanhood (Castillo, 1997). Castillo (1997) adds that eating disorders on college campuses continue to rise. Until recent years, eating disorders on college campuses reflected the trend in the general population, about 1%. A recent study has identified as much as 25% felt that their eating was out of control, 6% used laxatives or induced vomiting after meals, and 25% to 30% of young women were extremely worried about body image and weight control (Schwitzer and Bergholz, 1998).

## Perspectives Regarding the Emergence of Eating Disorders

*Psychological Understanding of Eating Disorders*

As the prevalence of eating disordered behaviors increase, so do treatments used with eating disorders, (Werne, 1996; Zimmerman & Dickerson, 1994). These researchers suggest that perhaps the strongest reasons for the increase in eating disordered behavior is

that the individual is living in a society which condones thinness. Many treatment procedures focus on behavioral or cognitive aspects that focus on observed symptoms when, in fact, the problem may be better approached in a more systemic as well as sociological way. In other words, in many cases, the eating disorder is not the problem; it is simply a manifestation of the problem that may be related to family or cultural issues, perfectionistic thinking, obsessive-compulsive natures, or many other struggles. Many of the current models are insufficient in terms of relational and social constructionist thinking thatlook s at eating disorders from a systems perspective. Research is growing that aims to identify the societal and cultural factors that contribute to eating disorders (Limbert, 2001). Eating disorders may be viewed as a persons' lack of familial differentiation, an over-emphasis on meeting expectations, or a need for the woman in the family to remain a child. Psychological approaches with eating disor ders are rapidly changing as the field continues to search for successful treatment of eating disorders.

*Common Etiologies*

*Gender Conflict*

One of the unanimously agreed upon aspect of eating disorders is that the vast majority of those struggling with eating disorders is female (APA, 2000; Gordon, 2000). Gordon (2000) discusses the influence of family and society on the facilitation of eating disorders by describing the feelings of inadequacy felt by many who struggle with eating disorders and the cultural push to be successful and independent while simultaneously encouraging behaviors that would keep a child dependent. Other researchers agree with Gordon's contentions and add that the increasing need for women to be in the public world and maintain the nurturance demanded in the private worlds leads to conflict that

often cannot be resolved (Gutwill, 1994). This, in combination with the media perception that "women that have it all" are also thin, continues to support the assumption that thin is ideal and better (Gutwill, 1994). Garner (1992, 1990) has included subscales within the Eating Disorder Inventory-2 that include two encompassing concepts. Drive for thinness, according to Garner (1990) is a construct intended to identify thoughts or feelings that represent an excessive fear of "fatness" and an insatiable need to be thin. In congruence, Body Dissatisfaction subscale is an identifier of how the individual feels about their overall body shape. The level of dissatisfaction is measured and in its extreme form is typical of individuals struggling with eating disorders. Certain body parts (stomach, thighs, hips, and buttocks) are more focused upon than others and are common etiological signs (Garner, 1990). Finally, perfection within this construct defines the level at which individuals have to perform above and beyond others and maintain unusually high standards. Often individuals who struggle with eating disorders carry a high expectation for themselves and often feel like they are a constant "failure" (Garner, 1990).

*Sexuality and Sexual Abuse*

Instances of sexual abuse in those struggling with eating disorders have ranged from up to 80 percent in the late 1980's to 25 percent in more recent literature (Gordon, 2000). Gutwill and Gitter (1994) postulate that eating disorders follow from sexual abuse related to familial and cultural avenues. They assert that many families with abuse are also families that are otherwise restrictive and often these children grow in families with chaotic and problems with early feeding behaviors, the use of food as reward, punishment, discipline. Further, many of these families pass on feelings of shame and

distrust of internal instincts and feelings (Gutwill & Gitter, 1994). Further, Limbert, (2001) postulates that a need to keep others at a distance can begin the process of an eating disorder and that this becomes a reciprocal relationship between the need to keep the eating disorder "secret" and isolation from others. A final distinction made by Gutwill and Gitter (1994) are intrapsychic adaptations that seem to result in an attempt to resolve an inability to escape trauma. For example, Gutwill and Gitter (1994) discuss the physical act of starvation to make one invisible or to become so emaciated as to be unattractive to a potential assailant. These assertions whether physical or psychological seem to be similar to those experiences of many with eating disorders and as such are important to remember that these are only some of the potential "causes" of eating disorders in modern society.

## Cultural Evolution Mirrors Individual Evolution

### *Evolutionary perspective for an anorexic framework*

Some researchers have hypothesized evolutionary, or genetic, predispositions based on the physical characteristics of eating disorders: gender bias, delayed ovulation, amenorrhea, and decreased reproductive hormone secretions (McGuire & Troisi, 1998). These researchers understand the importance of the interrelation of genetics, culture and family in the causes of eating disorders and look at these through an evolutionary lens. The evolutionary theories associate eating disorders with female-female competition and delaying of reproduction.

Female-female competition involves competition among females to increase their attractiveness and ability to attract mates. Both males and females engage in same-sex competition; however, females use derogatory statements about others' physical

appearance more than males and are more observant of other females' body imperfections (Buss, 1999). By following this theory, if females are more likely to judge the body size and shape of others, it would seem logical for females to be more concerned in minimizing the comments made towards them. In other words, a female may believe that the female who is the thinnest and has the best body shape wins with the opposite sex, this being one aspect of female competition, a vital aspect of evolutionary theory (Buss, 1999). In two studies, males and females rated various female shapes ranging from "thin" to "heavy." Researchers asked "which female shape is the most attractive?" Males consistently chose a female body shape that was two shapes "heavier" than females chose (Furnham, Hester, & Weir, 1990; Furnham, Tan, & McManus, 1997), which further lends evidence that ideal female shape is more about female competition than about female attractiveness to the opposite sex. Singh (1993, 1994) reported that hip-to-waist ratio (HWR) is a more salient feature of attractiveness than overall body shape. Their research indicated that both males and females were more likely to choose heavier shapes that had approximately .70 difference between hip/waist ratio than those slimmer shapes that did not maintain this ratio (Singh 1993, 1994).

*Eating disorders in the modern culture*

Evolutionary predisposition for eating disorders and modern culture are both likely to impact eating disorders. Throughout history, women have been known for their physical appearances and judged at least initially, on them. Caretakers begin the process of acculturating the female to adapt to what is acceptable in the culture, what it means to be a female. This "consensual reality" is created and edited continually as the girl learns acceptable patterns of behavior, attitudes, beliefs, and thoughts (Dazzo, 1998). Katzman

and Lee (1997) believe that a common reality is not necessarily the only factor in Western culture that invites eating disorders. Factors such as individual predisposition, genetic and environmental influences also contribute to the development of an eating disorder. However, researchers have noted that incidence ratings for eating disorders are far greater in those societies which are inundated by models and media descriptions of what is assumed to be ideal (Gordon, 2000; Lin & Kulik, 2002). As stated earlier, the development of eating disorders is more likely a compilation and relatedness of each of these factors to varying degrees on the life of an individual. Eating disorders is a relation between individual, family, and cultural values that are instilled and reinforced in females at birth (Katzman & Lee, 1997).

*The family as micro-culture*

In terms of culture, the family plays a foundational part in social development. Long before restriction or purging there was common behaviors found in many individuals suffering from eating disorders. Typically, these individuals were protected by parents, had many expectations placed on them, and were often criticized when expectations were not met (Schwitzer, & Bergholz, 1998). Families that promote dependence in the name of protection and engender perfection in the name of being successful can place undue stress on a young child. Families want their child to be safe from the outside world, and will often give subtle messages that are interpreted to the girl as shame about her body and sexuality. These factors can often invite a girl who may already have a more vulnerable personality to develop eating disorders.

In *Psychosomatic Families, Anorexia Nervosa in Context,* Minuchin, Rosman, and Baker (1978) discuss elements and characteristics of families with anorexic

members. They highlight issues such as extreme enmeshment, rigidity, and expectations. As such, the child learns early that his/her own issues and self-actualization is far less important than the loyalty and protection of the family. Further, they discuss the stressing of bodily functions on each family member that might also serve to enlist the child to anorexia to be considered valued and an important member of the family (Minuchin, Rosman, & Baker, 1978).

## From Theory to Technique: Treatment Applications for Eating Disorders

Although there are several individual treatment models used with individuals struggling with eating disorders, most agree that despite underlying theoretical differences in treatment, there are educational and physical considerations to be made. As such, the most effective models for treating eating disorders include a multidisciplinary approach that includes physicians, nurses, nutritionists, educators, and psychologists (Bowers, 2002; Garner, 1992; Miller & Pumariega, 2001).

### *Cognitive-Behavioral Therapy*

Cognitive behavioral therapy is perhaps the most common of all treatment with eating disorders. As the model dictates, CBT has integrated the behavioral component to address eating patterns and the cognitive component to target internal thought processes. Many of these researchers target changing eating behaviors, (Miller & Pumariega, 2001; Neziroglu, Hsia, & Yaryura-Tobias, 2000), indications for bulimia nervosa (Bowers, 2001; Wilson, 2002; Wilson, 2000; Wilson, Fairburn, & Agras, 1997), anorexia nervosa (Garner, Vitousek, & Pike, 1997; Wilson, 2002), and thought processes (Garner, Vitousek, & Pike, 1997; Wilson, 2002). In addition to the above individual therapy, many researchers are studying the efficacy of group therapy from a CBT model. Peterson and

Mitchell (1996) outline an outpatient CBT group for individuals with binge eating disorder. They conclude that the group model is effective in reducing symptomology (Peterson & Mitchell, 1996). More recently, a 4 phase cognitive behavioral group model with an inpatient population, indicated that those who completed the therapy began to accept more responsibility for their eating behavior (Gerlinghoff, Gross, & Backmund, 2003). The effectiveness of CBT models and the current emphasis on empirically validated treatments have encouraged the manualization of treatments for eating disorders.

Manualized treatments have increasingly gained favor within the field of psychology, especially with the proliferation of managed care and the necessity to treat eating disorders within the context of multidisciplinary teams. As such, CBT has been manualized as a treatment model for various types of eating disorders including anorexia and bulimia nervosa, eating disorder NOS, and binge eating disorder (Bowers, 2001; Mussell, Crosby, Crow, Knopke, Peterson, Wonderlich, & Mitchell, 1999; Wilson, 2000). The prevalence of manualized treatments has the potential to increase service coverage and knowledge of professionals who work with individuals struggling with eating disorders. Most recently comparison studies have been conducted that attempt to determine the efficacy of CBT with and without psychopharmaceutical interventions. Research has indicated that there is no significant difference in improvement in individuals as compared with those individuals who received CBT only (Wilson & Fairburn, 1998). Further, Wilson and Fairburn (1998) summarize research combining psychopharmacology with CBT, finding that in addition to non significant differences,

the dropout rate of CBT groups is lower, CBT is superior to drug treatment alone and long term maintenance is better with CBT.

Despite research to indicate that CBT is an effective model; researchers are not convinced that CBT is superior to other treatment methods. Much of the positive research to date has compared CBT with no treatment or placebo and has little follow-up research. Mussel et. al. (1999) conducted a study in which they surveyed various clinicians in order to determine the efficacy of empirically validated treatments. Their findings indicate that although CBT continues to have more research to support its efficacy in working with those struggling with eating disorders, most clinicians in the study did not use CBT in their practice with eating disorders. Wiseman, Sunday, Klapper, Klein, and Halmi (2002) compared CBT with a psychoeducational group in a short term inpatient facility. Their findings indicated that although staff and patients preferred CBT to psychoeducation, there was no statistical difference in the outcomes of the two treatments. Further, additional studies have found CBT marginally effective for adults, but inconclusive for adolescents and children (Lock, 2002). Other models, many based on the overarching tenets of cognition, have begun to surface and become popular as alternatives and additives to traditional CBT. These models utilize individual and group formats and add to cognitive processes, education and psychodynamic emphasis.

*Interpersonal and Psychodynamic Models*

Aside from CBT, interpersonal psychotherapy has been found to have the greatest efficacy in working with those with eating disorders. Interpersonal therapists maintain that increasing functionality of interpersonal relationships is cornerstone to decreasing maladaptive behaviors (Wilson & Fairburn, 1998). For example, two studies conducted

at Oxford and referenced by Fairburn (1997) indicate the efficacy of interpersonal therapy. The first compared focal psychotherapy with CBT and concluded that on most measures, focal psychotherapy elicited greater improvement in participants (Fairburn, 1997). The second study replicated the first and found that CBT was more effective in short-term follow-up (4-8 months), but that IPT was more effective at long-term follow-up (12 months) (Fairburn, 1997). The IPT program developed by Fairburn and others at Oxford seems to provide convincing data for the efficacy of IPT in working with bulimia nervosa (Fairburn, 1997). However, Fairburn (1997) also recognizes that the relatively slow progress of IPT as compared to CBT and suggests additional research and the use of IPT as an adjunct or alternative to CBT.

Many of the psychodynamic models also discuss the self-psychological model. Within this overarching theory is a drive-conflict and object relation model. Goodsitt (1997) explains the application of drive-conflict and object relations models based on the preposition that self-starvation is a defense against sexual fantasies or unresolved oral incorporation. These early developmental failures and resulting lack of "selfhood" contribute to eating disordered behavior (Goodsitt, 1997). Another study suggested that supportive expressive therapy was as successful as CBT in binge eating, however, several limitations may hinder the validity of the findings (Wilson and Fairburn, 1988).

*Family Therapy Models*

Although much of the research focuses on the individual processes of those struggling with eating disorders, family therapy has been used to treat families struggling with eating disorders. Several forms of family therapy have been adapted to working with eating disorders. Among these are structural (Fishman, 1996) and systemic (Asen,

2002; Cottrell & Boston, 2002). Fishman (1996) developed a family therapy program based on the following premises: The problem is maintained in the social context, each family strives for homeostasis, family patterns exist, and often a crisis is necessary to facilitate change in a family system. Other treatment models combine family systems with traditional individual therapy to illicit change both in the individual and within the system (Eisler, 1996).

Salvador Minuchin, a foremost family therapist discussed not only the "types" of families in which anorexics live, he, and his colleagues outline strategies for change that include short and long-term goals, challenging family patterns, enmeshment, conflict, and rigidity, and finally, ways to detour conflict (Minuchin, Rosman, & Baker, 1978). Minuchin includes strategic and structural therapy sessions and out of therapy assignments. Despite the prevalence of treatment processes and models, there has been little empirical research conducted. Wilson and Fairburn (1998) note only one empirical study conducted by Russell et. al. in 1987.

## Post-Modern Thought: The Narrative Way

### *Postmodernism*

One of the early postmodernists was Michel Foucault (White & Epston, 1990). Much of the later writings and theories of future narrativists were founded on Foucault's political, philosophical and psychological writings (Besley, 2002; Boldt & Mosak, 1998; Gorman, 2001; Stacey & Hills, 2001; White, 1990). Foucault discusses the discourse of the culture that allows power to exist within a certain group or groups of people that allow for the marginalization of others. Consider the broad topic of mental illness. In the Western culture, there exist rules and norms that the society in power ascribes to others.

These rules might indicate that behavior such as talking to God, seeing and hearing strange things and a lack of connection with others in this society is considered deviant and dangerous. However, another culture might find these qualities not only desirable but revered and shamanistic (Foucault, 1962). It is this type of thinking; that of challenging where the power is and "ought" to be that first enlisted the group of philosophers and psychologists known as postmodernists.

Postmodern views are postulated on four themes. The first of these are that realities are socially constructed. Social construction or the premise that our realities, truths, and interpretations of any given thing are constructed within the society is a common theme in many postmodern writers (Doan, 1997; Duran, Cashion, Gerber, & Mendez-Ybanez, 2000; Freedman & Combs, 1996; Malson, 1998; White, 1990). Berger and Luckmann (1966) discuss four progressions; typification, institutionalization, legitimation, and reification. From these tenets, Friedman and Combs (1996) discuss these in terms of typifying individuals into classes the "us" and the "them"; making these classes an institution, the institution of motherhood, making these classes legitimate and finally, making them real. Within this arena, institutions are organized, for example, the institution of women. For example, with eating disorders, the social ideal of how a woman should appear impacts how they are classified into a system. These legitimizations are an aspect of social construction that postulates that things are typified and institutionalized, then legitimized and reified - made real. This social construction has had profound impact on the stereotypical ideal of individuals. Authors, clinicians, and researchers both feminist and postmodern assert that the predominance of women struggling with eating disorders as compared to men and the instance of the gradually

thinning ideal has profound and detrimental affects on women's self perception (Gordon, 2000; Lin & Kulik, 2002; Sherwood & Neumark-Sztainer, 2001).

A second theme is that realities are constructed through language. Language is the pathway of stories. Speech isn't neutral or passive, but the builders of reality (Freedman & Combs, 1996). Flaskas (1999) argues that humans do not exist in a static form; rather, humans are created and recreated through relationships with others. Further, as Anderson (1997) believes this relation is always in the phase of becoming. With each interaction, we are constructing our realities through language with others, as their realities are being constructed by their relation with us, thereby creating yet another construction of reality. This construction is always fluid and never truly attained.

The third theme is that realities are organized and maintained through narrative. This simply implies that realities are organized and maintained by the stories we tell each other and ourselves and, perhaps necessary, to human survival (Freedman & Combs, 1997). The postmodern model states that our realities are internally constructed through a lens of past experience, society, family, and individual stories. Often, the shapes observed in the media reflect a body shape that is unhealthy and often unattainable to the female population. Despite this, women and girls continue to aspire to achieve this shape. Many researchers continue to find that the overall perception and reality of what is considered "normal" is, in fact, a dangerous product of current society (Bishop, 2001; Duran et. al., 2000; Gordon, 2000; Lin & Kulik, 2002).

The final theme is that there are no essential truths. This is best stated by Doan (1997) in which he states that the hallmark of postmodern thinking is that it has a loss of faith and trust in "the one absolute truth". Ascribing to the belief that there is no one

truth has sometimes been admonished as it relates to biology and physics. Many arguments pertain to "truth", such as the rotation of the earth, the particles of light, etc. These individuals assert that within each individual resides their internal realities and truths and, as such, they should be honored and considered equally as viable as any other (Gorman, 2001; Parry & Doan, 1994; White, 1990). Gorman (2001) states that, "A postmodern perspective challenges students to look beyond the beguiling expert knowledge contained within the DSM-IV, and to question the "truths" of the very field they are striving to join as professionals. It is the belief that pathology and diagnosis could be observed within a context that narrative psychology based its assumptions.

*The Narrative Model*

People are born into stories. Throughout childhood, they are encouraged to remember certain social and historical stories. As developmentalists see development fitting into schemas, narrativists see development as a series of stories created at and since birth that house new experiences. Narrative theorists, Michael White and David Epston are considered to be the forefathers of narrative therapy (Parry & Doan, 1994). Their theory is founded on the power of stories and how those stories are perceived as truths (Parry & Doan, 1994). If, for example, an individual is born into an abusive home they are likely to adopt a story that the world is a scary place. Is this truth? Does is matter? What is significant is that this individual has been written into stories, personal, family, cultural, etc. that places them in a role of fear. This example has become known as a discourse (Freedman & Combs, 1996). These discourses often lead individuals into therapy because they have reached a point where the story is no longer useful to them

(Parry & Doan, 1994). Using the above example, this individual may not want to continue to story the world as scary.

When individuals come into therapy, they are seeking solutions and alternatives to stories that are no longer useful to them. Stories come from many sources. Among the most powerful are the social and family stories. These often carry more power and are more heavily reinforced those individual stories. Freedman and Combs (1996) refer to these as social constructs. They believe that these stories determine the meaning of experiences and which aspects are to be used for expression. These stories determine real effects in terms of shaping persons' lives. These "survival stories" often develop in childhood and outlive their usefulness as adults. When this occurs, narrative therapy sees them as "wake-up" calls and stories not needed anymore. Their task is not to "fix" these individuals, rather, provide them with story revisions that may be more useful to them (Parry & Doan, 1994). It is important to remember that these story revisions are not therapist constructed, rather, stories of the individual. How then, does one take on such an arduous task? For the narrativist, this centers on the tool of externalization.

*The craft of externalizing the problem*

Externalization is perhaps one of the most defining aspects of narrative therapy and perhaps the foundation from which therapeutic application is derived. The term externalization is a means of separating the person from the problem. Michael White (1995) discusses this in terms of seeing the person as separate from the problem. They are external entities that have more influence over the person than the person would like (White, 1995). Roth and Epston (1996) add that externalization is a "language practice that shows, invites, and evokes generative and respectful ways of thinking about and

being with people who are struggling to develop the kinds of relationships they would prefer to have with the problems that discomfort them."

The use of externalization provides the client with the option to see more hope and freedom from the problem. Take, for example, these two sentences. "He is depressed." versus, "He is a person who is influenced by depression." Narrative therapy values the ability to discuss the problem as the problem, rather than posing questions that invite the person to be the problem. Doan (1995) describes a series of questions that facilitate externalizing language. Some of these include, what is the problem called? Does more than one externalization make sense? How much is the problem able to influence them at the present? What does the problem say, look like, and convince them to do? These examples encourage individuals to separate themselves from the problem and are a tool that proves to be powerful in story revisions.

The craft of separating the person from the problem involves several different stages or components that are enmeshed with the other elements of narrative therapy. For example, often individuals enter therapy with a "problem-saturated story" (Boldt, & Mosak, 1998; Merscham, 2000). This story is often how they see themselves and relate to the world. Through this problem saturation, the therapist can employ externalization as a means of giving identification to the story and providing the individual with a name for the story that is not necessarily reflective of them. Epston, Morris, and Maisel (1995) identified a program that has been named the Anti-anorexia/bulimia league that is enlisting individuals struggling with eating disorders to "unite" and work through areas that the eating disorder is controlling/influencing the individual. From the beginning of this program, anorexia/bulimia is discussed as a separate entity from the individual.

Through this, the individual is able to have a discussion that becomes external from them and allows for a more personal assessment/evaluation of how anorexia/bulimia is affecting their life (Epston, et. al., 1995). The notion of saturation implies that all aspects of the individual have been touched and that, perhaps, others in their life have been infected as well. Recognizing and honoring the impact of the problem seems to allow the client to have a voice in which they are not the problem, rather, they are infected by the problem. Finally, externalization allows the client more freedom from the self-depreciation and guilt associated with many problems. Nylund (2002) in his work with women struggling with anorexia found that using externalization undermined its ability to invite the individual from feeling guilt and shame as a result of thoughts and behaviors. Instead of "doing this to herself" anorexia was simply stronger than the person and she was not able to fight.

One of the hallmark methods of discussing problems in externalizing language is simply to discuss the problem as an entity. For example, an adolescent with anger problems would discuss "anger" or "trouble" and how it is impacting their daily life, their functioning, their relationships, and perhaps their future. Another helpful method of externalization is through metaphor. From the above example, instead of "anger" or "trouble" the externalization becomes "Godzilla". Several authors have utilized metaphor in relation to externalization with profound success (Epston, et. al., 1995; Legowsky & Brownlee, 2001; Levitt, Korman, & Angus, 2000; Merscham, 2000; Stacey & Hills, 2001). The use of metaphor often provides both therapist and client with a form or a picture of the problem that may be more attainable. Although little empirical research has been conducted on metaphor, Levitt, et. al. (2000) found that those who used

metaphor throughout the therapy process was linked to a more emotional process and marked therapeutic change. As a therapeutic tool for use with those struggling with eating disorders, individuals using metaphor in conjunction with externalization were more likely to reconnect with feelings, and move in the direction of self-acceptance as well as being more cognizant of internal feelings and drives (Epston, et. al., 1995).

There is relatively little discussion of the use of externalization as a positive influence in the person's life. Some narrativists are beginning to differentiate between externalizations that may be perceived as negative to the person from those who might be considered positive. In a paper on applications of narrative therapy, Stacey and Hills (2001) contend that "outer-externalizations" may be seen as those aspects that are uncomfortable to the individual and removable and include the protesting the effects and existence of the problem through transcending the problem and transitioning so that the problem no longer carries the power/weight it once did. The "internal-externalizations" included those aspects of the problem that are somehow connected to the individual and there is a necessity to see the problem as a potential resource. In this collaboration, balancing, and embodiment of the problem occurs in a fashion that works with the individual (Stacey & Hills, 2001). Other authors seek to use metaphor and externalization to further strengthen those aspects of the individual who can help to work through the problem. In other words, in addition to focusing on anorexia as an externalization, the therapist might also discuss individuality or strength as an externalization to increase self-efficacy of working through what is so often an extremely difficult process.

In a study of family success, Kahle and Robbins (1998) use “unique outcomes” and inherent family strengths/competencies to engage the family. Externalizations like “anger” became “coolness” attempt to invite change and encourage thinking that is more useful to the family (Kahle & Robbins, 1998). Providing positive or strength externalizations can help facilitate change in the individual. In addition, there may be instances in which the problem is seen as valuable and helpful to the person and to discuss how it might have been helpful can be valuable in therapy. Externalization allows therapist and client to discuss the benefits and hindrances of the problem and decide how much influence and collaboration the client wants with the problem.

The above sections have highlighted various components of narrative psychology and the value of this theory in an applied setting. To date, there are relatively few empirical studies examining the premises and techniques of narrative therapy. It is possible that there are currently no methodologies that are accurate in detecting and analyzing the internal workings of narrative. Perhaps current objective methodologies are ill suited to discussion of such a subjective process like therapy.

*A Model for De-Composing the Problem of Eating Disorder*

The definition of re-composition was founded in research by Parry and Doan (1994) in which they use the term re-visioning to discuss the process of seeing life from a different perspective. The “vision” of the person changes through use of externalization, deconstruction of stories, and other narrative processes (Parry and Doan, 1994). Re-composition is the process by which individuals examine their life story before and after application of externalization. This premise is based on research in both externalization and story telling. King (2001) conducted research in which individuals were asked to

write either about a trauma, their best possible self, or combination of both. Those in the best possible self group were found to experience more positive moods than those in the trauma, combination, and control group, with results maintained after three weeks.

Externalization work with individuals with eating disorders have indicated that speaking about the problem as if it is outside the person encourages change and allows individuals to tap into emotions that had otherwise not been reached (Epston, Morris, & Maisel, 1995). Additional research on narrative connection with emotions is discussed in a work by Alan Parry (1998) where he discusses the need for narrative to connect with emotions. His question is that often narrative therapists remain with the cognitive and remain analogous to the systemic therapies. This current model is proposed in an attempt to combine all theses elements as a way to facilitate change in those struggling with eating disorders. As found by King (2001) the process of writing helps emotional well being and positive mood. Many who struggle with eating disorders are unable to see themselves outside the bonds of the eating disorder and find difficulty finding hope in the future. Through the use of externalization as part of the storytelling process, individuals may be more able to separate their future goals from the future goals of eating disorder. Through conversations with therapists, family and friends, it is expected that the story telling process will evolve as a function of community; conversing and re-composing their stories with others. This model incorporates ideas from externalzed storytelling to help individuals see themselves as separate from their eating disorder while simultaneously providing a means of expressing emotions and for understanding themselves in relation to the eating disorder.

## Scope of the Current Research

Based on the postulations formed by previous researchers, a joining of narrative therapy, in particular, externalization may help facilitate change in eating disorders. With all the research conducted in the area of eating disorders, very few were found that combined the use of externalization in the treatment of eating disorders (Epston, Morris, & Maisel, 1995; Nylund, 1998; Zimmerman & Dickerson, 1994). These researchers found that through controlling food intake, exercise, etc., the therapist is taking more control away from have the individual and encouraging them to remain children; the exact same things that may led to the eating disorder. By using narrative metaphor and externalization, eating disorders become a construct of a society and family, rather than the problem of the individual. Goddard, Lehr, & Lapadat (2000) examined the use of externalization and deconstruction with parents of children with disabilities. They organized a group in which they explored with parents their experiences and facilitated discussions based on externalizing (how has *the problem* affected you and your family) and deconstruction (how has *the problem* affected how you see the world). Qualitative results indicated specific themes and commonalities of parents (Goddard, Lehr, & Lapadat, 2000).

Given that the foundational element of narrative psychology is the deconstruction, re-visioning, and understanding of stories, the experimental group will first participate in an externalized story writing process that will compare them to a group who writes on a novel topic. The second phase will be an extension of the experimental group from which each individual will be given the opportunity to continue writing from an

externalized framework to identify possible themes that emerge from the stories as well as any saliency effects of the story writing process.

*Research Questions*

The purpose of the current research will address several questions:

1. In phase I, will there be a statistically significant difference on pre/post test scores for participants who engage in the externalizing story process as compared with the control group (EDI-2 scores be reduced, internal locus of control on the ANSIE increase, and the relationship between eating disorder and self decrease while the relationship between self and preferred self increase)?

2. In phase II, will there be a significant difference in the dependent measure, I-SPI, across participants?

3. Will there be a significant difference between pre/post measures for those participants who complete both phase I and phase II as specified in research question 1?

4. Using qualitative analysis, will consistent themes emerge from stories for those participants who complete both phase I and phase II?

## Method

*Participants*

A total of 16 female clients volunteered through a local private practice specializing in the treatment of eating disorders. Clients were selected on basis of eating disorder diagnosis, as determined by their primary therapist. The majority of clients, 12, were diagnosed with Eating Disorder, NOS, with the three being diagnosed with Bulimia Nervosa and one diagnosed with Anorexia Nervosa. Clients averaged struggling with an eating disorder a mean of 7 years (SD = 4.1) and 12 had been hospitalized for an eating

disorder with lengths between 2 months and 9 months (M = 5, SD = 3.47). Of the 16 clients, 56% had been in previous counseling. Of that, 44% had been in individual counseling, 6% in group counseling, 38% in individual and group counseling, and 13% in individual and family counseling (Table 1).

General demographic information included age ranging between18 and 31 years-old (M = 22.06, SD = 3.27). Clients were primarily Caucasian (75%) with Hispanic and Eastern Indian each at 6%. Education levels ranged from high school (6%), some college (25%) and undergraduate degree (69%). 44% of clients lived alone, while 31% lived with a room mate, 6% with a partner, and 19% with family (Table 1).

As indicated in the demographic sample, although the sample was obtained from a single source, there was good variability within the sample. Some individuals had been in previous counseling some not. In addition, the length of time struggling with an eating disorder was relatively expansive. For the current research, this variability helps identify the impact of the story-writing task across varying individual experiences.

*Instruments*

*Eating Disorder Inventory – 2 (EDI-2)*

The Eating Disorder Inventory - 2 (EDI-2) (Garner, 1990) consists of 91 self-report statements intended to help identify psychological symptoms commonly present in anorexia nervosa and bulimia nervosa. The EDI-2 was revised form its original 64 item scale to the current format. This format is an easily administered 6 point “likert-type” scale that is scored with the 8 subtests that highlight different common eating disordered beliefs. The 8 subtests tap various aspects of eating disordered behavior and are Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal

Distrust, Interoceptive Awareness, and Maturity Fears. Scoring of the EDI-2 is weighted on as follows: Always = 3, Usually = 2, Often = 1, Sometimes = 0, Rarely = 0, and Never = 0 (Garner, 1990).

Reliability and validity indices for the EDI-2 are all strong and consistent among and between subscales. Reliability scores for internal consistency were found to be at least .80. Test-retest reliability was also strong and found to range from .77 to .96, except for Interoceptive Awareness (.67) (Garner, 1990). Additionally, all validity assessments were within appropriate ranges for the sample.

For this study, the EDI-2 is used as originally developed and administered to each client at pretest, after completion of story writing one and again after story writing four for those participants who complete both phases of the research. For those who completed the first phase of research, the EDI-2 was analyzed at pretest and after story writing one. For those who complete both phase I and II, the EDI-2 was analyzed at pretest and after the fourth story writing.

*The Adult Nowicki-Strickland Locus of Control Scale (ANSIE)*

The Adult Nowicki-Strickland Locus of Control Scale (ANSIE) was first developed as a children's scale by Nowicki and Strickland in 1973 for use as a tool to identify popularity, ability to delay gratification, and prejudice. The ANSIE contains 40 yes/no items and is made to be read by individuals with a $5^{th}$ grade reading level. The scoring of the scale is such that the higher the number the greater the external locus of control (Nowicki & Duke, 1974). Data was collected in 12 studies containing 766 participants and was found to be psychometrically sound with reliability from .74-.86 and test-retest at 6 weeks of .83.

For this study, the ANSIE is used as developed and administered to each client at pretest, after completion of story writing one and again after story writing four for those participants who complete both phases of the research. For those who completed the first phase of research, the ANSIE was analyzed at pretest and after story writing one. For those who complete both phase I and II, the ANSIE was analyzed at pretest and after the fourth story writing.

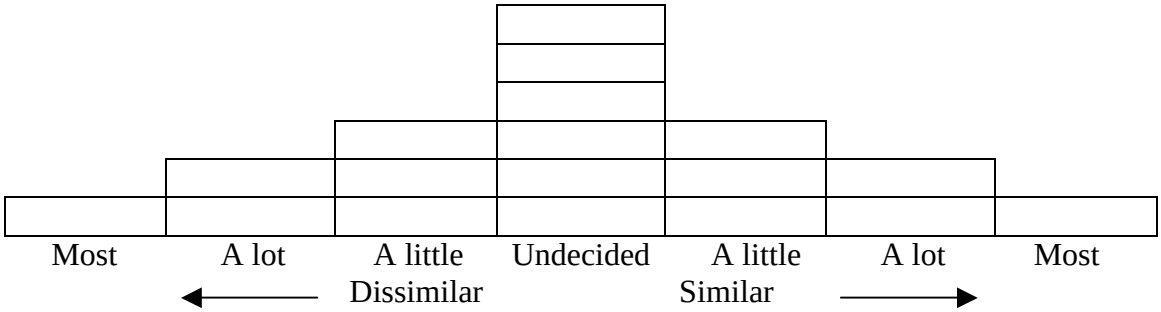
*The Ideographic Self-Perception Inventory (I-SPI)*

The Ideographic Self-Perception Inventory (I-SPI) (Knight, Frederickson, & Martin, 1987) is based on a general principle of Q-Methodology. I-SPI allows an individual to rank order adjectives according to their level of "fitness" to any given condition of instruction. Adjectives are used to describe these conditions of instruction, which are words such as self, preferred-self, eating disorder, etc. The original Q-sort data were gathered at a large Midwestern university using a customized Visual Basic Pro-5 Edition Q-Sort procedure called the Ideographic Self-Perception Inventory (I-SPI), (Hamlin & Knight, 1997). The I-SPI uses a list of adjectives that was normed by Anderson (1968). These adjectives are selected randomly from each of seven levels of similarity (one being most dissimilar, seven being most similar) from 555 adjectives normed from the most to least favorable adjectives. To accomplish this, Anderson administered the set of 555 adjectives to participant and asked them to rate them from one to seven; the most positive to most negative that would best represent their ideal self. The computer randomly selects across those ranking to provide a normally distributed set of 18 adjectives across the adjectives. The concourse provides the structure for participants to sort adjectives that are most to least like any condition of instruction.

Reliability and validity information for the I-SPI was also conducted at the University of Central Oklahoma. Internal validity was determined by a comparison between Undesirable (U) person and Ideal (I) person. If the U-I coefficient is between -.46 and -1.0, it is assumed that the person is committed to task. Further validity assessments were conducted to determine the level of relationship between Anderson's adjectives and Q-sort ratings. These correlations were found to be significant for both self and preferred self (Knight, Frederickson, & Martin, 1987).

In administering the I-SPI sort, the computer asks the individual to make a graduating series of choices in relation to the condition of instruction. The program represents all of the 18 adjectives as well as the distribution for viewing. The individual then chooses adjectives from the total 18 until all are selected and placed in a quasi-normal distribution (see Figure 1). The participant then is instructed to work from the extremes to the center asking herself, "Which adjective is the most like me?" and "Which is most unlike me?" Adjectives chosen are placed in positions 7 and 1 respectively and the process continues with the individual choosing the two most like and least like form the remaining 16, etc, until all adjectives are placed into the distribution. This process is then repeated for each condition of instruction

*Figure 1*




*An example of a Q-sorting concourse utilizing eighteen adjectives*

For this study, correlations will be utilized to indicate the degree of relationship between adjectives chosen for the various condition of instruction. This will allow the researcher to determine the amount of relationship between conditions and within each participant. The above-described randomized concourse of adjectives will be used to describe each of these conditions of instruction. For statistical purposes, the correlations between self/preferred self, self/eating disorder and preferred self/eating disorder will be investigated. Participants will complete the I-SPI pretest and after each of the story writings. For phase I, analysis will be from the pretest and following story writing one. Phase II data will be analyzed pretest and after the first story writing and paired t-test taken after each writing.

*Design*

The present study used a mixed methods design with two phases and three components: experimental, repeated measures, and qualitative. Participants in Phase I were randomly assigned to one of two groups, control or externalized story writing. Clients completed all dependent measures and wrote a story writing for 20 minutes. Clients then completed all dependent measures once more. Clients in phase II were clients from phase I who returned to the testing practice once a week for three more weeks, resulting in a total of four data collections. Due to the small sample size, this segment of the design included individuals from both groups. Clients wrote a story from the externalized perspective and completed the I-SPI instrument, with the last story writing being followed by all dependent measures. A final design component was to analyze the stories for any qualitative themes that emerged throughout the process.

The design used for the qualitative component was based primarily phenomenological (Creswell, 1998). According to Creswell (1998) phenomenological studies are not *a priori* and capitalize on the reduction and analysis of specific statements to discover themes and possible meanings. This type of analysis was applicable to narrative therapy as the basic tenets include no preconceived meaning, client guidance, and expression of various experiences as "truths" that are socially constructed and acceptable.

There are several elements crucial to the analysis of a phenomenological study. The first step is for the researcher to understand the importance of allowing the meanings of the statements to come from the participant, not from preconceived ideas of the researcher. Questions are then formed that address the experiences the researcher is after (Creswell, 1998). Typically, long interviews are the process for data collection, however, the current researcher focused on the written form to capture experiences of the participant. Since the research targeted stories constructed from eating disorders perspective and one of the benefits of externalization is reduction in the individual's tendency to censor, the interview format would likely be too censored for accurate data.

The actual data collection includes four stages and is discussed by Creswell (1998) through the work of Moustakas. According to Creswell (1998), Moustakas states, protocols are reduced to relevant, individual statements and then into groups of similar meanings. These are then described by the researcher through both textural and structural descriptions of the experiences. For the current study, the stories were analyzed and themes generated with important statements highlighted. These themes were then grouped into applicable sub-themes among participants, keeping both the importance of

group coherence and individual consistency across the four story writings. Stories were coded separately by the researcher and faculty advisor and these themes were then brought together to determine level of consistency between coding.

Finally, the researcher begins the task of describing the experiences in such a way that the experiences of the participants help the reader of the study better understand the meaning of the experience (Creswell, 1998). The goal of this phase of phenomenological study is to help the reader better understand the experience(s) of the participants. For the current study, one of the primary techniques for achieving this understanding is through the inclusion of several statements of the participants. This research yielded powerful statements that are likely to illicit empathy and understanding of the experiences. Further, the interpretation provided the reader with additional information about how these lived experiences are consistent with previous theories regarding eating disorders.

*Procedures*

*Phase I*

The groups were identified as either control or externalization (experimental) group. All individuals were asked not to discuss the research experience in their group settings and therapists were asked to encourage compliance with this protocol.

*Control Group*

All data collection occurred at the counseling practices in which clients were seen. Clients were directed to a table station that included writing space. Clients in the control group were checked in and seated at a table and given a packet including a confidentiality statement, demographic information (see appendix C), and the following measurement instruments, counterbalanced for order effect: the Adult Nowicki-

Strickland Locus of Control Scale (ANSIE), the Eating Disorder Inventory 2 (EDI-2), and the Ideographic Self-Perception Inventory (I-SPI). Clients were instructed to remove the contents of the packet and to lay them on the table in front of them in the order that they were in the packet. Clients were instructed to read through the confidentiality statement and allowed to ask any questions they may have and complete the pencil and paper instruments. Because of the location for the data collection, the computer I-SPI program was replicated in a paper format, with information coded and saved for later researcher entry into the I-SPI program. Clients were given written instructions for the I-SPI procedure and given a sheet of paper with the q-sort format (see appendix C) and the list of 18 adjectives. Clients were allowed to progress through the I-SPI, with the following instructions. Clients selected the adjective “most like self”, then the adjective from the remaining 17 that is “least like self”, the two from the remaining 16 that are “most like self”, two from the remaining 14 “least like self”, etc. until all adjectives were placed on the distribution. The same process was followed for self, preferred self, and eating disorder. Each group took a 5 minute break and return for the writing phase.

Following the break, clients returned to the testing room and back to their tables. Each participant in the control group was given instructions to write for 15 minutes on a neutral topic and 5 minutes on a time the previous week they were without eating disorder. This topic was their schedule for the upcoming weekend. After 20 minutes of writing, clients completed the Adult Nowicki-Strickland Locus of Control Scale (ANSIE), the Eating Disorder Inventory 2 (EDI-2), and the Ideographic Self-Perception Inventory (I-SPI) and were allowed to ask about the project.

*Narrative Re-Composing Externalization Group*

Clients in the externalizing experimental group were handed the packet including confidentiality statement, demographic information and the instruments, (EDI-2, ANSIE, and I-SPI) as described in the above control group. Following completion of the packet, clients were given instructions on the writing assignment. They were asked to imagine that they were their eating disorder and to write how that eating disorder sees them. For example, X would pretend to be "anorexia" and write a story from anorexia's perspective about how "anorexia" would describe X, how long they have known each other, "anorexia's" perceptions about X. Clients asked any questions about the writing instructions. Clients wrote for a full 15 minutes from their eating disorder's perspective, followed by 5 minutes on a time the previous week that they were without eating disorder. After writing, clients completed all measurement instruments (ANSIE, EDI-2, and I-SPI) and were allowed to ask about the project.

*Phase II*

All members of phase II participated in phase I and were asked to continue with the process. Clients returned on the scheduled day and followed the above externalizing procedure from phase I for a total of three times, including story writing in phase I. On the final (fourth) day of testing, clients returned and wrote an externalization story per previous procedures. After 20 minutes of writing, the clients were allowed to break for 5 minutes before returning to the room. Following break, clients completed the ANSIE, EDI-2, and I-SPI, and were allowed to ask questions about the project. All writings were from the externalized perspective. Writing 2 and 3 were followed by the I-SPI only; writing 4 was followed by completion of all measurement instruments.

## Results

*Research Question I: Will there be a statistically significant difference on pre/post test scores for participants who engage in the externalizing story process as compared with the control group in phase I?*

A Multiple Analysis of Covariance (MANCOVA) was conducted to determine whether there was a significant difference in groups depending on the dependent measures. Although there was a significant relationship between the covariate and the dependent variable for the EDI, $F(5,5) = 85.74$, $p = .>001$, $\eta^2 = .99$, power of 1.00 and for ANSIE, $F(5,5) = 4.96$, $p = .05$, $\eta^2 = .83$, power of .64, the results of the analysis indicated no significant difference between groups (Table 3,4). Further, although power was small at .10, analysis of the multivariate results indicate a moderate effect size, $\eta = .32$ between the two groups. It is possible that these results are impacted by the small sample size utilized for this research.

*Research Question II*: *Will there be a significant difference in the dependent measure, I-SPI, across participants in phase II?*

A repeated measures MANOVA was conducted on each of the levels of the I-SPI (self/preferred self, self/eating disorder, and preferred self/eating disorder) to determine any significant differences across each of the four story writing phases. Neither multivariate nor univariate analyses yielded significant results. This is also likely due to the small sample size.

*Research Question III: Will there be a significant difference between pre/post measures for those participants who complete both phase I and phase II as specified in research question 1?*

A repeated measures MANOVA was conducted for each of the dependent variables to determine if there was a significant difference between pre/post scores with the post score taken after the completion of the final ($4^{th}$) story writing. Although the MANOVA did not yield significant results, the difference between the ANSIE pre and post only approached significance, $F(1,12) = 3.27$, $p = .07$, $\eta = .36$, with power of .52.

*Research Question IV*

*Data analysis*

The data used for research question IV were the individual stories written by the participants. Participants completed either three or four stories, depending on random assignment grouping in phase I (control group, three stories, externalization, four stories). This data was then analyzed for thematic content utilizing a phenomenological approach (Creswell, 1998). Broad themes across participants were identified both individually by the researcher and research supervisor and collaboratively to increase validity of themes. These broad themes were then re-analyzed to determine what possible sub-themes were present, following the same cross-checking procedure.

The question was asked: will themes emerge from stories for those participants who complete both phase I and phase II? Each participant completed three or four stories, over a period of four weeks. These stories were then analyzed for themes, both within the writings of each participant, and across participant's writings to determine if there were themes found in the stories about perspectives and relationships of the participants to eating disorder. Several themes emerged throughout the stories (Table 5). All stories in the experimental condition and in phase II were written from eating disorders perspective. This perspective allowed for analysis of how "it" (eating disorder)

sees the person. Many individuals gave eating disorder a name and, for ease of reading, the name given to eating disorder here is ED.

Some overall patterns emerged from the obtained sample. Of the 15 participants in phase II, 11 identified an age when ED first came into their life. Of those 11, 2 reported their first meeting ED at age 5, five met in early puberty, and four in late high school/college. According to research (Bloom & Kogel, 1994; Gordon, 2000) eating disorders are more common at certain ages, or milestones, early puberty and college being two of those times. Another finding was related to the impressions participants shared about the process of the writing. The act of writing in third person from eating disorder's perspective was new to all participants. Several times during the writing phase, participants made statements like "I looked back at what I wrote and can't believe it was me that said it." In addition, several psychological and perceptual themes emerged through the stories; self concept, family/social relationships, eating disorder character, deification of eating disorder, allies to eating disorder, sexuality, and inner strength. Each of these themes will be described in the following sections.

*Self-concept*

Self concept for this research is defined as how the person sees themselves, their skills, personality traits, body image, and relationships to others. Themes related to self concept were those writings in which the eating disorder wrote about how it sees the person's self concept. Twelve of 15 participants' stories contained themes about self concept. Within this over arching theme, several sub-themes emerged; appearance/body dissatisfaction, perfection/worthlessness, and comparison to others. The most prevalent theme of self concept (10 of 15 participants) related to appearance/dissatisfaction with the

body. Many participants shared feelings of shame in regard to their bodies. "Both she and I are unhappy with her muscle tone in her legs. I'm not sure about her ever wearing shorts or bikinis again." "I (ED) find everything wrong with her. I make all the bad, ugly, gross things within her blatantly apparent, as if they were tattooed upon her forehead…." The shame for their bodies is generalized into an overall dissatisfaction with life. Appearance goes beyond the physical dissatisfaction. For example, ED said in one story, "I suppose I came along because she never really felt happy or loved, so she resorted to looking happy and loved." Here, a facade is a substitute for contentment.

Several researchers have identified similar feelings of shame, body dissatisfaction, and an over-focus on appearance among individuals struggling with eating disorders (Fraze, 2000; Laberg, Tornkvist, and Andersson, 2001; Lin and Kulik, 2002). From a narrative perspective, many researchers and clinicians (Duran, Cashion, Gerber, & Mendez-Ybanez, 2000; Madigan & Goldner, 1998; Nylund, 2002) believe eating disorders are likely to reflect feelings of shame and dissatisfaction, which may become all consuming. Duran et. al. (2000) discusses this phenomenon as a socially constructed desire for women in today's society to look a certain way and invites feelings of over-concern with weight and shape above all other appearance features.

There was also strong evidence of perfection in self concept, and its negative compliment, worthlessness. Consistent with previous research, many participants shared a need to be perfect to avoid feelings of worthlessness (Laberg, et al., 2001). Seven participants expressed a need to be perfect, while seven expressed feelings of worthlessness. A clear theme of perfection emerged, not only related to body image, but also school, work, social relationships, and even eating disorder. In one story, ED stated

that "…deep down the only thing that she is really good at is the eating disorder." " I knew keeping weight off would help keep that perfect image she desired and did have." In another, "if she doesn't do as I say, people will find fault in her and I help her be perfect." In several stories, ED asserted that the participant has to look perfect, be perfect, or at least act perfect. Interestingly, the converse to this need to be perfect was feelings of worthlessness. ED suggests if one is not perfect, then one is worthless. "…without me, she is unlovable." and "You are a failure."

Not only was there an obsessive need to be perfect but also to maintain an image of perfection. As the above comments suggest, if one does not project the image that they are perfect, others will see them as unacceptable, unlovable, and as a failure. This finding in the current research is consistent with other findings in the literature (Fraze, 2000; Ghizzani & Montomoli, 2000; Gordon, 2000).

Comparing oneself to others occurred frequently in the stories. This theme was found in 6 of 15 participants and was expressed with powerful rhetoric. The "compared other" took the form of a significant other whom ED was able to represent in terms of perfection; of being who the individual should be. For example, there is a stereotypical image of what a perfect female should be and ED is often able to take this image and continually remind her of this perfect image. "Was what she needed to be, small, blonde, thin, and popular." This ideal of beauty in Western society was pervasive and present in all individuals who compared themselves to others. In one story, ED laid claim to being able to "get the best results" through the media, which portrays a thin ideal. Conversely, ED convinced one individual that she was "too skinny" in comparison to others. "She had thoughts and didn't want people to comment that she was too thin, but what she didn't

realize was everything afterward. I wasn't just going to go away." ED attempted to invite negative comparison to others.

*Family/social relationships*

Family and social relationships are often depreciated by eating disorders. Consistent among all individuals, was a decrease in the presence of eating disorder during times of connection with others. Individuals were asked to write about a time in the past week when they were without eating disorder. All individuals reported that the times they were without ED was when they were with others, family, friends, working, in class, and at times that they felt connected to something, or a part of something. They often connected that the times were periods during which they felt "useful" or "accepted." "I was taking care of a little girl, who's 2…. That little girl didn't care what size I was, she just cared that I was nice to her and cared about her…." "It's times like these, when I am joking around with coworkers that I am comfortable and just myself." "I was at a party with my friend. We mingled and laughed and I never stopped to add up the calories in my drink."

In direct contrast, 9 of the 15 individuals wrote that it was during times of disconnection that ED used family and friendships to increase its power. ED capitalized on times when conflicts existed with friends and family to make its presence stronger. "Her father is writing out terms for separation from her mom and I encourage her to think about the woman he is seeing…and watch her anger rise." "I also make her think that everytime he [father] gets mad it somehow has something to do w/the way she looks.' ED states in one story "Not only do I know ____, but I also haunt her mother."

The above themes are present in previous research involving individuals struggling with eating disorders. Olson (2000) discusses how conflictual parental relationships contribute to the need of persons who struggle with an eating disorder and a need to please their parents. Zimmerman and Dickerson (1994) discuss how anorexia feeds on isolation from significant others who may provide a buffer against ED.

Many individuals wrote that ED attempted to replace the significant people in their lives. They stated that if ED became the parent or best friend, they were less likely to seek outside relationships. Seven of 15 individuals described ED as a friend, family member, and/or partner. This research identified two main themes of replacement; parental and friend/partner. Of the 7 individuals who endorsed ED replacement, 4 were related to parental/caretaking roles. Although these results were more tentative, statements ranged from pride to unfaltering love and included, "I don't think she can handle the 'real world.' She needs me." and "I couldn't be more proud of her. She has to know that all I want is to make her happy. I'm the only one who cares more about HER than anything else, the only one that will put her first." "Everyone wants me to let her go. But when you have been w/someone for 14 years and so much of her success she owes to me it is harder to say good bye than one might think." "She knows I love her and will take care of her when she needs me."

In addition to the parental representation of ED, 4 individuals' stories included statements about a friendship/sexual relationship with ED. Although 4 individuals indicates a more tentative result, one individual reported the she and ED were "best friends" who "went everywhere together and she needed no one as long as she had me." Another wrote, "I'm your only safety net and your only friend." "I try to be her

company, I try to fill the empty spaces in her days." For another, ED became analogous to a drug dealer, "The high I give her as she stepped on the scale was more profound than anything else, good grades, parental love, boyfriends, friends, you name it."

From these descriptions, ED was presented as a caring entity who wanted the best for its child. Research has indicated that often individuals who struggle with eating disorders have a fear of responsibility and autonomy. For example, Wechselblatt, Gurnick, and Simon (2000) outline how lack of autonomy and relatedness can lead to eating disorders like anorexia. It is possible that an internal ED can take the place of or supplement the parent relationship in caretaking responsibilities. Further, this inner reliance on a parent-like role model may also help keep the person from becoming autonomous and learning self-responsibility. It may be that women who struggle with eating disorders also have fears about growing up. This internal caretaker/parent may help ease these anxieties.

*Eating disorder character*

In the stories of 14 of 15 participants, ED took on definitive personality characteristics. Descriptions of ED ranged from worst enemy to savior. For example, in 6 stories, ED was described with manipulative and almost oppressive qualities.

> Throw up, throw up you fat, ugly cow I screamed. She tried to push those thoughts out of her mind, but _____ is too weak. Why does she fool herself. She needs me. She raced to the toilet & lifted the seat. She knew it was wrong, but she couldn't hear her own thoughts over my screaming. Do it! Do it! You will feel better! She put her finger down her throught and vomited. Purged until she could taste bile. Purged until she felt calm, sane.
> I wouldn't let her feel that for long. She flushed the toilet & walked to the sink. She wiped the vomit from her face & rinsed her mouth out. She looked at herself in the mirror, 'You weakling' I shouted! 'You idiot, you failure!'

Other participants also attested to ED's arrogant and belittling voice. "She is a fat pig who can't really ride, so why try?", "I am dancing around boastfully as she sits still, wistfully looking at a fashion magazine that I bought for her…..I like to taunt her. I eat all I want and never gain a pound." ED said in one story, "…yell and scream at her. Point out her faults." and with another, "I like to trick people out of enjoying life without them even ever realizing it." These statements seem to indicate ED's ability to keep the person feeling ashamed, belittled, and degraded.

Again, there is a compliment or flipside to ED's character. It also assumes the caretaker/teacher role. As in the family/social theme, ED can assume a form who offers solace, safety, and security. In fact, 8 of the 15 individuals suggested that ED is not "all bad". ED said "I have been more comforting to you during these hard times." "I have, after all, kept her from feeling things that might scare her, or hurt her…", "I come to the rescue, like a saving grace…", and "I provide her with comfort and security."

ED often offers the reader tender and nurturing images of its relationship with the participant. "If she doesn't have me, she has nothing. Nothing to turn to in the dark watches of the night when she feels utterly alone. Who will comfort her?" Finally, in another participants' story "I hold her hair back as everything inside her comes outside, soothing and calming her, always encouraging." The above statements sound like a parent worried about a sick child. While it is typical to think of ED as bad, or something to be fought against (Epston, Morris, & Maisel, 1995; Nylund, 2002; Zimmerman & Dickerson, 1994) the above comments suggest that participants in this study perceive ED

as positive and/or comforting. Roth and Epston (1996) contend that an eating disorder can be viewed as a friend, and/or something that once was useful and meaningful.

*Deification of eating disorder*

In several stories, ED claimed to be omniscient, omnipresent, and/or omnipotent. Of the 15 individuals, 9 described ED as possessing these qualities. In 7, ED claimed to know everything about who the victims were, what she feared, her weaknesses and those things that she kept secret from the outside world. "I know how to occasionally work my way through her web of confidence…." In another account, ED took the help of treatment and brought it back to ED's omniscience, "I heard the word 'treatment'. So off we went. I decided to let up a little and let her think that maybe there was hope (right!) I just sat back, I knew she could not forget me." Other statements included more general knowing the individual would panic, return to ED, and knowing what is best for the person.

There was an equally persuasive theme of omnipresence. Seven participants described ED as a consistent and undying presence in their life, whether active, or patiently waiting. "I'll never be completely gone, and I know that she knows that, no matter how good she gets at keeping me at bay, I'll always be there to tempt and destroy." From another participant, "What she doesn't realize is that I have been a part of her for longer than she can remember and she doesn't remember how to live without me." "No matter what, I can't be avoided. I am one of the oldest theories she's ever nurtured and probably the most recurring.", and "An added bonus is that you can be with them for the rest of their lives, maybe not actively, but you learn when to hide and when to come back into the open." Another haunting entry consistent with ever-presence was "_____

can't run or hide from me and I will NEVER leave her. We will die together someday, or be alone in her thoughts and no one will shed a tear."

ED is described with characteristics that make it indestructible or omnipotent. Five individuals portrayed ED as having qualities that make it unbeatable. "It's great fun; if only all were as lucky as I to be indestructible, and keenly intuitive about what makes her tick." Several individuals described this indestructibility as a war which ED claims to win. "The day that she will be fully free of me is the day her heart stops beating….I'll be back.", "She can't fight me all the time.", and "She would have me to deal with."

Although this endurance of eating disorder is present in the current research, not much previous research has been conducted in this area. Narrative psychologists, through the use of externalization have elicited similar descriptions of eating disorders (Epston, Morris, & Maisel, 1995 and Nylund, 2000).

*Allies to eating disorder*

Narrative therapists, Roth and Epston (1996) often describe things, people, and feelings that are in "alliance" or "league" with the problem. Participants in the current study often described shame, guilt, anger, depression, confusion, and insecurities as being allied with their eating disorders. Of the 15 individuals, 10 expressed ED in terms of its connections to their feelings. One individual spoke of how ED seemed to wane in the midst of guilt, but later explained that ED was "a way to fix her guilt." Another story reflected, "She started to excel, to learn, to love herself. I made her feel guilty for this." Previous research supports the link between shame, guilt, and ED, both in terms of bodily shame and character shame (Swan & Andrews, 2003).

Several participants described alliances between anger and depression and ED. Research has indicated that how anger is managed and expressed is overall character strength (Fassino, Daga, Piero, Leombruni, & Rovera, 2001). Within the present study anger was present in 4 stories and was often expressed in relation to family/social situations, which sometimes provided an entry for ED. ED also reminded the person of times of depression, or as one individual shared, "I color the long-term with a certain, faint shade of depression, because I know that as long as I'm around, nothing will truly make my victim happy or fulfilled." Within another individual, ED stated "…that doesn't stop me from bringing my good friends depression & anxiety to cause her problems." Both anger and depression were represented in 4 participants stories each, for a total of 8 participants, and as such, the results are likely to be more tentative.

Two individuals expressed a connection between ED and confusion and insecurity. Although this sub-theme is a smaller representation of the total sample and results are likely to be more tentative, it conveys powerful examples. "She's confused and lonely and I know she doesn't want to resort to me, but its almost unconscious, automatic." "She gets confused and feels defeated about her fat little body so she pretty much just gives up & I get to take the wheel then." These expressions suggest that the individual is more vulnerable during these emotional times and also echo the findings found in the endurance theme regarding *ever presence*.

*Sexuality*

Researchers have studied the relationship between sexuality and/or sexual abuse and eating disorders extensively (Fallon & Wonderlich, 1997; Ghizzani & Montomoli, 2000; Gordon, 2000; Gutwill & Gitter, 1994). In addition to the7 of 15 individuals who

shared dating issues, sexual body shame, and/or avoidance of sexual relationships, six participants expressed ED in sexual terms. In one participants' story, ED clearly takes on a male persona and writes almost as if it were a manipulating boyfriend. "Yeah, I've got a pretty good set of lines. I guess you could even so as far to call me one smooth bastard. Big Pimpin." In another story, ED actually states that it is "her secret lover."

Other participants described ED in more subtly seductive ways. ED expressed sexuality in connotative language. The relationship between ED and the participant are described as intimate, and one participant even used the word "affair" to describe their relationship. In another story, ED described their relationship as a secret hidden from the parents. "…they [parents] got pretty angry and threatened to send her to a treatment facility unless we ended the affair. …we ran into each other during her 1st year at college. We met in private…." Other examples included "I won't hurt you.", "I'll always be here", "I want her to use me", "I love her indiscriminately", and even so extreme as "I want her to love me and die with me and I know that she wants that too."

*Inner strength*

The above sections have outlined and analyzed the themes of stories that are related to who eating disorder is, how it is perceived by the individual, and how it infiltrates the various parts of participants' lives. While more negative and restrictive themes are pervasive, there also emerged threads of the participant strengths in the face of the eating disorder. Traces of inner strength were especially evident when participants wrote about times they were without the eating disorder. Seven of 15 stories contained elements of inner strength. ED's primary reactions were typically through anger or insecurity. In one story, ED said, "Two years ago, regardless of whatever happened

during the day, if ____ had lost weight, then she would be totally happy. That this is no longer the situation, really pisses me off." Another participant related "Slowly, very slowly _____ is beginning to challenge me. Challenge my importance & challenge my beliefs. How dare she. She can't survive w/out me, yet she is beginning to." In another, ED said, "I'm sure if I'm persistent I can break the wall of Health she has so diligently built." In another, "Now its as though I have to fight my way to get her to do what I want. Sometimes she blocks me out completely giving me no way in at all." Finally, one individual talked about the effects of treatment on her strength. "…she has developed what ____ calls "anchors" which are people she turns to that help her deal with life. She has been reaching out to them and not to me and it pisses me off."

Not only did ED express anger at the seeming strength of the individual, it expressed insecurity found in other participants' writings. "Knowledge" was viewed as the worst hindrance for ED. In another story, ED said, "I'm starting to worry, because she is beginning to pick up steam with her therapy, her relationships, her activities, and the schoolwork she enjoys."

In a few stories ED suffers from what might be described as the "puffer fish" syndrome. This result is also likely to be tentative with a total of 3 participants, but remain powerful examples of ED's reaction to change. When participants began to realize their inner strength, ED blew up like an oceanic puffer fish to make it look bigger than it was, expressing bombastic anger or express pervasive insecurity. For example, immediately following ED's expression of how a participant was gaining strength, it said "I will never leave. I am a part of her. I am as much a part of her as her eyes or soul….I will be there. I will be waiting patiently until she begins to forget, & then I'll be back."

Another person wrote, “She is trying to prevent me from coming back full-force. This hurts me. It makes me angry. It makes me want to scream at her at the top of my lungs ‘You are making a big mistake! Don’t get rid of me!” Finally, “I’ve worked hard to get where I am. I’m the boss & nothing’s going to change that! So I’m not sweaten it….okay…maybe I have been feeling a bit insecure lately…but I refuse to just give in. I want to be in charge & I will be!” Each of these expressions indicated that even ED fears not being everlasting and/or omnipresent. The extravagant display of anger and invulnerability may cloak its own insecurities.

*The Voice*

ED sometimes attempted to hijack this research project, claiming to have been given a voice through the writing assignments. In 3 of 15 stories ED bragged about its growing embodiment through participant writings and provides tentative evidence of ED’s ability to adapt to changing situations. ED expressed a certain amount of joy and added security in being able to become “real”, “I am getting a voice. She likes to pretend I don’t exist, but these are my words, and what has words has existence.” At the same time, ED expressed some concern that this reality may make it more vulnerable. “Oh, but now, I’ve been given a voice, not a sneaky in her head voice, but a real on paper voice. I’m not sure about this whole …thing. She exposes me for what I am, and that could do some damage…”

## Discussion

The pre/post difference on the Adult Nowicki-Strickland Internal External Locus of Control (ANSIE) approached significance. Participants post scores were lower than their pre scores, where the lower the score, the more internal their locus of control. It

may be that the act of externalization allowed the individual to begin to experience more internal control over their lives. Individuals reported being able to see greater difference between those adjectives chosen for eating disorder and those chosen for preferred self. This internal locus of control, which may have been impacted by the externalizing writing process, may have allowed the individuals to feel more power over their eating disorder. It is possible that through the externalizing process, they were able to see a difference between the eating disorder and themselves.

The basic principle of externalization is that it is able to separate the person from the problem, thereby bring the focus on the problem and away from the person (Freedman & Combs, 1996). As Stacey and Hills (2001) indicate, externalization can not only separate the person from the problem, but also help determine the relationships between the person and the problem. Often individuals become so enmeshed with their problem that they are unable to see an escape from it and may begin to feel that they are not in control over their fate, similar to what White (1990) calls "problem-saturated stories." It is possible that through the act of writing a story about their problems from eating disorder's perspective, clients in this study, as reflected in the results of the ANSIE, were able to begin to separate themselves from eating disorder and perhaps feel more control over their lives.

Perhaps the most striking of the results was found in the qualitative data. Eight themes emerged from the analysis of the participants. They included: self concept, family/social relationships, eating disorder character, deification of eating disorder, allies to eating disorder, sexuality, and inner strength. The themes that emerged are similar and reflective of previous research concerning eating disorders and family support, body

dissatisfaction, perfection, and emotions (Fassino, Daga, Piero, Leombruni, & Rovera, 2001; Fraze, 2000; Lin and Kulik, 2002; Olson, 2000).

The problems of low self concept often interweave complex issues, such as: body dissatisfaction, comparison, and perfection/worthlessness. Together, participants frequently claimed to feel shame and distaste with their own body as they compared themselves to ideal bodies, and in the same breath expressed a strong desire to be perfect. This constant focus on unattainable perfection and a need to embody an image that is impossible, keeps the person from dealing with other issues. For example, several participants discussed counting and recounting every calorie they consumed as well as those that weren't consumed. Consequently other daily tasks/problems are left unaddressed. In addition, several participants engaged in the act of constantly comparing their bodies to others. This ideal person was always the same: blonde, thin, tall, and popular. Participants claimed to spend inordinate time focusing on how they could manipulate their bodies to achieve this impossible goal. Further, they reported condemning themselves each day for being unable to reach such an ideal.

Along with individual self concept, there was a consistent inverse relationship between eating disorder and family/social relationships. All participants reported that they were without eating disorder when they were with others and indicated that eating disorder needs isolation to gain power. When participants were involved in relationships eating disorder was less of a problem. The eating disorder needed secrecy. Participants struggle with eating disorders in private, perhaps because of the possible ridicule and shame that would result from exposure. The more they trusted and engaged in relationships with others, the more they risked others knowing about their struggles.

Participants described being in a predicament in which they had a choice to either engage in social activities and ignore eating disorder, or to avoid social situations and consequently indulge their eating disorder.

Participants described how the eating disorder attempted to persuade them to avoid relationships. The eating disorder often pointed out the faults in relationships. Eating disorder focused attention on problems in familial and friendships. For example, often ED convinced participants their parents/family thought they weren't pretty enough, thin enough, or perfect enough. They typically responded by striving to make their families happy by secretly starving themselves, thinking that would help them to achieve the standard of beauty that would make them acceptable. Many participants felt intense shame and engaged in avoidance when their eating disorder was "exposed." Participants often found themselves in a downward spiral in which eating disorder became more convincing in its arguments that the individuals were worthless, which invited more eating disordered behaviors, more shame, and a seemingly inescapable cycle begins.

Participants described eating disorder having complex characteristics and were among the most consistent of the themes. Participants' ascription of characteristics to eating disorder may shed light on the relationship that was built between the individual and the problem. Eating disorder was not only seen as condescending, belittling, and manipulative, but, interestingly enough, also as comforting and caring. Roth & Epston (1996) talk of how problems may have at one time been useful and/or necessary to the individual and may be seen as a friend or ally. If this is also possible with eating disorders, there may be two crucial points to consider. Suppose you and a bully who you consider your best friend go to a camp and the camp leader tries from the first day to

separate the two of you and convince you that your friend is really mean and doesn't care about you. All you know is that this bully, who sometimes picks on you, also makes sure that no other kids tease you, pick on you, and hurt you. The participants in this study appeared to have a similar relationship with ED. It was something that clearly was causing problems for them, but also as a protector and friend. As such, it is likely something that the person isn't willing to give up immediately. Further, considering the current focus on the thin ideal perpetuated in today's society, some clients may be reluctant to give up such a seemingly socially appropriate skill.

The deification of eating disorder was also a theme that was pervasive among participants. Many described ED as having almost superpowers that allowed it to be everywhere, know everything, and see everything. Related to the idea of "problem-saturation" by White (1990) is the possibility that individuals are so consumed with eating disorder that there doesn't seem to be an escape. One of eating disorders skills seemed to be to convince the person that it is and would always be around. Participants often reported first experiencing ED early in their life, and that they know every intimate detail about the person. Eating disorder had convinced them that it was omnipotent, that is, so powerful that the person has never been able to escape, and never will be able to.

A significant number of participants reported that eating disorder enlisted the help of other struggles/emotions in order to gain further power. As Roth and Epston (1996) suggest, problems can enlist the assistance of other problems in the persons' life and make them seem even more insurmountable. For example, they reported that their eating disorder frequently struck an alliance with shame. Several participants described feeling ashamed that they had worried their parents because of their struggles with their eating

disorders. This caused them to retreat from their parents into isolation that exacerbated their problems with eating. They began to restrict and purge more frequently.

Other emotions enlisted by eating disorder included depression, anger, and insecurity. For example, if eating disorder was able to convince the person that she was a failure because she couldn't lose weight, she was likely to feel guilt, depression, and insecurity. The longer or more often this occurred, the more power the eating disorder gained over the person. Psychologically, this may become a function of another downward spiral in which participants begin to feel physical "failures" as personal failures and begin to feel shame, which often leads to depression. Participants expressed anger at parents' divorce, perceived favoritism of siblings, and other conflicts. Participants also described how eating disorder convinced them that their family conflicts were a reflection on them. Eating disorder was able to convince the person that if somehow she were thinner, better, smarter, prettier, the problems she was angry about would dissipate and they would feel secure. In other situations, participants expressed eating disorder as being their comfort, providing a sense of sensuality, sexuality and love. Not only were descriptions of eating disorder being manipulative, but also the intimacy that emerges from a very close relationship. Participants described eating disorder as knowing them intimately, as a secret lover. The alliance between eating disorder and these "positive" feelings only lend to add to the complexity of emotions that are involved with eating disorders. One can only speculate whether the sexual descriptions were related to a connection between eating disorders and sexual abuse as described by Gutwill and Gitter (1994)

Finally, several participants discussed an inner strength that emerged, possibly through treatment around the eating disorder. This likely emerged through realizations that what eating disorder had been telling the person for so long wasn't really truth. It may be that as participants began to see that there were "holes" in eating disorder's story, other fallacies may also exist. Psychologically, the challenges to commonly held stories and abilities to see a difference between perfection and reality may be foundations to illicit this change.

*Clinical Implications*

Externalized story writing is a simple technique that allows exploration of unique aspects of the individual (White, 1995). Many clients shared that it allowed them to express a different perspective about their eating disorder that otherwise would have been censored out. Perhaps one of the assets of the externalization writing technique is that it is easily adaptable to a variety of therapeutic situations. For example, a cognitive behavioral therapist may utilize the externalized writing technique as a writing assignment. They and their clients may look at irrational thinking in the stories. An insight therapist might examine the stories for their unconscious content.

A narrative therapist might help their client to differentiate themselves from the eating disorder. In response to the data gathered from this research, a particular the bully theme, a narrative therapist might validate clients in their need to see ED as caring and supporting may develop a more profound rapport with them. Further, therapists may eventually be able to help clients see that the care and support they see in eating disorder may exist in them and be utilized in a more healthy way. Perhaps, eating disorder can teach the individual about how to care for and love themselves? ED may have first

emerged as a way to protect the individual from a perceived harmful environment. It may also be that through ED, the individual has developed skills for self-care and self-protection that need only be sifted and transferred from ED to the individual.

One of the clearest themes that emerged was how the person was without ED during times of connection to others. One clinical implication of this may be to include social skills, support, and involvement as an integral part of overall therapy. In addition, since eating disorders can be seen as influenced by societal standards, it is likely that therapists would also include buffers and/or supports that will help the individual combat possible negative social messages.

While the notion of story writing/journaling has long been a technique used in clinical practice, the externalization technique expands on the regimen of typical journaling to a writing process by helping clients distance themselves from their problem. Both therapist and client can examine the writing samples for opportunities and "unique outcomes." Clinically, this can impact the function and movement of therapy by providing the therapist with information that may otherwise may be missed. Using the externalized writing, the therapist learns what the problem means to the client in a manner that may not have been shared in a face to face interview.

The I-SPI can also be a powerful clinical tool for periodic assessment and treatment. For example, several of the stories indicated an increase in the passion or struggle for eating disorder. This was especially found in those stories that contained the "puffer fish" and omnipotence themes. Graphically, the average of all correlations on a line graph indicates that at this point, the relationship between self/eating disorder was the most related. In other words, at the point that the stories reflected eating disorder

expressing itself passionately and emotionally, the relationship between self and eating disorder was most strongly related. Since the I-SPI looks at correlations, the greater the negative correlation, the more disparate the relationship between self and eating disorder. At this point, the difference is the least negative of all I-SPI's. The technique I-SPI, provides the therapist with a unique window of how this individual sees their world.

*Limitations of the Study*

In regard to quantitative results, the small sample size used in this study is a limitation. The small sample would have required great power to show significant results and therefore would be difficult to interpret. Further, the demographic sample used in the study came largely from a single counseling practice, involving two different therapists. There was one additional participant who was working with another therapist. Because the majority of the sample was localized, generalization is limited. Another possible constraint of the current research was that individuals participated in the research project while they were in the counseling setting. It was therefore, difficult to control for extraneous variables such as noise levels and distractions of the office.

Another possible limitation was the method of coding and the possible bias and subjectivity that may have been present. It is likely that an objective individual to triangulate the qualitative results would have enhanced and strengthened the validity of the findings.

In addition, the act of externalization could be a limitation in itself. Although there are advantages in terms of therapeutic change in using externalization, it is also possible that certain disadvantages could occur. For example, for clients who may exhibit disassociative coping skills, the act of externalization could invite the emergence

of these potentially problematic skills. As such, it is crucial that a therapist who is using this type of intervention be cognizant of the possible challenges and/or possible negatives to this process, as well as their advantages.

Finally, there may have been confounding quantitative information because all participants were invited to participate in both phase I and phase II regardless of experimental condition. As such, the participants who were in the control group wrote only three stories from the externalized perspective while those in the experimental group wrote four externalized stories.

*Future Directions*

As in clinical work, much of the research on eating disorders has addressed behavioral attributes of the problem: eating habits, negative "self-talk", family dysfunctionality, and other tangible aspects (Cottrell & Boston, 2002; Miller & Pumariega, 2001; Neziroglu, Hsia, & Yaryura-Tobias, 1997; Peterson & Mitchell, 1996). Narrative psychology has been under-researched and has been largely with single individuals, often within a case study. This research opens the door to exploration of narrative techniques in a more empirical fashion than has previously been achieved. With a larger sample, both traditional assessments and the Q methodology instrument may yield significant results.

This research project focused on a specific narrative technique's effectiveness to bring about a specific change in a unique population. This focus may be a blue print for future narrative studies. For instance, future studies may utilize a narrative technique such as deconstruction when working with "obsessive-compulsive" clients. Also, the technique and its effectiveness may be monitored in therapy sessions rather than in

writing. Finally, there may be comparative studies of participants in more distinct control/experimental categories as well as comparisons between narrative and other types of therapy.

Finally, these stories can become a part of continual therapy. For example, an individual can write an externalized story during the initial stages of therapy, throughout the process, and at termination. Externalization could be a means of eating disorder writing good-bye to the client when they feel the person is ready, or a letter to eating disorder from the individual when they are strong enough to be "ok" without it.

*Concluding Comments*

The primary focus of this study was to determine the effectiveness externalization in written form, in changing the relationship between the person and the eating disorder. Using a small sample from a clinical population, quantitative and qualitative measures were analyzed. These analyses provided differing information and unique perspectives.

This study provides evidence of clear and definable themes that are consistent and supported by previous research. Further, this study provides a unique expression of how eating disorders "personality characteristics" of eating disorder emerge, are substantiated, and how participants perceived opportunities for liberation from eating disorder's control. This research study provided evidence that externalization may effect changes in the participants' relationships with their eating disorder. Through the externalized story writing, participants may experience some freedom from the power of the eating disorder. Making eating disorder a separate entity allowed the participant to explore origins, means of power and control, and ways in which individual strength can be increased, hopefully to a point where the individual no longer needs the eating disorder.

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# Tables

Table 1
Demographic Information (N = 16)

| Category | Number | Percent |
|---|---|---|
| Ethnicity | | |
| Caucasian | 14 | 75 |
| Hispanic | 1 | 6 |
| Eastern Indian | 1 | 6 |
| Education Level | | |
| High School | 1 | 6 |
| Some College | 11 | 25 |
| Undergraduate | 4 | 69 |
| Living Arrangement | | |
| Alone | 7 | 44 |
| With Roommate | 5 | 31 |
| With Partner | 1 | 6 |
| With Family | 3 | 19 |
| Type of Counseling | | |
| Individual | 7 | 44 |
| Group | 1 | 6 |
| Individual and Group | 6 | 38 |
| Individual and Family | 2 | 13 |
| Hospitalization | | |
| Yes | 12 | 75 |
| No | 4 | 25 |
| Other Counseling | | |
| Yes | 9 | 56 |
| No | 7 | 44 |

Table1a

Demographic Information

| Category | Min | Max | Mean | Std.dev |
|---|---|---|---|---|
| Age | 18 | 31 | 22.06 | 3.27 |
| Years with Eating Disorder | 1 | 14 | 7 | 4.1 |
| Counseling for Eating Disorder | 2 mo | 5 y | 1.49y | 1.45 |
| Length of Hospitalization | 2 mo | 9 mo | 5 mo | 3.47 |
| Length of Previous Counseling | 2 mo | 5 y | 1.42y | 1.5 |

N = 16

Table 2

Descriptive Statistics Phase I

| | Group | N | Mean | Sd |
|---|---|---|---|---|
| EDI2 | 1 | 8 | 94.13 | 41.33 |
| | 2 | 8 | 97.88 | 37.62 |
| ANSIE2 | 1 | 8 | 11.13 | 4.58 |
| | 2 | 8 | 12.00 | 3.29 |
| SPS2 | 1 | 8 | 0.58 | 0.27 |
| | 2 | 8 | 0.48 | 0.43 |
| SED2 | 1 | 8 | -0.22 | 0.31 |
| | 2 | 8 | 0.11 | 0.42 |
| PED2 | 1 | 8 | -0.65 | 0.005 |
| | 2 | 8 | -0.33 | 0.42 |

Descriptive Statistics Phase II

| | Group | N | Mean | Sd |
|---|---|---|---|---|
| EDI | 1 | 15 | 101.38 | 38.92 |
| | 2 | 15 | 101.31 | 38.27 |
| | 3 | 15 | 94.46 | 40.14 |
| ANSIE | 1 | 15 | 12.15 | 4.28 |
| | 2 | 15 | 11.31 | 4.17 |
| | 3 | 15 | 10.69 | 3.86 |
| SPS | 1 | 15 | 0.45 | 0.28 |
| | 2 | 15 | 0.52 | 0.35 |
| | 3 | 15 | 0.45 | 0.33 |
| | 4 | 15 | 0.49 | 0.37 |
| | 5 | 15 | 0.45 | 0.36 |
| SED | 1 | 15 | -0.004 | 0.28 |
| | 2 | 15 | -0.009 | 0.37 |
| | 3 | 15 | -0.0004 | 0.36 |
| | 4 | 15 | -0.11 | 0.41 |
| | 5 | 15 | -0.101 | 0.4 |
| PED | 1 | 15 | -0.47 | 0.33 |
| | 2 | 15 | -0.54 | 0.21 |
| | 3 | 15 | -0.44 | 0.29 |
| | 4 | 15 | -0.46 | 0.35 |
| | 5 | 15 | 0.4 | 0.35 |
| | | | | |

Table 3

Phase I

Multivariate Analysis of Covariance

Multivariate Tests

| Source | *df* | F | η | *p* |
|---|---|---|---|---|
| EDI1 | 5 | 85.739** | 0.99 | <.001 |
| ANSIE1 | 5 | 4.964* | 0.83 | 0.05 |
| I-SPI Self/Preferred Self1 | 5 | 0.379 | 0.28 | 0.84 |
| I-SPI Self/Eating Disorder1 | 5 | 0.316 | 0.24 | 0.88 |
| I-SPI Pref Self/Eating Disorder1 | 5 | 0.329 | 0.25 | 0.87 |
| GROUPID | 5 | 0.466 | 0.32 | 0.78 |

* $p$ = .05
** $p$ = <.001
Covariate = EDI1, ANSIE1, SPS1, SED1, PED1

N = 16

Table 4

Phase I

Tests of Between Subjects Effects

| Source | Dependent Variable | *df* | F | *p* |
|---|---|---|---|---|
| EDI1 | EDI2 | 1 | 98.53** | <.001 |
| | ANSIE2 | 1 | 0.67 | 0.434 |
| | SPS2 | 1 | 0.281 | 0.609 |
| | SED2 | 1 | 0.461 | 0.514 |
| | PED2 | 1 | 0.625 | 0.45 |
| ANSIE1 | EDI2 | 1 | 0.235 | 0.639 |
| | ANSIE2 | 1 | 42.77** | <.001 |
| | SPS2 | 1 | 0.95 | 0.355 |
| | SED2 | 1 | 2.1 | 0.181 |
| | PED2 | 1 | 0.014 | 0.908 |

** $p$ = <.001

N = 16

Table 5

Qualitative Endorsements

| Theme | Sub-theme | Number Endorsed |
|---|---|---|
| Self Concept | Body dissatisfaction/appearance | 10 |
| | Perfection/worthlessness | 14 |
| | Comparison to others | 6 |
| Family/Social Relationships | Unique Outcomes | 15 |
| | Isolation | 9 |
| | Replacement of significant other | 7 |
| Eating Disorder Character | Degrading/manipulative/oppressive | 6 |
| | Caretaker/teacher | 8 |
| Deification of Eating Disorder | Omniscience | 7 |
| | Omnipresence | 7 |
| | Omnipotence | 5 |
| Allies to Eating Disorder | Guilt/shame | 4 |
| | anger/depression | 4 |
| | confusion | 2 |
| Sexuality | | 6 |
| Inner Strength | Anger | 4 |
| | Insecurity | 2 |
| Puffer Fish | | 3 |

N =15

# Appendix A: Prospectus

RUNNING HEAD: Narrative Therapy and Eating Disorders

# The Impact of Narrative Storytelling on Cognitive Re-Composition in Individuals Struggling with Eating Disorders

A Dissertation as Partial Completion of the Doctoral Program in

Counseling Psychology at the

University of Oklahoma

by

Chelle' Marie Lodge-Guttery, MS

# The Value of Narrative Therapy in Creating Space and Change in Individuals Struggling with Eating Disorders

Once upon a time, our society valued shapes such as Marilyn Monroe; the voluptuous, round, sexy shape. This was the goal that females attempted to emulate. Today, psychologists are beginning to wish for those days again. In our society today, Ms. Monroe would be considered big and beautiful, full-figured, and dare I say fat. Today, what females hope to be like when they "grow up" is the emaciated shape of many of today's idols.

Eating disorders are reaching epidemic proportions. In fact, a recent article has named eating disorders the fastest growing category of psychological disorders (Schwitzer & Bergholz, 1998). Eating disorders has been divided into three sub-categories, anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (American Psychological Association [APA], 2000). Each of these categories has similarities and differences; among the commonalties is an extreme fear of gaining weight and obsessions to control weight gain or food consumption (Castillo, 1997). Current treatment for eating disorders has primarily focused on means to alter underlying fears and obsessions that leads to dysfunctional eating behaviors, such as the cognitive behavioral approach and the addictive model (12-step), which emphasizes a strong support system. Other common treatments include a psychoeducational, psychodynamic individual, group therapy (Brisman, 1996; Morris, 2001), and various forms of family therapy (Colahan & Robinson, 2002; Eisler, 1996; Fishman, 1996) However, despite their individual successes and usefulness, relapse is high, and overall treatment is often incomplete in the long term.

Recent alternative approaches, which do not abandon, rather extend, the above approaches has evolved from postmodern thinking. Foundational for much of the postmodern philosophies is the idea that reality is socially constructed. That is, what we call "reality" is filtered through individual and collaborative language, which is never a perfect replica of an external reality. In recent years, postmodern/social constructionist thought has been debated heavily in all areas of the social sciences. Many "modernist" social scientists who espouse a mimetic perspective of language and reality, who advocate a "hard" empirical, even chemistry-like scientific approach to psychological research, have opposed the social constructionist approach. William Gergen (2001) is one of the most vocal and passionate current advocates of postmodern/social constructionism within the realm of psychology. He discusses the subtle, yet visible ways in which postmodern/social constructionist philosophies have begun to challenge the modernist camp.

A recent psychological approach emerging from the postmodernism/social constructionism Gergen espouses is Narrative Psychology, developed by Michael White and David Epston (1990). Narrative psychology offers individuals a means of understanding the world in terms of the stories they tell themselves. Central to Narrative Psychology is the premise that meanings are socially constructed yet experienced by every individual subjectively (White & Epston, 1990). This social construction has provided a philosophical framework for many psychologists to apply new approaches to practice with individuals in crisis. Assuming the socially constructed aspect of eating disorders, Narrative Psychology believe they have begun to make some critical advances in terms of success with these individuals that have not been seen in more popular

therapies (Duran, Cashion, Gerber, & Mendez-Ybanez, 2000; Kahle, & Robbins, 1998; Zimmerman & Dickerson, 1994).

Research of social constructionist approaches, in particular, Narrative Psychology has proven to be challenging. Standard forms of assessment seem to be inadequate in understanding the stories and intricacies of the individual in the therapy process. More and more researchers whose basic precepts are social constructionist by nature have moved increasingly toward combining qualitative approaches with traditional quantitative approaches. In some cases, researchers have adapted Q methodology to measurement in this area (Hamlin & Knight, 1997; Knight & Doan, 1994; Knight, Frederickson, and Martin, 1987). Although relatively new to the area of psychology, Q methodology was developed 50 years ago by William Stephenson (Brown, 1999). The process of Q-methodology allows for the subjective to be quantifiably measured. Brown argues that Q-methodology is able to compete with other forms of behavioral analysis in terms of internal causal variables. Postulates are achieved without sacrificing the value of subjectivity; my thoughts, feelings, and behaviors are mine (Brown, 1999). There are several advantages to a subjective behavior analysis. One, a person's opinion about a given thing is simply their opinion, while its relationship to any "truth" or "actual event" is a separate matter. These opinions serve as validation for their individual experiences and become part of their reality.

The Idiographic Self Perception Inventory (I-SPI), which will be used in the present study, is a computer psychometric instrument developed and tested by Mike Knight and Bill Frederickson on the University of Central Oklahoma campus (Knight & Doan, 1994). I-SPI is postulated on Q-methodology and uses the Q-sort technique

previously discussed. The I-SPI allows an individual to rank order adjectives according to its level of "fitness" to any given condition of instruction. The I-SPI concourse uses adjective presentation that was normed by Anderson (1968). These adjectives are selected randomly from each of seven categories of similarity (one being most dissimilar, seven being most similar) from 555 normed from the most to least favorable adjectives. Adjectives are "rank ordered" for each condition of instruction and analysis is used by identifying significant correlations between these conditions.

As a result, one may ask, "Is there a way to combine an epidemic like eating disorders with a proven successful treatment modality to facilitate change?" "If so, how best to attempt such a task?" Brown (1999) has provided a possible explanation in the form of subjective behavior analysis utilizing a Q-methodology. This methodology allows behavior to be studied subjectively, one individual at a time. Thus an individual struggling with an eating disorder is able to explore her perceptions and thoughts through a statistical procedure that is both inductive and deductive.

The first task of the present study will be to discuss key methodologies in a theoretical framework. The first subsection is a description of eating disorders from individual, social, and biological contexts. The second section looks at current treatment models. The third and fourth subsections are discussions of the basic predispositions and principles of narrative therapy as well as the effectiveness of a life story journaling treatment. In the fifth subsection, there will be a detailed discussion current measurement tools leading to a discussion of subjective behavior analysis and Q-methodology.

## The Issue

*What is an eating disorder?*

Eating disorders include features found in obsessive-compulsive or addictive behaviors. It is often seen as similar to obsessive compulsive disorder, with the compulsion being in relation to restriction or bingeing on food, and obsessive behaviors towards calorie counting or exercise (American Psychological Association [APA], 2000). It is also commonly linked with other addictive disorders such as drug or alcohol, with the food itself serving as the additive substance. Mood alterations have also been linked to eating disorders. With any sub-category of eating disorder, mood-altering chemicals in either the food or the body are activated (Castillo, 1997). For example, bingeing on high sugar items or excessive exercise will induce chemical changes in the body that mimic those of other drugs. There are three main categories of eating disorders included in the Diagnostic and Statistical Manual Fourth Edition, (APA, 2000) Anorexia nervosa, Bulimia nervosa, and Eating Disorder Not Otherwise Specified.

Anorexia nervosa has been defined as refusal to maintain a normal body weight, within 85% of normal weight for height and age and intense fear of gaining weight or becoming fat regardless of low body weight. Other characteristics include disturbance in how weight is perceived; including obsession about weight, food intake, and shape, the denial of seriousness of weight, and the cessation of menstruation in age-appropriate females. There are two sub-categories within the diagnosis of anorexia known as restricting type, consisting of only restriction of calories and exercise, and binge-purge type, which is characterized by occasions of bingeing on foods purging them (APA, 2000).

The DSM-IV defines Bulimia Nervosa as recurrent episodes of binge eating. Binge eating is consuming an amount of food that is usually greater in quantity than most people would eat during a similar period of time and under similar circumstances and/or a sense of lack of control over eating during the episode. Another symptom is usage of compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise. These compensations occur on average at least twice a week for 3 months. Finally, the perception of self is influenced by body shape/weight. The DSM-IV (2000) further divides Bulimia Nervosa into two types, Purging and Non-purging. The first involves self-induced vomiting and misuse of laxatives, diuretics, and enemas. The later does not involve use of behaviors described in purging type, but rather the use of excessive exercise or fasting as a means of compensating (APA, 2000).

The third type of eating disorder, which was not formally addressed until the fourth edition of the DSM, is diagnostically referred to as Eating Disorder Not Otherwise Specified, (NOS), which is defined as a combination of behaviors included in Anorexia and Bulimia Nervosa, and occurs with more frequency than the aforementioned types. For example, an individual who exhibits the low body weight of Anorexia and the binge/purge cycles of Bulimia would fall into this category. These individuals often show an intense fear of being "fat", however cannot maintain the restriction which is characteristic of Anorexia Nervosa (APA, 2000). Another example of Anorexia Nervosa NOS entailed meeting all criteria for Anorexia Nervosa except for the cessation of menses. Schwitzer and Bergholz (1998) continue to reinforce the necessity of the NOS diagnosis based on two conditions. These include symptomology not fully fitting the

diagnosis yet consistent with behaviors that lead to extreme debilitation. Before the addition of Eating Disorder, NOS to the DSM-IV, diagnosis of eating disorders was difficult and inadequate. Now, individuals who before had not been diagnosable are able to receive help. It is with these individuals that the final criteria is so necessary and is, in part, responsible for the increase in reports of eating disorders.

*How common are eating disorders?*

Persons with eating disorders are more likely to live in modern, industrial cultures where there is an abundance of food, and female beauty is associated with thinness (Castillo, 1997). This thin=beautiful stereotype as a measure of adequacy has led to an increase in both the incidence of eating disorders and a general dissatisfaction in the body for many individuals. Although females in general continue to become heavier with each generation, the ideal female becomes thinner (Harvard Mental Health [HMH], 1997). Females, in particular, are susceptible to the stereotype that being thin is what is desirable. The prevalence of eating disordered behavior among females is reaching epidemic proportions (Gordon, 2000). Eating disorders are more common in "industrialized societies" and those societies in which the continuation of thinness continues to be desirable (Miller & Pumariega, 2001). Further, Miller and Pumariega (2001) and many other researchers/clinicians agree that among all psychiatric illnesses, anorexia nervosa carries the highest mortality rate, yet seems to have been abandoned by much of the physical and mental health systems.

Eating disorders have become the most misunderstood and most culturally acceptable of all the diagnosable disorders. It is through the encouraging and perpetuating of thinness as the ideal that some individuals find themselves in the grip of

eating disorders. For example, several researchers have noted that the overall body dissatisfaction of women has increased as the ideal body weight has decreased (Garner, Garfinkel, Schwartz, & Thompson, 1980; Gordon, 2000). This message, juxtaposed with the concern over individual emaciation and food control may be sending contradictory information to young individuals that may already have other predispositions to eating disordered behaviors, like perfection, lack of control, fear of adulthood, and low self-esteem.

Anorexia and Bulimia Nervosa are more common in females, accounting for 90% - 95% of the eating disordered population. They occur primarily in adolescence and young womanhood (Castillo, 1997). Castillo (1997) adds that eating disorders on college campuses continue to rise. Until recent years, eating disorders on college campuses reflected the trend in the general population, about 1%. A recent study has identified as much as 25% felt that their eating was out of control, 6% used laxatives or induced vomiting after meals, and 35% to 45% of young women were extremely worried about body image and weight control. As more females are affected, diagnostic criteria become less useful due to the extreme variability between individuals. Of importance is that these changes and trends have expanded DSM-IV eating disordered criteria to include the category “not otherwise specified” (NOS) (Schwitzer & Bergholz, 1998).

*Distorted images*

Remember the “Hall of Mirrors” at the county fairs? It may be argued that the distortions seen in these amusement parks are analogous to what an individual suffering with eating disorders sees. As the incidences of eating disorders increases, so has the research to find common psychological traits for eating disorders. Questions have arisen

as to how they see themselves, why can't they control their behavior, what feelings that they have, and how they view the world. These wonderings have lead to views of eating disorders that are more forgiving than had previously been thought.

One of the common thought patterns of those struggling with eating disorders is a perception of viewing themselves as fat, regardless of actual weight. Garrett, (1998) challenges the theory that eating disordered see themselves as fat. She argues that these individuals often know they are thin. Despite this "knowing", their disturbance is found in the fear that they "feel" fat. She also discusses the lack of "body boundaries" that is present among many women in today's society, mainly in terms of what it means to be beautiful in this culture and who defines beauty. For example, the anorectic is refusing to accept others' versions of her and the bulimic is gushing out the invasion of others (Garrett, 1998).

Boundaries seem to be central to the eating disordered, particularly in terms of control. In short, these individuals tend to feel out of control of their lives. By controlling food by restriction or purging, anorectics or bulimics are able to achieve a sense of control over one area of their lives; an area that no one else can gain control of. Garrett discusses control more as a rebellion. By severe restriction, an anorectic can be attempting to gain control over her environment. At the same time, she is rebelling against that culture that demands she be "ideal" (Garrett, 1998). From this standpoint, it is seen as a "symbolic struggle against forms of authority and an attempt to resolve the contradictions of the female self" (Garrett, 1998).

## Perspectives Regarding the Emergence of Eating Disorders

*We make our own destinies by our choice of Gods.*
Virgil

### *Psychological Understanding of Eating Disorders*

As the prevalence of eating disordered behaviors increase, so do treatment modalities used for eating disorders, (Werne, 1996; Zimmerman & Dickerson, 1994). These researchers suggest that the strongest of the reasons for the increase in eating disordered behavior is that the individual is living in a society, which condones thinness. Many treatment procedures focus on behavioral or cognitive aspects that focus on observed symptoms when, in fact, the problem may be better approached in a more systemic as well as sociological way. In other words, in many cases, the eating disorder is not the problem; it is simply a manifestation of the problem that may be related to family or cultural issues, perfectionistic thinking, obsessive-compulsive natures, or many other struggles. Many of the current models are insufficient in terms of relational and social constructionist thinking thatlook s at eating disorders from a systems perspective. Research is growing that aims to identify the societal and cultural factors that contribute to eating disorders (Limbert, 2001). Eating disorders may be viewed as a persons' lack of familial differentiation, an over-emphasis on meeting expectations, or a need for the woman in the family to remain a child. Psychological approaches with eating disorders are rapidly changing as the field of psychology continues to search for successful treatment of eating disorders.

### *Common Etiologies*

#### *Gender Conflict*

One of the unanimously agreed upon aspect of eating disorders is that the vast majority of those struggling with eating disorders is female (APA, 2000; Gordon, 2000). Although there are potential genetic influences that predispose females to enduring eating disorders, one example is that women can physiologically tolerate starvation longer than a male, this cannot account for the large discrepancy found within eating disorders. Gordon (2000) discusses the influence of family and society on the facilitation of eating disorders by describing the feelings of inadequacy felt by many who struggle with eating disorders and the cultural push to be successful and independent while simultaneously encouraging behaviors that would keep a child dependent. Other researchers agree with Gordon's contentions and add that the increasing need for women to be in the public world and maintain the nurturance demanded in the private worlds leads to conflict that often cannot be resolved (Gutwill, 1994). This, in combination with the media perception that "women that have it all" are also thin continues to support the assumption that thin is ideal and better (Gutwill, 1994). Garner (1992, 1990) has included subscales within the Eating Disorder Inventory-2 that include two encompassing concepts. Drive for thinness, according to Garner (1990) is a construct intended to identify thoughts or feelings that represent an excessive fear of "fatness" and an insatiable need to be thin. In congruence, Body Dissatisfaction subscale is an identifier of how the individual feels about their overall body shape. The level of dissatisfaction is measured and in its extreme form is typical of individuals struggling with eating disorders. Certain body parts (stomach, thighs, hips, and buttocks) are more focused upon than others and are common etiological signs (Garner, 1990). Finally, perfection within this construct defines the level at which individuals have to perform above and beyond others and maintain unusually high

standards. Often individuals who struggle with eating disorders carry a high expectation for themselves and often feel like they are a constant "failure" (Garner, 1990).

*Sexuality and Sexual Abuse*

Instances of sexual abuse in those struggling with eating disorders have ranged from up to 80 percent in the late 1980's to 25 percent in more recent literature (Gordon, 2000). Whatever the prevalence, sexual abuse or sexuality can be seen in a correlational manner connected to eating disordered behavior. Consider the defining feature of anorexia nervosa of amenorrhea. The physical act of starvation to the point of cessation of menses results from lack of body fat and essential nutrients that menses cannot occur. The body at this point is often so emaciated that those curves and shapes that define female sexuality are no longer visible (Gordon, 2000). Gutwill and Gitter (1994) have a different understanding of the link between sexual abuse and eating disorders. In contrast to the physical changes, they postulate that eating disorders follow from sexual abuse related to familial and cultural avenues. Gutwill and Gitter (1994) believe that many families with abuse are also families that are otherwise restrictive and often these children grow in families with chaotic and problems with early feeding behaviors, the use of food as reward, punishment, discipline. Further, many of these families pass on feelings of shame and distrust of internal instincts and feelings (Gutwill & Giter, 1994). This aspect of internalization of shame has also been used as diagnostic instruments by Garner (1990) as interpersonal distrust or a fear of forming close relationships and an overall feeling of separation from other individuals. Further, Limbert, (2001) postulates that a need to keep others at a distance can begin the process of an eating disorder and that this becomes a reciprocal relationship between the need to keep the eating disorder

"secret" and isolation from others. Along with interpersonal distrust is an inability to correctly identify emotional states and to attend to physiological signals (Garner, 1990). A final distinction made by Gutwill and Gitter (1994) are intrapsychic adaptations that seem to result in an attempt to resolve an inability to escape trauma. For example, Gutwill and Gitter (1994) discuss the physical act of starvation to make one invisible or to become so emaciated as to be unattractive to a potential assailant. These assertions whether physical or psychological seem to be similar to those experiences of many with eating disorders and as such are important to remember that these are only some of the potential "causes" of eating disorders in modern society.

## Cultural Evolution Mirrors Individual Evolution

### *Evolutionary perspective from an anorexic framework*

The nature of eating disorders has a strong connection to cultural changes. Recent research suggests that there is some genetic or evolutionary predisposition to eating disorders. As the study of human behavior is seen more as an anthropological study, a rising question is if mental disorders on the whole have some ancestral gravity. In relation to eating disorders, is there a possibility that there is a genetic advantage to restriction of intake?

Some researchers have hypothesized genetic predispositions based on the physical characteristics of eating disorders: gender bias, delayed ovulation, amenorrhea, and decreased reproductive hormone secretions (McGuire & Troisi, 1998). These researchers understand the importance of the interrelation of genetics, culture and family in the causes of eating disorders and look at these through an evolutionary lens. The evolutionary theories associate eating disorders with female-female competition and delaying of reproduction.

Female-female competition involves competition among females to increase their attractiveness and availability to attract mates. Of course, this mechanism is most useful during and after sexual maturity has taken place, a significant factor in the onset of eating disorders. For example, both males and females engage in same-sex competition; however, females use derogatory statements about others' physical appearance more than males and are more observant of other females' body imperfections (Buss, 1999). By following this theory, if females are more likely to judge the body size and shape of others, it would seem logical for females to be more concerned in minimizing the

comments made towards them. In other words, a female may believe that the female who is the thinnest and has the best body shape wins with the opposite sex, this being one aspect of female competition, a vital aspect of evolutionary theory (Buss, 1999). In one study males and females rated various female shapes ranging from "thin" to "heavy." Researchers asked the question; "which female shape is the most attractive?" Males consistently chose a female body shape that was, on average, two shapes "heavier" than females chose (Furnam, Hester, & Weir, 1990), which further lends evidence that ideal female shape is more about female competition than about female attractiveness to the opposite sex. Singh (1993, 1994) reported that hip to-waist ratio (HWR) is a more salient feature of attractiveness than overall body shape. Their research indicated that both males and females were more likely to choose heavier shapes that had approximately .70 difference between hip/waist ratio than those slimmer shapes that did not maintain this ratio (Singh 1993,1994). Singh contends that overall attractiveness is measured by HWR by both males and females, but Furnham, et.al. (1990) assert that males prefer a more hourglass shape (representative of the HWR) than do females. These results were later replicated by Furnham, Tan, and McManus (1997) whose results were consistent with previous research.

Another theory of evolution that relates to eating disorders is the theory that by reducing body fat, women are able to control ovulation and therefore reproduction. This is seen as evolutionary adaptation in the event that the environment is not suited for child raising (McGuire & Troisi, 1998). Particularly in the anorectic population, fat reduction to the point of amenorrhea is common. Assuming that there is a predisposition that the "genes" know when the environment is suitable, anorexia can be seen as an effective

adaptation allowing the female to control ovulation until successful birth and raising is promoted by the environment. Another area of this theory postulate that girls fear that once puberty is reached there is an increase in the likelihood of male exploitation or that they may not be attractive to mates. From the previously mentioned study comparing attractiveness ratings of body shape, emaciated women are not only less attractive to males, but often lose ability to menstruate (reproduce) and therefore are less desirable. (McGuire & Troisi, 1998).

Although the above may be identified as adaptive mechanisms, that facilitate survival, today, these "adaptive mechanisms" may result in deaths. The drive for thinness, which may stem from genetic, social, family and individual differences may, in contemporary settings may become more destructive than adaptive.

*Eating disorders in the modern culture*

Evolutionary predisposition for eating disorders and modern culture are both likely to impact eating disorders. One could be related to the other. Throughout history, women have been known for their physical appearances and judged at least initially, on them. This cultural evolution begins at birth. Caretakers begin the process of acculturating the female to adapt to what is acceptable in the culture, what it means to be a female. This "consensual reality" is created and edited continually as the girl learns acceptable patterns of behavior, attitudes, beliefs, and thoughts (Dazzo, 1998). Katzman and Lee (1997) believe that a common reality is not necessarily the only factor in Western culture that invites eating disorders. Factors such as individual predisposition, genetic and environmental influences also contribute to the development of an eating disorder. However, researchers have noted that incidence ratings for eating disorders are

far greater in those societies which are inundated by models and media descriptions of what is assumed to be ideal (Gordon, 2000; Lin & Kulik, 2002). Support of this finding is found in the Harvard Mental Health Letter (1997) that found that cultures that are more impoverished and isolated, a fuller, healthier body is seen as an attractive in females. As stated earlier, it is important to remember that the development of eating is not merely about a media, social, genetic, or individual factors. Rather, the development of eating disorders is more likely a compilation and relatedness of each of these factors to varying degrees on the life of an individual. Eating disorders is a relationship between individual, family, and cultural values that are instilled and reinforced in females at birth (Katzman & Lee, 1997).

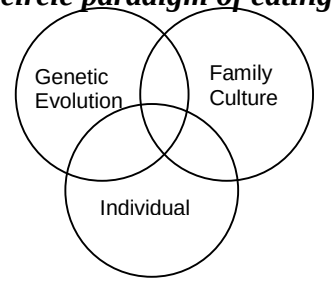
*The family as micro-culture*

The decision that eating disorders are either genetic or cultural will continue to be debated. Family is present at birth, providing the child with the first lessons of culture. In terms of culture, the family plays a foundational part in the social development of individuals. Often, the characteristics that are present at the onset of an eating disorder have been present for years in more subtle forms. Long before restriction or purging there was common behaviors found in many individuals suffering from eating disorders. Typically, these individuals were protected by parents, had many expectations placed on them, and were often criticized when expectations were not met (Schwitzer, & Bergholz, 1998). Families that promote dependence in the name of protection and engender perfection in the name of being successful can place undue stress on a young child. Families want their child to be safe from the outside world, and in particular, the opposite gender, and will often give subtle messages that are interpreted to the girl as

shame about her body and sexuality. These factors can often invite a girl who may already have a more vulnerable personality to develop eating disorders.

In *Psychosomatic Families, Anorexia Nervosa in Context,* Minuchin, Rosman, and Baker (1978), all well known systems therapists, discuss elements and characteristics of families with anorexic members. They highlight issues such as extreme enmeshment, rigidity, and expectations. As such, the child learns early that his/her own issues and self-actualization is far less important than the loyalty and protection of the family. Further, they discuss the stressing of bodily functions on each family member that might also serve to enlist the child to anorexia to be considered valued and an important member of the family (Minuchin, Rosman, & Baker, 1978).

***The three circle paradigm of eating disorders***




The above diagram is a useful visual representation of the factors leading to an eating disorder. From this diagram, it can be seen that eating disorders stem from three basic factors: genetic or evolutionary, family or culture, and the individual. Each of these elements has been discussed and it seems from previous research that it is unlikely that eating disorders are "caused" by any one of these three factors. It is more likely that an individual develops eating disordered behaviors through a combination of any of these influences. It is the interaction that facilitates the female cultural narrative of what we now call eating disorders.

## From Theory to Technique: Treatment Applications for Eating Disorders

Although there are several individual treatment models used with individuals struggling with eating disorders, most agree that despite underlying theoretical differences in treatment, there are educational and physical considerations to be made. As such, the most effective models for treating eating disorders include a multidisciplinary approach that includes physicians, nurses, nutritionists, educators, and psychologists (Bowers, 2002; Garner, 1992; Miller & Pumariega, 2001). The following treatment models, though different in terms of theory and technique, are all used within a multidisciplinary framework.

### *Cognitive-Behavioral Therapy*

Of perhaps all models used to treat individuals struggling with eating disorders, cognitive behavioral therapy is the most common. As the model dictates, CBT has integrated the behavioral component to address eating patterns and the cognitive component to target internal thought processes. Many of these researchers target changing behaviors, (Miller & Pumariega, 2001; Neziroglu, Hsia, & Yaryura-Tobias, 1997), indications for bulimia nervosa (Bowers, 2001; Wilson, 2002; Wilson, 2000; Wilson, Fairburn, & Agras, 1997), anorexia nervosa (2002Garner, Vitousek, & Pike, 1997; Wilson,), and thought processes (Garner, Vitousek, & Pike, 1997; Wilson, 2002). In addition to the above individual therapy, many researchers are studying the efficacy of group therapy from a CBT model. For example, Peterson and Mitchell (1996) outline an outpatient CBT group for individuals with binge eating disorder. They outline a treatment that begins bi-weekly for the first 6 weeks and weekly for the remaining two weeks. Their model, presented as a case study, concludes that the group model is

effective in reducing symptomology (Peterson & Mitchell, 1996). More recently, 4 phase Cognitive Behavioral Group model with an inpatient population, indicated that those who completed the therapy began to accept more responsibility for their eating behavior (Gerlinghoff, Gross, & Backmund, 2003). The effectiveness of CBT models and the current emphasis on empirically validated treatments have encouraged the manualization of treatments for eating disorders.

Manualized treatments have increasingly gained favor within the field of psychology, especially with the proliferation of managed care and the necessity to treat eating disorders within the context of multidisciplinary teams. As such, CBT has been manualized as a treatment model for various types of eating disorders including anorexia and bulimia nervosa, eating disorder NOS, and binge eating disorder (Bowers, 2001; Mussell, Crosby, Crow, Knopke, Peterson, Wonderlich, & Mitchell, 1999; Wilson, 2000). The prevalence of manualized treatments has the potential to increase service coverage and knowledge of professionals who work with individuals struggling with eating disorders. These treatments target typical behavioral and cognitive processes that are affected by eating disorders and also allow for increasing research into the efficacy of these treatments. Most recently comparison studies have been conducted that attempt to determine the efficacy of CBT with and without psychopharmaceutical interventions. Research has indicated that there is no significant difference in improvement in individuals as compared with those individuals who received CBT only (Wilson & Fairburn, 1998). Further, Wilson and Fairburn (1998) summarize research combining psychopharmacology with CBT, finding that in addition to non significant differences,

the dropout rate of CBT groups is lower, CBT is superior to drug treatment alone and long term maintenance is better with CBT.

Despite research to indicate that CBT is an effective model; researchers are not convinced that CBT is superior to other treatment methods. Much of the positive research to date has compared CBT with no treatment or placebo and has little follow-up research. Mussel et. al. (1999) conducted a study in which they surveyed various clinicians in order to determine the efficacy of empirically validated treatments. Their findings indicate that although CBT continues to have more research to support its efficacy in working with those struggling with eating disorders, most clinicians in the study did not use CBT in their practice with eating disorders. Additional studies have compared treatment models. Wiseman, Sunday, Klapper, Klein, and Halmi (2002) compared CBT with a psychoeducational group in a short term inpatient facility. Their findings indicated that, although staff and patients preferred CBT to psychoeducation, there was no statistical difference in the outcomes of the two treatments. Further, additional studies have found CBT marginally effective for adults, but inconclusive for adolescents and children (Lock, 2002). Other models, many based on the overarching tenets of cognition, have begun to surface and become popular as alternatives and additives to traditional CBT. Often, these models utilize both individual and group formats and add to cognitive processes, education and psychodynamic emphasis.

*Interpersonal and Psychodynamic Models*

Aside from CBT, interpersonal psychotherapy has been found to have the greatest efficacy in working with those with eating disorders, Interpersonal therapists maintain that increasing functionality of interpersonal relationships is cornerstone to decreasing

maladaptive behaviors (Wilson & Fairburn, 1998). For example, two studies conducted at Oxford and referenced by Fairburn (1997) indicate the efficacy of interpersonal therapy. The first compared focal psychotherapy with CBT and concluded that on most measures, focal psychotherapy elicited greater improvement in participants (Fairburn, 1997). The second study replicated the first and found that CBT was more effective in short-term follow-up (4-8 months), but that IPT was more effective at long-term follow-up (12 months) (Fairburn, 1997). From the evidence of this and other studies, the IPT program developed by Fairburn and others at Oxford seems to provide convincing data for the efficacy of IPT in working with bulimia nervosa (Fairburn, 1997). However, Fairburn (1997) also recognizes that the relatively slow progress of IPT as compared to CBT and suggests additional research and the use of IPT as an adjunct or alternative to CBT.

Many of the psychodynamic models also discuss the self-psychological model. Within this overarching theory is a drive-conflict and object relation model. Goodsitt (1997) explaines each of these models and the application of drive-conflict and object relations models are based on the preposition that self-starvation is a defense against sexual fantasies or unresolved oral incorporation, respectively. These early developmental failures and resulting lack of "selfhood" contribute or invite eating disordered behavior (Goodsitt, 1997). Goodsitt (1997) outlines the stages of therapy to include the beginning stage – patient reluctance, middle stage – establishing self-object transference, and termination stage. Another study suggested that supportive expressive therapy was as successful as CBT in binge eating, however, several limitations may hinder the validity of the findings (Wilson and Fairburn, 1988). Unfortunately, according

to Wilson and Fairburn (1998), with the exception of Garner et. al., there has been very few empirical studies determining the efficacy of psychodynamic therapies. Despite this, Wilson and Fairburn (1998), assert that psychodynamic psychotherapies continue to be common and favored in the United States.

*Family Therapy Models*

Although much of the research focuses on the individual processes of those struggling with eating disorders, family therapy has been used to treat families struggling with eating disorders. One of these motivations may be directly related to the proportionately large percentages of adolescents who are diagnosed. Several forms of family therapy have been adapted to working with eating disorders. Among these are structural (Fishman, 1996) and systemic (Asen, 2002; Cottrell & Boston, 2002). Fishman (1996) developed a family therapy program based on the following premises: The problem is maintained in the social context, each family strives for homeostasis, family patterns exist, and often a crisis is necessary to facilitate change in a family system. Other treatment models combine family systems with traditional individual therapy to illicit change both in the individual and within the system (Eisler, 1996).

Salvador Minuchin, a foremost family therapist discussed not only the "types" of families in which anorexics live, he, and his colleagues, outline strategies for change that include short and long-term goals, challenging family patterns, enmeshment, conflict and rigidity, and finally, ways to detour conflict (Minuchin, Rosman, & Baker, 1978). Other elements of the text include strategic and structured therapy sessions and out of therapy assignments. Despite the prevalence of treatment processes and models, there has been little empirical research conducted. Wilson and Fairburn (1998) note only one empirical

study conducted by Russell et. al. in 1987. Their conclusion of the research indicted that an unusually high dropout rate and poor outcome rendered this study inadequate in terms of efficacy. It seems that CBT remains the most empirically studied of all therapies with psychodynamic and family falling short in terms of empirical research.

## Post-Modern Thought: The Narrative Way

A quote:

> [Three umpires] are sitting round over a beer, and one says, "There's balls and there's strikes, and I call 'em the way they are." Another says, "There's balls, and there's strikes, and I call 'em the way I see 'em." The third says, "There's balls and there's strikes, and they ain't nothin' until I call 'em." (Walter Truett Anderson, 1990)

### *Modernism*

The objective of modernist thought is that there is a universal truth that all must ascribe to. For example, it is perfectly logical for a modernist to state that gravity is a fact or that women should stay at home and have babies. These are perceived as truths, or reifications, and not to be challenged. This is primarily the thinking of the medical model. It is in this thinking that smallpox was extinguished, and psychoanalysis was born. The modernist view seems to have had its usefulness, and is now in the upswing of the pendulum. The same thoughts that fought to legitimize life, society, and individuals have bred a world of individuals convinced that their way is the "truth" and there is no other way. Moreover, these individual thinkers challenged the certainties with the theory of relativity and Heisenberg principle (Parry & Doan, 1994).

### *Postmodernism*

One of the early postmodernists was Michel Foucault (White & Epston, 1990). Much of the later writings and theories of future narrativists were founded on Foucault's political, philosophical and psychological writings (Besley, 2002; Boldt & Mosak, 1998; Gorman, 2001; Stacey & Hills, 2001; White, 1990). Foucault's readings speak in terms

of power and culture. He discusses the discourse of the culture that allows power to exist within a certain group or groups of people that allow for the marginalization of others. For example, Foucault (1962) discusses discourses and was perhaps the first to question the purpose that a discourse serves. It could be that there are connections between those in power and those who create the discourses. Consider the broad topic of mental illness. In the Western culture, there exist rules and norms that the society in power ascribes to others. These rules might indicate that behavior such as talking to God, seeing and hearing strange things and a lack of connection with others in this society is considered deviant and dangerous. However, other cultures might find these qualities not only desirable but revered and shamanistic (Foucault, 1962). It is this type of thinking; that of challenging where the power is and "ought" to be that first enlisted the group of philosophers and psychologists known as postmodernists.

If we were to re-visit the connection of modernism to postmodernism, they would be seen as opposite sides of a pendulum: one emphasizes truth, the other emphasizes truths. One is a uni-verse, one way; the other is a multi-verse, many ways. Narrative therapy is based on the premise that there is no one way to see things; it is a postmodern view on therapy. Freedman and Combs (1996) proposed that postmodernists believe that there are limits as to how well humans can describe and interpret behavior in precise and absolute ways. They find exceptions more interesting than rules, and see differences rather than similarities. For example, White (1990) in one of his early works discusses the idea of "lived experience" to indicate that individuals only make meaning of their experiences by storying them into some context, either existing or created and

that this storying is what creates internal truths. Within this overarching postmodern thinking are several additional components.

Postmodern views are postulated on four themes. The first of these are that realities are socially constructed. Social construction or the premise that our realities, truths, and interpretations of any given thing are constructed within the society is a common theme in many postmodern writers (Doan, 1997; Duran, Cashion, Gerber, & Mendez-Ybanez, 2000; Freedman & Combs, 1996; Malson, 1998; White, 1990). Berger and Luckmann (1966) discuss four progressions; typification, institutionalization, legitimation, and reification. From these tenets, Freedman and Combs (1996) discuss these in terms of typifying individuals into classes the "us" and the "them"; making these classes an institution, the institution of motherhood, making these classes legitimate and finally, making them real. It is also noted that this process is unavoidable and perhaps necessary for effective communication (Freedman & Combs, 1996). Within this arena, institutions are organized, for example, the institution of women. These institutions stem from the ability for individuals to perceive things into types or classes, i.e. anorectics. Therefore, the social ideal of how a woman should appear impacts how they are classified into a system. These legitimizations are an aspect of social construction that postulates that things that are typified and institutionalized can be legitimized and reified - made real. This social construction has had profound impact on the stereotypical ideal of individuals. For example, several researchers have linked the existence of eating disorders to have its epidemiology rooted in social rules. Authors, clinicians, and researchers both feminist and postmodern assert that the predominance of women struggling with eating disorders as compared to men and the instance of the gradually

thinning ideal has profound and detrimental affects on women's self perception (Gordon, 2000; Lin & Kulik, 2002; Sherwood & Neumark-Sztainer, 2001).

A second theme is that realities are constructed through language. Language is the pathway of stories. Speech isn't neutral or passive, but the builders of reality (Freedman & Combs, 1996). As discussed previously, language is our connection to each other – it is how we relate and remain a group. Further, it may be that this is foundational to our survival in that we are more likely to survive as a member of a group, family, church, neighborhood, work, society, country, etc. (Buss, 1999; McGuire & Troisi, 1998). It may be that through language, one is able to relate to others within their group and that this group finds a unifying element where the "norms" are understood. The philosopher William Gergen has long been a proponent and advocate of this "social construction" of language. It can also be argued that this language or dialogue with others is the hallmark of our reality. Flaskas (1999) argues that humans do not exist in a static form; rather, humans are created and recreated through relationships with others. Further, as Anderson (1997) easily one of the foremost social constructionist theorist believes, this relation is always in the phase of becoming. With each interaction, we are constructing our realities through language with others, as their realities are being constructed by their relation with us, thereby creating yet another construction of reality. This construction is always fluid and never truly attained.

The third theme is that realities are organized and maintained through narrative. This simply implies that realities are organized and maintained by the stories we tell each other and ourselves (Freedman & Combs, 1997). This internalization of stories is common and, perhaps necessary, to human survival. The postmodern model states that

our realities are internally constructed through a lens of past experience, society, family, and individual stories. As such, my interpretation of a bar-room fight is likely to be different from your view of the same altercation. Remember the very simple "telephone" game that is often played by children. Even through this rough analogy, it can be seen that the original instance can easily be altered by translations and perception. As previously stated, the current culture facilitates and invites an unrealistic perspective of what is considered ideal. Often, the shapes observed in the media reflect a body shape that is unhealthy and often unattainable to the female population. Despite this, women and girls continue to aspire to achieve this shape. I can think of no greater illustration of the power of sustained stories on the realities that each of us hold. However, recently, there has been research to indicate that this societal reality is beginning to shift to a more adaptive view (Sherwood & Neumark-Sztainer, 2001). However, many researchers continue to find that the overall perception and reality of what is considered "normal" is, in fact, a dangerous product of current society (Bishop, 2001; Duran et. al., 2000; Gordon, 2000; Lin & Kulik, 2002;).

The final theme is that there are no essential truths. This is best stated by Doan (1997) in which he states that the hallmark of postmodern thinking is that it has a loss of faith and trust in "the one absolute truth". A basic summation to the postulates of modern versus postmodern thinking is as follows: narrative therapy is to postmodernism as psychoanalysis is to modernism (Doan, 1997). Ascribing to the belief that there is no one truth has sometimes been admonished as it relates to biology and physics. Much of the modernist arguments pertain to "truth", such as the rotation of the earth, the particles of light, etc. However, this has not been the focus of postmodern psychologists. Rather

these individual assert that within each individual resides their internal realities and truths and, as such, they should be honored and considered equally as viable as any other (Gorman, 2001; Parry & Doan, 1994; White, 1990). Gorman (2001) states that in terms of diagnosis, "A postmodern perspective challenges students to look beyond the beguiling expert knowledge contained within the DSM-IV, and to question the "truths" of the very field they are striving to join as professionals. To many postmodernists, is the belief that pathology and diagnosis could be observed within a context and in the face of difference, rather than from the mechanistic pathological patient that once it was thought that narrative psychology based its assumptions.

*The Narrative Model*

People are born into stories. Throughout childhood, they are encouraged to remember certain social and historical stories. As the developmentalists see development fitting into schemas, narrativists see development as a series of stories created at and since birth that house new experiences. Narrative theorists, Michael White and David Epston are considered to be the forefathers of narrative therapy (Parry & Doan, 1994). For a narrativist, there is no white-lab-coat guru telling others what is best for their lives. Their theory is founded on the power of stories and how those stories are perceived as truths (Parry & Doan, 1994). If, for example, an individual is born into an abusive home they are likely to adopt a story that the world is a scary place. Is this truth? Does is matter? To narrative therapy, it doesn't. What is significant is that this individual has been written into stories, personal, family, cultural, etc. that places them in a role of fear. This example has become known as a discourse (Freedman & Combs, 1996). These discourses often lead individuals into therapy because they have reached a point where

the story is no longer useful to them (Parry & Doan, 1994). Using the above example, this individual may not want to continue to story the world as scary.

A cornerstone to narrative therapy is listening. As has been discussed, human beings are storytellers and all have a story to tell. It is, therefore, the responsibility of the narrativist to hear these stories before any lasting change will occur. This is achieved by several means. Of course, the hallmark of successful listening is the establishment of a therapeutic relationship. The postmodernists contend that this relationship is not didactic, parental, or expert. Rather, this relationship is a collaborative experience in which both client and therapist are honored to the fullest for their knowledge and uniqueness that is brought to the therapy. Further, as Anderson (1997) states, what she calls collaborative therapy is based on the premise that the therapist is a collaborative, non-knower that is on an exploration with the client and that his/her own personal narratives are as important as the therapists. It seems that her contention is that in a therapeutic relationship, the aspects, stories, and self-definitions of the therapist are not abandoned. They are all about who the therapist is and how they relate to the client. It is an integral part of a truly collaborative relationship. Next, is the ability to listen deconstructively. By this, the therapist is gathers information about the client from a "not knowing" frame of reference. They act more as detectives that therapists at this point, trying to glean as much information as possible about the clients stories, where they came from, how powerful they are, family stories, cultural stories, etc. (Freedman & Combs, 1996; Merscham, 2000). By wording questions in a positive way or a way that reframes thinking, more can be gathered from the individual. Another step is complete unconditional positive regard, which begins at the deconstructive listening phase and continues throughout treatment.

By this, the narrativist must believe that the person has good reasons for behavior regardless of what that behavior is. This is a skill that is not always easy to master. Freedman and Combs (1996) discuss unconditional positive regard as being the first and most crucial step in facilitating change in individuals. To these authors, change will not occur until the person feels safe, understood, and not judged. Only when this is achieved will story deconstruction begin.

When individuals come into therapy, they are seeking solutions and alternatives to stories that are no longer useful to them. Stories come from many sources. Among the most powerful are the social and family stories. These often carry more power and are more heavily reinforced those individual stories. Freedman and Combs (1996) refer to these as social constructs. They continue to believe that these stories determine the meaning of experiences and which aspects are to be used for expression. These stories determine real effects in terms of shaping persons' lives. These "survival stories" often develop in childhood and outlive their usefulness as adults. When this occurs, narrative therapy sees them as "wake-up" calls and stories not needed anymore. Their task is not to "fix" these individuals, rather, provide them with story revisions that may be more useful to them (Parry & Doan, 1994). It is important to remember that these story revisions are not therapist constructed. They are the stories of the individual. How then, does one take on such an arduous task? For the narrativist, this centers on the tool of externalization.

*The craft of externalizing the problem*

From this author's perspective, externalization is perhaps one of the most defining aspects of narrative therapy and perhaps the foundation from which therapeutic

application is derived. The term externalization is a means of separating the person from the problem. Michael White (1995) discusses this in terms of seeing the person as separate from the problem. They are external entities that have more influence over the person than the person would like (White, 1995). Roth and Epston (1996) add that externalization is a "language practice that shows, invites, and evokes generative and respectful ways of thinking about and being with people who are struggling to develop the kinds of relationships they would prefer to have with the problems that discomfort them."

The use of externalization provides the client with the option to see more hope and freedom from the problem. Take, for example, these two sentences. "He is depressed." versus, "He is a person who is influenced by depression." Narrative therapy values the ability to discuss the problem as the problem, rather than posing questions that invite the person to be the problem. Doan (1995) describes a series of questions that facilitate externalizing language. Some of these include: What is the problem called? Does more than one externalization make sense? How much is the problem able to influence them at the present? What does the problem say, look like, and convince them to do? These examples encourage individuals to separate themselves from the problem and are a tool that proves to be powerful in story revisions.

The craft of separating the person from the problem involves several different stages or components that are enmeshed with the other elements of narrative therapy. For example, often individuals enter therapy with a "problem-saturated story" (Boldt, & Mosak, 1998; Merscham, 2000). This story is often how they see themselves and relate to the world. Through this problem saturation, the therapist can employ externalization

as a means of giving identification to the story and providing the individual with a name for the story that is not necessarily reflective of them. Epston, Morris, and Maisel (1995) identified a program that has been named the Anti-anorexia/bulimia league that is enlisting individuals struggling with eating disorders to "unite" and work through areas that the eating disorder is controlling/influencing the individual. From the beginning of this program anorexia/bulimia is discussed as a separate entity from the individual. Through this, the individual is able to have a discussion that becomes external from them and allows for a more personal assessment/evaluation of how anorexia/bulimia is affecting their life (Epston, et. al., 1995). It seems that the idea of problem saturation allows a dialogue between client and therapist that not only invites discussion, but gives unconditional acknowledgement and respect for the difficulty and pain the problem has caused the person. The notion of saturation implies that all aspects of the individual have been touched and that, perhaps, others in their life have been infected as well. Recognizing and honoring the impact of the problem seems to allow the client to have a voice in which they are not the problem, rather, they are infected by the problem. Finally, externalization allows the client more freedom from the self-depreciation and guilt associated with many problems. Nylund (2002) in his work with women struggling with anorexia found that using externalization undermined its ability to invite the individual from feeling guilt and shame as a result of thoughts and behaviors. Instead of "doing this to herself" anorexia was simply stronger than the person and she was not able to fight.

One of the hallmark methods of discussing problems in externalizing language is simply to discuss the problem as an entity. For example, an adolescent with anger

problems would discuss “anger” or “trouble” and how it is impacting their daily life, their functioning, their relationships, and perhaps their future. Another helpful method of externalization is through metaphor. From the above example, instead of “anger” or “trouble” the externalization becomes “Godzilla”. Several authors have utilized metaphor in relation to externalization with profound success (Epston, et. al., 1995; Legowsky & Brownlee, 2001; Levitt, Korman, & Angus, 2000; Merscham, 2000; Stacey & Hills, 2001). The use of metaphor often provides both therapist and client with a form or a picture of the problem that may be more attainable. Although little empirical research has been conducted on metaphor, Levitt, et. al. (2000) in a study of individuals struggling with depression, found that those who used metaphor throughout the therapy process was linked to a more emotional process and marked therapeutic change. As a therapeutic tool for use with those struggling with eating disorders, individuals using metaphor in conjunction with externalization were more likely to reconnect with feelings, and move in the direction of self-acceptance as well as being more cognizant of internal feelings and drives (Epston, et. al., 1995).

As discussed, much of the research looks at the use and alliance of the therapist and client/family against the problem. There is relatively little discussion of the use of externalization as a positive influence in the person’s life. From this authors perception, one of the foundations of narrative is that individuals come by their “pathology” logically and systemically. It does not develop in a vacuum. Consider the individual entering therapy for “borderline personality disorder.” In many instances, these individuals tell a story about a childhood of substance abusing parents, disconnection from parents, inability to connect with school or other peer relationships, and an adaptive learning style

that allowed them to fade into the woodwork. This story that once served an adaptive, survival purpose, now has outlived its usefulness. This belief is only just beginning to be used in the narrative therapeutic arena. Some narrativists are beginning to differentiate between externalizations that may be perceived as negative to the person from those who might be considered positive. In a paper on applications of narrative therapy, Stacey and Hills (2001) contend that "outer-externalizations" may be seen as those aspects that are uncomfortable to the individual and removable and include the protesting the effects and existence of the problem through transcending the problem and transitioning so that the problem no longer carries the power/weight it once did. The "internal-externalizations" included those aspects of the problem that are somehow connected to the individual and there is a necessity to see the problem as a potential resource. In this collaboration, balancing, and embodiment of the problem occurs in a fashion that works with the individual (Stacey & Hills, 2001). Consider some of the more severe "pathologies" like Dissociative Personality Disorder, or certain levels of schizophrenia. In these situations, the individual may not be able to "defeat" the problem, but may embrace it and learn from it. Other authors seek to use metaphor and externalization to further strengthen those aspects of the individual who can help to work through the problem. In other words, in addition to focusing on anorexia as an externalization, the therapist might also discuss individuality or strength as an externalization to increase self-efficacy of working through what is so often an extremely difficult process.

In a study of family success, Kahle and Robbins (1998) use "unique outcomes" and inherent family strengths/competencies to engage the family. Externalizations like "anger" became "coolness" attempt to invite change and encourage thinking that is more

useful to the family (Kahle & Robbins, 1998). Providing positive or strength externalizations can help facilitate change in the individual. In addition, there may be instances in which the problem is seen as valuable and helpful to the person and to discuss how it might have been helpful can be valuable in therapy. Revisiting the previous example of the client diagnosed borderline, it is likely that this adaptation was not only helpful, but possibly allowed the person to survive in a situation that without may not have. Externalization allows the therapist and client to discuss both the benefits and hindrances of the problem and decide from without (rather than within) how much influence and collaboration the client wants with the problem.

*A Model for De-Composing the Problem of Eating Disorder*

The above literature review has discussed various theoretical frameworks as they apply to eating disorders. The purpose of this research is to apply a narrative model to help facilitate change in eating disordered perceptions. This embarks on a unique application of narrative therapy in several ways. First, utilization of a storytelling framework in which individuals will write a story of how they would like to be. Second, the application of externalization will be used to help them separate from the problem, and finally, assessment of the process of change is unique as compared to existing approaches.

The definition of re-composition was founded in research by Parry and Doan (1994) in which they use the term re-visioning to discuss the process of seeing life from a different perspective. The "vision" of the person changes through use of externalization, deconstruction of stories, and other narrative processes (Parry and Doan, 1994). Re-composition is the process by which individuals examine their life story before and after

application of externalization. This premise is based on research in both externalization and story telling. King (2001) conducted research in which individuals were asked to write either about a trauma, their best possible self, or combination of both. Those in the best possible self group were found to experience more positive moods than those in the trauma, combination, and control group, with results maintained after three weeks. Externalization work with individuals with eating disorders have indicated that speaking about the problem as if it is outside the person encourages change and allows individuals to tap into emotions that had otherwise not been reached (Epston, Morris, & Maisel, 1995). Additional research on narrative connection with emotions is discussed in a work by Alan Parry (1998) where he discusses the need for narrative to connect with emotions. His question is that often narrative therapists remain with the cognitive and remain analogous to the systemic therapies. This current model is proposed in an attempt to combine all theses elements as a way to facilitate change in those struggling with eating disorders. As found by King (2001) the process of writing helps emotional well being and positive mood. Many who struggle with eating disorders are unable to see themselves outside the bonds of the eating disorder and find difficulty finding hope in the future. Through the use of externalization as part of the storytelling process, individuals may be more able to separate their future goals from the future goals of eating disorder. Another aspect of this model relies on the relation of the individual with society. Through conversations with therapists, family and friends, it is expected that the story telling process will evolve as a function of community; conversing and re-composing their stories with others. Finally, the process of writing from the dual perspective may enlist feelings that are otherwise kept from them through eating disorder, as discussed by

Epston et. al.(1995). This model will incorporate ideas from emotional externalized storytelling to help individuals see themselves as separate from their eating disorder while simultaneously providing a means of expressing emotions and for understanding themselves in relation to the eating disorder.

The above sections have highlighted various components of narrative psychology and the value of this theory in an applied setting. To date, there are relatively few empirical studies examining the premises and techniques of narrative therapy. It is possible that there are currently no methodologies that are accurate in detecting and analyzing the internal workings of narrative. Perhaps current objective methodologies are ill suited to discussion of such a subjective process like therapy. In the next section, I will discuss current methodologies/assessments used for the treatment of eating disorders. These methodologies have proven useful and tend to align with current treatment models, CBT, psychoanalysis, etc. Finally, I will discus a methodology that delves into the subjective mind of the individual in a quantitative and translatable manner. This methodology is most applicable to the field of Narrative psychology in that it is a means of quantifying perceptions and stories in an effective manner.

## From Therapy to Assessment of Eating Disorders

### *Traditional Assessment*

Traditional assessment of eating disorders tends to focus on the behavior and thought perceptions of individuals in an attempt to identify those actions and perceptions that are common to eating disorders on the whole. Many of the assessment tools currently in use accurately identify either the diagnostic criteria for eating disorders or the behaviors and thought processes that are common with eating disorders (Chiodo, 1989; Dalgleish, et. al., 2001; Limbert, 2001; Lindeman & Stark, 2001; Mussell, Crosby, Crow, Knopke, Peterson, Wonderlich, & Mitchell, 1999; Placinica, Faunce, & Soames, 2001Ricca, Mannucci, DiBernardo, Zucchi, Paionni, Placidi, Rotella, & Faravelli, 2001). Each of these measurement tools have been helpful in identifying behaviors and issues as well as provide a basis for conceptualization for client treatment. Although there have been several various assessment tools, Garner and his colleagues have been most successful in developing solidly valid and reliable testing instruments (Garner, 1992, 1991). One of the successes of these instruments is the ease of administration and tabulation of results. However, it is important to note that none of these instruments is to be used in isolation; rather as a supplement to interview and other diagnostic criteria.

### *A Unique Assessment Approach: The Science of Subjectivity*

> -A poet, alone in the quiet of his study, brow furrowed and eyes shut, ponders the right word to carry the feeling he wishes to express. His thoughts a cascade of shimmering words inseparable from feelings, and he encourages the inner babble, waiting for it to flow into the order of a well made sonnet
> -A quantum scientist sketches mazy formulae on a chalkboard in front of a small group of grad students. She pauses in her scrawling, and smiles. “The amplitude, “she

> says, “Is like a leaf-its form directed by the observing and nutritious sys of the sun.” (Knight & Rupp, 1997).

What, if anything relates these two stories? It appears that these are both examples of individuals behaving subjectively, making reference to themselves. The difficult task regarding subjectivity is finding a solid methodology that is as powerful as those determined by and from biological sciences. Knight and Rupp (1997) postulate that subjectivity is psychology’s domain, however, despite this our quest for quality, our alliance remains with science. We have wandered the path of objectivity, often at the expense of the richness of subjective differences. Modern psychology seems to have grounded itself in the operant study of objectivity – what is known as R-Methodology. Assuming that the practice of psychology goes hand in hand with subjectivity, should we not devote time to the development of sound methodology that would better serve us? It has also been hypothesized that humans are narrating creatures and that this distinction is primarily subjective. Assuming this, would it not follow that “stories are the atoms of the mind” (Knight & Doan, 1994)?

*R-Methodology: Not good for psychology?*

Traditionally, psychological statistics and design has attempted to establish validity and reliability either by analyzing as many individuals as possible to increase validity/reliability or by studying one individual with several question and answer sessions and behavioral observations. Both of these analyses have provided a wealth of invaluable information that has fueled all aspects of modern psychology. R-methodology, or the traditional view of quantitative analysis has been perhaps the most used and preferred method of experimental design. It carries with it the opportunity to be objective, global, precise, and manipulated. Knight and Doan (1994) suggest that the

basis of R-methodology is born of Spearman's elementalism, the supposition that the human is a collection of various attributes and behaviors that can be generalized. For example, R-methodology rests on the assumption of *a priori* truth, which states that one can know without doubt that a thing studied and validated can exist as truth on its own (Knight & Doan, 1994). Take for example the fairly recent debate of homosexuality. There was a time when many psychologists assumed that homosexuality was a disorder that should be diagnosed, treated, and cured. To make this claim today might be considered religious fanaticism and in fact the revision of the DSM has recanted and removed such a diagnosis.

A second difficulty with applying R-methodology to individuals is that it tends to move the focus away from the individual and towards the average behavior. Milam (1999) argues that R-methodology was developed by Cyril Burt as a means of placing an individual in a group of other individuals based on a grouping of "things". For example, under this measurement, an individual who experienced sadness, sleeplessness, and hopelessness could be placed in a group called "depressed" not because of their individual characteristics, stories, and beliefs, but rather behaviors that matched a normative group of sadness, sleeplessness, and hopelessness. From the above example about depression, the individual's unique experiences, beliefs, and stories are lost to the label of depression. Suddenly, the individual becomes depressed, rather than being an individual who IS depressed. Knight and Doan (1994) argue that the focus on the "average" behavior at the expense of the individual is one of the limitations of psychology. A recent passionate and powerful debate in psychology has been a discussion involving the same struggles between R and Q methodologies. If we were to

assign these to modern and postmodern psychology, respectively, one can see that this is a complimentary issue. As postmodern thought struggles to gain acceptance and respectability, modern thought seems to remain wedded to what is "known." What can be called "truth?" What then is Q-methodology?

*Q-methodology – Postulates and Premises*

As has been discussed previously, Q methodology allows for the subjective to be quantified and discussed objectively. This concept has been referred to by McKeown and Thomas (1988) as *Operant Subjectivity* and states that in Q, no definition of meaning is made *a priori* and meaning is generated *post hoc* by the individual(s). This definition is generated by how the individual "ranks" statements or words (Q-sample) in the Q-sort. For example, consider the case of identifying gay rights. The Q-sample consisted of 60 statements that related to gay rights issues that were rank ordered by each of several respondents (McKeown & Thomas, 1988). McKeown and Thomas (1988) discuss two kinds of samples, naturalistic, which are constructed directly from the individual, like an interview; ready made samples, samples from other sources outside the individual, like standardized samples and quasi-naturalistic samples.

Making the decision of which type of sample to choose is largely based on the type of experimental design chosen. Within Q methodology there are two types of designs, extensive and intensive. These words are identified contextually as 50 participants in a traditional R methodology would likely be considered small or intensive, however, an equal sample size of 50 would be considered large or extensive by Q standards (McKeown & Thomas, 1988). As such, extensive studies in Q methodology would likely be to determine similarities on a particular idea or belief. The above

example of gay rights or a design that would determine political views based on statements ranged from liberal to conservative. In this, the researcher is hoping to identify constructs or "factors" that group individuals who identify with the same concepts. Conversely, an intensive study is usually a single subject design in which the researcher is interested in studying the internal workings of the individual mind (McKeown & Thomas, 1988). Often the extensive phase precludes the intensive phase as the researcher would like to have a set of constructs common to the research question. Therefore, whether extensive or intensive, the goal is to look at intersubjective responses and make connections and inferences based on the commonalities of these beliefs. One of the beginnings of the quest for intersubjectivity comes from Newton and his "fifth rule".

Q-methodology is based at least in part on Newton's fifth rule, which states that:

> Different hypotheses for a concourse, none capable of proof or disproof, are subjective hypotheses; therefore, determine operant factor structure for them—this will offer opportunity for induction of new hypotheses inherent in the concourse.

Knight and Rupp (1999) utilize conditions of instruction (to be explained) for Q-sorts to represent different hypotheses. None of these are capable of proof or disproof and these factors open the door to new hypotheses. Q-methodology is concerned with two methodological considerations, conditions of instructions and concourses. The first of these, conditions of instruction are the terms used to sort adjectives. Using the above gay rights example, a condition of instruction was self. Conditions of instruction can be anything necessary to achieve the goal. For example, conditions of instruction can be self, preferred self, mother, father, fear, home, etc. Each of these conditions will be

sorted with adjectives in terms of most like to least like (Knight & Doan, 1994). A concourse is a collection of self-referable statements for any experience (Knight & Doan, 1994). Using the conditions of instruction from above, for example, self may be correlated strongly with home for one individual and not another. The relation between self and home represents a concourse (Knight & Doan, 1994).

*Subjective behavior analysis*

Among the problems with subjective measurement is its relation to external reliability. For example, subjective data may not be related to actual events. In addition, individuals are known for misrepresenting events and being inaccurate in the remembrances of these events (Brown, 1999). Both Skinner and Wolf would agree that individuals might report an event that is directly conflictual with the actual event (Brown, 1999). These elements add to the general disinterest in subjectivity as a natural phenomenon. General science of behavior cannot be restricted to the assessment of true assertions (Brown, 1999).

Steven Brown has been regarded as the "torch carrier" of subjective behavior analysis since Stephenson and has taken the principles of Skinnerian experimental analysis and applied Q-methodology to generate subjective behavior analysis. The conceptual framework and problems with subjective analysis may have been corrected by the application of Q-methodology, which places itself on the scientific footing (Brown, 1999). Q-methodology has the advantage of transforming subjective, intangible responses into operant factor structures, particularly "normal" daily events. For example, Stephenson (1980) demonstrated a Q-sort, using Q-methodology. In this task, the subject was shown a list of adjectives and asked to sort them based on "most like" to "least like"

the individual. Those adjectives were removed from the pile and the remainder shuffled. The subject then chose the two most and least like. This process continued until all cards had been sorted, these "piles" represented a pyramid. The contents of the "pyramid" can then be quantified and used in various analyses to make a description of beliefs and thoughts of the individual.

Another example is found in a recent research by William Frederickson and his student, Scott Goldman (2000), involved participants sorting cartoons into various piles. The hypothesis was that there would be differences in humor selections depending on gender. In other words, gender would influence the cartoons considered to be humorous. Each participant was given the instruction to choose the cartoon that was most like them and the cartoon that was least like them. This process continued until they had 7 piles of cards ranging from most like to least like, visually represented in a normal distribution. Each cartoon was number coded and used in a factor analysis to detect if there were gender differences between the humor choices. The factor analysis yielded two factors, which upon further analysis were concluded to be a male and a female factor (Frederickson & Goldman, University of Central Oklahoma, 2000),

The process of Q-methodology allows for the subjective to be quantifiably measured. Brown concludes that Q-methodology is able to compete with other forms of behavioral analysis in terms of internal causal variables. These postulates are achieved without sacrificing the value of subjectivity, my thoughts, feelings, and behaviors are mine (Brown, 1999). There are several advantages to a subjective behavior analysis. One, a person's opinion about a given thing is simply their opinion. Its relationship to any "truth" or "actual event" is a separate matter. Second, it relies on functional

groupings, which keeps with the assertions of specificity (Skinner, 1957). Although Skinner seemed to be unaware of Q-methodology, his works indicate that he conceded that there should be more flexibility in behavioral study. For the first time, an observable, behavioral change in individuals can be seen and quantified. Q-methodology places the science of subjectivity under the microscope for the first time. Since its conception, the popularity of Q has expanded and the uses of subjectivity have moved from the behavioral to the perceptual.

Although there have been several documented studies using Q-methodology in other academic disciplines, relatively few studies have been found within the field of psychology. Among those within this discipline exist studies on personality profiles (Westen & Harnden-Fischer, 2001), power in couples (Kogan, Walters, & Daniels, 2002; Pinsent, 2001), counseling education (Allgood, 1999), understanding creativity (Hodges, 1999), and eating disorders (Russell, 1998). Recently, a group of psychologists, researchers, and other clinicians organized to develop an instrument based on Q-methodology, intended to tap into the narrative concepts of internal stories in an attempt to enter into the "black box" of human perceptions.

With the proliferation of literature combined with the emphasis on empirically validated treatments and "proving" the efficacy of treatment models, increasing methodologies and assessment instruments seem more necessary than previously thought. Moving out of the "comfortable" is needed in order to continue providing both existing and new treatments for working with individuals with various problems and struggles. Q methodology is one such means of effectively quantifying the unquantifiable and reaching those theories not previously tapped into. The description of a narrative model

that utilizes both externalization and story-telling as previously discussed will utilize Q methodology to supplement other assessment instruments in a unique manner.

## Scope of the Current Research

*Biologically, physiologically, we are not so different from each other:*

*historically, as narratives – we are, each or unique.*

*Oliver Sacks (1987)*

The preceding literature review discussed and analyzed past research on the identification and progress of eating disorders as well as literature on narrative therapy and the use of Q-methodology as a measurement tool. Further, it included the existence, benefits, and limitations of popular measurement tools to identify eating disordered behaviors. Studies on eating disorders report that it is far more than an individual disorder that exists in a vacuum. As the literature suggests, eating disorders are a systematic, familial, and socially centered means of expressing stress and anxiety. Further, eating disorders are more likely to be the symptom of a problem, rather than the problem. Without treatment, many individuals who suffer from eating disorders will continue to live destructive lives that often result in severe and elaborate physical and emotional problems, and in some cases, death. Finally, research has suggested that early prevention is most effective and that the criteria for formal diagnosis of an eating disorder occurs long after perceptions, thoughts, and behaviors occur.

Based on the postulations formed by previous researchers, it seems that a joining of narrative therapy, in particular, externalization, may help facilitate change in eating disorders. However, with all the research conducted in the area of eating disorders, very few were found that combined the use of externalization in the treatment of eating disorders (Epston, Morris, & Maisel, 1995; Nylund, 2002; Zimmerman & Dickerson, 1994). These researchers found that most treatments for eating disorders played into

eating disorders' hand. In other words, through controlling food intake, exercise, etc., the therapist is taking more control away from have the individual and encouraging them to remain children; the exact same things that may led to the eating disorder. Zimmerman & Dickerson (1994) quoted Michael White's ideas of the origins of eating disorders:

> The social context in which anorexia occurs allows women to have authority only in areas such as food and thinness…. In some families, for various reasons, these specifications seem to operate to an even greater extent than others. Anorexia encourages parents to have a greater involvement in their child's life, further inviting the child to have involvement with anorexia. (p. 297)

By using narrative mataphor and externalization, eating disorders become a construct of a society and family, rather than the problem of the individual. Although research in this area is sparse, Goddard, Lehr, & Lapadat (2000) examined the use of externalization and deconstruction with parents of children with disabilities. They provided a group lasting from 90 minutes in which they explored with parents their experiences and facilitated discussions based on externalizing (how has *the problem* affected you and your family) and deconstruction (how has *the problem* affected how you see the world). Qualitative results indicated specific themes and commonalities of parents (Goddard, Lehr, & Lapadat, 2000).

Given that the foundational element of narrative psychology is the deconstruction, re-visioning, and understanding of stories, the experimental group will participate in a story-telling process in which they will write about their future, their goals and plans, and how their life will be. Based on previous research, participants who write their future story have more benefits than those who wrote a story on a novel topic (King, 2001).

From this research, an externalized future story from eating disorders perspective may alter perceptions of who they want to be.

The purpose of the current research it to test several hypotheses: (1) There will be a significant difference on pre/post test scores for participants who engage in the externalizing story process as compared with the control group (EDI-2 scores will be reduced, internal locus of control on the ANSIE will increase, and the relationship between eating disorder and self will decrease while the relationship between self and preferred self will increase); (2) There will be a difference in process measure for participants in the experimental condition (relationship between self and preferred self will increase); and (3) There will be a difference in pre/post scores depending on length of time struggling with an eating disorder (with above instruments showing less change for those who have struggled with an eating disorder longer).

## Method

The previous chapters have outlined the history of externalization and narrative psychology and how it can be applied to a population struggling with eating disorders. Narrative psychology, until recently, has struggled to find statistical analyses that can effectively quantify the components of narrative. The application of Q methodology is able to more effectively address the concerns and constraints found in other methodologies as a process instrument and therapeutic tool. It is able to quantify the internal stories, themes, and trappings of the human psyche. To further support this type of research, Gabe Rupp, in a book by Mike Knight and Robert Doan (1994), states that:

> We know ourselves, and others in relation, through observation. In our minds we stand apart from our world models and observe both the past and the future independent of the constraints of space and time. In this way, we plan and think contingently with self-reference, cybernetically molding reality by narrating it. To observe a mental representation of "self in relation" is a process most accurately described by Parry and Doan (1994) as selfing. To verbalize these observations and share them with others seem fittingly described as psyching.

The act of story telling is one of the hallmarks of narrative psychology. Apart from those "truths" that are known and adhered to, the truths that weave and connect us internally are not as reliable. As previously stated, narrative psychology assumes that there is no "ultimate truth", rather stories placed along a continuum of myth to likely stories (Besley, 2002). Somewhere along this continuum lie the experiences, thoughts, memories, and pictures of human selfing. As stated above, selfing is the process of knowing who you are through observation of and relationships with other individuals. These elements combine and intertwine to make a story about the person. None of these stories are "truth" as commonly believed; however, this selfing is what the individual perceives as

truth. Therefore, truth in human selfing is relative and dependent on the internal constructs and workings of the individual. Family, gender, society, religion, location, environment, and genetics all play a part in this story formulation. Until recently, much of narrative psychology premises have been limited to individual case studies and theoretical discussions of implications and applications. As with many other theories, empirical testing has been difficult and unreliable.

Through Q methodology, there is now a way to quantify the internal "selfing" Doan and Knight speak about. By expertly quantifying the intersubjective "selfing" through Q methodology, it is now possible to successfully invite small group studies into mainstream research. In a sense, each individual in this project will represent an internal control in a type of N-1 research. Each individual will represent his/her own ideas and thoughts through I-SPI that will be compared both within themselves (pre and post), between individuals in the same group, and individuals between groups.

*Participants*

Estimation of power indicates a group number of approximately 20; therefore total of 40 to 45 participants will volunteer through local counseling psychological practices in the metropolitan area that specialize in the treatment of eating disorders. Participants diagnosed with an eating disorder will be selected based on criteria set by the American Psychological Association, Diagnostic and Statistical Manual IV (American Psychological Association, 2000), as determined by the primary therapist. Participants chosen will meet DSM-IV criteria for Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder, Not otherwise specified. Participants will be adult females from local counseling practices and grouped according to length of time with an eating disorder.

Participants will be randomly placed in one of two groups (control or externalization). All participants will receive a Standard Confidentiality Statement and will be treated in accordance with the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 2000) as well as under full approval of the Institutional Review Board.

*Instruments*

For the present study, a series of instruments will be administered to participants in order to establish a comparison between the instruments for each individual and across participants. These instruments will include a locus of control scale, an eating disorder scale, and a Q methodological scale identifying relationships between conditions of instruction (previously discussed). The locus of control scale was chosen to determine the amount of external/internal control felt by and across participants. All instruments will be obtained directly from the developer or publisher.

*Adult Nowicki-Strickland Locus of Control Scale (ANSIE)*

The Adult Nowicki-Strickland Locus of Control Scale (ANSIE) was originally developed as a children's scale by Nowicki and Strickland in 1973 for use as a tool to identify popularity, ability to delay gratification, and prejudice and was found to be related to achievement. A later variation of the original scale was developed and named the *Adult Nowicki-Strickland Locus of Control Scale (ANSIE).* This scale contains 40 yes/no items and is designed to be read by individuals with a 5$^{th}$ grade reading level. The scoring of the scale is such that the heigher the number, the greater the external locus of control (Nowicki & Duke, 1974). Data was collected in 12 studies containing 766 participants and was found to be psychometrically sound with reliability ranging from

.74-.86 and test-retest of 6 weeks at .83. In contrast to other locus of control scales, the ANSIE was found to be unrelated to intelligence and social desirability. Further evidence for the construct validity of the ANSIE was demonstrated in substantial correlations with the Rotter Internal/External scale for personality needs (Duke & Nowkicki, 1973) For the present study, the ANSIE was chosen to determine what level of internal/external control changes are present during the externalizing story phase. It is thought that as individuals begin to see themselves as different from their eating disorder, internal levels of control in their lives may increase.

*The Eating Disorder Inventory 2 (EDI-2)*

The Eating Disorder Inventory 2 (EDI-2) (Garner, 1990) has been purchased through *Psychological Assessment Resources, Inc,* and consists of 91 self-report statements intended to help identify psychological symptoms commonly present in anorexia nervosa and bulimia nervosa. The most recent version of the instrument is intended to provide a more standardized approach and is designed to help formulate a diagnosis, but not as the sole basis for diagnosis.

The EDI-2 was revised from it's original 64 item, eight subscale format that taps into varying dimensions of attitudes and behaviors regarding weight, food, and body shape (Drive for Thinness, Bulimia, and Body Dissatisfaction) as well as general psychological traits (Ineffectiveness, Perfection, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears) common to those struggling with eating disorders. The current version of the EDI retains the original 62 items and adds 27 items and expands the original 8 subscales to include three additional scales (Asceticism, Impulse Regulation, and Social Insecurity). This format is an easily administered 6 point

"likert-type" scale that are scored within the above subtests that highlight different common eating disordered beliefs. These subscales form the basis for the multi-dimensional aspects of identification of eating disordered behaviors. Scoring of the EDI-2 is weighted on as follows: Always = 3, Usually = 2, Often = 1, Sometimes = 0, Rarely = 0, Never = 0. Scoring consists of summing all scores within each subscale, with reverse-scored items the inverse of the above (Garner, 1990).

Each of the subscale constructs measure different components, or perceptions of eating disordered behavior: (1) drive for thinness identifies perceptions consistent with a fear of gaining weight and an excessive concern about weight and dieting; (2) bulimia identifies binge/purge behaviors; (3) body dissatisfaction measures the overall dissatisfaction with body shape; (4) ineffectiveness assess feelings of inadequacy, insecurity, and worthlessness; (5) perfectionism identifies perceptions consistent with a need to be perfect and maintain unrealistically high standards; (6) interpersonal distrust looks at a fear of forming close relationships; (7) interoceptive awareness measures the ability to correctly identify feelings; and (8) maturity fears assess the need to feel like a child (Garner, 1990). There are also three additional subscales (asceticism, impulse regulation, and social insecurity) (Garner, 1990) that are in the research literature, but will not be used in the current research.

Reliability and validity indices for the EDI-2 are all strong and consistent among and between subscales. Reliability scores for internal consistency were found to all be at least .80. Test-retest reliability was also strong and found to range from .77 to .96, except for Interoceptive Awareness, (.67). (Garner, 1990). Additionally, all validity

assessments, content, construct, criterion, and concurrent were within appropriate ranges for the sample.

*The Ideographic Self-Perception Inventory (I-SPI)*

The I-SPI (Knight, Frederickson, & Martin, 1987) is based on a more general principle of Q-methodology, which is the subjective analysis of individual perceptions. I-SPI allows an individual to rank order adjectives according to their level of "fitness" to any given condition of instruction. Adjectives are used to describe these conditions of instruction, which are words such as self, preferred self, anorexia, etc. The original Q-sort data were gathered at a large Midwestern university using a customized Visual Basic Pro-5 Edition Q-sort procedure called the Ideographic Self-Perception Inventory (I-SPI), (Hamlin & Knight, 1997). This program administers the I-SPI sorts in a user-friendly interface. The I-SPI allows the individual to choose which conditions of instruction are to be sorted, depending on the type of correlations desired. For example, the default conditions of instruction include items such as self, preferred self, anger, home, father growing up, spouse, etc. This allows the researcher/therapist to select conditions that are useful. For the purpose of the current research, the researcher will choose the conditions of instructions*a priori* for standardization and assessment purposes.

The I-SPI uses a list of adjectives that was normed by Anderson (1968). These adjectives are selected randomly from each of seven levels of similarity (one being most dissimilar, seven being most similar) from 555 normed from the most to least favorable adjectives. To accomplish this, Anderson administered the set of 555 adjectives to participants and asked them to rate from one to seven, the most positive to most negative adjective that would best represent their ideal self. For example, among respondents, the

highest ranked word for ideal self was trustworthy and the lowest ranked word was dishonest. This indicates that ranked according to what the respondents felt was important in an ideal self was trustworthiness and the least desirable was dishonest. Words were similarly ranked along a continuum representing each of the 555 adjectives. The computer is programmed to randomly choose one adjective from the top (positive) 31 adjectives and one from the bottom (negative) 31 adjectives. The computer continues to select in a similar manner two adjectives from the top and bottom of the next 62, three from the next top/bottom 93, and six from the middle remaining 183 adjectives. The resulting sample, as is shown in figure 1, serves as the concourse for each of the Q-sorts within the experimental session. The concourse provides the structure for participants to sort adjectives that are most like to least like any given condition of instruction.

Reliability and validity information on the I-SPI was also conducted at the University of Central Oklahoma. Internal validity was determined by a comparison between Undesirable (U) person and Ideal (I) person. If the U-I coefficient is between -.46 (equivalent to .01 level of significance) and -1.0, it is assumed that the person is committed to task. Further validity assessments were conducted to determine the level of relationship between Anderson's adjectives and Q-sort ratings. These correlations were found to be significant for both self and preferred self (Knight, Frederickson, & Martin, 1987). Individuals ranked adjectives for each of the Q-sorts similar to the rankings found previously in Anderson's adjectives. Not long after construction of the I-SPI, Stephenson (1987) responded to the original premise and found it to be promising, although needing certain modifications. Knight and his colleagues addressed these concerns and modified the instrument, however, sadly, Stephenson passed away before responding to the new

instrument. Current research with the revised I-SPI has been conducted utilizing the I-SPI as a measurement tool (Milam, 1999) and has found it to be a useful instrument. However, both these studies utilized the I-SPI as a single process instrument to form a more theoretical approach, rather than an empirically based research project. More recently, an empirically based study attempted to validate the use of the I-SPI with the EDI-2. This study endeavored to evaluate the correlation between responses on the EDI-2 with the I-SPI (Lodge-Guttery, 2003). Results indicated a significant correlation between the EDI-2 and the I-SPI and, as a preliminary study, is a promising beginning to additional validation studies to determine the applicability and usefulness of the I-SPI as a measurement tool.

In administering the I-SPI sort, the computer asks the participant to make a graduating series of choices in relation to the condition of instruction. The program presents all of the eighteen adjectives as well as the distribution for viewing. The participant then chooses adjectives from the total eighteen until all are selected and placed in a quasi-normal distribution (see Figure 1). The participant is instructed to work from the extremes to the center asking herself, “Which adjective is most like me?” and “Which is most unlike me?” Adjectives chosen are placed in the distribution and the process continues with the participant choosing the two most like and least like from the remaining 16, etc., until all adjectives are placed into the distribution. This process is repeated for each condition of instruction. The condition of instruction automatically changes once all adjectives have been sorted into the distribution. After completing the sorting, the program saves the data for later retrieval.

*Figure 1*

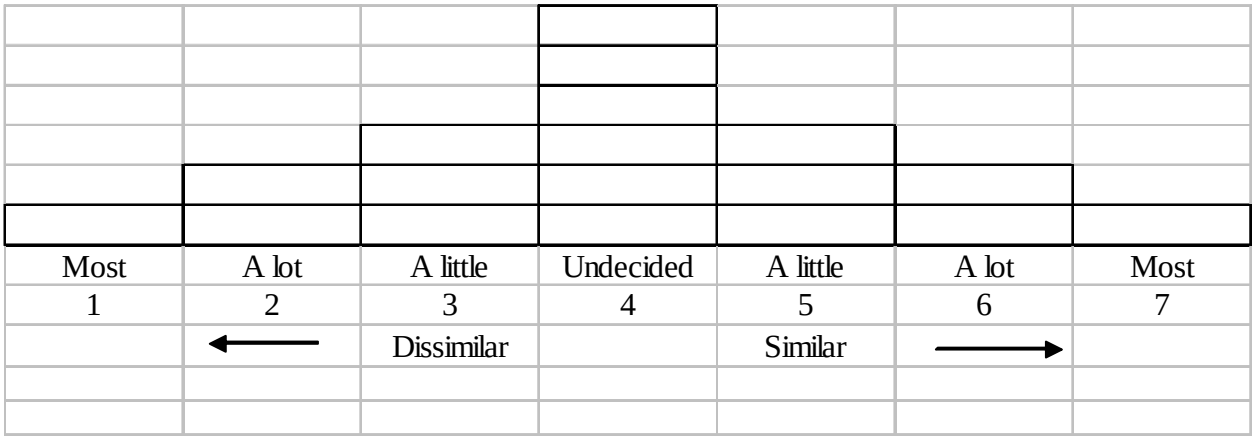



*Figure 1. An example of a Q-sorting concourse utilizing eighteen adjectives.*

Although the computer program contains default conditions of instruction, the researcher modified these for the purpose of this research. For the current research, the conditions of instruction are as follows: self, preferred-self, and eating disorder. Correlations will be utilized to indicate the degree of relationship between adjectives chosen for various conditions of instruction. This will allow the researcher to determine the amount of relationship between conditions within each participant. The above described randomized concourse of adjectives will be used to describe each of these conditions of instruction. For statistical purposes, the correlations between self/preferred self, self/eating disorder, and preferred self/eating disorder will be investigated. Therefore, there will be a correlation coefficient generated for each of the parings, self/preferred self, etc. after each story telling phase and pre/post for a total of 4 correlations for each pairing. These correlations will be placed in a statistical program and compared to determine levels of change within each of the correlations generated.

*Design*

The present study represents the relationships that exist between eating disorders and the perceptions of an individual and their world. To accomplish the identification of

perceptions, the experimental group will participate in a story-telling process in which they will imagine that they are their eating disorder and to write how the eating disorder sees them. Based on previous research, participants who write their future story have more health benefits and a more hopeful outlook than those who wrote a story on a novel topic (King, 2001). The intent of this research is that through the addition of externalizing language, individuals can begin to see themselves as different from their "problem" and are more able to work through the "problem." Further, this process is strengthened through the individual choosing what the "problem" means to them. This ownership of meaning seems to further the process of externalization, rather than remaining with a clinical diagnosis (Freedman & Combs, 1996). The present study will include several related hypotheses: (1) There will be a significant difference on pre/post measurement scores for participants who engage in the externalizing story process as compared with the control group; (2) There will be a difference in process measure (I-SPI) during the experimental condition; and (3) There will be a difference in scores depending on length of time struggling with an eating disorder as determined by demographic coding. In addressing these questions, this research will be divided into two phases. The initial phase will include a control and experimental group and will answer the first and third hypotheses. The second phase will include individuals who wish to continue the procedures for a total of four stories will provide additional information on the salience of the story-writing and will answer the second and third hypotheses.

The first hypothesis states that there will be a significant difference on test scores for participants who engage in the externalizing story process. This will be measures using each of the three instruments; (Adult Nowicki-Strickland Locus of Control Scale

(ANSIE), Eating Disorder Inventory 2 (EDI 2), and the Ideographic Self-Perception inventory (I-SPI)) using a 2 group Multivariate Analysis of Variance (MANOVA). This analysis will provide scores that can be analyzed and discussed as they related to the groups.

The second hypothesis states that there will be a significant difference within the externalizing group during the experimental condition. This question will be answered using the same measurements (ANSIE, EDI-2, and I-SPI). A MANOVA will indicate the levels of difference between the pre/post externalization stories. Further, the I-SPI will be utilized as a process measurement with data points following each of the externalization stories. Through this analysis, not only will there be a graphical representation of the level of change occurring throughout the data collection within the control and the experimental groups, but a statistical representation accounting for each of the five data collection points. The current hypothesis is that there will be greater change in positive mood and feelings of a future story following use of externalization. Comparison both through pre/post scores and process scores at each of the stories will help to identify change in eating disordered perceptions.

Hypothesis three states that there will be a difference between those individuals depending on length of time with an eating disorder. The testing of this hypothesis will be extraneous variable control and an experimental variable. It is hypothesized that those individuals who have struggled for less time with an eating disorder may experience greater change through the writing process than those who have struggled more long term. A 2 (groups) X 3 (<12 months, 12-24 months, >24 months) MANOVA will be

conducted on each of the groups to determine differences that occur based on internal motivation of the participants and length of relationship with an eating disorder.

*Self-perception measure*

Although the I-SPI will be used to address each of the above hypotheses in terms of outcome, it will also be used as a process measurement, requiring unique consideration. As a process instrument, the I-SPI will be administered throughout the testing process to indicate any levels of change in the participant during each of the story writing phases. As such, the process component will indicate trends and provide more continuous data and the pre-post will indicate any overall changes. The I-SPI will be used as a correlation coefficient. As shown in figure 1, correlations will be based on the location of adjectives selected. From the figure, the adjective chosen as most like self carries a number of 7, the adjective least like self, a number of 1, two most like self, 6, least like self 2, three most like self 5, least like self 3, and the remaining six undecided for self a number 4. These number locations are compared across conditions of instruction (self, preferred self, and eating disorder), resulting in the Pearson product moment correlations used in the current research. Since correlation coefficients are not able to statistically stand independently, it is necessary to transform these coefficients to standard scores (Martin & Bateson, 1993). Fisher's exact z formula (Martin & Bateson, 1993) will be used to achieve this purpose. For this experiment, the dependent variable will measure the relationship or degree of similarity between multiple conditions of instruction. As previously discussed, conditions of instruction are an element of the Q-sorting procedure that serve as "things" that are able to be described from the selection of adjectives presented with them. As such, each condition of instruction (self, preferred

self, and eating disorder) will be shown individually and participants asked to describe that condition from the list of 18 adjectives given. Each condition of instruction is described independently of the others and the resulting ranking of adjectives is then correlated using Pearson product moment analysis with each of the other conditions of instruction (Figure 2).

Because of the nature of the I-SPI, the correlations will be formed between the following conditions of instruction: self/preferred self, self/eating disorder, and preferred self/eating disorder. Participants will complete the I-SPI at each meeting of both groups resulting in a total of 5 correlations for each of the above pairings. These correlations will be converted into the Fisher z scores and for the outcome measure, entered into a (MANOVA). In terms of process, the I-SPI data will be entered into a 2 (group) by3 (self/preferred self, self/eating disorder, and preferred self/eating disorder) Univariate Analysis of Variance (ANOVA), which will be a subset of the above MANOVA.

*Procedures*

*Phase I*

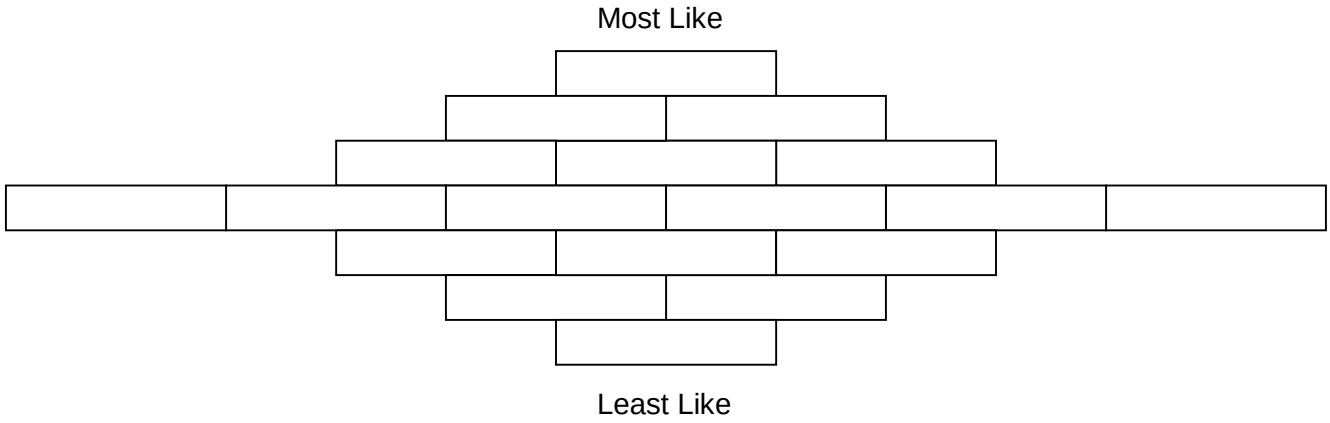
There will be two randomly assigned groups for the current research. These groups will be identified as either the control or the externalization (experimental) group. It is expected that many of the participants will be in treatment settings that include group formats. Therefore, all individuals will be asked not to discuss the research experience in their group settings and therapists will be asked to encourage compliance.

*Control Group*

All data collection will occur at the counseling practices in which they are seen. Participants will be directed to a table station that includes writing space. Participants in

the control group will be checked in and seated at a table and will be given a packet including a confidentiality statement, demographic information (see appendix C), and the following measurement instruments, counterbalanced for order effect: the Adult Nowicki-Strickland Locus of Control Scale (ANSIE), the Eating Disorder Inventory 2 (EDI-2), and the Ideographic Self-Perception Inventory (I-SPI). Participants will be instructed to remove the contents of the packet and to lay them on the table in front of them in the order that they were in the packet. Participants will be instructed to read through the confidentiality statement and will be allowed to ask any questions they may have and complete each of the three pencil and paper instruments. Because of the location for the data collection, the computer I-SPI program will be replicated in a paper format, with information coded and saved for later researcher entry into the I-SPI program. Participants will be given written instructions for the I-SPI procedure and given a sheet of paper with the q-sort format (see figure 2) and the list of 18 adjectives

*Figure 2.*




*Example of actual computer q-sort.*

If participants have no questions, they will be allowed to progress through the application of the I-SPI. The participant will be asked to select the adjective from the pile of 18 that is “most like self”, then the adjective from the remaining 17 that is “least like self”, the two from the remaining 16 that are “most like self”, two from the remaining 14 “least like self”, etc. until all adjectives are placed on the distribution. Once the distribution is completed for the first condition of instruction, the researcher will record adjective placement and the participant will follow the above process for all conditions of instruction. The researcher will later enter the adjective placement into the computer program for later data retrieval. Once participants complete the instruments, the senior researcher will allow each participant to ask any questions or express any concerns they may have. Each of the groups will be allowed to take a 5 minute break and return for the writing phase.

Following the break, participants will return to the testing room and back to their tables. Each participant in the control group will be given instructions to write for 20 minutes on a neutral topic. This topic will be their schedule for the upcoming weekend. If they are not able to write for the full 20 minutes, they will be asked to write about the clothes they are wearing. After 20 minutes of writing, participants will complete the following measurement instruments: the Adult Nowicki-Strickland Locus of Control Scale (ANSIE), the Eating Disorder Inventory 2 (EDI 2), and the Ideographic Self-Perception Inventory (I-SPI). At this point, participants will be allowed to ask about the project. The story-writing phase should take approximately 60-70 minutes.

*Narrative Re-Composing Externalization Group*

Participants in the externalizing experimental group will be handed the packet including confidentiality statement, demographic information and the instruments, (EDI-2, ANSIE, and I-SPI) as described in the above control group. Following completion of the packet, participants will be given instructions on the writing assignment. They will be asked to imagine that they are their eating disorder and to write how that eating disorder sees them. For example, X would pretend to be "anorexia" and write a story from anorexia's perspective about how "anorexia" would describe X, how long they have known each other, "anorexia's" perceptions about X. Participants will be allowed to ask any questions about the writing instructions. Participants will then write for a full 20 minutes from their eating disorder's perspective. After writing, participants will complete all measurement instruments (ANSIE, EDI-2, and I-SPI) and will be allowed to ask about the project. This phase should take approximately 60-70 minutes.

*Phase II*

Phase II will be designed as a small group or single subject, continuation study to help further identify any relationship between externalization and eating disorder. All members of this phase will have participated in phase I and will simply be continuing the story-telling phase as follows.

Participants in the externalizing experimental group who wish to participate in this phase will be scheduled a time following completion of phase I. Participants will return on the scheduled day and follow the above externalizing procedure from phase I for a total of three times, including story writing in phase I. On the final (fourth) day of testing, participants will return and be asked to write an externalization story per previous

procedures. After 20 minutes of writing, the participants will be allowed to break for 5 minutes before returning to the room. Following break, participants will complete the ANSIE, EDI-2, and I-SPI, counterbalanced for order effects and will be allowed to ask questions about the project. Once debriefed, the participants will be thanked for their participation and allowed to leave the clinic. All writings will be from the externalized perspective. Writing 2 and 3 will be followed by the I-SPI only; writing 4 will be followed by completion of all measurement instruments. It is expected that each writing phase will take approximately 30-45 minutes.

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Appendix B: IRB Approval Letters, Consent Forms, and Request for Participation

The University of Oklahoma

OFFICE OF HUMAN RESEARCH

PARTICIPANT PROTECTION September 29, 2003

Ms. Chelle' Lodge-Guttery
Educational Psychology/Counseling Psychology
ECH321
CAMPUS MAIL

Dear Ms. Lodge-Guttery:

The Institutional Review Board-Norman Campus, has reviewed your proposal, "The Value of Externalizing Stories in Creating Space and Change in Individuals Struggling with Eating Disorders" at the convened meeting on September 17, 2003. The Board found that this research would not constitute a risk to participants beyond those of normal, everyday life except in the area of privacy which is adequately protected by the confidentiality procedures. Therefore, the Board has approved the use of human subjects in this research.

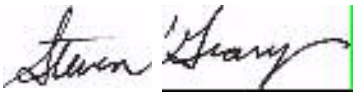
This approval is for a period of 12 months from September 17, 2003, provided that the research procedures are not changed from those described in your approved protocol and attachments. Should you wish to deviate from the described subject procedures, you must notify this office, in writing, noting any changes or revisions in the protocol and/or informed consent document and obtain prior approval from the Board for the changes. A copy of the approved informed consent document(s) is attached for your use.

At the end of the research, you must submit a short report describing your use of human subjects in the research and the results obtained. Should the research extend beyond 12 months, a progress report must be submitted with the request for continuation, and a final report must be submitted at the end of the research.

If data are still being collected after five years, resubmission of the protocol is required. Should you have any

questions, please contact me at 325-8110 or irb@ou.edu.

Sincerely yours



Steven O'Geary, Ph.D.
Director, Human Research Participant Protection
Administrative Officer
Institutional Review Board - Norman Campus (FWA #00003191)

ISO
FY2004-9

cc: Dr. E. Laurette Taylor, Chair, Institutional Review Board
Dr. Rockey Robbins, Educational Psychology/Counseling Psychology

**Informed Consent Form**

For Research Being Conducted Under the Auspices of the University of Oklahoma – Norman Campus
Department of Educational Psychology

**Introduction**

Hello, my name is Chelle' Lodge-Guttery, MS and I am conducting research at the University of Oklahoma. As a graduate student, I am supported and sponsored by Dr. Rockey Robbins who is on faculty at the University of Oklahoma, Counseling Psychology department. This research is titled "The Impact of Narrative Storytelling on Cognitive Re-Composition in Individuals Struggling with Eating Disorders" This form tells you about your rights as a research participant and allows you to formally consent to participation.

**Description of the Study**

The purpose of this study is to determine the usefulness of telling your life story. You will be placed in one of two different groups. I will be asking you to complete four brief tests and write a story. All of these tests are in a pencil and paper form and the last is a computerized modification intended to provide insights into the ways you think and perceive statements that has been modified to a paper format. I will be asking you to identify how much these statements are like or dislike you at this moment. The pencil and paper tests will be taken at the first and last day of testing and the paper form of the computer test will be completed after each of the testing days. I will ask for information about you, but your name or other identifying information will not be asked. I will ask your age, gender, education level, length of time with an eating disorder, time in therapy, and marital status. On the first day of testing, the instruments will take about 30-35 minutes to complete and the story about 20 minutes for a total of 60-70 minutes. The researcher will then ask for volunteers to continue on to the next phase of the research. Should you volunteer, the next two days you will complete the computerized test and write a story that will take about 30 minutes total. The final day you will write a story and complete all measurements will take approximately 40-50 minutes. There will be a total of 4 days of testing and you will be encouraged to complete all days once started, however, you may discontinue participation at any time without penalty.

**Potential Risks and Benefits of Participation**

A. Risks

Although you have been determined to struggle with an eating disorder, I will not be asking you any information about your eating disorder. Should you have any negative experiences, you will be provided with helpful referrals. I will not be sharing any information that you provide with anyone other than the faculty sponsor. Your name or other identifying information will not be on any materials. All materials will be kept in a locked cabinet. If you feel uncomfortable sharing any information, you may skip the question. You may also discontinue participation at any time without penalty.

You will be asked to write several stories about your life, both from your perspective and the perspective of your eating disorder. These stories may be personal and sensitive to you and you may experience strong emotions as a result of this process. These emotions may be positive or negative. During the externalizing story phase, you may begin to discover things about your eating disorder that you did not realize and it is important that you share this information with someone you trust. You are encouraged to discuss any feelings, thoughts, or experiences as a result of your participation with your therapist/counselor. You will be requested, however, not to discuss impressions of the experiment during group counseling session. This is because it is possible that members of your group are participating in different experimental groups. However, remember that you are encouraged to discuss any issues with your primary therapist and are allowed to withdraw from participation at any time, without penalty.

B. Benefits

The project you are about to participate in may be a direct benefit to you in how you perceive your future. It will provide you with information about how you see the world. While there may be no other direct rewards for participation, the information you share with me may indirectly help you (and others) by providing more useable information for therapists to use with individuals in therapy. The stories you create could help broaden the use of measurement tools in therapy that can provide valuable insights to both clients and therapists and provide more successful experiences for clients. In addition, small gift bags will be given to all participants at the beginning of the study in appreciation for your participation, and will be yours regardless of whether you complete the study.

**Subjects Assurances**

A. Conditions of Participation

Your participation in this research is voluntary. If you refuse to participate, you will not experience any penalty or loss of benefits to you, which you are otherwise entitled.

B. Confidentiality

The information you provide is confidential. What this means is that we will not tell anyone what you share with us. There is no information on the tests you will complete that will indicate who you are in any way and no one will have access to your information other than myself and the faculty researcher. None of the reports will ever contain information about who you are. All information will be kept securely locked and accessible by the senior researcher, Chelle' Lodge-Guttery, and the faculty sponsor, Rockey Robbins, Ph.D.

C. Contacts for Questions About Research Subject's Rights

If you have questions about the research project, please contact either Chelle' Lodge-Guttery at (405) 325-2914 or Dr. Rockey Robbins at (405) 325-8442. If you have questions about your rights as a research participant, please contact the University of Oklahoma Norman Campus Institutional Review Board at (405) 325-8110. In addition, counseling information will be provided, should you become uncomfortable when participating in this study.

_____ _____
Participant Signature Date

_____ _____
Researcher/Witness Sign. Date

Request for Participation
For Research Being Conducted Under the Auspices of the University of
Oklahoma – Norman Campus
Department of Educational Psychology

Hello, my name is Chelle' Lodge-Guttery, MS and I am conducting research at the University of Oklahoma. As a graduate student, I am supported and sponsored by Dr. Rockey Robbins who is on faculty at the University of Oklahoma, Counseling Psychology department. This research is titled "The Impact of Narrative Storytelling on Cognitive Re-Composition in Individuals Struggling with Eating Disorders" This form tells you about your rights as a research participant and allows you to formally consent to participation.

The purpose of this study is to determine the usefulness of telling their life story. They will be placed in one of two different groups. I will be asking them to complete three brief tests and write a story. Two of these tests are in a pencil and paper form and the last is a manual presentation of a computerized program intended to provide insights into the ways you think and perceive statements. I will be asking them to identify how much these statements are like or dislike them at this moment. I will ask for information about the client, but their name or other identifying information will not be asked. I will ask their age, gender, race, education level, length of time with an eating disorder, time in therapy, and marital status. On the first day of testing, the instruments will take about 20-30 minutes to complete and the storytelling phase 20 minutes for a total of 40-50 minutes. This will be the primary focus of the research. I will then ask for anyone who would like to continue the research by committing three additional testing days. These days will allow the researcher to gain additional information about the power of the story writing process. Those clients who wish to continue will be scheduled for another day and will complete the modified computerized test and write a story that will take about 30 minutes. They will be scheduled for another day one week following and complete the same story and modified computerized test. The final day they will write a story and complete all measurements that will take approximately 40-50 minutes. This phase will be a total of 3 days of testing and the clients will be encouraged to complete all days once started, however, they will be able to discontinue participation at any time. Additionally, those in concurrent counseling will be encouraged to discuss their feelings and reactions with their therapist.

Would you pass this information to those clients who struggle with an eating disorder? Participation would involve a commitment of approximately 60 minutes for the primary phase and 45 minutes on each of 4 days, for any who might like to continue. I believe that this is valuable research that can add to treatments currently used for those who struggle with an eating disorder, as well as with other issues. Research has indicated that the ability to separate the person from the problem has definite positive changes in instillation of hope and therapy outcome. All individuals will be anonymous and information kept confidential.

Your support and the support of those you refer will be greatly appreciated. It is my dedication that they will be treated with great care and steps taken to ensure their positive experience through this project.

If you could provide interested individuals with my contact information, they will be able to contact me to set up appointment times. If preferred and available, I, or my graduate research assistant, can meet clients at your practice following a group or individual meeting.

Thank you in advance for your support

Chelle' Lodge-Guttery, MS
405-314-7100
greenpsi@aol.com

# Appendix C: Supplemental Tables

Table C-1

**Demographic Information**

Identification Number (From the front of the packet) _____

Age _____

Circle one: Living alone With Romantic Partner

With Roommate With Parents

Circle highest level of education

Some High School High School Some College

2-year degree 4-year degree Graduate School

How long have you struggled with an eating disorder?_____

How long have you been receiving counseling for an eating disorder? _____

What kind of counseling was it (individual, group, family, etc.)_____

Have you ever been hospitalized for an eating disorder?

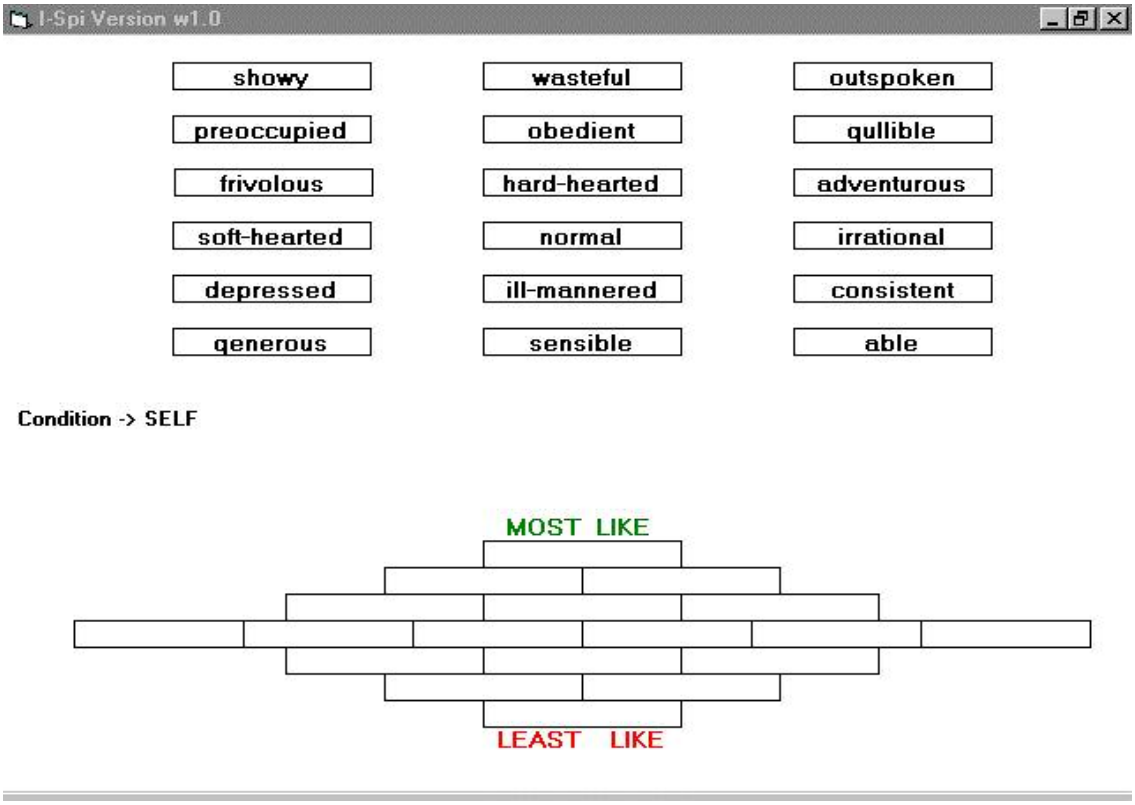
If so, how long?_____ How many times?_____

Have you received any other counseling?_____

If so, how long?_____

Table C-2

Example of I-SPI Program




Condition will change once adjectives are sorted and a new condition will be randomly chosen from the remaining conditions.